

The New York City
**Early Intervention
Program**

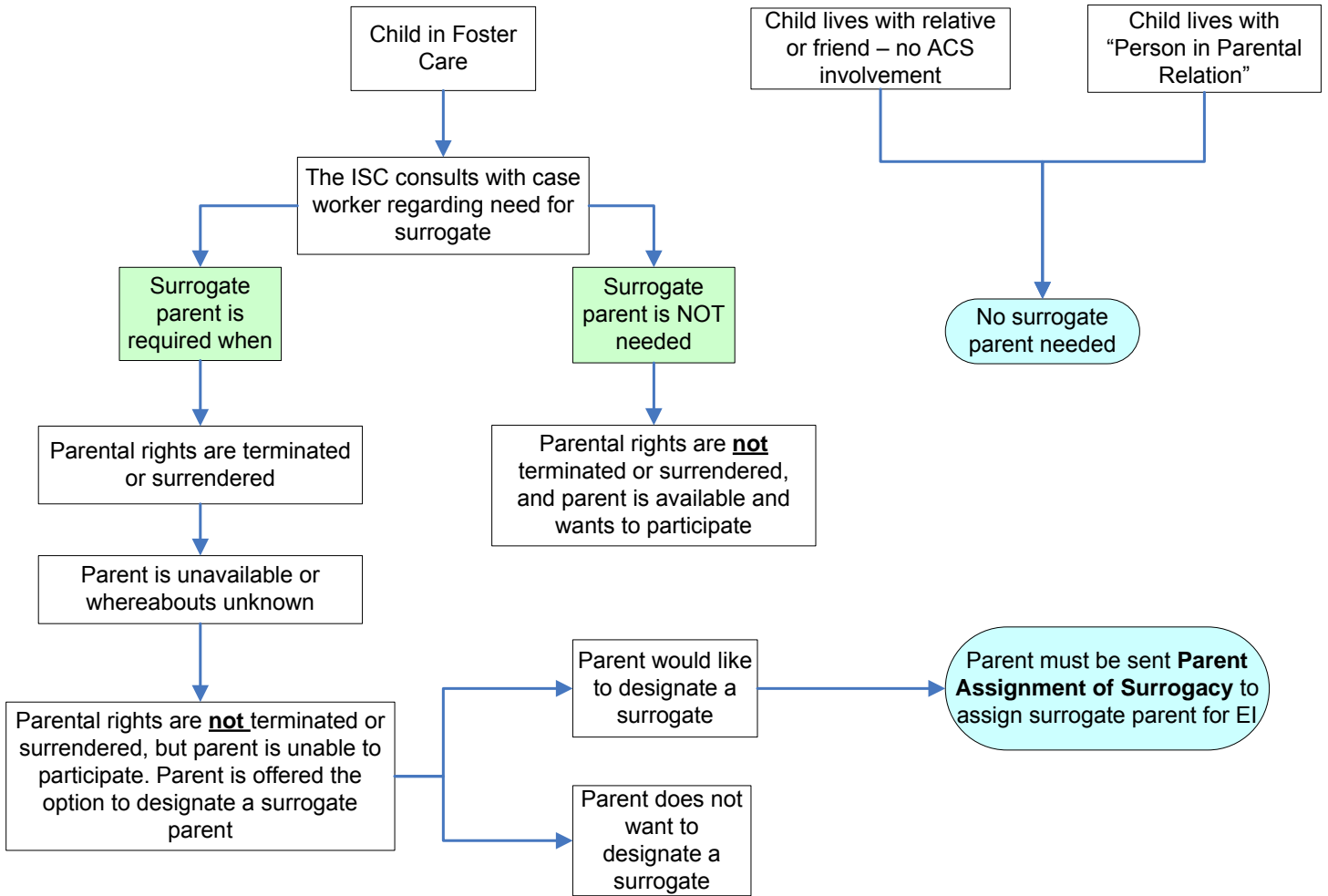
For Babies and Toddlers With
Developmental Delays or Disabilities

The Earlier The Better

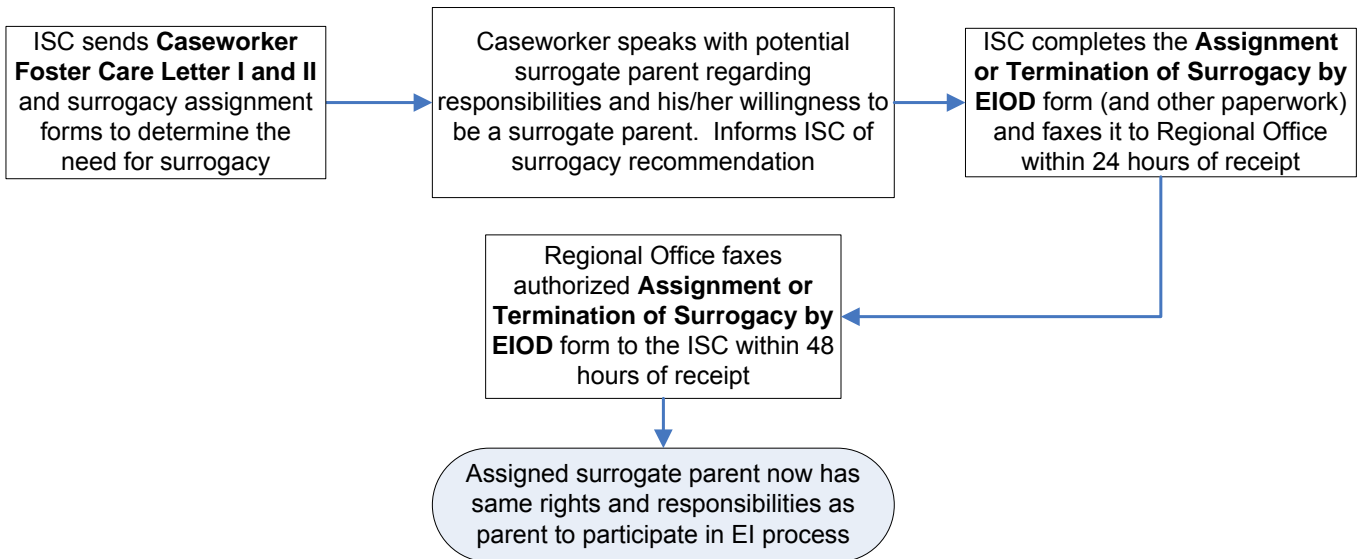


Chapter 2: Foster Care and Surrogacy

**NYC 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



New York City Early Intervention Program

Policy Title: Determining The Need For Assigning A Surrogate Parent	Effective Date: July 1, 2010
Policy Number/Attachment: 2-A	Supersedes: N/A
Attachments: Applicable Forms: <ul style="list-style-type: none"> • Fax Confirmation of Initial Service Coordinator and Important Dates • Referral Form Surrogacy Forms: <ul style="list-style-type: none"> • Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care Form • Foster Care Letter Part I • Foster Care Letter Part II • Surrogate Parent Designation by Parent Form. 	Regulation/Citation: NYS Regs. 69-4.15 Children in Care (a) – (k)

I. POLICY DESCRIPTION:

The New York City Early Intervention Program (EIP) is committed to ensuring that children in foster care receive a timely Multidisciplinary Evaluation (MDE) to establish eligibility. Once eligibility has been established, an Individualized Family Service Plan (IFSP) meeting will be held within **forty-five (45) days** of referral to the EIP.

When the parent(s)' availability to participate in the Early Intervention (EI) process is limited due to life circumstances, including the child's placement in foster care, the Initial Service Coordinator (ISC) must:

- Facilitate the parent's involvement in the EI process;
- Determine whether the parent will be involved or whether a surrogate parent is needed; and
- Inform the EIP of the need for a surrogate.

Note: This policy also applies to instances when a child, already in the EIP, should need a surrogate parent for the first time.

II. PROCEDURE:

Responsible Party	Action
Initial Service Coordinator	<ol style="list-style-type: none"> 1. Reviews the Referral Form to determine if a child resides with a biological parent. <ul style="list-style-type: none"> • Referral Form – <i>Section 1 – Relation to Child</i>; • Referral Form - <i>Section 1 –Referral Source Type</i>; • Referral Form – <i>Section 2 – Child Known to ACS</i>; 2. Contacts the Referral Source, ACS and/or the foster care agency to determine the availability of the parent.

- a. If the child is **not in foster care and there is a "person in parental relation,"**:
- i. **10NYCRR69-4.1 (1) (ah) defines *parental relation* as:**
 - the child's legal guardian;
 - the child's standby guardian appointed by the Surrogate Court;
 - 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 such child or are living outside the state or their whereabouts are unknown; or
 - Persons acting in the place of a parent, such as a grandparent or stepparent with whom the child lives (person in parental relation), as well as persons who are legally responsible for the child's welfare
 - ii. **A person in parental relation** may sign all consents, including the **Consent for Evaluation**.
 - iii. A surrogate parent does not need to be assigned.

Note: When a child is a ward of the State, and lives with a foster parent, the child may need a surrogate parent.

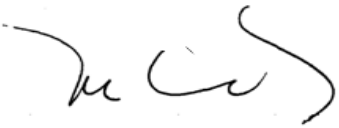
- b. For children **in foster care**, the steps described below should be followed in a timely manner.
- i. All steps must be thoroughly documented on the **Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care Form**.

Steps to Determine Need for Surrogate

1. Sends to child's Foster Care Caseworker (FCC) the **Foster Care Letter Parts I and II** within **two (2) days** of receipt of the **Fax Confirmation of Initial Service Coordinator and Important Dates**, and **Referral Forms** for a child in foster care from the Regional Office.
 - a. If the FCC was the primary referral source, the **Foster Care Letter Part I** will:
 - i. Serve as confirmation of the referral to EIP; and
 - ii. Provide the name and phone number of the Initial Service Coordinator (ISC).
 - b. If someone other than the caseworker made the referral (eg: foster parent, child's doctor), the **Foster Care Letter Part I** will serve as:
 - i. Notification to the FCC that a referral to EI has been made; and
 - ii. Provide the name and phone number of the ISC.
2. Calls the FCC **no later than three (3) business days** after the letter is sent to confirm receipt and discuss whether a surrogate parent needs to be appointed.
 - a. If the FCC has not yet received the **Foster Care Letters**, a copy

	<p style="text-align: center;">must be faxed to him/her.</p> <p>Note:</p> <ul style="list-style-type: none"> • If the ISC cannot reach the FCC, s/he should speak with a supervisor. If the supervisor cannot be reached, the ISC can contact the RO for assistance. <ul style="list-style-type: none"> b. Ask the FCC if parental rights have been terminated or voluntarily surrendered. <ul style="list-style-type: none"> i. If parental rights have been terminated or voluntarily surrendered: <ul style="list-style-type: none"> • The parent must not be contacted and a surrogate parent must be assigned; • Refer to Policy on <i>Assignment a Surrogate Parent</i>. ii. If parental rights have not been terminated or voluntarily surrendered: <ul style="list-style-type: none"> • ISC must request that the FCC contact the parent(s) within three (3) business days.
<p>Foster Care Caseworker</p>	<ol style="list-style-type: none"> 1. Contacts the parent within three (3) business days of speaking with the ISC in order to: <ol style="list-style-type: none"> a. Notify him/her of the referral to EI; b. Determine whether s/he will participate in the EI process: <ol style="list-style-type: none"> i. If the parent wants to participate in EI, the FCC will: <ul style="list-style-type: none"> • Inform the ISC and provide the parent’s contact information; • Give the parent the ISC’s contact information; • Let the parent know that the ISC will be contacting him/her to discuss the parent’s participation in the IFSP process or the designation of a surrogate parent. ii. If the parent is unable to participate in EI and wants to designate a surrogate, the FCC will inform the parent that: <ul style="list-style-type: none"> • The ISC will contact him/her; or • S/he can call the ISC; or • S/he can give the name of the surrogate to the FCC who will then convey the information to the ISC. iii. If the parent is unable to participate in EI, and does not want to designate a surrogate, the FCC will: <ul style="list-style-type: none"> • Contact ISC to discuss who should be designated as a surrogate. iv. If the parent objects to the child’s participation in EIP, the FCC will inform the parent that: <ul style="list-style-type: none"> • The ISC will contact him/her to discuss EI with them. 2. Complete Foster Care Letter Part II and send it to the ISC.
<p>Initial Service Coordinator</p>	<p><u>If the parental rights have not been terminated:</u></p> <ol style="list-style-type: none"> 1. Receives completed Foster Care Letter Part II from the FCC. 2. Contacts the parent within three (3) business days of being notified by the

	<p>FCC to discuss the parent's choice to participate in EIP, to assign a Surrogate Parent or to close the child's case:</p> <ol style="list-style-type: none"> a. If the parent would like to participate in EIP: <ol style="list-style-type: none"> i. Discusses the parent's role in the EI process. b. If the parent is unable to participate but would like to designate a <u>specific person</u> to be the surrogate parent: <ol style="list-style-type: none"> i. Completes the Surrogate Parent Designation by Parent Form with the name provided by the parent (or by the caseworker on behalf of the parent); and ii. Sends the form to the caseworker to complete with the parent; or iii. Sends the Surrogate Parent Designation by Parent Form to the parent for completion along with a self-addressed, stamped envelope and instructions to complete and return the form to the ISC as soon as possible. c. If the parent notifies the caseworker that s/he objects to the child's participation in EI: <ol style="list-style-type: none"> i. Discusses the EIP with the parent. If the parent continues to object to the child's participation in EIP: <ul style="list-style-type: none"> • Notifies the FCC that the parent continues to object or if the ISC was unable to reach the parent; • Closes the Case (see Closure Policy).
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Approved By:
Assistant Commissioner, Early Intervention

Date: 4/28/2010

New York City Early Intervention Program

Policy Title: Assignment of Surrogate Parents	Effective Date: July 1, 2010
Policy Number/Attachment: 2-B	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> • Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care • Surrogate Parent Designation by Parent Form • Foster Care Letter Part I • Foster Care Letter Part II • Assignment or Termination of Surrogate Parent Assignment by EIOD • Child Information Change Form 	Regulation/Citation: NYS Regs. 69-4.16 (c) -(f), (i), (j), (k)

I. POLICY DESCRIPTION:

Once the need for a surrogate has been established by the Initial Service Coordinator (ISC) or Ongoing Service Coordinator (OSC) and Foster Care Caseworker (FCC), the surrogate parent must be named and appointed by the Early Intervention Regional Office. An evaluation agency may not conduct the Multidisciplinary Evaluation (MDE) if a child's parental status is unknown.

The surrogate parent may not be an employee of any agency involved in the provision of EI or other services to the child, including staff from the New York City Administration for Children's Services (ACS) or the foster care agency serving the child. A foster parent is not considered to be a "person in parental relation" and technically is not an employee of a foster care agency. Therefore, a foster parent may be selected as the surrogate parent after consultation with the FCC or another representative from the foster care agency.

Other choices for surrogate parent are:

- a person voluntarily designated by the parent;
- a relative who has an ongoing relationship with the child;
- a friend of the parent who has an ongoing relationship with the child; and
- if no suitable individual is identified, a qualified volunteer.

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

- screening, evaluation, and assessment of the child;
- development and implementation of the IFSP, including **six (6) month** and annual

- reviews;
- the ongoing provision of EI services;
- the right to request mediation or an impartial hearing in the event of a dispute; and
- any other rights accorded to families in the EIP.

II. PROCEDURE:

Responsible Party	Action
Initial/Ongoing Service Coordinator	<p><u>If the parent rights have been terminated, voluntarily surrendered, or the parent cannot be contacted (See Determining Need for a Surrogate Parent):</u></p> <ol style="list-style-type: none"> Faxes the following documents within two (2) business days of receiving Foster Care Letter Part II from the FCC, to the Assistant Director/EIOD: <ul style="list-style-type: none"> Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care; Foster Care Letter Part I; Foster Care Letter Part II; Child Information Change Form (when needed); and Assignment or Termination of Surrogacy by EIOD. <p><u>If the parental rights have not been terminated:</u></p> <ol style="list-style-type: none"> Faxes the following documents within two (2) business days of contacting the parent, and receiving Foster Care Letter Part II from the FCC, to the Assistant Director/EIOD: <ul style="list-style-type: none"> Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care; Foster Care Letter Part I; Foster Care Letter Part II; Assignment or Termination of Surrogate by EIOD; Child Information Change Form (when needed); and Surrogate Parent Designation by Parent Form (if the parent decided to designate a surrogate).
Regional Office Assistant Director/EIOD	<ol style="list-style-type: none"> Reviews the submitted information and indicates his/her approval of the surrogate assignment by signing the Assignment/Termination of Surrogacy by EIOD. Faxes it to the ISC <u>within two (2) business days</u> of receipt.
Initial Service Coordinator/Ongoing Service Coordinator	<ol style="list-style-type: none"> Receives approved Assignment/Termination of Surrogacy by EIOD. Meets with surrogate parent to obtain consents.

	<p>3. Faxes approved Assignment/Termination of Surrogacy by EIOD Form to the Evaluation Agency with ISC paperwork:</p> <p>a. Refer to the Initial Service Coordinator Responsibilities Policy.</p>
Evaluation Site	<p>1. Receives the approved Assignment/Termination of Surrogacy by EIOD form with the ISC packet of forms from the ISC.</p> <p>a. The surrogate parent is now authorized to sign the Consent for Evaluation and other consents that parents would sign.</p> <p>b. The evaluation process can proceed.</p>
Initial Service Coordinator	<p>1. At the conclusion of the IFSP meeting:</p> <p>a. Ensures that the OSC and all service providers receive a copy of the approved Assignment/ Termination of Surrogacy by EIOD form with the IFSP.</p>
Initial Service Coordinator/Ongoing Service Coordinator	<p>If a change in surrogate parent is necessary:</p> <p>1. The Service Coordinator does not need to reissue the Foster Care Letters Part I and Foster Care Letters Part II.</p> <p>2. The SC must:</p> <ul style="list-style-type: none"> • Complete a new Assignment/Termination of Surrogacy by EIOD and Child Information Change Form; • Obtain the EIOD's written authorization, and send the approved forms to all service providers; and • Send the Assignment/Termination of Surrogacy by EIOD Form to the newly assigned surrogate parent, Foster Care Caseworker, and the evaluation agency and/or service provider(s) (as needed). <p>Note:</p> <ul style="list-style-type: none"> - If, at any time, the birth parent wants to assume responsibility, the SC should complete a new Assignment/Termination of Surrogacy by EIOD and Child Information Change Form, obtain the EIOD's written authorization, and send the approved forms to all service providers. - If, while the child is receiving EI Services, there is a need to newly assign a surrogate parent: <ul style="list-style-type: none"> • Refer to the Determining the Need for Assigning a Surrogate Parent Policy for the appropriate steps to follow.



Approved By:
Assistant Commissioner, Early Intervention

Date: 4/28/2010

New York City Early Intervention Program

Policy Title: Foster Care Information in Child Records	Effective Date: July 1, 2010
Policy Number/Attachment: 2-C	Supersedes: N/A
Department/Unit: Bureau of Early Intervention	Regulation/Citation: Early Intervention Program & Administration for Children’s Services Agreement; State Department of Health Guidance 2000

I. POLICY DESCRIPTION:

At the inception of the New York City Early Intervention Program (EIP) in 1993, EIP and the Administration for Children’s Services (ACS) agreed upon a policy regarding children’s addresses. Early Intervention (EI) records would contain the names, addresses, and telephone numbers of foster care agencies but not the addresses or phone numbers of foster parents. This procedure prevented parents, who have the right to review their child’s records, from obtaining information that might otherwise be unavailable to them. Subsequently, State Department of Health (SDOH) provided guidance in a letter dated January 27, 2000, **that it is permissible to maintain foster home contact information in EI files, if it is removed prior to releasing foster children’s EI records to parents.**

II. PROCEDURE:

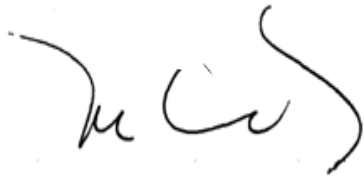
Responsible Party	Action
Service Coordinators/ Regional Office Staff	<p><u>Foster Care Information Maintenance</u></p> <ol style="list-style-type: none"> 1. Foster home contact information is maintained in EI files, <ol style="list-style-type: none"> a. Names, addresses and other identifying information of foster parents can be used on all EI forms and paperwork. This includes: <ol style="list-style-type: none"> i. Referral form; ii. All consent forms; iii. Initial, Review and Annual Individualized Family Service Plan (IFSP); and iv. The Family Information Form in the “Child Lives With” section. 2. Foster care agency information will be documented where appropriate on all EI forms. Foster care agency information includes but is not limited to: <ol style="list-style-type: none"> a. Agency name, address, telephone and fax numbers; and b. Caseworker name and telephone number.

Request for Records for Children in Foster Care

1. A record of a child in foster care is requested by a parent:
 - a. Identifying information of a foster care placement (name, phone number, and address) **must** be removed by the sending party (through the use of a black marker or white redaction tape, and subsequent photocopying) prior to release of any records to the parent.
 - i. Identifying information must be completely obscured and not readable.

Note:

- Upon request, the service coordinator (SC) should share all records with the Foster Care Caseworker (FCC), including, but not limited to: Evaluations; IFSPs; and Progress reports.
- The SC should also invite the ACS/FCC to IFSP meetings and scheduled conferences.



Approved By:
Assistant Commissioner, Early Intervention

Date: 5/28/2010

SURROGACY FORMS

**STEPS TAKEN TO DETERMINE NEED FOR SURROGATE PARENT
FOR CHILDREN IN FOSTER CARE**

Child's Name: _____ EI # _____
(Last) (First)

The service coordinator (SC) must complete this form, keep a copy in the child's case file and send a copy to the Regional Director/EIOD

1. a. Upon receipt of the referral of a child in foster care, the SC must send the **Foster Care Letter Parts I and II** to the child's Foster Care Caseworker (FCC).

b. If the child is already in Early Intervention and has been removed from the home, the SC must send the **Foster Care Letter Parts I and II** to the child's FCC.

Date **Foster Care Letter Parts I and II** sent: ____/____/____

Comments:

2. The SC must call the FCC to discuss whether a surrogate parent needs to be appointed and, if so, who it should be.

Date of phone call to FCC: ____/____/____

Result of discussion:

3. The SC must send to the Regional Director/EIOD the **Foster Care Cover Letter Part II; Surrogate Parent Designation By Parent** form (if done); completed **Surrogate Parent Assignment by EIOD** form; **Child Information Change Form** (if needed); and a copy of this form completed through Section 3.

Date forms sent: ____/____/____

Comments:

4. The Regional Director/EIOD will review the information submitted and indicate his/her approval of the surrogate by signing the form and returning it to the SC.

Date approved: ____/____/____

Date **Assignment/Termination of Surrogacy by EIOD** form received from Regional

Director/EIOD: ____/____/____

Comments:

5. The SC will send copies of the approved form to the surrogate parent, the evaluation agency/or service providers, and the FCC.

Date copies of this form sent to the above: ____/____/____

Comments:

INSTRUCTIONS FOR COMPLETION

STEPS TAKEN TO DETERMINE NEED FOR SURROGATE PARENT FOR CHILDREN IN FOSTER CARE

The **Initial Service Coordinator (ISC)** must use this form to document the steps taken to assess the need for a surrogate parent for a child in foster care. When completed, a copy should be kept in the service coordinator's case record and a copy sent to the Regional Director/EIOD. Refer to the **Surrogate Parent Assignment Process** for guidance in following the steps outlined on this form.

Sections 1, 2 and 3 document the steps the ISC must follow from referral through possible assignment of a surrogate parent. A copy of this form completed through Section 3, with the other forms listed in this section, must be sent to the EIOD/Regional Director when completed.

When this form is completed through Section 5, copies of this form and the approved **Assignment of Surrogacy by EIOD** must be sent by the ISC to the:

- Surrogate parent
- Evaluation site
- Foster Care Caseworker

NOTE: If, due to a change in life circumstances, a child currently participating in the Early Intervention Program needs to have a surrogate parent assigned for the first time, all of the steps noted in this form must be taken by the Ongoing Service Coordinator.

NYC EARLY INTERVENTION PROGRAM

FOSTER CARE LETTER PART I

RE: Child's Name (Last, First):	
EI #:	DOB: / /
Foster Care Agency:	
Address:	

Date: ____/____/____

Dear _____:
Name of Foster Care Caseworker

The above-named child, who is in foster care with your agency, has been referred to/is participating in the NYC Early Intervention Program (EIP) by _____ for service coordination, evaluation, and possible therapeutic services. Please complete the attached **Foster Care Letter Part II** and return it to me within three (3) business days.

If, when you contact the parent(s) to inform her/him of the EIP, the parent indicates a desire to participate in the Early Intervention process, please provide me with the contact information for the parent. You should also share my contact information with the parent. If I cannot reach the parent or if the parent does not contact me within three (3) business days, I will contact you.

If the parent is unable to participate but would like to designate someone to be a surrogate parent, please proceed in one of the following ways:

- If the parent wants to speak with me to discuss the designation, I will contact him/her or s/he can contact me. If I am not able to speak with the parent within three (3) calendar days, I will be in touch with you.
- If the parent prefers to address the designation process with you, please contact me so that I can complete the **Surrogate Parent Designation by Parent** form with the name provided to you by the parent or send you the form to complete and return. If the parent does not designate a surrogate, the EIP will assign a surrogate parent with your input, as provided for in Article 25 of the New York State Public Health Law.

If parental rights have **not** been terminated or voluntarily surrendered **and** the parent objects to the child's participation in the EIP, check the appropriate box on the **Foster Care Letter Part II** and return it to me immediately so that I can follow up with the parent. If the parent continues to object, we will close the EI case and send you a copy of the case closure form.

I will be calling you to discuss the possible need for a surrogate parent and who your agency thinks would be most appropriate if a surrogate parent is required and not designated by the parent.

If you have any questions, I can be reached at (____)_____.

Sincerely,

SC Signature: _____

Print Name: _____

Agency/address: _____

INSTRUCTIONS FOR USE

FOSTER CARE LETTER PART I

- The **Initial Service Coordinator (ISC)** must send this letter and the **FOSTER CARE LETTER PART II** to the foster care agency within two (2) days of receipt of the referral when a child who is in foster care has been referred to the NYC Early Intervention Program (EIP).

If the referral source was someone other than the ACS or Foster Care Caseworker (FCC) (such as the foster parent or a primary health care provider), this letter serves as a way of informing the foster care agency of the child's referral to the EIP. If the FCC made the referral, this letter serves as confirmation of EIP's receipt of the referral.

The ISC must monitor the time frames to ensure that the child receives a timely evaluation.

- **The Ongoing Service Coordinator (OSC)** must send this letter and the **FOSTER CARE LETTER PART II** to the foster care agency within two (2) days of notification that a child currently receiving Early Intervention services has been placed in foster care

The letter informs the FCC of the steps required for the child to continue the Early Intervention (EI) process. It also specifies the time frames for the FCC's responsibilities and response to the service coordinator.

**NYC EARLY INTERVENTION PROGRAM
FOSTER CARE LETTER PART II**

RE: Child's Name (Last, First):	
EI #:	DOB: / /
Foster Care Agency:	
Address:	

Date: ____/____/____

Dear _____:
(Name of Service Coordinator)

Parental rights have been terminated or surrendered. Surrogate Parent assignment is necessary.

OR

I have attempted to contact the parent(s) of the above-named child to discuss the referral to the NYC Early Intervention Program.

The parent(s) responded/did not respond in the following manner (check one):

Response received - parent wants to participate in the IFSP process.
Contact the parent (parent's name) _____ at (_____) _____. If you cannot reach the parent, contact me so that I can assist.

Response received - parent is unable to participate in the IFSP process and wants to designate someone to be the surrogate parent. Contact the parent (parent's name) _____ at (____) _____. If you cannot reach the parent, contact me so that I can assist.

Response received- parent is unable to participate in the IFSP process and wants to designate someone to be the surrogate parent. Parent stated that s/he will call you by ____/____/____ to discuss the designation. If you do not hear from the parent by this date, please call the parent (parent's name) _____ directly at (____) _____ or contact me.

Response received - parent is unable to participate in the IFSP process and wants to designate someone to be the surrogate parent. Send me a copy of the surrogate parent designation form, and I will return the form to you or call you with the name of the surrogate parent.

Response received - parent is unable to participate in IFSP process and did not designate someone to be the surrogate parent. A surrogate parent is needed.

No response from parent. Surrogate parent is needed.

Response received - parent objects to the child's participation in the Early Intervention process. Contact the (parent's name) _____ at (____) _____. If the parent continues to object, I understand that you will close the EI case, and send me a copy of the Closure Form.

Name of Foster Care Caseworker:	
Phone #:	Fax#:
Name of Supervisor	Phone #:

INSTRUCTIONS FOR COMPLETION

FOSTER CARE LETTER PART II

To determine whether a Surrogate Parent is needed:

- If parental rights **have been terminated** or **voluntarily surrendered**, **do not attempt to contact** the parent. The Service Coordinator (SC) should consult with the Foster Care Caseworker (FCC) to determine who would be an appropriate surrogate parent.
- If parental rights have **not** been terminated or voluntarily surrendered, the FCC must make a good faith effort to contact the parent to discuss whether s/he wants to be involved or wishes to designate a surrogate parent

After the attempt to contact the parent(s) [refer to the **Surrogate Parent Assignment Process** for guidelines], the FCC must use this form (**Part II**) to notify the SC of the response or lack of response by the parent(s) by checking the appropriate boxes.

When the parent wants to participate in the process, the SC should contact the parent to discuss his/her involvement. The parent may also contact the SC. If the contact between the parent and SC does not occur within three (3) business days, the ISC should immediately call the FCC to discuss whether the assignment of a surrogate parent has become necessary and if so, who should be assigned.

If the parent wants to designate a surrogate parent, the SC should contact the parent or the parent may contact the ISC. When the parent(s) wants to call the SC to discuss the designation of a surrogate parent, the FCC should give the parent(s) a deadline of three (3) business days by which s/he must make the call. If the contact between the parent and SC does not occur within three (3) business days, the SC should immediately call the FCC to discuss whether the assignment of a surrogate parent has become necessary and, if so, who should be assigned. Alternately, the parent can tell the FCC who s/he would like designated, and the FCC can provide the name of that person to the SC or complete the **Surrogate Parent Designation by Parent** form and return it to the SC.

When the SC sends the **Foster Care Letter Part I** to the FCC, the **Foster Care Letter Part II** should be attached.

INSTRUCTIONS FOR COMPLETION

SURROGATE PARENT DESIGNATION BY PARENT

NOTE: This form need only be used when parental rights have not been terminated or voluntarily surrendered. If parental rights have been terminated or surrendered, the parent(s) should not be contacted.

This form is to be completed by:

- The parent *or*
- An NYC Early Intervention Program (EIP) staff person or a Foster Care Caseworker (FCC) when they have information provided by the parent who is unable to participate in the IFSP process or make decisions about the EIP and would like to designate a particular person to serve as the surrogate parent.

For children in foster care, the address of the person designated by the parent may be confidential and in those cases, should not be shared with the parent. In addition, if at any time the parent requests to withdraw or change his/her designation, the service coordinator should notify the FCC.

The service coordinator (SC) is responsible for ensuring that the parent has been offered the option of voluntarily appointing a surrogate parent. However, the parent is not required to designate a specific person. (If the parent does *not* name a surrogate parent, the SC will follow the surrogacy procedures described in the [Determining the Need for Assigning a Surrogate Parent policy](#).)

The SC must keep a copy of this form in the child's case record and send a copy to:

- The Regional Director/EIOD
- The evaluator(s)
- The service provider(s).

NYC EARLY INTERVENTION PROGRAM

ASSIGNMENT or TERMINATION OF SURROGACY BY EIOD

RE: Child's Name (Last, First):	
EI #:	DOB: / /
Foster Care Agency:	
Caseworker:	

To: Assistant Regional Director/EIOD: _____ Date: ____/____/____

ASSIGNMENT

After consulting with the above Foster Care Caseworker, it has been agreed that

_____ _____
 Print Name of Surrogate Parent Relationship to Child

may be assigned as the surrogate parent for the above-named child. I have discussed the Early Intervention Program (EIP) with her/him, and s/he is willing to be the child's surrogate parent. I have explained the rights and responsibilities of the surrogate parent in the EIP. **Child Information Change Form** is attached

TERMINATION

Name of Surrogate: _____ is currently assigned. This assignment will need to be terminated as of ____/____/____

Please assign the following person for the reasons indicated below. **Child Information Change Form** is attached.

_____ _____
 Print Name of New Surrogate Relationship to Child

REASON FOR CHANGE IN SURROGACY:

No new surrogate assignment is necessary; the parent is now available and wants to participate. **Child Information Change Form** is attached.

Signature of Service Coordinator	
Print Name	Telephone Number:
Telephone Number:	Fax Number

- Approved
 Denied

EIOD Signature: _____ Date: ____/____/____

INSTRUCTIONS FOR COMPLETION

ASSIGNMENT or TERMINATION OF SURROGACY BY EIOD

Initial Service Coordinator (ISC)

- The ISC must obtain the information requested and complete this form after consultation with the Administration for Children's Services (ACS) or the foster care agency involved with the child.
- The ISC must send the completed form to the Regional Director/EIOD for approval before the surrogate parent may sign any consents and the evaluation can be initiated.
- After a surrogate parent is assigned, that person is authorized to sign all consents that a parent would sign.

A foster parent may be assigned as a surrogate parent only after consultation with ACS or the foster care agency. Other possible choices for surrogate parent are:

- a person voluntarily designated by the parent (use the **Surrogate Parent Designation by Parent form**)
- a relative or friend(s) of the parent who has an ongoing relationship with the child
- if no suitable individual is identified from these choices, a qualified volunteer.

Refer to the **Surrogate Parent Assignment Process** for more information on the selection of a surrogate parent.

Ongoing Service Coordinator (OSC)

1. When reviewing the IFSP at the Six (6) Month or Annual Review or at other appropriate times, the EIOD shall, in consultation with the foster care caseworker, determine whether there have been any changes in circumstances that warrant a review of the appointment of a particular surrogate parent. If a change in surrogate parent is found to be necessary, the EIOD will appoint a new surrogate and will indicate the termination of the previous surrogate parent on the **Assignment/Termination of Surrogacy by EIOD** form.

2. When a child, already in the Early Intervention Program should need a surrogate parent for the first time due to changes in life circumstances, the SC should complete this form, along with the other necessary surrogacy forms. Refer to the **Determining the Need for a Surrogate Parent Policy**, and the **Assignment of a Surrogate Parent Policy**.

The SC must complete a **Child Information Change Form** and submit it with the **Assignment/Termination of Surrogacy by EIOD** form whenever there is a change in the surrogate parent assignment.

NOTE: When the child is not in foster care, his/her birth or adoptive parents are unavailable, and the child has no one in parental relation, the Regional Director/EIOD shall appoint a qualified surrogate parent.

The surrogate parent assignment may be changed at any time upon written request by the birth or adoptive parent(s), the surrogate parent or the Regional Director/EIOD. The SC must keep a copy of the approved form in the child's case record and send copies to the evaluation site and/or all service providers.

Chapter 3:
Before the Individualized
Family Service Plan (IFSP)

New York City Early Intervention Program

Policy Title: Initial Service Coordinator Responsibilities	Effective Date: 12/20/10
Policy Number: 3-A	Supersedes: N/A
Attachments: - Consent to Initial Service Coordination Form - Surrogate Parent Assignment by EIOD Form (if applicable) - Consent to Release/Obtain Information Form - Family Information Form - Insurance Information Form - Parent Refusal to Provide Insurance Information Form (if applicable) - “Your Rights in Early Intervention” - Reason for Delay of Evaluation Completion/MDE Submission Form (if applicable)	Regulation/Citation: NYCRR 69-4.7(a) (b)

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)	<ol style="list-style-type: none"> 1. Receives the Referral and Fax Confirmation of Initial Service Coordinator and Important Dates Forms from the Regional Office (RO); 2. Contacts the parent/caregiver within two (2) days of referral to the Early Intervention Program in order to set up an appointment at a time and place convenient to the parent within seven (7) calendar days from referral. <p>Note:</p> <ul style="list-style-type: none"> • In all contacts with the family, emphasize that Early Intervention (EI) is a family-centered program designed to enhance the capacities of families to meet their child’s needs, with services provided in the child’s natural environment. <p><u>Initial Meeting with the Parent(s)/Caregivers:</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 NYC Early Intervention Program (EIP): <ol style="list-style-type: none"> a. Provide a copy of “Your Rights in Early Intervention”;

- b. Inform parents of their rights and responsibilities in the EIP:
 - i. Explain the voluntary nature of the EIP.
- 3. Provide a copy of the SDOH booklet **The Early Intervention Program: A Parent's Guide**:
 - a. Review the EI process with the parent(s) and their rights to due process;
 - b. Copies of this handbook in English can be obtained from the State Department of Health by writing to Publications, NYS Department of Health, Box 2000, Albany, New York 12220, and requesting "A Parent's Guide," Code #0532. Please note that this handbook is available in multiple languages. Go to: www.health.state.ny.us/forms/order_forms/eip_publications.pdf for the listing of available languages.
- 4. If the child is in Foster Care:
 - a. Refer to the policies for *Surrogate Parent Assignment* in the Surrogacy chapter of this manual.
- 5. Obtain the parent's signature on:
 - a. **Consent to Initiate Service Coordination Form**;
 - b. **Consent to Release/Obtain Information Form**;
- 6. Explain to the family that services are at no cost to parents, and use of Medicaid and/or third party insurance for payment of services is required under the EIP:
 - a. Complete the **Insurance Information Form** with the family.
 - b. If parent refuses to provide insurance information, complete the **Parent Refusal to Provide Insurance Information Form**.
- 7. Inform the 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:
 - a. Refer to the **Collection of Social Security Numbers Policy**.
- 8. Complete the **Family Information Form** with the parents:
 - a. Ensure that the Race/Ethnicity section is completed.
- 9. If the child does not have health insurance, contact the DOHMH Office of Insurance Services in the Division of Health Care Access and Improvement (call 311 to be connected with the office).
- 10. Ask the parent in a sensitive manner if s/he 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 (e.g., home vs. evaluation agency):
 - a. Provide the parent with a list of evaluation agencies in contract with the NYC EIP;
 - b. Refer to the **Parental Choice of Evaluation Site Policy**.
- 12. If the child was previously receiving EI services in another NYS county:
 - a. Refer to the **Transfers to NYC from Another NYS County Policy**.
- 13. If the child appears to have an immediate need for EI services:
 - a. Refer to the **Interim IFSP Policy**.

After the Initial Meeting with Parent/Caregiver:

1. At the parent's request, assist the parent in arranging for the child's evaluation.
2. Send the following documentation to the Evaluation Agency(ies):
 - a. **Surrogate Parent Assignment by EIOD Form** (if applicable) (and other foster care forms outlined in the Surrogacy Chapter of this manual):
 - i. **No evaluations can begin before the surrogate parent has been assigned.**
 - b. **Consent to Initiate Service Coordination Form;**
 - c. **Consent to Release/Obtain Information Form;**
 - d. **Family Information Form;**
 - e. **Insurance Information Form or the Parent Refusal to Provide Insurance Information Form ; and**
 - f. **Reason for Delay of Evaluation Completion/MDE Submission Form** (if applicable).
3. Follow-up with the evaluator and parents to ensure that the evaluations are proceeding in a timely fashion.

After the Evaluation:

1. Ensure that the family understood 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:
 - i. Refer to the **Closure Policy**.
 - a. The child can be referred to Developmental Monitoring for continued surveillance;
 - b. The parents can request a re-evaluation;
 - c. The parents can exercise their due process rights.
3. If the child is found eligible for the 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 choosing;
 - 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 final decisions about the services to be provided will be made by the parent and the EIOD;
 - vii. Remind the parent/caregiver that their participation in the EIP is voluntary;
 - viii. Show the parents the IFSP forms and review how the meeting will be conducted.
 - 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 coordination and the EIOD.

Note:

- Ensure that the Evaluation Site forwards the results of the evaluation to the EI RO and the parent(s).
- Ensure that Evaluation Agency forwards the MDE packet that includes all of the forms listed above, as applicable, to the RO **within thirty (30) days of the referral to the EIP.**

1. Arrange for an IFSP meeting:

- a. Refer to the **IFSP Scheduling Policy**;
- b. If the parents are deaf, request a sign interpreter if needed:
 - i. Refer to the **Requesting a Sign Language Interpreter Policy.**

After the IFSP Meeting:

1. If the Initial Service Coordinator (ISC) is named as the OSC at the IFSP Meeting:


- a. Send the following documentation to the Service Provider agency(ies) once located:
 - i. **Consent to Obtain/Release Information Form;**
 - ii. **Copy of the evaluation packet;**
 - iii. **Copy of the IFSP.**

2. If the ISC was not named as the OSC:

- a. Copies of the above named documents must be sent within two days to the OSC chosen by the parent(s) at the IFSP meeting.

Note:

- In the event that the ISC cannot contact or remain in contact with a family, refer to the **Closure Policy.**
- All of the above described activities must be clearly documented in the SC activity notes.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 11/10/10

NYC EARLY INTERVENTION PROGRAM

PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

Child's EI ID No.: _____ Child's DOB: ___/___/___

Child's Name: _____
Last First

I have been informed by the Early Intervention 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 other 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 ID Number

I give permission for my child's service coordinator to send a copy of the following to his/her physician(s): initial IFSP.
 I do not give permission for my child's service coordinator to send a copy of the following to his/her physician(s): initial IFSP.

Service Coordinator Must Complete:

Date ISC agency received assignment from Regional Office: ___/___/___
Date ISC provided parent(s) the EIP Parent's Guide or directed parent to Guide on SDOH website: ___/___/___
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: ___/___/___

- Note:***
- **ISC must ensure that a copy of the Parent's Guide is sent to the family within seven (7) business days of referral.**
 - **If parental consent is obtained, a copy of the IFSP should be sent by the ISC upon its completion.**

INSTRUCTIONS FOR COMPLETION

PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

All fields on this form must be completed. This form must be signed by the parent when service coordination (SC) first begins. At this time, the parent confirms that s/he gives permission for SC. If the SC 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. The ISC must send a copy to the Evaluation Agency(ies) together with the other forms listed in the ISC Responsibilities Policy.

**NYC EARLY INTERVENTION PROGRAM
CONSENT TO RELEASE/OBTAIN INFORMATION**

Child's Name: _____ EI #: _____ DOB: ___ / ___ / ___

Address: _____ Apt #: _____

City/Town: _____ State: New York Zip Code: _____

I, (Parent/Guardian's Full Name) _____, seek services for my child from the NYC 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, B, or C):

A. Released to all EI providers providing evaluation, service coordination, or services to my child and family

B. Released to the Individual/Agency below:

(Name/ Organization)

(Street Address, Borough/City, Zip Code)

() _____
(Telephone Number)

() _____
(Fax Number)

C. Obtained from the Individual/Agency below:

(Name/ Organization)

(Street Address, Borough/City, Zip Code)

() _____
(Telephone Number)

() _____
(Fax Number)

The information will be sent to:

(Name/ Organization)

(Street Address, Borough/City, Zip Code)

() _____
(Telephone Number)

() _____
(Fax Number)

D. 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 and

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 ___/___/___).

Signed: _____ 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.

Consent to Release/Obtain Information Revised 12/10

INSTRUCTIONS FOR COMPLETION CONSENT TO RELEASE/OBTAIN INFORMATION

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

*NOTE: A parent must never be asked to sign a blank **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 to obtain information.

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

- After referral, at the Initial Service Coordinator (ISC)'s first visit;
- At the Interim Individualized Family Service Plan (IFSP), if there is one;
- At the Initial IFSP;
- At each subsequent Annual and Review IFSP;
- Whenever a parent agrees to release information to a specific person, such as the child's health care provider.

NOTE: The parent must be given a choice of signing a general release ("A") or a selective release ("B"). If the parent decides to sign a selective release, each provider or individual must be specified on a separate form.

- a. Check the appropriate box(s) to indicate the **specific information to be released**.
 - b. Complete "A" to indicate the parent's **general** consent to release information to Early Intervention evaluation, service coordination, or services provider.
- OR
- c. Complete "B" to indicate the name and contact information of the individual/agency that the information is being released to.
 - d. Check the appropriate box(s) at "D" to detail **the purpose of the requested information**.
 - e. 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.
 - f. 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 individuals/agencies outside the EIP **such as:**

- To request an evaluation report conducted by a non-EI provider; or
 - To request medical reports.
- a. Check the appropriate box(s) to indicate the **Specific information to be obtained**.
 - b. Completed "C" 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.
 - c. Check the appropriate box(s) listed under "D" to detail **the purpose of the requested information**.
 - d. 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.
 - e. 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.

**New York City Early Intervention Program
FAMILY INFORMATION FORM**

Child's Name: _____ EI #: _____ DOB: ___/___/___
 (Last) (First)
 Service Coordinator: _____ SC #: _____ Phone #: _____
 Date Form Completed: ___/___/_____

Child Lives With: <input type="checkbox"/> Parents <input type="checkbox"/> Relative <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Surrogate Parent(s)		
Mother:	Home #: ()	Work # ()
Cell #:	Email *	
Father:	Home #: ()	Work # ()
Cell #:	Email *	
Address:	Apt. #	School District:
City/Borough	State:	Zip Code:
Language(s) spoken at home:		

*Email can only be included with consent

OTHER MEMBERS OF HOUSEHOLD (use codes below)				Relationship Codes: A- Mother I- Foster Mother B- Father J- Foster Father C- Grandmother K- Parent Partner D- Grandfather L- Sibling E- Aunt M- Other F- Uncle N- Not Related G- Stepmother O- Kinship Foster H- Stepfather Care Grandmother U- Unknown P- Kinship Foster Care Other
Name	Relationship	Name	Relationship	

Foster Care Information:	Child Care Arrangements:
Agency Name:	<input type="checkbox"/> None <input type="checkbox"/> Day Care Center/Nursery School
Contact Person:	<input type="checkbox"/> Family Daycare <input type="checkbox"/> Babysitter/Relative
Address:	(Weekdays)
City: State: Zip Code:	Name:
Phone: () Fax: ()	Phone:

Race/Ethnicity : THIS AREA MUST BE COMPLETED FOR EVERY CHILD Check all that apply: Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Native Hawaiian/ other Pacific Islander Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Birth History
	Hospital of Birth:
	County of Residence:
	County of Birth:
	Wks Gestation:
	Birth Weight: ___ lbs. ___ ozs or gms ___
If multiple births (twins etc): ___ of ___	

Family Concerns: What brought you to Early Intervention? 	Area(s) of Suspected Delay: Check as many as applicable & circle status codes* * Codes: N - No Delay S - Suspected C - Confirmed U - Unknown																								
	<table> <tr> <td><input type="checkbox"/> A- Adaptive</td> <td>N</td> <td>S</td> <td>C</td> <td>U</td> </tr> <tr> <td><input type="checkbox"/> B- Cognitive</td> <td>N</td> <td>S</td> <td>C</td> <td>U</td> </tr> <tr> <td><input type="checkbox"/> C- Communication</td> <td>N</td> <td>S</td> <td>C</td> <td>U</td> </tr> <tr> <td><input type="checkbox"/> E - Social/ Emocional</td> <td>N</td> <td>S</td> <td>C</td> <td>U</td> </tr> <tr> <td><input type="checkbox"/> F- Physical</td> <td>N</td> <td>S</td> <td>C</td> <td>U</td> </tr> </table>	<input type="checkbox"/> A- Adaptive	N	S	C	U	<input type="checkbox"/> B- Cognitive	N	S	C	U	<input type="checkbox"/> C- Communication	N	S	C	U	<input type="checkbox"/> E - Social/ Emocional	N	S	C	U	<input type="checkbox"/> F- Physical	N	S	C
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<input type="checkbox"/> B- Cognitive	N	S	C	U																					
<input type="checkbox"/> C- Communication	N	S	C	U																					
<input type="checkbox"/> E - Social/ Emocional	N	S	C	U																					
<input type="checkbox"/> F- Physical	N	S	C	U																					

INSTRUCTIONS FOR COMPLETION FAMILY INFORMATION FORM

The Initial Service Coordinator (ISC) must:

- Complete the **Family Information** form prior to the Initial IFSP meeting.
- Send it to the evaluation site with the other required forms detailed in the ISC Responsibilities Policy upon choice of evaluation site by the parent.

If the evaluation site finds that the child is **not eligible**, the completed **Family Information** form must be sent to the Regional Office (RO) with the **Closure Form**.

NOTE: The evaluation site – not the Service Coordinator (SC) - is responsible for submitting the **Evaluation/Screening Summary and Data Entry Forms** and the evaluation/screening reports to the RO.

1. Complete all demographic information requested, printing legibly: the full names of the child, the SC, and the parents. Give all available phone numbers, writing N/A if the number is not available or not applicable.
 - a. Include email addresses only with written parental consent. Refer to the following memorandum on the NYS Department of Health website:
(www.health.state.ny.us/community/infants_children/early_intervention/memoranda.htm)
Dear Colleague Letter - Clarification to Early Intervention Providers on Parental Consent to Use E-mail to Exchange Personally Identifiable Information
2. **Other Members of Household:** List all individuals residing in the same household as the EI child using the codes listed in the box titled "Relationship Codes" to indicate their relationship to the child.
3. **Foster Care Information:** Complete all items if the child is in foster care.
4. **Child Care Arrangements:** Indicate if the child is in child care and give the name and phone number of the child care provider. This information is collected to help determine possible service settings, and contact information for those settings.
5. **Race/Ethnicity: This information is required by the NYS DOH and the Federal Office of Special Education Programs (OSEP).** Both areas (race and ethnicity) must be completed. *More than one racial designation for a child can be selected.*
6. **Birth History:** Complete as much information as is available.
7. **What brought you to Early Intervention:** Document family concerns related to meeting their child's needs and the primary developmental concerns (ex: "Child is not meeting developmental milestones, like rolling over, playing with toys, and holding her bottle").
8. **Area of Suspected Delay:** Check as appropriate, using the codes above.

**NYC EARLY INTERVENTION PROGRAM
INSURANCE INFORMATION**

Complete this form in its entirety and fax the form and a copy of the insurance card(s) to the Early Intervention Regional Office in the child's borough of residence. Use the following fax numbers:

Bronx (718) 410-4482

Brooklyn (718) 722-2310

Manhattan (212) 487-3930

Queens (718) 271-6114

Staten Island (718) 420-5360

Note: If a copy of the insurance card(s) cannot be obtained at the initial meeting with the parent/caregiver, the parent/caregiver should make a copy available no later than the Initial IFSP meeting.

() Check if this form contains information different from the initial insurance information form.

Please Print

A. IDENTIFYING INFORMATION

CHILD'S NAME (Last, First and Middle): _____

EI #: _____ DOB: _____ / _____ / _____ Date Information Collected: _____ / _____ / _____

Service Coordinator: _____ SC #: _____

SC Provider Agency: _____ Agency EI #: _____

No insurance Applications in process: Medicaid Child Health Plus SSI

B. HEALTH CARE PROVIDER

Child's Primary Care Provider: _____ Phone: (_____) _____

Address: _____

C. INSURANCE INFORMATION Attach a Copy of the Insurance Card(s).

PRIMARY INSURANCE COMPANY INFORMATION

Company Name: _____ Type of Plan: _____

(For Child Health Plus, write insurance company name)

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Subject to New York State Insurance Law (if known): Y N Unknown

Flexible Spending Account: []

Policyholder's Name (Last, First, and Middle) _____

Date of Birth: _____ / _____ / _____ Policyholder Relationship to Child: _____

Policyholder's Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____ Effective Date: From _____ To _____

Policy #: _____ Group Number: _____

Self-Employed (Y/N): Y N Employer's Name (if policy through employer): _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

**NYC EARLY INTERVENTION PROGRAM
INSURANCE INFORMATION**

SECONDARY INSURANCE COMPANY INFORMATION

Company Name: _____ Type of Plan: _____
(For Child Health Plus, write insurance company name.)

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Policyholder's Name (Last, First): _____

Date of Birth: ____/____/____ Policyholder Relationship to Child: _____

Policyholder's Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____ Effective Date: From _____ To _____

Policy #: _____ Group Number: _____

Self-Employed (Y/N): ____ Employer's Name *(if policy through employer)*: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

D. MEDICAID INFORMATION (Attach a copy of child's Medicaid card)

Child covered by Medicaid? Yes No

Child's Medicaid/CIN #: _____
Letter Letter Number Number Number Number Number Letter

E. ACKNOWLEDGEMENT OF NEW YORK CITY EI PROGRAM INTENT TO EXERCISE SUBROGATION

RIGHTS

I attest that the information I have provided in this acknowledgment is accurate and true to the best of my knowledge. I understand that the New York City Early Intervention Program intends to seek payment from third party payors. I give the New York City Early Intervention Program permission to seek reimbursement from my health insurance company. I authorize the release of any medical information or other information necessary to process claims. I authorize payment of medical benefits to the New York City, Early Intervention Program. I have been informed that under the Public Health Law and Insurance Law the use of insurance is at no cost to me.

Policyholder Signature

Date

NYC EARLY INTERVENTION PROGRAM INSURANCE INFORMATION INSTRUCTIONS

Service Coordinators (SC) must use this form to record the child's insurance information prior to the initial IFSP meeting, and whenever the family informs the SC that the child's insurance coverage has changed.

For the purpose of this requirement "insurance" refers to any third-party coverage, including private insurance, Medicaid, Medicaid managed care, and Child Health Plus.

1. Complete all of Sections A and B.
2. If the child has insurance, complete all areas of either Section C or D as directed below.
3. Fax the completed form to the NYC Early Intervention Program (EIP) Regional Office **and** bring a copy to the IFSP meeting.
4. If the parent refuses to provide the information, follow the instructions regarding parent refusal and complete the **Parent Refusal to Provide Insurance Information Form**.

Families must be informed that according to State regulations, (NYCRR Sec 69-4.22) "*the municipality shall pay all co-payments and deductibles to meet any requirement of an insurance policy or health benefit plan in accessing funds applied to payment for early intervention services.*"

A. IDENTIFYING INFORMATION

Child's Name (Last, First and Middle): The child's complete legal name (no nicknames), last name, followed by first and middle names. Verify correct spelling.

EI #: The identification number assigned by the NYC EIP to this child.

DOB: Date of child's birth, in month, day and year order.

Date Information Collected: The date of the meeting with the parents when this information was obtained.

Service Coordinator & SC #: The Initial Service Coordinator's name and SC number.

SC Provider Agency & Agency EI #: The employing service coordination agency name and Early Intervention (EI) contract number.

No Insurance: If the child has no insurance, check the box marked "No Insurance" **and** indicate, by checking the appropriate box, whether the application process has begun for Medicaid, Child Health Plus or Social Security Income (SSI).

B. HEALTH CARE PROVIDER

Child's Primary Care Provider: The name of the physician (or in some cases the clinic) who provides primary health care to the child. Include the phone number and address for the primary care provider.

C. INSURANCE INFORMATION

More than one insurance plan: If the family is covered by more than one plan, ask the parent to provide complete information about all third party payers

NYC EARLY INTERVENTION PROGRAM INSURANCE INFORMATION INSTRUCTIONS

PRIMARY AND SECONDARY INSURANCE COMPANY INFORMATION

Company Name: The complete and correct name of the insurance company (verify name and spelling). If the family is covered by Child Health Plus, record the insurance company name; *do not write* “Child Health Plus.”

Type of Plan: This information may be available from the family, the documentation of the family’s plan, or from the insurance company. Examples of the general types are below.

- **Health Maintenance Organizations (HMO)**
- **Point of Service Plans (POS)**
- **Preferred Provider Organizations (PPO)**
- **Fee for Service (FFS) – Indicate Basic, Major or Comprehensive**

Address, City, State, and Zip & Phone: The insurance company’s complete billing address and phone number (important for obtaining authorizations).

Subject to New York State Insurance Law (if known): Indicate if the insurance company is subject to NYS insurance law, or if this is not known.

Policyholder’s Name: The legal name, last name first, followed by first and middle names of the person who holds the insurance policy. Verify correct spelling.

Date of Birth: Policyholder’s date of birth, in month, day and (four digit) year order.

Policyholder Relationship to Child: The relationship of the policyholder to the child, e.g., mother, father, step-parent, legal guardian, etc.

Policyholder’s Address, Apt. #, City, State, and Zip & Phone: The complete address where the policyholder is currently residing and the home telephone number.

Effective Dates From: The date on which the plan became effective. This information is mandatory. If the policyholder does not know exactly when the plan began, it is acceptable to use the date when the information is collected.

Effective Dates To: The expected date on which the insurance will change. If there is no change expected, leave the space blank.

Policy #: The number of the insurance policy. This number can be obtained from the family or frequently from the insurance card. Other names for policy number might be Member ID, Participant Number, etc.

Group Number: The number of the “group”. This number can be obtained from the family or frequently from the insurance card. Other names used may be Plan Number, Plan ID, etc.

Self-Employed: Is the policyholder self-employed? Write Y (yes) or N (no).

Employer’s Name (if policy through employer): The complete legal company name including abbreviations such as LLC, Inc., etc.

Employer’s Address, Apt. #, City, State, and Zip & Phone: The employer’s complete address and telephone number.

**NYC EARLY INTERVENTION PROGRAM
INSURANCE INFORMATION INSTRUCTIONS**

D. MEDICAID INFORMATION (Attach a copy of child's Medicaid card)

Child covered by Medicaid? Yes No

Child's Medicaid/CIN #

_____/_____/_____/_____/_____/_____/_____/_____
Letter Letter Number Number Number Number Number Letter

Note: All Medicaid assigned Client Identification Numbers follow this format.

Verify against the child's Medicaid card/documentation that the number is correct. You must attach a copy of the child's Medicaid card.

E. ACKNOWLEDGEMENT OF NYC EI PROGRAM INTENT TO EXERCISE SUBROGATION RIGHTS

Obtain signature of the policyholder and date of signature.

NYC EARLY INTERVENTION PROGRAM
PARENT REFUSAL TO PROVIDE INSURANCE INFORMATION

CHILD'S NAME: _____ EI ID #: _____
(Last, First and Middle)

The NYC Department of Health and Mental Hygiene is notifying the NYS Department of Health that the following parent has declined to provide health insurance information to the Early Intervention Program and has not provided documentation that the insurance policy under which their child is covered is not governed under New York State laws and regulations.

Parent's/Caregiver's Name: _____ Relation to child: _____

Address: _____ Apt. #: _____ Borough: _____ Zip code: _____

Home Phone: () _____ Alternate Phone: () _____

The parent/caregiver declined for the following reason(s): _____

Initial Service Coordinator Name: _____ Number: _____

Agency: _____

Address: _____

Phone: () _____

Ongoing Service Coordinator Name: _____ Number: _____

Agency: _____

Address: _____

Phone: () _____

I/we certify that the following actions were taken in an effort to obtain insurance information from the parent:

- The Service Coordinator requested the information of the parent.
- The Service Coordinator reviewed the protections in Public Health Law and Insurance Law that assures use of insurance is at no cost to the parent and will not be applied toward insurance policy lifetime or annual limits.
- The parent was asked and could not or would not provide documentation from their insurer that insurance coverage applicable to their child is not governed under New York State laws and regulations.
- The parent has been informed and understands that this notice will be sent to the New York State Department of Health Early Intervention Program.

Parent/ Caregiver Signature *Date* _____

Initial/Ongoing Service Coordinator Signature *Date* _____

EIOD Signature *Date* _____

PARENT REFUSAL TO PROVIDE INSURANCE INFORMATION

INSTRUCTIONS FOR COMPLETION

The Service Coordinator (SC) must complete this form when:

- a parent/caregiver has refused to provide health insurance information to the Early Intervention Program *and*
- the parent/caregiver has not provided documentation that the insurance policy under which their child is covered is not governed under New York State laws and regulations.

A copy of this form will be sent to the NYS Department of Health by the NYC Early Intervention Program to notify them that the parent has refused to provide insurance information.

A. Identifying Information

Complete the parent's/caregiver's name, relation to the child (e.g., mother, father, stepfather), address, home and alternate telephone numbers.

B. Reason for Declining

Explain in full the parent's/caregiver's reason for not providing the health insurance information.

C. Service Coordination Information

Complete the identifying information for the current Service Coordination (either the Initial or Ongoing SC), including name, SC number, name of SC provider agency, provider Early Intervention number, address and telephone number.

D. Attestation

The parent/caregiver, SC and Early Intervention Official Designee must sign and date this box indicating that required actions were taken to obtain medical insurance information and that the parent has refused to provide this information. The date of the parent signature will serve as the effective date of refusal.

New York City Early Intervention Program

Policy Title: Choice of Evaluation Site	Effective Date: 12/13/10
Policy Number: 3-B	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> - Active Providers: Language and Specialties List - Reason for Delay in Evaluation Completion/ MDE Submission Form 	Regulation/Citation: 10NYCRR69-4.1 (j); 10NYCRR69-4.1 (k); 10NYCRR69-4.1 (l).

I. POLICY DESCRIPTION:

“The Initial Service Coordinator (ISC) shall review all options for evaluation and screening with the parent from the list of approved evaluators including location, types of evaluations performed, and settings for evaluations (e.g., home vs. evaluation agency). Upon selection of an evaluator by the parent, the ISC shall ascertain from the parent any needs the parent may have in accessing the evaluation.”


“The ISC shall at the parent's request assist the parent in arrangement of the evaluation after the parent selects from the list of approved evaluators.”

“If the parent has accessed an approved evaluator prior to contact by the ISC, the ISC shall contact the parent to assure that the parent has received information concerning alternative approved evaluators and ascertain from the parent any needs the parent may have in accessing the evaluation.”

II. PROCEDURE:

Responsible Party	Action
Initial Service Coordinator (ISC)	<ol style="list-style-type: none"> 1. Review the Active Evaluation Providers: Language and Specialties List with the parents, and assist them in selecting an Evaluation Agency: <ol style="list-style-type: none"> a. Service Coordinators (SC) must be familiar with specific information about each evaluator, including: <ol style="list-style-type: none"> i. Available settings for evaluations (e.g. home vs. facility); and ii. Languages spoken: <ul style="list-style-type: none"> • If upon review of the Active Evaluation Providers: Language and Specialties List, an appropriate evaluation agency cannot be located, the ISC will inquire if the evaluation agency can find an interpreter; • Refer to the Bilingual Evaluations Policy. iii. Types of evaluations performed; iv. Expertise with special populations; and

	<p>v. Ability of the Evaluation Agency to complete the Multidisciplinary Evaluation (MDE) and send it to the Regional Office (RO) within thirty (30) days of referral to the Early Intervention Program (EIP) (as per the NYC Provider Agreement).</p> <p>2. If a parent chooses an evaluator knowing that there is a waiting list for evaluations:</p> <p>a. Inform the parent that by waiting for a specific evaluator, the Initial IFSP meeting may not be able to be held within forty-five (45) days of referral and the start of Early Intervention (EI) services may be delayed.</p> <p>i. Document the family’s informed choice in the service coordination activity notes;</p> <p>ii. Complete Section I of the Reason for Delay of Evaluation Completion/ MDE Submission Form.</p> <ul style="list-style-type: none"> • Obtain parent signature. <p>3. If the parent has accessed an approved evaluator before being contacted by the ISC:</p> <p>a. Contact the parent/caregiver to ensure that the parent has received information concerning other approved Evaluation Agencies; and</p> <p>b. Determine if the parent/caregiver needs assistance in the evaluation process.</p> <p>Note:</p> <ul style="list-style-type: none"> • All of the above described activities must be clearly documented in the SC activity notes.
<p>Evaluation Agency</p>	<p>1. Notify parent and ISC if:</p> <p>a. The evaluations cannot be completed within thirty (30) days from the child’s referral to the EIP.</p> <p>b. Explain the following to the parent:</p> <p>i. The reason that evaluations will not be provided in a timely manner;</p> <p>ii. The right of the parent to choose another evaluation agency.</p> <p>c. Complete Section II of the Reason for Delay of Evaluation Completion/ MDE Submission Form.</p> <p>i. Obtain parent signature;</p> <p>ii. Submit to the RO with the completed MDE;</p> <p>iii. Refer to the Multidisciplinary Evaluation Policy.</p> <p>Note:</p> <ul style="list-style-type: none"> • The Reason for Delay of Evaluation Completion/ MDE Submission Form should only be completed if the MDE cannot be completed within thirty (30) days of referral.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 11/10/10

**NYC EARLY INTERVENTION PROGRAM
REASON FOR DELAY OF EVALUATION COMPLETION/ MDE SUBMISSION FORM**

Child's Name:	DOB:
EI Number:	Date of Referral to EI: / /

Section I: Filled out by the Initial Service Coordinator (if needed) and submitted to the Evaluation Agency with the other required paperwork as outlined in the Initial Service Coordination Responsibilities Policy

Parents chose: _____
(Evaluation Site Name)
(Provider #)

which was/will be unable to complete the child's evaluation within thirty (30) days of the date of referral to the NYC Early Intervention Program due to the following reason (s):

1. Waiting List 2. Evaluator backlog/delay 3. Other reason (s): _____

The child is now scheduled for an evaluation on (date): _____ / _____ / _____ at _____

(Evaluation Site Name)
(Provider #)

Initial Service Coordinator Signature: _____

Date: ____ / ____ / ____ Agency: _____ Phone number: _____

Parent Acknowledgement

I understand that my child is entitled to an evaluation and to the convening of an IFSP meeting within forty-five (45) days of the date of referral to the New York City Early Intervention Program (EIP). I understand that the evaluation site I have selected will not be able to complete the evaluation and send the required report to me and the NYC EIP so that this timeline can be met.

Parent signature: _____ Date: _____ / _____ / _____

Date this form was sent to Evaluation Agency: _____ / _____ / _____

Section II: Filled out by the Evaluation Agency (if needed) and submitted the Regional Office and Service Coordinator with the Evaluation Packet

Name of Evaluation Agency(ies) _____

Please Indicate the Reason(s) for Delayed Submission of MDE:

A. 1. Child ill 2. Parent ill 3. Delay Signing Consent for Evaluation 4. Child not eligible at first evaluation 5. Family missed evaluation appointment 6. Parental scheduling delay 7. Other family reasons: _____

B. 1. Delayed referral from SC to Evaluation Agency 2. Other provider reasons/Comments: _____

Signature of Evaluation Representative: _____ Date: ____ / ____ / ____

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

Parents must never be asked to sign this form before any delays occur.

**NYC EARLY INTERVENTION PROGRAM
REASON FOR DELAY OF EVALUATION SUBMISSION/ MDE SUBMISSION FORM
INSTRUCTIONS FOR COMPLETION**

This form should only be completed if delays occur

The contract between the New York City Early Intervention Program (NYCEIP) and provider agencies requires submission of the complete Multidisciplinary Evaluation (MDE) to the Regional Offices (RO) within thirty (30) days of the date the child was referred to the NYCEIP. The Initial Service Coordinator is responsible for monitoring the completion of the evaluation and assisting the evaluation site and/or parent in the timely completion/submission of all evaluations.

Section I: The Initial Service Coordinator (ISC) must clearly document the reason for any delay if the selected Evaluation Provider has indicated that it will be unable to complete the evaluation in a timely fashion.

1. Complete this section if the parent chooses an evaluation site that was unable to complete the evaluation within thirty (30) days of the referral to the Early Intervention Program.
 - a. It is the responsibility of both the evaluation site and the ISC to clearly explain to the parent that by choosing an evaluation site that is unable to complete and submit an evaluation within thirty (30) days of referral, an IFSP meeting will not be held within forty-five (45) days of referral.

The Service Coordinator (SC) should indicate:

- a. The name of the evaluation site initially chosen by the parent;
- b. The agency reason(s) for the delay of evaluation submission;
- c. The date that the evaluation is now scheduled; and
- d. If the parent chooses another evaluation site, the name of that agency.

The ISC must sign the form and obtain the parent's signature.

Section II: The Evaluation Provider Agency must clearly document the reason for any delay in **completing or submitting the** Multidisciplinary Evaluation (MDE).

1. **Complete "A"** if the MDE was not completed or submitted in a timely fashion due to family reasons.
2. **Complete "B"** if the MDE was not completed or submitted in a timely fashion due to agency reasons.

The Evaluation Representative must sign the form and obtain the parent's signature.

Parents must never be asked to sign this form before any delays occur.

New York City Early Intervention Program

Policy Title: Requests for Sign Interpreters	Effective Date: 12/13/10
Policy Number/Attachment: 3-C	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> – Request for a Sign Language Interpreter Form – Fax Confirmation of Sign Language Interpreter Assignment – Fax Confirmation of IFSP Meeting with Sign Language Interpreter – Request for Cancellation of Sign Language Interpreter Form 	Regulation/Citation:

I. POLICY DESCRIPTION:

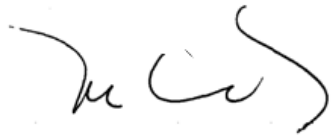
Accurate Communications, Inc. has been contracted by Department of Citywide Administrative Services to perform sign language interpretation for the Department of Health and Mental Hygiene. This is the only agency that the Department can reimburse for sign interpreting for the Early Intervention Program.

Please note that the Department authorizes sign interpreters for **Initial IFSP meetings only**. It is assumed that by the time the child is receiving services that agency personnel will be able to communicate with the parent without the use of an interpreter (as in the case of all families speaking languages other than English).

II. PROCEDURE:

Responsible Party	Action
Initial Service Coordinator (ISC)	<ol style="list-style-type: none"> 1. Contacts the Director of Consumer Affairs (DCA) or designee no later than 48 hours prior to IFSP meeting using the Request for Sign Language Interpreter Form: <ol style="list-style-type: none"> a. Requests only apply to Initial IFSP meetings. 2. Informs DCA at 212-219-0392 and Accurate Communications Inc. at 877-682-1333 if the IFSP meeting is cancelled for any reason: <ol style="list-style-type: none"> a. Notifies the DCA of meeting cancellation by faxing the Request for Cancellation of Sign Language Interpreter Form no later than 48 hours of scheduled meeting. <p>NOTE:</p> <ul style="list-style-type: none"> • Initial Service Coordinators (ISCs) may not request a sign language interpreter directly from Accurate Communications, Inc.
Director of	<ol style="list-style-type: none"> 1. Receives the completed Request for Sign Language Interpreter Form.

Consumer Affairs or Designee	<ol style="list-style-type: none"> 2. Receives a confirmation from an Accurate Communications, Inc. representative by Email or fax. 3. Sends a Fax Confirmation of Sign Language Interpreter Assignment to the ISC, and copies the RO office manager immediately after receiving confirmation of assignment.
Early Intervention Regional Office	<ol style="list-style-type: none"> 1. Reminds the ISC to send a Request for Cancellation of Sign Language Interpreter Form if an IFSP meeting is canceled.
Initial Service Coordinator	<ol style="list-style-type: none"> 1. Completes the Fax Confirmation of IFSP Meeting with Sign Language Interpreter and returns it to the DCA within 12 hours of the scheduled meeting.



Approved By:
Assistant Commissioner, Early Intervention

Date: 11/10/10

NYC EARLY INTERVENTION PROGRAM

REQUEST FOR SIGN LANGUAGE INTERPRETER FORM
FOR INITIAL IFSP MEETINGS ONLY

I. Individualized Family Service Plan (IFSP) Information	
Is this an Initial IFSP meeting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this meeting rescheduled from an earlier date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of this IFSP Meeting: / /	
Time: From: To:	Location:
II. Child Information	
Child's Name:	
EI ID Number:	DOB:
Name of Deaf Individual:	Relationship to child:
III. Initial Service Coordinator (ISC) Information	
ISC Name:	
ISC Agency:	
Telephone #:	Fax #:
IV. Individual to be Contacted the Day of the IFSP Meeting	
Name:	
Telephone #:	

Notification of cancellation for any reason MUST be made by the Service Coordinator no later than 48 HOURS before the date of the IFSP meeting by calling both Beverly Samuels at 212-219-0392 AND Accurate Communications, Inc. at 877-682-1333.

Fax this form to Beverly Samuels at 212-219-5221

INSTRUCTIONS FOR COMPLETION

REQUEST FOR AN INTERPRETER FOR THE DEAF FOR INITIAL IFSP MEETINGS ONLY

This form must be sent to the Director of Consumer Affairs as soon as an IFSP meeting is scheduled when a sign language interpreter is needed. Requests received less than 48 hours before the meeting will not be honored.

NYC Early Intervention Program will provide sign interpreters for Initial IFSP meetings **only**.

This form must be completely filled out and faxed to 212-219-5221. Please follow-up with a phone call to 212-219-0392 to ensure that the form was received.

Confirmation of assignment with the sign interpreter's name will be faxed back to the Service Coordinator as soon as an assignment has been made.



NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas Farley, MD, MPH
Commissioner

Marie B. Casalino, MD, MPH
Assistant Commissioner

Fax Confirmation of Sign Language Interpreter Assignment

Bureau of Early Intervention
93 Worth Street, Room 303
New York, NY 10013

212-219-5213 tel
212-219-5221 fax

TO: _____, **Service Coordinator**

AGENCY:

FAX:

FROM: **Beverly Samuels, Director of Consumer Affairs**

PHONE: **212-219-0392**

TOTAL NUMBER OF PAGES (including cover): 3

MESSAGE: IFSP meeting for _____.

- Notification of cancellation for any reason **MUST** be made by the Service Coordinator at least **48 HOURS** before the date of the IFSP meeting by calling Accurate Communications, Inc. at 1-888-342-1650 and Beverly Samuels at 212-219-0392.

Interpreter's name:

- The Service Coordinator **MUST** fax the attached questionnaire **(Fax Confirmation of IFSP Meeting with Sign Language Interpreter)** to Beverly Samuels at 212-219-5221 within **12 hours** of the scheduled meeting.

This transmission and any attachments may contain confidential and privileged information for the use of the designated recipient named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify us immediately by telephone. Thank you.



**NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE**
Thomas Farley, MD, MPH
Commissioner

Marie B. Casalino, MD, MPH
Assistant Commissioner

Fax Confirmation of IFSP Meeting with Sign Language Interpreter

Bureau of Early Intervention
93 Worth Street, Room 303
New York, NY 10013

212-219-5213 tel
212-219-5221 fax

TO: Beverly Samuels, Director of Consumer Affairs

FAX: 212-219-5221

FROM: _____, Initial Service Coordinator

PHONE:

RE: Sign Interpreting services for initial IFSP meeting for:
Child:
EI ID #:
Date of Meeting:

The Service Coordinator must return this form within **12 hours** of the scheduled meeting.

- The IFSP meeting took place did not take place.
- The parent cancelled/did not show, (circle one if appropriate).
- If the meeting did not take place for any reason, please explain:

- The sign interpreter was/was not present.
- Sign interpreter (name) _____
- There were no problems with the sign interpreter.
- There were the following problems with the sign interpreter:

Other comments:



- Regular
- Emergency

Beverly Samuels – Director,
 Consumer Affairs
 (MHAA-9-0093)
 Phone: (212) 219-0392
 Fax : (212) 219-5221
 e-mail: bsamuell@health.nyc.gov
 Lori Gallo (212) 219-0392

New York
Request for Cancellation of Sign Language Interpreter
Agency: Dept of Health & Mental hygiene
Division: Early Intervention Program
PO # 20090920237

Today's Date:
Client Name:
Case Manager:
Called in by:
Title:
Phone Number: Ext:
Fax Number:
E-mail:
Cancellation Requested: <input type="checkbox"/> ASL Interpreter <input type="checkbox"/> Cued Speech Transliterator <input type="checkbox"/> Other Language
Assignment Date and Time:
Assignment Number:
Assignment Type:
Number of Interpreters:
Location Information:
Name of Person on Site:

*****For Office Use Only*****

Entered in System by :
Date:
Interpreter Notified by:
Date:
Confirmation to Agency sent by:
Date Sent:
Copy of e-mail or fax attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:

Chapter 5: Individualized Family Service Plan (IFSP)

New York City Early Intervention Program

Policy Title: Initial Family Service Plan Scheduling Policy	Effective Date: June 1, 2010
Policy Number: 5-A	Supersedes: N/A
Attachments: 1. IFSP Meeting Request and Confirmation Form 2. Notice of IFSP Meeting (IFSP meeting notice for parents)	Regulation/Citation: NYCRR 69-4.11(a)(1); NYCRR69 -4.11 (a) (5); NYCRR 69 4.20 (b) (3); Early Intervention Administrative Contract with NYS

I. POLICY DESCRIPTION:

“If the evaluator determines that the infant or toddler is an eligible child, the early intervention official shall convene a meeting within 45 days of the receipt of the child’s referral, to develop the initial IFSP, except under exceptional circumstances, including illness of the child or parent.”

“With parent consent, the early intervention official shall convene a conference with the parent, service coordinator, and the chairperson of the Committee on Preschool Special Education or designee, at least 90 days prior to the child’s eligibility for services under education Law, Section 4410, or no later than 90 days before the child’s third birthday, whichever is first to review program options and if appropriate, establish a transition plan.”

“Meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.”

II. PROCEDURE:

Responsible Party	Action
Regional Office Scheduling Unit	Contact the Initial/ Ongoing Service Coordinator or OSC agency representative, via telephone or fax, to determine the family’s preference for IFSP meeting time and location. Note: IFSP scheduling should begin on the same day that the Multidisciplinary evaluation is reviewed in the Regional Office (RO).
Initial/Ongoing Service Coordinator	1. Verbally confirms the meeting time, date, and location of meeting with: <ol style="list-style-type: none"> a. Scheduler, b. Parent/ guardian, c. Evaluation representative or interventionist, and d. Others (with parental consent). 2. Sends IFSP Meeting Request/Confirmation Form to the RO within 48 hours of verbal confirmation. <ol style="list-style-type: none"> a. An evaluation representative or an interventionist must be present at Initial and Annual IFSP meetings.

- b. If the evaluation representative or interventionist cancels, the OSC must notify the Regional Office **24 hours** before the scheduled meeting of their availability by phone.
 - i. The OSC will notify the RO by completing and faxing Section IV of the **IFSP Meeting Request/Confirmation Form**.
- c. If the evaluation site representative/ interventionist is available by phone, s/he should be available for the pertinent portions of the meeting as required by the EIOD (at a minimum: the discussion of the evaluation, outcome determination, and recommendations for services).
- d. OSC must bring a copy of the faxed notification to the Initial or Annual IFSP meeting.

Note:

- Scheduling staff will remove the meeting request from the schedule (calendar) if written confirmation is not received within **48 hours** of the verbal confirmation.
- Scheduling staff may call OSC to confirm cancellation before removing the meeting request from the calendar.

IFSP Review (6/18/36 mo) Meetings:

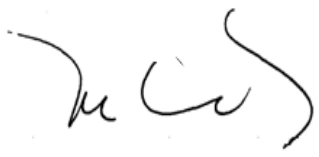
1. OSC will submit the **IFSP Meeting Request/Confirmation Form** to the RO within **48 hours** of verbal confirmation, and note if:
 - a. The parent would like to exercise the option of a paper review with correspondence.
 - b. The parent would like to exercise the option of a conference call
 - i. A working telephone number for the conference must be included, on the **IFSP Meeting Request/Confirmation Form**.
 - c. Any interventionist (s) who is unable to attend should be available by phone.
 - i. Participation is required for the pertinent portions of the meeting as indicated by the EIOD.
 - ii. OSC must send to the RO, via fax, the participant's telephone number.

Note: See **IFSP Review Policy** for details regarding paper review with correspondence.

Transition

1. Prior to the IFSP closest to the child's second birthday, transition should be explained to the parent by the OSC.
2. At the IFSP closest to the child's second birthday, a transition plan should be developed.
 - a. A Transition Conference can only be scheduled with parental consent.
 - b. The Transition Conference can be scheduled in conjunction with an Initial, Annual, or Review IFSP meeting.
3. A representative from the Committee on Preschool Special Education (CPSE) must be invited to the conference. CPSE administrators are not required to attend the transition conference in person; they may be available by phone.
4. The EIOD must be present at the Transition Conference.

	<p>a. If an IFSP Review Meeting is scheduled as a Transition Conference, the EIOD must be present.</p> <p>5. The ISC/OSC must submit the Consent for Transition Conference form signed by the parent when requesting a transition conference with the IFSP Meeting/ Confirmation Form.</p> <p>Note: Participation in a Transition Conference is voluntary on the part of the parent.</p>
<p>Regional Office Scheduling Unit</p>	<p>1. Complete and fax Section II of the IFSP Meeting Request/Confirmation Form:</p> <p>a. The form will indicate confirmation of the IFSP date requested.</p> <p>b. Confirmation for the IFSP is certain only after the Scheduling Unit faxes back a signed IFSP Meeting Request/Confirmation Form.</p> <p>c. If the IFSP can not be confirmed, the Scheduler will give a reason via phone or fax.</p>
<p>Initial/ Ongoing Service Coordinator</p>	<p>1. Receives confirmation of IFSP date, time and location from RO:</p> <p>a. ISC/OSC sends written confirmation to all attendees no later than 2 days before the scheduled meeting.</p> <p>i. See Parent Notice of IFSP Meeting.</p> <p>ii. Final IFSP Meeting Request/Confirmation Form and Parent Notice of IFSP Meeting are kept in the child's Service Coordination file.</p> <p>2. Does <u>not</u> receive confirmation of IFSP date and time from RO</p> <p style="text-align: center;">Or</p> <p>The ISC or OSC, Evaluation Representative, or Parent needs to reschedule:</p> <p>a. ISC/ OSC must submit a new IFSP Request/Confirmation Form with a new date and time.</p> <p>b. ISC/OSC must fill out section III of the IFSP Request/Confirmation Form with the new submission.</p> <p>c. Reason for IFSP meeting reschedule must be included.</p> <p>Note: If an evaluation representative or interventionist is not available for the IFSP meeting, 24 hour advance notice must be submitted to the Regional Office/ EIOD via fax.</p>



Approved By:
Assistant Commissioner, Early Intervention

Date: 4/26/2010



IFSP Meeting Request / Confirmation Form

Section I: IFSP Meeting Request: Completed by Service Coordinator

Date:	Regional Office Fax #	Attn(Scheduler):
Child's Initials	EI #:	Family's phone #
Service Coordinator	SC Phone #:	SC Fax #:

Type of IFSP: Interim Initial Initial with Transition Conference Review Review with Transition Conference Amendment
 Assistive Technology Transition Conference Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the existing plan (SC must submit a copy of this form with the paper review to the EIOD)

Date of IFSP: _____ Location of IFSP Meeting (please check one):
Time of IFSP: _____ Parent Home Agency Regional Office Other location: _____
Address: _____
Phone #(s) of IFSP meeting location : _____
Special Circumstances: _____

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
 Parent Eval. Site/Interventionist Foster Care Agency CPSE Administrator Other: _____
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section II: Meeting Confirmation: Completed by Regional Office

The above IFSP request is confirmed: The above IFSP request CANNOT be confirmed for the following reasons:
 Time/Date not available Other: _____
Signature _____ Date: _____

Section III: Reschedule: Completed by Service Coordinator

Previous IFSP meeting was cancelled due to: Parent Eval. Rep SC EIOD
Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
Date confirmation sent _____ Parent Eval. Site Foster Care Agency CPSE Administrator
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section IV: FAX Confirmation of Provider Availability by Phone: Completed by Service Coordinator

Any person participating by phone is expected to call into the meeting. Providers participating by phone must be available for pertinent portions of the meeting.
Provider will forward a signed attestation page to the EIOD during or within 24 hours of the IFSP meeting.
Who will be available by phone?
 Eval Site Representative Interventionist CPSE Representative Other _____
Phone #(s) of person available by phone: _____
The Service Coordinator MUST notify the RO of the change 24 hrs before the meeting by completing and Faxing Section IV of this form.



IFSP Meeting Request / Confirmation Form

Section I: IFSP Meeting Request: Completed by Service Coordinator

Date:	Regional Office Fax #	Attn(Scheduler):
Child's Initials	EI #:	Family's phone #
Service Coordinator	SC Phone #:	SC Fax #:

Type of IFSP: Interim Initial Initial with Transition Conference Review Review with Transition Conference Amendment
 Assistive Technology Transition Conference Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the existing plan (SC must submit a copy of this form with the paper review to the EIOD)

Date of IFSP: _____ Location of IFSP Meeting (please check one):
Time of IFSP: _____ Parent Home Agency Regional Office Other location: _____
Address: _____
Phone #(s) of IFSP meeting location : _____
Special Circumstances: _____

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
 Parent Eval. Site/Interventionist Foster Care Agency CPSE Administrator Other: _____
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section II: Meeting Confirmation: Completed by Regional Office

The above IFSP request is confirmed: The above IFSP request CANNOT be confirmed for the following reasons:
 Time/Date not available Other: _____
Signature _____ Date: _____

Section III: Reschedule: Completed by Service Coordinator

Previous IFSP meeting was cancelled due to: Parent Eval. Rep SC EIOD
Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
Date confirmation sent _____ Parent Eval. Site Foster Care Agency CPSE Administrator
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

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Type of IFSP: Interim Initial Initial with Transition Conference Review Review with Transition Conference Amendment
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Address: _____
Phone #(s) of IFSP meeting location : _____
Special Circumstances: _____

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Phone #(s) of person available by phone: _____
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Child's Initials	EI #:	Family's phone #
Service Coordinator	SC Phone #:	SC Fax #:

Type of IFSP: Interim Initial Initial with Transition Conference Review Review with Transition Conference Amendment
 Assistive Technology Transition Conference Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the existing plan (SC must submit a copy of this form with the paper review to the EIOD)

Date of IFSP: _____ Location of IFSP Meeting (please check one):
Time of IFSP: _____ Parent Home Agency Regional Office Other location: _____
Address: _____
Phone #(s) of IFSP meeting location : _____
Special Circumstances: _____

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
 Parent Eval. Site/Interventionist Foster Care Agency CPSE Administrator Other: _____
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section II: Meeting Confirmation: Completed by Regional Office

The above IFSP request is confirmed: The above IFSP request CANNOT be confirmed for the following reasons:
 Time/Date not available Other: _____
Signature _____ Date: _____

Section III: Reschedule: Completed by Service Coordinator

Previous IFSP meeting was cancelled due to: Parent Eval. Rep SC EIOD
Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
Date confirmation sent _____ Parent Eval. Site Foster Care Agency CPSE Administrator
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

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Any person participating by phone is expected to call into the meeting. Providers participating by phone must be available for pertinent portions of the meeting.
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Who will be available by phone?
 Eval Site Representative Interventionist CPSE Representative Other _____
Phone #(s) of person available by phone: _____
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IFSP Meeting Request / Confirmation Form

Section I: IFSP Meeting Request: Completed by Service Coordinator

Date:	Regional Office Fax #	Attn(Scheduler):
Child's Initials	EI #:	Family's phone #
Service Coordinator	SC Phone #:	SC Fax #:

Type of IFSP: Interim Initial Initial with Transition Conference Review Review with Transition Conference Amendment
 Assistive Technology Transition Conference Paper Review of IFSP: No formal meeting requested by parent due to no requested changes to the existing plan (SC must submit a copy of this form with the paper review to the EIOD)

Date of IFSP: _____ Location of IFSP Meeting (please check one):
Time of IFSP: _____ Parent Home Agency Regional Office Other location: _____
Address: _____
Phone #(s) of IFSP meeting location : _____
Special Circumstances: _____

Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
 Parent Eval. Site/Interventionist Foster Care Agency CPSE Administrator Other: _____
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section II: Meeting Confirmation: Completed by Regional Office

The above IFSP request is confirmed: The above IFSP request CANNOT be confirmed for the following reasons:
 Time/Date not available Other: _____
Signature _____ Date: _____

Section III: Reschedule: Completed by Service Coordinator

Previous IFSP meeting was cancelled due to: Parent Eval. Rep SC EIOD
Service Coordinator must send written confirmation of the IFSP meeting no later than 2 days before the meeting to:
Date confirmation sent _____ Parent Eval. Site Foster Care Agency CPSE Administrator
Written confirmations must always be sent to the Regional Office within 48 hours of verbal confirmation

Section IV: FAX Confirmation of Provider Availability by Phone: Completed by Service Coordinator

Any person participating by phone is expected to call into the meeting. Providers participating by phone must be available for pertinent portions of the meeting.
Provider will forward a signed attestation page to the EIOD during or within 24 hours of the IFSP meeting.
Who will be available by phone?
 Eval Site Representative Interventionist CPSE Representative Other _____
Phone #(s) of person available by phone: _____
The Service Coordinator MUST notify the RO of the change 24 hrs before the meeting by completing and Faxing Section IV of this form.

**INSTRUCTIONS FOR COMPLETION
IFSP MEETING REQUEST/ CONFIRMATION FORM**

The Service Coordinator (SC) will work with the family to determine a convenient meeting time, date and location for their participation in the IFSP.

The Regional Office (RO) will contact the SC, via the telephone, to determine the family's preference for the meeting. Once the SC is contacted, he/she will complete the IFSP Meeting Request/Confirmation Form as appropriate.

Section I: Completed by SC to submit IFSP meeting request

1. **Date** - Write date that the form is sent to the RO
2. **Child's Initials** - First name initial, then last name initial
3. **EI #** - Child's EI ID #
4. **Family's phone #** - A phone number where the family can be reached at all times
5. **Service coordinator**- Name of SC assigned to the child and family, phone and fax numbers for the SC
6. **Type of IFSP**- Check type of meeting scheduled.
7. **Date & Time Requested for IFSP** – Write the date and time of the IFSP meeting **AFTER** it is verbally confirmed with RO Scheduling Unit, parent/guardian, evaluation site representative and others (if applicable and with parent consent).
8. **Location of IFSP Meeting, and Address** – Check the location and write the address **AFTER** it is verbally confirmed with the RO Scheduling Unit, parent/guardian, evaluation site representative and others (if applicable and with parent consent).
9. **Phone Number of IFSP meeting location** - The phone number to be called by members participating by phone.
10. **Special Circumstances:** Describe any special circumstances for which you are requesting more time for the meeting when the situation is complex enough to warrant additional time. It should not be presumed that certain diagnoses, e.g., PDD/autism, will need additional time. As appropriate, the RO will try to schedule additional time.
11. **Service Coordinator must send written confirmation 2 days before the meeting to** – Check the boxes for those invited to attend and sent written confirmation of the scheduled meeting. Send copies of written confirmations to the RO within 48 hours of the verbal confirmation.

Section II: Completed by RO Scheduling Unit when confirming a requested or rescheduled IFSP meeting:

1. **The above IFSP request is confirmed** – Check as confirmation of verbal confirmation if SC faxes form to RO within 48 hours of verbal confirmation.
2. **The above IFSP request CANNOT be confirmed for the following reasons** – Check all applicable choices. If this form is not received within 48 hours of verbal confirmation, the meeting slot will be removed from the schedule.
3. **Signature and Date** – RO staff will sign, date, and fax back to the SC final confirmation of the meeting request. Meetings are considered confirmed only after the RO faxes back, at least two days before the IFSP date, a signed confirmation/written notice to the SC. A copy of this form will be filed in the child's chart.

Section III: Complete only if the request is to reschedule an already confirmed meeting.

1. **Previous IFSP meeting was cancelled due to** – Check the box indicating who cancelled the previous IFSP meeting when rescheduling.
2. **Service Coordinator must send written confirmation 2 days before the meeting to** - Check those who you invited to attend and sent written confirmation of scheduled meeting. Write date confirmation was sent. Send copies of written confirmations to the RO within 48 hours of verbal confirmation.

Section IV: Complete only if the Evaluation representative, Interventionist or CPSE representative will be available by phone for the meeting.

1. **Who will be available by phone** – Check the appropriate box to indicate who will be available via conference call.
2. **Phone Number(s) of person available by phone** – Provide all the phone numbers of any individual participating by phone.

The SC must complete and fax this form to the RO at least 24 hours prior to the IFSP meeting when s/he finds out that any of the participants will be available by phone. A copy of the fax confirmation of this form should be brought to the IFSP meeting.

The evaluation site representative or interventionist is expected to call in at the scheduled time of the meeting and to be available for the pertinent portions of the meeting as required by the EIOD (at a minimum: the discussion of the evaluation, outcome determination and recommendations for services).

- The evaluation site representative or interventionist is expected to fax to the EIOD his/her signed attestation (p. 8 of the IFSP) within 24 hours of the IFSP meeting.

Unless the signed attestation form is received from the evaluation site representative or the interventionist, this participant is considered absent from the meeting.

**NYC Early Intervention Program
Notice of IFSP Meeting**

Parent's Name

Date

Address

Dear _____,

As we discussed, an IFSP meeting has been scheduled for your child. The IFSP meeting will be held on (date/time) _____ at (location) _____

As we also discussed, if available, please bring the following information to the meeting:

1. Health insurance information;
2. Social Security Numbers for you and your child;

If you do not have some of this information, services will still be authorized for your child and family.

You have the following rights at the IFSP meeting:

1. You have the right to participate in the IFSP meeting where the needs of your child and family are discussed and a service plan is developed.
2. You have the right to consent to or refuse to consent to any services recommended at the IFSP meeting. If you give consent for services, you can withdraw it at any time.
3. You have the right to review and obtain copies of all records used for the meeting.
4. You have the right to disagree with some parts of the IFSP and you may file a systems complaint or request mediation or an impartial hearing (due process). Please refer to **A Parent's Guide to the Early Intervention Program** if you need more information:

www.health.state.ny.us/community/infants_children/early_intervention

5. If you request due process, all services in dispute must continue without change until after the mediation and/or impartial hearing is held.

If the time or place listed above is not convenient for you or you have any additional questions, we can reschedule this meeting. Please call me at (_____) _____ if you have any questions.

Sincerely,

Name

Title

Programa de Intervención Temprana de la Ciudad de New York
Notificación de la Reunión Individualizada de Servicios para la Familia

Nombre de Padre

Fecha

Dirección

Estimado _____,

Como acordamos anteriormente, una reunión para desarrollar un plan de servicios individualizado para la familia (IFSP) ha sido programada para su niño/a.

La reunión se llevara a cabo el _____ en

_____.

Como también acordamos, si los tiene disponible, por favor traiga con usted la siguiente información:

1. Información sobre seguro medico
2. Números de Seguro Social para usted y su niño/a.

Si no tiene esta información, esto no impide que se le autoricen los servicios para su niño y familia.

Usted tiene los siguientes derechos en esta reunión:

1. Tiene derecho de participar en la reunión donde se hablara sobre las necesidades de su niño/a y familia y se desarrollará un plan de servicios.
2. Tiene el derecho de dar su consentimiento o rehusar a dar su consentimiento a cualquiera de los servicios recomendados en la reunión. Si da su consentimiento, puede revocar ese consentimiento en cualquier momento.
3. Tiene el derecho a revisar y obtener copias de todos los documentos usados en esta reunión.
4. Tiene el derecho de estar en desacuerdo con algunas partes del plan de servicios y puede pedir una mediación y/o una audiencia imparcial. Por favor refiérase a la Guía para los Padres del Programa de Intervención Temprana si necesita mas información:
www.health.state.ny.us/community/infants_children/early_intervention
5. Si pide una mediación y/o audiencia imparcial, todos los servicios que se disputan continuaran sin cambios hasta que la mediacion y/o audiencia imparcial se lleve a cabo.

Si el lugar o la hora de esta reunión no son convenientes para usted o tiene preguntas adicionales, podemos cambiar la fecha. Por favor llámeme al _____ con sus preguntas.

Sinceramente,

Nombre

Titulo

New York City Early Intervention Program

Policy Title: The Initial Individualized Family Service Plan Meeting	Effective Date: June 1, 2010
Policy Number: 5-B	Supersedes: N/A
Applicable Forms: <ul style="list-style-type: none"> - Consent to Release/Obtain Information - “Your Family Rights in Early Intervention” - Social Security Number Collection Form IFSP Forms <ul style="list-style-type: none"> - Page 1: Identifying Information - Page 2: Current Development, and Family Concerns - Page 3: Daily Routines, Parent Priorities and Resources - Page 4: Functional Outcomes - Page 5: Service plan: Service Setting and Incorporating Interventions into Natural Routines. - Page 5a: Service Authorization Data Entry Form - Page 5b: Co-visits (if applicable) - Page 6: Transportation, Assistive Technology, and Respite Services (if applicable) - Page 7: Service Coordination Activities - Page 7A and 7B: Transition Plan (if applicable) - Page 8: Attestations, Consent for Services - Transportation Data Entry Form (If applicable) - Assistive Technology Data Entry Form (If applicable) 	Regulation/Citation: NYCRR 69-4.11(a)(1); NYCRR 69-4.11 (6); Early Intervention Memorandum 95-2

I. POLICY DESCRIPTION:

“If the evaluator determines that the infant or toddler is an eligible child, the early intervention official shall convene a meeting within 45 days of the receipt of the child’s referral, to develop the initial IFSP...(NYCRR 69-4.11(a)(1)) ”

“The early intervention official, initial service coordinator, parent and evaluator or designated contact for the evaluation team shall jointly develop an IFSP for a parent who requests services. (NYCRR 69-4.11 (6))”

“The written IFSP document is developed through a collaborative planning process intended to result in a service package tailored to the child’s unique developmental strengths and needs, and responsive to the family’s concerns, resources, and priorities for their child’s development.... The team goal is to:

- Develop outcomes to meet child and family needs that are relevant to the Early Intervention Program.
- Agree on appropriate Early Intervention services that will be provided to achieve identified outcomes.
- Identify and mobilize other services and supports which are not reimbursed or required by the Early Intervention Program, but will enhance the child’s development and family’s capacity to care for their child.”
(Early Intervention Memorandum 95-2)

II. PROCEDURE:

Responsible Party	Action

<p>Early Intervention Official Designee</p>	<p>The initial Individualized Family Service Plan (IFSP) meeting is convened at a time and place convenient to the family and within 45 calendar days of receipt of the child’s referral to the New York City Early Intervention Program (EIP).</p> <p>The IFSP is the written plan for providing Early Intervention (EI) services to an eligible child and family. The IFSP is an agreement between the parent and the Early Intervention Official Designee (EIOD). The IFSP is developed collaboratively by a team of individuals. Each member of the team serves a primary role:</p> <ul style="list-style-type: none"> • Parent(s): Describes the child; provides information on the family’s resources, priorities, and concerns; collaborates with the other team members to develop desired outcomes for the child and family for the next six (6) months; determines with the EIOD what services will be authorized. • Initial Service Coordinator (ISC): Provides support to the family during the meeting, encouraging their participation; contributes to the discussion as appropriate, writes the IFSP document. • Early Intervention Official Designee (EIOD): Facilitates and guides the meeting ensuring team participation; determines with the parent what services will be authorized. • Evaluator: Participates in the development of the IFSP by providing clinical input based on the Multidisciplinary Evaluation (MDE). • Advocate or person outside the family (if invited by the parent). • Foster care caseworker (if appropriate). • Committee of Pre-school Special Education (CPSE) administrator (if Initial IFSP is also a Transition Conference). • Service providers (as appropriate). • Other persons such as the child's primary health care provider or child care provider whom the parent(s) or ISC (with the parent's consent) may invite. <ol style="list-style-type: none"> 1. The EIOD facilitates the IFSP meeting by: <ol style="list-style-type: none"> i. Introducing all members, reviewing parent rights; ii. Encouraging the active participation of the parent(s), the representative of the evaluation team, the ISC, and any other individual(s) present. 2. The EIOD determines if the parent(s): <ol style="list-style-type: none"> i. Received the written MDE report and summary, “Your Family Rights in Early Intervention,” and “A Parent’s Guide” <ol style="list-style-type: none"> a. If parent has not received a copy of “A Parent’s Guide”: <ul style="list-style-type: none"> • EIOD will provide a copy or weblink (with parental consent) to the guide by the end of the meeting. ii. Provided insurance information <ol style="list-style-type: none"> a. If the parent has not provided insurance information or has updates to the insurance information, the EIOD: <ul style="list-style-type: none"> • Informs the parent about the use of insurance information in EIP. • Completes the insurance section on Page 5a of the IFSP: Service Authorization Data Entry Form. iii. Understands the results of the evaluation <ol style="list-style-type: none"> a. If parent has not received a written copy of the MDE and summary, the EIOD: <ul style="list-style-type: none"> • Asks if the parent feels comfortable proceeding with the meeting if the evaluation team representative explains the results before the meeting begins, and if not, • Postpones the IFSP meeting until the parent has had an opportunity to read and discuss the results of the MDE with the Evaluator, and share reactions to
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the MDE with the ISC.

3. Team completes IFSP:

i. Page 1: **Identifying Information**

- a. Identify demographic information and attendees at the meeting;
 - Indicate Race and Ethnicity (required).
- b. Collect relevant medical information, including diagnosis, medical alerts (allergies, medications) and results of hearing and vision screening.
- c. If a participant is present by telephone conference, note as such on this page.
 - If the Evaluation Representative is available by phone s/he should be available for the pertinent portions of the meeting as required by the EIOD (at a minimum: the discussion of the evaluation, outcome determination and recommendations for services).
 - The Evaluation Representative must also sign the attestation (IFSP Page 8) and return it to the Regional Office (RO) for inclusion with the IFSP.

ii. Social Security Information

- a. **Social Security Number Collection** form MUST be completed by the EIOD as per State Department of Health (SDOH) guidance.
- b. The Early Intervention Program (EIP) will provide services whether or not the parent provides Social Security Numbers.

iii. Page 2: **Current Development and Family Concerns**

- a. Document family concerns in each area of development, and if family concerns reflect those in the MDE.
 - a. MDE Summary must be attached to Page 2 of the IFSP.

iv. Page 3: **Daily Routines, Parent Priorities, and Resources**

- a. Team discusses:
 - Which daily routines are most affected by the developmental concerns identified on Page 2;
 - Parents' priorities for their child's development;
 - Other persons involved in child's daily care;

NOTE:

- Information gathered about daily routines and activities should guide the development of functional outcomes in the **Service Plan** Section (Pages 4 & 5).
- The resource section of Page 3 must be filled out by the ISC and parent prior to the IFSP meeting and reviewed by the team at the meeting.

v. Page 4: **Functional Outcomes**

- a. EIOD will emphasize that functional outcomes are the cornerstone of the IFSP which describe the practical, desired results that the EI services will help the child and family achieve in the next six (6) months.
- b. Before any functional outcomes are written, the EIOD will discuss that outcomes are:
 - Related to everyday routines, activities, and priorities identified during the discussion on page 3;
 - Designed to help the parent/caregiver encourage the child's development;
 - Developmentally appropriate for the child;
 - Specific and designed to be achieved in the authorization period of the IFSP (next six (6) months); and
 - Described in a manner agreed upon by the IFSP team.
- d. Once the functional outcome(s) is developed, the team will write the objectives (short term goals) necessary to achieve the functional outcome.

- vi. Page 5: Service plan: **Service Setting and Incorporating Interventions into Natural Routines.**
 - a. EIOD will explain that federal and state law requires that services be delivered in the natural environment of the child and family whenever possible.
 - SDOH regulations [NYCRR 69-4.1(ae)] define 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..., child care setting, or other community setting in which children without disabilities participate.”
 - EI services can be delivered in places where the child and family normally spend their time and include activities that are part of the child’s and family’s typical routine;
 - If services will not be delivered in the natural environment, indicate why this is appropriate.
 - b. Team discusses ways in which the therapists may involve and coach the family in using everyday activities/routines as learning opportunities for the child.
 - c. Ways in which parent/caregiver would like to be involved in the child’s EI services will also be discussed.
 - vii. Page 5a: **Service Authorization Data Entry Form**
 - a. Team discusses types of services which could best achieve the outcomes developed on page 4 and discussion on page 5.
 - b. EIOD and parent(s) agree on the service plan to be authorized.
- NOTE:** Service authorizations are written for a maximum period of six (6) months and reauthorized, terminated or amended, as appropriate, based upon the child’s progress and current needs every six (6) months.
- viii. Page 5b: **Co-visits**
 - a. Periodic co-visits (e.g., monthly, bimonthly, quarterly) *are not considered necessary for all children and families* in the EIP. However, when children are experiencing multiple delays and/or disabilities that affect multiple areas of development and functioning (such as Cerebral Palsy, Autism, Down Syndrome, and other conditions), and families are receiving EI services from two or more professionals, the IFSP team may consider the use of co-visits. (per 2006 SDOH Guidance letter)
 - **The reason for a co-visit must be documented in the IFSP.**
 - Co-visits should use existing service units whenever possible. However, there may be particular situations that require the authorization of additional service units and /or a waiver.
 - ix. Page 6: **Transportation, Assistive Technology, and Respite Services**
 - a. Transportation: If services will not be delivered in the home:
 - i. The IFSP Team will discuss transportation options in the order that they are listed on page 6:
 - ii. Consideration is first given to transportation being provided by the parent of a child to Early Intervention services.
 - iii. If car service is authorized, a responsible adult must accompany the child.
 - iv. Transportation services can only be provided by approved providers to:
 - Sites that have SDOH and New York City Department of Health and Mental Hygiene approval, and
 - Subcontracted sites which are listed on the agency’s NYC EIP contract.
 - b. Assistive Technology
 - i. Refer to Policy on *Assistive Technology*
 - c. Respite Services
 - i. Refer to Policy on *Respite Services*

- x. Page 7: **Service Coordination Activities**
- a. EIOD ensures that the parent is given a choice of Ongoing Service Coordinator (OSC).
 - i. Use the **2009 Active Providers, Languages and Specialties** list to give parents the choice of OSC.
 - b. IFSP team identifies specific areas where the OSC will assist the family such as:
 - i. Applying for Public Programs;
 - ii. Applying for other non-EI services needed by child/family;
 - iii. Monitoring all services, including co-visits;
 - iv. Locating bilingual services as authorized; and
 - v. Assisting the family with transition.
 - c. Inquire if parent would like to release EI information to the child's Primary Health Care Provider
 - i. If yes, obtain parent consent on this page.
 - d. IFSP team will discuss any additional concerns and note them in the *Additional Concerns* section such as:
 - i. Services that have been recommended but rejected by parent;
 - ii. Reason for waiving billing rules;
 - iii. If the discussion indicates that another evaluation type is needed, document evaluation type and concern.
 - Complete **Request for Additional Evaluation** form and attach to IFSP document
- xi. Page 7A and 7B: **Transition Plan**
- a. The Transition Plan pages must be completed at the Initial IFSP meeting for children entering the EIP after age 2.
 - i. Transition must be discussed at the initial IFSP including:
 - Government service options such as CPSE, Office of Mental Retardation and Developmental Disabilities (OMRDD) and Head Start.
 - Private Service options such as Preschool and Playgroup.
 - ii. Steps that will be taken to ensure a smooth Transition such as:
 - Information about site visits,
 - Information on how to contact community agencies.
 - iii. If parent has declined the Transition Conference:
 - Refusal must be documented on page 7A.

NOTE: Prior to proceeding to the attestation section of the IFSP, the EIOD ensures that all of the necessary information is documented in the IFSP, especially:

- **MDE Summary must be attached to Page 2 of the IFSP**
Information must include a general statement about the child's overall development.
- **Functional Outcomes (page 4);**
- **Service Plan: Service Settings (Page 5);**
- **Service Authorization Data Entry Form (s) (Page 5a)**
- **Transportation and Respite Services and AT devices (if applicable) (Page 6);**
- **Selection of the Ongoing Service Coordinator (Page 7);**
- **Additional Concerns (Page 7); and**
- **Transition out of the Early Intervention Program (if applicable).**

xii. Page 8: **Attestations, Consent for Services**

- a. EIOD will inform the family that:
 - i. If the parents believe the child needs a change in services not recommended on the IFSP, they have the right to request an amendment to the IFSP.

	<ul style="list-style-type: none"> ii. Justification for the change is required. (See section on <i>Amendments</i> in this chapter.) iii. If the request is not approved by the EIOD, the parent will receive Prior Written Notice from the EIP iv. Parent has the right to accept or decline any EI service without jeopardizing other EI services. v. No services can be provided without written parental consent. vi. Occupational Therapy, Physical Therapy, and Nursing services cannot begin without a prescription from a primary care provider. <p>b. Parent signs to attest that:</p> <ul style="list-style-type: none"> i. S/he understands his/her rights under EI ii. S/he agrees/ disagrees with the Plan: <p>c. If the EIOD and the parent(s) agree on the services authorized and the parent has selected an ongoing service coordinator:</p> <ul style="list-style-type: none"> i. The IFSP is considered final and is signed by the EIOD and parent. <p>d. If the EIOD and the parent(s) do not agree on all aspects of the IFSP:</p> <ul style="list-style-type: none"> i. The services that the parent and EIOD agree upon are to be implemented at the conclusion of the IFSP meeting; ii. The EIOD should explain the parent's due process rights and assist the parent accordingly to resolve the disagreement (e.g., re-evaluation, mediation, impartial hearing,). iii. The EIOD will clearly document all services offered and those declined by the parent. <p>4. EIOD must accurately complete the legally mandated components of the IFSP, including:</p> <ul style="list-style-type: none"> • Collection of Social Security Numbers form; • Consent to Release/Obtain Information form, and when needed; • Transportation Service Data Entry Form (if applicable); and • Assistive Technology Device Data Entry Form (if applicable). <p>5. Completed IFSP package is copied, and all IFSP team members receive a copy:</p> <ul style="list-style-type: none"> a. Copies of the Transportation Services Data Entry Form(s) and the Assistive Technology Device Data Entry Form(s) are distributed to Data Operations and provider agencies only: b. Collection of Social Security Information form is maintained in the RO and NOT given to providers or the OSC. c. If the IFSP meeting is held in the parent's home or other location where the IFSP cannot be copied: <ul style="list-style-type: none"> i. The EIOD will ensure that the OSC gets copies of the IFSP document within one (1) week of the authorization. ii. OSC will ensure all other meeting participants receive a copy of the IFSP expeditiously, but no later than 48 hours after receipt.
Regional Office Data Entry Staff	<ul style="list-style-type: none"> 1. IFSP is checked for completeness. 2. IFSP is scanned and given a barcode. 3. IFSP is sent to EI Data Operations for entry into the KIDS system. 4. After data entry, IFSP is returned to the RO to be filed.

Approved By: 

Date: 4/26/2010

Assistant Commissioner, Early Intervention

New York City Early Intervention Program

Policy Title: The Individualized Family Service Plan Review	Effective Date: June 1, 2010
Policy Number: 5-C	Supersedes: N/A
Department/Unit: Applicable Forms: <ul style="list-style-type: none"> - Consent to Release/Obtain Information - “Your Family Rights in Early Intervention” - Provider Progress Notes - Parent Progress Notes (if applicable) - IFSP Meeting Request/Confirmation Form IFSP Forms <ul style="list-style-type: none"> - Page 1: Identifying Information - Page 4: Functional Outcomes - Page 5: Service plan: Service Setting and Incorporating Interventions into Natural Routines. (if applicable) - Page 5a: Service Authorization Data Entry Form - Page 5b: Co-visits (if applicable) - Page 6: Transportation, Assistive Technology, and Respite Services (if applicable) - Page 7: Service Coordination Activities (if applicable) - Page 7A and 7B: Transition Plan (if applicable) - Page 8: Attestations, Consent for Services - Transportation Data Entry Form (if applicable) - Assistive Technology Data Entry Form (if applicable) 	Regulation/Citation: NYCRR 69-4.11(b)

I. POLICY DESCRIPTION:

“The IFSP shall be reviewed at six (6) 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.” “IFSP Reviews shall be conducted by a meeting or other means amenable to the parent”.

II. PROCEDURE:

Responsible Party	Action
Early Intervention Service Provider Agency	<ol style="list-style-type: none"> 1. Discuss the current service plan with the parent to determine if: <ol style="list-style-type: none"> a. Service changes may be necessary b. If the parent would like a face-to-face meeting with the Early Intervention Official Designee (EIOD) 2. Ensure that all Provider Progress notes are forwarded to the Ongoing Service Coordinator (OSC) at least (2) weeks before the expiration of the IFSP period.
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. Gather the following information at least (2) weeks before the expiration of the IFSP: <ol style="list-style-type: none"> a. Three (3) and Six (6) month Progress Notes from each interventionist for each service type; or documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider. b. Three (3) and Six (6) month Parent Progress Notes, (if the parent chose to complete). c. Calendars or alternate tools completed by the parent, if available. d. Supplemental Evaluations and/or Justifications for Changes in Services <p>Note: Parents/caregivers should receive a copy of all progress notes prior to the IFSP meeting so that they may review them.</p>

2. Contact the Regional Office (RO) scheduling staff by phone to arrange for the IFSP meeting. This should be done at least two (2) weeks before the end of the IFSP period.
 - a. Submits the IFSP **Meeting Request/Confirmation Form** to the RO scheduling staff within 48 hours of verbal confirmation from the RO Scheduling Staff, and notes if:
 - i. The parent would like to exercise the option of a review of applicable records and meeting with the Interventionists and Ongoing Service Coordinator (OSC) (referred to as paper review with correspondence).
 - A paper review with correspondence can be conducted when:
 - There is no requested change in services, **and**
 - Parent does not request an in-person meeting, **and**
 - An in-person meeting was conducted at the most recent IFSP (for example, Initial and Annual IFSPs are held in person).

Note:

- When the above conditions are met, a paper review may be conducted and services reauthorized for six (6) months.
 - When a paper review is confirmed, *the Early Intervention Official Designee (EIOD) will not be present at the IFSP review meeting.*
 - ii. The parent would like to exercise the option of a conference call with the EIOD present:
 - Phone conference number must be noted on the **Meeting Request/Confirmation Form**.
 - OSC will ensure contact information is current and correct for the parent and interventionist(s).
 - b. If information is needed from an interventionist (s) who is(are) unable to attend:
 - i. RO should be notified **24 hrs** before the scheduled meeting via fax (refer to the policy on *Scheduling* in this chapter of the manual).
 - ii. The individual(s) should participate through a telephone conference call.
 - Interventionist(s) participating through a conference call should be available for the pertinent portion of the meeting as required by the EIOD (at a minimum: the discussion of child progress, outcome determination and recommendations for services).
3. OSC is responsible for obtaining and sending the following documents to the RO **at least two (2) weeks prior to the expiration date of the current IFSP:**
 - a. Three (3) and Six (6) month **Provider Progress Notes** from each interventionist for each service type; or documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider.
 - b. Three (3) and Six (6) month Parent Progress Notes (if parent has chosen to complete).
 - c. Calendars or alternate tools completed by the parent (if available).
 - d. **Supplemental evaluations and/or Justifications for Changes in Services**
 - i. If a supplemental evaluation was approved prior to the meeting, it is expected that the report will be made available prior to the IFSP meeting.
 4. The OSC should bring a copy of the previous IFSP (Initial or Annual) to the Review meeting with all other documents that reflect current child development such as:
 - a. Private evaluations
 - b. Updated medical information

Note:

- Missing Progress Notes will not prevent convening an IFSP Review meeting.
- **No changes in services will be authorized if sufficient information, (ex: progress notes for the particular service type, additional evaluations etc.) noting child status, is not available at the meeting.**

Regional Office	<ol style="list-style-type: none"> 1. Collect Progress Notes sent by the OSC <ol style="list-style-type: none"> a. If progress notes are not received two (2) weeks prior to scheduling the IFSP meeting:
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<p>Scheduling Staff</p>	<ul style="list-style-type: none"> i. RO will call the OSC to follow-up on the receipt of the progress notes. ii. If the OSC remains unable to collect the Progress Notes: <ul style="list-style-type: none"> • Program Monitoring and Quality Improvement (PMQI) will be notified by the RO for follow-up action.
<p>EIOD/ Ongoing Service Coordinator</p>	<ol style="list-style-type: none"> 1. Convene the Six (6) Month Review meeting at least two (2) weeks prior to the expiration date of the current IFSP. The participants include: <ul style="list-style-type: none"> • The parent(s) • The Early Intervention Official Designee (EIOD) (when required) • The Ongoing Service Coordinator (OSC) • The evaluator or interventionist(s) working with the child and family • The foster care worker (if appropriate) • Any other person whom the parent or the service coordinator, with the parent’s consent, invites. 2. Inform the parent of his/her rights, and give him/her “<i>Your Family Rights In Early Intervention</i>” 3. Ask the parent if there are any changes in the child’s insurance coverage. <ol style="list-style-type: none"> a. Enter updated Insurance information on Page 5a of the IFSP: Service Authorization Data Entry Form. 4. Facilitate a team review and discussion of: <ol style="list-style-type: none"> a. The current needs of the child and family b. Progress toward achieving outcomes c. The effectiveness of strategies used during intervention sessions d. Any needed modification of the outcomes or Early Intervention (EI) services 5. Complete the Six (6) Month IFSP required paperwork: <ol style="list-style-type: none"> a. Page 1: Identifying Information, Signatures <ol style="list-style-type: none"> i. New form is completed with current demographic information and signatures of all present at the meeting. ii. If an EIOD/evaluator/interventionist participates via telephone conference, document it on this page. b. Page 4: Functional Outcomes <ol style="list-style-type: none"> i. Update (as per the instructions for this page) <ul style="list-style-type: none"> • Indicate outcomes that have been met, need to be revised, and those that will continue as previously written. • New or revised outcomes should be written on a new Functional Outcomes page. <p>Note: Both Functional Outcomes Pages must be included in the completed IFSP Packet if new /revised outcomes are developed.</p> <ol style="list-style-type: none"> c. Page 5: Service Setting <ol style="list-style-type: none"> i. Only completed if a new services setting is authorized. d. Page 5a: Service Authorization Data Entry Form <ol style="list-style-type: none"> i. New Service Authorization data Entry Form must be written at the Six (6) Month Review by the facilitator of the meeting (EIOD or OSC). ii. The <i>Effective Date of IFSP</i> must be the day after the <i>End Date</i> of the <u>previous</u> IFSP. d. Page 7a and 7b: Transition Plan <ol style="list-style-type: none"> i. Update or complete Transition Plan for all children in EI who are: <ul style="list-style-type: none"> • Leaving EI for any reason; or • If the Review IFSP is closest to the child’s second birthday. ii. A child may receive EI services only until the day before his/her third birthday unless s/he has been found to be eligible for services from the Committee on Pre-School Special Education (CPSE). iii. The parent is responsible for making the referral to CPSE.

- iv. The OSC will assist the parent with making the referral to CPSE. (Refer to Transition Chapter for more information and specific time frames for referral.)

Note: An IFSP Review meeting may be combined with a Transition Conference when appropriate.

e. Page 8: **Attestations, Consent for Services**

- i. New **Consent Page** with parent signature(s) and EIOD stamp and signature is required.

Note: Updated information can be added to other pages of the current IFSP, but *it is not necessary to write an entire new IFSP*.

g. **Transportation Service Data Entry Form(s)**

- i. New Authorization Worksheet must be written at the conclusion of the Six (6) Month Review by the facilitator of the meeting (EIOD or OSC).
- ii. The *Effective Date of IFSP* must be the day after the *End Date* of the previous IFSP.

Note:

- In the rare circumstance that the review meeting or paperwork cannot be completed **before** the expiration of the current IFSP **and** the provider agency continues to provide services as previously authorized, the *Begin Date* of service(s) is written as:

- The day after the *End Date* of services on the previous IFSP Page 5a: **Service Authorization Data Entry Form**.
- **The *Begin date* will cover the time period in which services have continued past the prior authorization period (usually the date of the IFSP).**

- The *End Date* of that/those service(s) will be :

- The *End Date* of the six (6) month IFSP period if:
 - The service ended at the end date of the six (6) month IFSP

OR

- The date the particular service will end if changes in service are agreed upon at this IFSP meeting:
 - If the services continued past the end date of the six (6) month IFSP
- In such situations, the EIOD or OSC will write a new service authorization line reflecting the change on the IFSP Page 5a: **Service Authorization Data Entry Form** and/or write an additional IFSP Page 5a: **Service Authorization Data Entry Form** for the new provider agency.

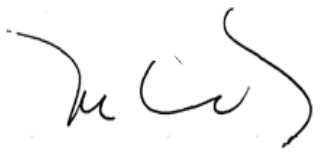
Conclusion of the IFSP Review Meeting:

1. If the EIOD is not present at the review meeting:
 - a. The completed review IFSP is sent to the EIOD who reviews, stamps and signs the IFSP document.
 - i. If the IFSP review is incomplete, the EIOD will notify the OSC by phone or fax.
 - ii. The EIOD may send the six (6) month review back to the OSC without authorization if documentation or corrections are not received by the EIOD within a week.
 - Services that the child is currently receiving will not be impacted.
 - b. The EIOD sends the authorized IFSP back to the OSC.
2. If the meeting is convened and services authorized by the EIOD:
 - a. The EIOD will ensure that the OSC gets copies of the IFSP document within one (1) week of the authorization.
 - i. OSC will ensure all other meeting participants receive a copy of the IFSP expeditiously, but no later than 48 hours after receipt.
 - Copies of the Service Authorization Forms are distributed to Data Operations and provider agencies only:

Regional

1. EIOD submits the approved **Six (6) Month Review and Data Entry Form(s)** to Data

Office Data Entry Staff	Central.
Ongoing Service Coordinator	<ol style="list-style-type: none">1. Sends copies of the Six (6) Month Review to all providers of services and to the parents.2. Ensures that new services begin within two (2) weeks of the authorization on the IFSP (see Policy on <i>Start Date of Services</i>).



Approved By:
Assistant Commissioner, Early Intervention

Date: 4/26/2010

New York City Early Intervention Program

Policy Title: The Annual Individualized Family Service Plan	Effective Date: June 1, 2010
Policy Number: 5-D	Supersedes: N/A
Applicable Forms: <ul style="list-style-type: none"> - Consent to Release Information - “Your Family Rights in Early Intervention” - Provider Progress Notes - Parent Progress Notes (if applicable) - IFSP Meeting Request/Confirmation Form IFSP Forms <ul style="list-style-type: none"> - Page 1: Identifying Information - Page 2: Current Development, and Family Concerns - Page 3: Daily Routines, Parent Priorities and Resources - Page 4: Functional Outcomes - Page 5: Service plan: Service Setting and Incorporating Interventions into Natural Routines. - Page 5a: Service Authorization Data Entry Form - Page 5b: Co-visits (if applicable) - Page 6: Transportation, Assistive Technology, and Respite Services (if applicable) - Page 7: Service Coordination Activities - Page 7A and 7B: Transition Plan (if applicable) - Page 8: Attestations, Consent for Services - Transportation Data Entry Form (if applicable) - Assistive Technology Data Entry Form (if applicable) 	Regulation/Citation: 10NYRR69-4.11(b)(3)

I. POLICY DESCRIPTION:

“An IFSP meeting shall be conducted at least annually to evaluate the IFSP for the child and the 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.”

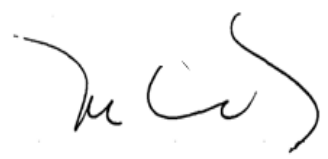
II. PROCEDURE:

Responsible Party	Action
Early Intervention Service Provider Agency	<ol style="list-style-type: none"> 1. Discuss the current service plan with the parent to determine if: <ol style="list-style-type: none"> a. Service changes may be indicated, and b. The parent would like a face-to-face meeting with the Early Intervention Official Designee (EIOD). 2. Ensure that all Provider Progress notes are forwarded to the Ongoing Service Coordinator (OSC) at least two (2) weeks prior to the expiration of the IFSP.
Ongoing	<ol style="list-style-type: none"> 1. Gather the following information at least two (2) weeks before the expiration

<p>Service Coordinator</p>	<p>of the IFSP:</p> <ol style="list-style-type: none"> a. Nine (9) and Twelve (12) month Provider Progress Notes from each interventionist for each service type; or <ol style="list-style-type: none"> i. Documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider. b. Nine (9) and Twelve (12) month Parent Progress Notes, if the parent chooses to complete. c. Calendars or alternate tools completed by the parent, if available d. Supplemental Evaluations and/or Justifications for Changes in Services. <ol style="list-style-type: none"> 2. Contact the Regional Office (RO) scheduling staff to arrange for the IFSP meeting. This should be done two (2) weeks before the end of the IFSP period. 3. Submit the IFSP Meeting Request/Confirmation Form to the RO scheduling staff within 48 hours of verbal confirmation from the RO. <ol style="list-style-type: none"> a. Refer to the policy on <i>IFSP Scheduling</i>. <p>Note:</p> <ul style="list-style-type: none"> - Required participants for the Annual IFSP meetings must meet in-person. - If an Interventionist is unable to attend: <ul style="list-style-type: none"> • RO should be notified 24 hrs before the scheduled meeting via fax by the provider agency. • That individual(s) should participate through a telephone conference call. • Interventionist(s) participating through a conference call should participate for the pertinent portions of the Annual IFSP meeting as required by the EIOD (at a minimum: the discussion of child progress, outcome determination and recommendations for services). <ol style="list-style-type: none"> 4. Submit the following documents to the RO at least two (2) weeks prior to the expiration date of the current IFSP: <ol style="list-style-type: none"> e. Nine (9) and Twelve (12) month Provider Progress Notes from each interventionist for each service type; or <ol style="list-style-type: none"> i. Documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider f. Nine (9) and Twelve (12) month Parent Progress Notes (if parent has chosen to complete). g. Calendars or alternate tools completed by the parent (if available). h. Supplemental evaluations and/or Justifications for Changes in Services <ol style="list-style-type: none"> i. If a supplemental evaluation was approved prior to the meeting it is expected that the report will be made available prior to the IFSP meeting 5. Bring a copy of the previous IFSP (six (6) month, eighteen (18) month) to the Review meeting with all other documents that reflect current child development such as: <ol style="list-style-type: none"> a. Private evaluations b. Updated medical information
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	<p>Note:</p> <ul style="list-style-type: none"> - Missing Progress Notes will not prevent the convening of the Annual IFSP meeting - No changes in services will be authorized if sufficient information, (ex: progress notes for the particular service type, additional evaluations ect.) noting child status, is not available at the meeting.
<p>Regional Office Scheduling Staff</p>	<ol style="list-style-type: none"> 1. Collect Progress Notes sent by the OSC <ol style="list-style-type: none"> a. If progress notes are not received two (2) weeks prior to the scheduling of the IFSP meeting: <ol style="list-style-type: none"> i. RO will call the OSC to follow-up on the receipt of the progress notes. ii. If the OSC is unable to collect the Progress Notes: <ul style="list-style-type: none"> • Program Monitoring and Quality Improvement (PMQI) will be notified by the RO for follow-up action.
<p>Early Intervention Official Designee</p>	<ol style="list-style-type: none"> 1. Convene the meeting at least two (2) weeks prior to the expiration date of the current IFSP. The meeting must include the following individuals: <ul style="list-style-type: none"> • The parent(s); • The Early Intervention Official Designee (EIOD); • The Ongoing Service Coordinator (OSC); • The evaluator or interventionist(s) working with the child and family; • The foster care worker (if appropriate); • The Committee of Pre-school Special Education (CPSE) administrator, if IFSP meeting is combined with a transition conference. • Any other person whom the parent or the service coordinator, with the parent’s consent, invites. 2. Encourages and explain the importance of active participation by the parent(s), the OSC, any interventionists present, and any other individuals attending the meeting. 3. Inform the parent of his/her rights, and give him/her “<i>Your Family Rights in Early Intervention</i>” fact sheet. 4. Ask the parent if there are any changes in the child’s insurance coverage. <ol style="list-style-type: none"> a. Update Insurance Information on Page 5a (Service Authorization Data Entry Form) of the IFSP. 5. Facilitate a team review and discussion of: <ul style="list-style-type: none"> • The current needs of the child and family • Progress toward achieving outcomes • The effectiveness of strategies used during intervention sessions • Any needed modification of the outcomes or Early Intervention (EI) services <ol style="list-style-type: none"> a. The following new forms must be completed: <ol style="list-style-type: none"> i. All IFSP pages (See <i>Initial IFSP Policy</i>); <p>Note: On Page 5a: Service Authorization Data Entry Form(s), The <i>Effective Date of IFSP</i> must be the day after the <i>End Date</i> of the <u>previous</u> IFSP</p> <ol style="list-style-type: none"> ii. Transportation Service Data Entry Form(s) (if

	<p style="text-align: center;">applicable).</p> <p style="text-align: center;">iii. Parental Consent to Release/Obtain Information</p> <p>Note:</p> <p><u>Prescriptions</u></p> <ul style="list-style-type: none"> - A new prescription from a physician is required for Physical Therapy, Occupational Therapy or Nursing services. - A current Health Assessment Form is required for a child attending group developmental services. <p><u>Transition</u></p> <ul style="list-style-type: none"> - Update or complete Transition Plan (pages 7a and 7b) for all children in Early Intervention who are leaving EI for any reason or if the Annual IFSP is closest to the child's second birthday. <ul style="list-style-type: none"> • The parent is responsible for making the referral to CPSE. • The OSC will assist the parent with making the referral to CPSE. (Refer to policy on Transition in the Transition Chapter for more information and specific time frames for referral.) - Combine an Annual meeting with a Transition Conference, when appropriate (See <i>IFSP Scheduling Policy</i>). <p>6. Ensure that the completed IFSP is copied and distributed to all IFSP team members as appropriate:</p> <ol style="list-style-type: none"> a. Copies of the Transportation Service Authorization Form(s) and the Assistive Technology Service Authorization Form(s) are distributed to Data Operations and provider agencies only: b. If the IFSP meeting is held in the parent's home or other location where the IFSP cannot be copied: <ol style="list-style-type: none"> i. The EIOD will ensure that the OSC gets copies of the IFSP document within one (1) week of the authorization. ii. OSC will ensure all other meeting participants receive a copy of the IFSP expeditiously, but no later than 48 hours after receipt.
Regional Office	1. Submit the approved IFSP and Service Authorization Data Entry Form(s) to Data Operations.
Ongoing Service Coordinator	1. Send copies of the Annual IFSP to all providers of services. 2. Ensure that all new services begin within two (2) weeks of authorization (See <i>Start Date of Services policy</i>).



Approved By:
Assistant Commissioner, Early Intervention

Date: 4/26/2010

IFSP FORMS

**INDIVIDUALIZED FAMILY SERVICE PLAN
IDENTIFYING INFORMATION (Page 1)**

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____
Today's Date: ____/____/____ Gender: [] M [] F

IFSP meeting held within
45 days? [] YES [] NO
(If no, verify reason for
delay on Transmittal Form)

IFSP Meeting (check as appropriate): Interim Initial 6 month 12 Month 18 Month 24 Month 30 Month 36 Month Amended
(If this is an Amendment meeting, check *amended* and the IFSP period) Transition Conference Transition Plan (check the transition conf./plan box and the IFSP period)
Date of Initial IFSP : ____/____/____ At initial IFSP, write effective dates: 6 Month Review: ____/____/____ Annual IFSP: ____/____/____

Mother's/Guardian's Name: _____ Father's/Guardian's Name: _____
Child's Address: _____ Apt. # _____ Zip Code _____ Parents' Language: _____
(Street) (Borough/City)
Home Phone #: (____) _____ Alternate Phone #: (____) _____ Cell Phone #: (____) _____

Is child in foster care: () No () Yes **If yes, please fill out the following information:**
Foster Parent/Surrogate's Name: _____ Agency: _____ Caseworker's Name: _____
Agency Address: _____ Phone #: (____) _____
Fax #: (____) _____

Ethnicity: Hispanic Not Hispanic **Race:** White Black Native American or Alaskan Asian Native Hawaiian/ Other Pacific Islander
NOTE: More than one racial category can be checked.

<u>IFSP Participants:</u>	<u>Print Name:</u>	<u>Agency:</u>	<u>Signature:</u>
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent	_____	_____	_____
<input type="checkbox"/> Early Intervention Official Designee	_____	_____	_____
<input type="checkbox"/> Initial SC <input type="checkbox"/> Ongoing SC ID #: _____	_____	_____	_____
Phone #: (____) _____	_____	_____	_____
<input type="checkbox"/> Evaluator <input type="checkbox"/> Interventionist	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

Health/ Medical Information

Diagnosis: _____ **Medical Alerts:** _____

INSTRUCTIONS FOR IFSP PAGE 1

IDENTIFYING INFORMATION, SIGNATURES

1. **Child's Name** - The child's complete legal name, written last name first. The child's name should be written **last name first** throughout the IFSP document. Do not use nicknames and/or abbreviations. If the child is/was known by another name, write **AKA** and the other name below the (*last*) or (*first*) sections of the line.
2. **EI Number** - The child's EI number as issued by the NYC EIP.
3. **Child's DOB** - Child's date of birth in month, date, year (2 digits) order. For example, March 25, 2008 would be written 03/25/08.
4. **Today's Date** - Write the date on which the IFSP meeting is being held. This date will appear at the top of each page of the IFSP.
5. **Gender** - Check the box for male (M) or female (F).
6. **IFSP Meeting** - Check the appropriate box to indicate whether the IFSP is an Interim, Initial, 6 Month, etc. Also check the *Amended* box if this is an amended IFSP, so that it is clear which IFSP period is being amended. If the Transition Plan is developed or the Transition Conference is held as part of the IFSP meeting, check the box for *Transition Plan* or *Transition Conference* in addition to the IFSP period.
7. **Date of Initial IFSP** - Write the date on which the initial IFSP meeting is (or was) held. If this is an Initial IFSP, this will be the **same** date as **Today's Date** in the upper right hand corner. For all other meetings, always write the date the initial meeting was held.
8. **Effective Dates** - At the initial IFSP, write the effective dates of the 6 Month Review and Annual IFSP.
 - *The effective date of the 6 month IFSP is the day after the end date of the initial IFSP*
 - *The effective date of the annual IFSP is the day after the end date of the 6 month IFSP*(Refer to the schedules in the Appendix.)
9. **Mother's/Guardian's Name** - The biological or adoptive mother's/guardian's name.
10. **Father's/ Guardian's Name** - The biological or adoptive father's/guardian's name.
11. **Child's Address/Apartment Number** - The complete address where the child resides. If the address is a *private residence*, write **PH** next to *Apt. #*. Be sure to include the borough of residence or city (for Queens) and the zip code. (**NOTE:** This is the address of the foster parent if the child is in foster care. Block out the name, address and phone number of the foster parent before the IFSP is given to the biological parent or advocate.)
12. **Parents' Language** - The dominant language spoken by the family. Indicate more than one language if two languages are regularly spoken in the home. Indicate if parent/guardian uses sign language primarily. This information is used, in part, to determine if accommodations will be needed for future reviews
13. **Home Phone #** - Indicate N/A if there is no telephone.
14. **Alternate Phone #** - An alternate daytime telephone number at which a family member can be reached.
15. **Cell Phone #** - Indicate N/A if there is no cell phone.

16. **Foster Care Information** - Indicate whether the child is in foster care, the names of the foster parent/surrogate, the foster care agency and the caseworker involved, and the *agency* address, telephone and fax numbers. (See NOTE for #12 above.).
17. **Ethnicity/Race** – Check the appropriate box for **both** *Ethnicity* and *Race*. (**NOTE:** This is a federal requirement which *must* be completed.) Parents should be asked to check the boxes that they are most comfortable with. **More than one racial designation for a child can be selected.** If the parent refuses to complete this information, write this on the form.
19. **Participant’s Name and Signature** – Each person attending the meeting, including any interpreter, prints and signs his/her name to indicate his/her presence.
21. **Agency-** The employer of each person present, except the parent/guardian, who may write “N/A” in this section or leave it blank.

NOTE: In an emergency situation, in which a clinician can only participate in the meeting via telephone, the EIOD must document the clinician’s name, title/discipline, Agency name and that the individual was “available by phone.”

MEDICAL INFORMATION

1. List relevant diagnoses or conditions, e.g., cerebral palsy, autism, Down syndrome, failure to thrive, etc. Write the diagnoses in words; do not use the ICD 9 codes.
2. List relevant medical alerts such as allergies, medications or other information that the interventionist should know.

**INDIVIDUALIZED FAMILY SERVICE PLAN (Page 2)
CURRENT DEVELOPMENT, and FAMILY CONCERNS**

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____ Today's Date: ____/____/____

Concerns: What my (parent) concerns are: (Provide example(s) of how daily routines are affected/ when this concern is most noticeable to the parent/family.)

Motor: Ability to get around- gross motor (ex: sitting, rolling, standing, crawling, walking), handling small objects- fine motor, sensory skills) hearing, vision.

Parent Concern: I have no concerns in this area at this time. Parent is concerned about this area of development (provide examples):

MDE Results: There are no concerns at this time; the child is developing typically in this domain. The evaluation results indicate concerns (Concern in attached MDE Summary):

Adaptive: Sucking, eating solid foods, drinking from a cup. Sleeping, dressing, toileting.)

Parent Concern: I have no concerns in this area at this time. Parent is concerned about this area of development (provide examples):

MDE Results: There are no concerns at this time; the child is developing typically in this domain. The evaluation results indicate concerns (Concern in attached MDE Summary):

Communication: Understanding what is being said, using sounds, words or gestures to let others know what he/she needs.

Parent Concern: I have no concerns in this area at this time. Parent is concerned about this area of development (provide examples):

MDE Results: There are no concerns at this time; the child is developing typically in this domain. The evaluation results indicate concerns (Concern in attached MDE Summary):

Cognitive: Thinking, Learning, Using Toys, Paying Attention, Controlling Environment

Parent Concern: I have no concerns in this area at this time. Parent is concerned about this area of development (provide examples):

MDE Results: There are no concerns at this time; the child is developing typically in this domain. The evaluation results indicate concerns (Concern in attached MDE Summary):

Social Emotional: Relating to and getting along with adults and children, getting used to new places and expressing emotions (self-calming)

Parent Concern: I have no concerns in this area at this time. Parent is concerned about this area of development (provide examples):

MDE Results: There are no concerns at this time; the child is developing typically in this domain. The evaluation results indicate concerns (Concern attached in MDE Summary):

INSTRUCTIONS FOR IFSP PAGE 3

DAILY ROUTINES AND ACTIVITIES

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on – List the daily activities that are difficult for the family/caregiver, such as bath time, meal time, nap time, family outings, etc. For example, does the child really enjoy playing with other children yet find it difficult due to a communication delay? Does the child become upset at the shopping mall or on the street when there are a lot of people and noise? Include those activities or routines about which the parent has concerns, such as bathing, mealtime, sleeping, or transitioning from one activity to another.
2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority) - List the parent's concerns in order of in which you would like them addressed

Resources:

This page must be completed by the ISC with the parent prior to the IFSP meeting.

1. **Where does your child spend most of his/her time during a typical day?** - Select the settings where the child spends the most time, e.g., home, day care, a relative's home, a babysitter's home, a playgroup.
2. **Day Care/Caregiver Information** –Complete the caregiver's or program's name, address, and telephone number.
3. **If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare?** Select the individual who assists with child care that the parent wants to be involved in the Family Service Plan. These individuals' participation in the Service Plan may be direct (working with an interventionist) or indirect (learning new skills from parent/caregiver). For example, a parent may request that the interventionist work directly with the child's babysitter (direct) and the parent may also want assistance to learn how to show the child's grandmother speech games to use with the child when they visit the grandmother's home (indirect).
4. **What language does your child hear most of the day?** – List the language that the child hears or uses during most of the day. This may be different from the dominant language of the parent (e.g., an English speaking child may have a Spanish speaking babysitter.)

**INDIVIDUALIZED FAMILY SERVICE PLAN
DAILY ROUTINES, PARENT PRIORITIES and RESOURCES (Page 3)**

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____
Today's Date: ____/____/____

When early intervention services are provided in places where your family typically lives, learns and plays, (family's daily routine/natural environment), progress is made more quickly. Young children learn best by socializing and playing with people they are close to (parents, family members, babysitters, childcare workers, and other children), and in places they know and like. The questions on this page will help families identify natural learning opportunities throughout the child's day and, how interventions can be made a part of your daily activities.

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on (ex: **At home:** bath time, meal time, naps, dressing/ **Outside:** Shopping, attending childcare, visiting friends or family **Events:** Family get-togethers/ Places parent and child go together)?

2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority)?

Resources: (This Section must be filled out by the ISC with the parent/guardian before the IFSP meeting)

1. Where does your child spend most of his/her time during a typical day? (Some of these places may be possible sites for early intervention activities)
 *Daycare/ Child Care Program/ Babysitter At home Other _____

If child attends Daycare/ Child Care Program/ Babysitter, please fill out the following:

Name of caregiver, or program: _____

Address _____

Phone #: (_____) _____

2. If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare? Grandparent Friend Other _____
3. What language does your child hear most of the day? _____

INSTRUCTIONS FOR IFSP PAGE 3

DAILY ROUTINES AND ACTIVITIES

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on – List the daily activities that are difficult for the family/caregiver, such as bath time, meal time, nap time, family outings, etc. For example, does the child really enjoy playing with other children yet find it difficult due to a communication delay? Does the child become upset at the shopping mall or on the street when there are a lot of people and noise? Include those activities or routines about which the parent has concerns, such as bathing, mealtime, sleeping, or transitioning from one activity to another.
2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority) - List the parent's concerns in order of in which you would like them addressed

Resources:

This page must be completed by the ISC with the parent prior to the IFSP meeting.

1. **Where does your child spend most of his/her time during a typical day?** - Select the settings where the child spends the most time, e.g., home, day care, a relative's home, a babysitter's home, a playgroup.
2. **Day Care/Caregiver Information** –Complete the caregiver's or program's name, address, and telephone number.
3. **If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare?** Select the individual who assists with child care that the parent wants to be involved in the Family Service Plan. These individuals' participation in the Service Plan may be direct (working with an interventionist) or indirect (learning new skills from parent/caregiver). For example, a parent may request that the interventionist work directly with the child's babysitter (direct) and the parent may also want assistance to learn how to show the child's grandmother speech games to use with the child when they visit the grandmother's home (indirect).
4. **What language does your child hear most of the day?** – List the language that the child hears or uses during most of the day. This may be different from the dominant language of the parent (e.g., an English speaking child may have a Spanish speaking babysitter.)

**INDIVIDUALIZED FAMILY SERVICE PLAN
FUNCTIONAL OUTCOMES (Page 4)**

Child's Name: (Last) _____ (First) _____ EI #: _____

DOB: / / Today's Date: / / Date of Review: / /

Functional Outcome: A practical result that your child will gain as a result of Early Intervention supports and services in the next 6 months

Note: Outcomes are not discipline specific. Interventionist must work together on all outcomes identified in the IFSP.

<p>1. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue</p> <p>Progress Note Dates:</p>	<p>2. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue</p> <p>Progress Note Dates:</p>
<p>3. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue</p> <p>Progress Note Dates:</p>	<p>4. Functional Outcome:</p> <p>Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:</p> <p>Six Month Review: Will this outcome: <input type="checkbox"/> Continue <input type="checkbox"/> Be Revised (Complete new outcome page) <input type="checkbox"/> Discontinue</p> <p>Progress Note Dates:</p>

Signature of Person Completing 6 18 30 mo Review

Signature of Parent/Guardian (at Review)

Signature and Stamp of EIOD (at Review)

INSTRUCTIONS FOR IFSP PAGE 4
FUNCTIONAL OUTCOMES

1. **Today's Date** – The date of the initial or annual IFSP meeting at which the outcomes are developed.
2. **Date of Review** – The date of the 6, 18 or 30 month review meeting at which the IFSP outcomes are reviewed.
3. **Functional Outcomes** – The outcomes, recorded on page 4, represent one of the most important aspects of the IFSP meeting. Outcomes are statements of the changes or results that are expected to happen for the child and family as a result of EI services. All team members at the IFSP meeting should collaborate in developing these outcomes. The outcomes should be related to the child's developmental needs, the family's concerns and geared toward the child's ability to function during the everyday activities outlined on page 3. For example, "Johnny will be able to sit without support during dinner." The team may also develop outcomes for the family, especially to guide services such as Family Counseling. For example, "*Mr. and Mrs. Bowen will learn about Down syndrome and what to expect for their child in order to explain the condition to their friends and family*"

Specify changes that are expected to occur over the next six months. If necessary, use a second page to list additional outcomes. For example, "*Thomas will be able to communicate his needs by pointing or with words instead of screaming so that the family can visit relatives.*" The outcomes should be unique to the family and give enough information to the interventionist(s) working with the child and family. This will allow the interventionist(s) to develop therapeutic goals and coach family members or caregivers in the activities that can be applied throughout their daily routines. Interventionists will document how they have involved the family in the **Session** and **Progress Notes** (Refer to *Service Delivery Chapter.*) If desired, family members and caregivers can document their use of the activities or techniques in which they have been coached by the interventionist on a calendar or other tool. (See sample calendar and other suggestions in the *Service Delivery Chapter.*)

4. **Objectives:** List the objectives associated with the Functional outcomes. Objectives are short term goals that should be achieved in order for the child to reach the functional outcome. For example,
IFSP Functional Outcome: Ida will be able to pick up small bits of food from like raisins and cheerios with either hand using the thumb and index figure without resting her arm on the table so that she can feed herself every day during meal time.

Objective: Ida will pick up a Cheerio with fingers using a scraping movement.
Objective: Ida will pick up a Cheerio with the side of her finger and thumb
5. At the **Six Month Review** meeting, write the date of the review meeting on a copy of the *Outcomes* page from the prior IFSP. Review the outcomes and discuss the child's and family's progress toward the outcomes. Check the appropriate box next to each outcome to indicate whether the outcome should be *continued*, *revised*, or *discontinued*. Write the dates of the **Progress Notes** for the relevant service type and method.

Write new or revised outcomes for the next six month period on a new functional outcomes page.

NOTE: When a new service is added or an Assistive Technology device is authorized, whether at a six month review or an amendment meeting, a new outcome(s) is required. This outcome will guide the interventionist in working with the family and/or using the AT device with the child and family and can be documented on a new *Outcomes* page.

6. **Signatures** – The parent(s) and the EIOD must sign this page at the 6 Month IFSP Review meeting or the Amendment meeting to indicate agreement with the outcomes for the next six month period. The person who writes the information on this page must also sign (i.e., the OSC or EIOD). This is particularly important for the OSC who may be conducting the review meeting without the EIOD being present.

INDIVIDUALIZED FAMILY SERVICE PLAN
Service plan (Page 5): Settings and Incorporating interventions into natural routines.

Child's Name: (Last) _____ (First) _____
 EI #: _____ DOB: ____/____/____
 Today's Date: ____/____/____

Are all services being provided in child's **natural environment**? Yes No
 If no, explain.

If any service is being provided in **group settings** without typically developing peers, explain why the IFSP team agrees this is appropriate:

If the family is unable to be present during therapeutic sessions with the child, how will the service provider communicate with the family to assist them in learning ways to improve the child's functioning in his/her natural environment:

- Calendar
- Notebook
- Phone Calls
- Other:

How will interventions be made a part of your daily routines and activities?

- Teacher/therapist will utilize child's play, mealtime, bathing, dressing, bedtime, morning routine, shopping, playground, family events, and weekends activities for individual intervention
- Parent/Caregiver will participate in intervention sessions when possible and incorporate teacher/therapist suggestion into child's daily routine
- Teacher/therapist will communicate on a regular basis with parent/caregiver, other interventionist, and day care/child care providers to coordinate strategies and accommodate the needs of the child (if child is in a daycare setting).

Teacher/therapist responsibilities:

- Teacher/therapist will provide a schedule of agency holidays and planned time off to the parent/caregiver at the beginning of the authorization period
- Teacher/therapist will review and provide a copy of each progress note to the parent/caregiver.
- Teacher/therapist will submit completed progress notes to the service coordinator at least 2 weeks before each 6 month review period.

INSTRUCTIONS FOR IFSP PAGE 5

SERVICE PLAN

This page describes the ways in which the interventionist(s) may involve the family and coach them in activities to practice in their daily routines. Use language that is clear and understandable for the family. The plan should address how the outcomes might be achieved.

1. **Are all services being provided in the child's natural environment?** – Check *yes* or *no*. If *no* is checked, explain why the services cannot be delivered where the child spends most of his/her time. Please note that the rationale needs to be as specific, detailed and developmentally sound. This information is required by the Individuals with Disabilities Education Act (IDEA).
2. **Is any service being provided in a group setting without typically developing peers?** – 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?
4. **If the family is unable to be present during therapeutic sessions with the child, how will the service provider assist the family in learning ways to improve the child's functioning in his/her natural environment.** – For example, the interventionist may use a notebook to communicate with the family about the skills on which s/he is working and how the family might practice those skills during the child's natural routines; phone calls can be arranged at regular times; emails can be exchanged, etc. When appropriate, Family Training sessions can be arranged on a regular basis (monthly, bi-monthly etc.) at the center or in the home to teach parents/caregivers/siblings to help the child generalize his/her new skills during daily routines. The parent may be interested in having the interventionist attend a monthly family meeting to explain the child's status and give suggestions that various family members can incorporate into the child's and family's routines.

**INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE AUTHORIZATION FORM Page 5a**

CHILD INFO: Child's Name: (Last) _____ (First) _____
 (Middle) _____ EI #: _____ DOB: ____/____/____
 Effective Date of IFSP: ____/____/____ End Date of IFSP: ____/____/____

TYPE OF IFSP
 Interim Initial
 6 Month
 ____ 6 ____ 18 ____ 30
 Annual
 ____ 12 ____ 24 ____ 36
 Amendment to IFSP
 Dated: ____/____/____

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)
 PROVIDER NAME: _____
 PROVIDER EI #: _____
 CONTACT PERSON: _____
 CONTACT PERSON'S PHONE: (____) _____
 CONTACT PERSON'S FAX: (____) _____
 SC: _____ SC #: _____
 PHONE: (____) _____ FAX: (____) _____

Service Provider not identified at time of IFSP for the following services (Pending):
 Service Type: _____ Frequency/ Duration Authorized: _____
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 OSC will identify provider by ____/____/____
 NOTE: OSC must contact EIOD if provider is not identified within two weeks

EIOD Name _____ **DATE:** ____/____/____

EIOD Signature: _____

Private Insurance Name (Do not write Child Health Plus)
 Insurance Company Name: _____
 Policy Holder Name: _____ DOB: ____/____/____
 Relationship to Child: _____ Policy #: _____
 Group Name: _____ Group #: _____
 Effective Date: ____/____/____

NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.

Insurance Information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child's Medicaid number, as well as insurance Company Information.
 Child Medicaid Eligible: Yes No
 Child's Medicaid OR CIN #: ____/____/____/____/____/____/____/____
 Ltr / Ltr / # / # / # / # / # / # / Ltr

1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)	2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	10: Waiver Code(s)	11: Status	Provider Instructions	
											12: Bilingual Request?	13: Prescription Needed?
1: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____ Initial Start date: _____	<input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
2: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____ Initial Start date: _____	<input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
3: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____ Initial Start date: _____	<input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
4: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____ Initial Start date: _____	<input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing
5: TYPE SVC Code Letter	_____	_____	_____	_____	_____	_____	_____	_____	Waiver Code(s) _____ Initial Start date: _____	<input type="checkbox"/> ADD <input type="checkbox"/> END	<input type="checkbox"/>	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Nursing

Data Entry Name: _____ Date: ____/____/____

<p>1. SERVICE TYPE (Category A services)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">A Assistive Technology (svc)</td> <td style="width: 50%;">J Psychological</td> </tr> <tr> <td>B Audiology</td> <td>K Respite Care</td> </tr> <tr> <td>C Family Counseling</td> <td>L Social Work</td> </tr> <tr> <td>D Health</td> <td>M Special Instruction</td> </tr> <tr> <td>F Nursing</td> <td>N Speech/Language</td> </tr> <tr> <td>G Nutrition</td> <td>Q Vision</td> </tr> <tr> <td>H Occupational Therapy</td> <td>R Service Coordination</td> </tr> <tr> <td>I Physical Therapy</td> <td>T Family Training</td> </tr> <tr> <td>S Family Support Group</td> <td></td> </tr> </table> <div style="border: 1px dotted black; padding: 5px; margin-top: 10px;"> <p style="text-align: center;"><i>Assistive Technology and Transportation:</i></p> <p>Use the AT Device for AT equipment and Transportation Service DE Forms for bus or other transportation.</p> </div>	A Assistive Technology (svc)	J Psychological	B Audiology	K Respite Care	C Family Counseling	L Social Work	D Health	M Special Instruction	F Nursing	N Speech/Language	G Nutrition	Q Vision	H Occupational Therapy	R Service Coordination	I Physical Therapy	T Family Training	S Family Support Group		<p>2. PAYMENT RATE / METHOD TYPE</p> <p>Z Office/Facility Individual/Collateral Visit (O/F)</p> <p>A Basic Home/Community Individual/Collateral Visit (H/C)</p> <p>H Extended Home/Community Individual/Collateral Visit</p> <p>B Basic Group Developmental Visit</p> <p>C Enhanced Group Developmental Visit</p> <p>D Basic Group Developmental Visit with 1:1 Aide</p> <p>G Enhanced Group Developmental Visit with 1:1 Aide</p> <p>E Parent-Child Group</p> <p>F Family-Caregiver or Sibling Support Group</p>
A Assistive Technology (svc)	J Psychological																		
B Audiology	K Respite Care																		
C Family Counseling	L Social Work																		
D Health	M Special Instruction																		
F Nursing	N Speech/Language																		
G Nutrition	Q Vision																		
H Occupational Therapy	R Service Coordination																		
I Physical Therapy	T Family Training																		
S Family Support Group																			
<p>3. LOCATION TYPE</p> <p style="text-align: center;"><u>Group Service Codes:</u></p> <p>A Group 51% TD Group designed for 51% or more typically developing children</p> <p>D Group 50% TD Group designed for 50% or less typically developing children</p> <p>C Group 0% TD Group designed for no typically developing children</p> <p style="text-align: center;"><u>Individual Service Codes:</u></p> <p>B Family Day Care E Home</p> <p>F Hospital Inpatient G Provider Location (office, clinic, or hospital)</p> <p>I Residential Facility O Other</p> <p>K Community Recreation Center M All Group Community Child Care Locations</p>	<p>4. & 5. BEGIN & END DATES</p> <p>Designate the “Begin” and “End” dates for each specific service, frequency and duration. The end date cannot exceed the IFSP end date.</p> <p>6, 7, & 8. FREQUENCY AND DURATION CODES</p> <p>6. Min = Minutes of service per session</p> <p>7. Days = Number of days per week</p> <p>8. Weeks = Number of weeks of service (Maximum 26 for six months)</p>																		
<p>9. UNITS: (Days x weeks for each service.)</p> <p>Service Coordination: Refer to the Units Table. One unit of service coordination = 15 minutes (¼ hr.)</p> <p>¼ hr. per week x 26 weeks = 26 units</p> <p>½ hr. per week x 26 weeks = 52 units</p> <p>1 hr. per week x 26 weeks = 104 units</p> <p>1½ hr per week x 26 weeks = 156 units</p> <p>2 hrs. per week x 26 weeks = 208 units</p> <p>A unit of Early Intervention Services is a “visit”. The total number of units equals the number of visits per week X the total number of weeks.</p> <p><u>Service Type Unit Table</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1 x 26 weeks = 26 units</td> <td style="width: 50%;">2 x 26 weeks = 52 units</td> </tr> <tr> <td>3 x 26 weeks = 78 units</td> <td>4 x 26 weeks = 104 units</td> </tr> <tr> <td>5 x 26 weeks = 130 units</td> <td></td> </tr> </table> <p><i>Refer to Appendix F of the NYC Forms and Procedures Manual for additional calculations.</i></p>	1 x 26 weeks = 26 units	2 x 26 weeks = 52 units	3 x 26 weeks = 78 units	4 x 26 weeks = 104 units	5 x 26 weeks = 130 units		<p>10. WAIVER CODES <i>(Billing Rule Exceptions)</i></p> <p>1 More than three H/C visits per day</p> <p>2 More than one H/C visit per discipline per day</p> <p>3 More than three O/F visits per day</p> <p>4 More than one O/F visit per discipline per day</p> <p>5 More than one Parent Child group session per day</p> <p>6 More than one Group Developmental session per day</p> <p>7 More than two Family/Caregiver Group sessions per day</p> <p>8 More than one core evaluation in one year</p> <p>9 More than four supplemental evaluations in one year</p> <p>NOTE: If a non-waived service authorization changes to a waived status, check in the waiver box, provide the reason codes (above) that apply, and document the begin date for when services may be exempted from the above billing rules. Also place a check mark in the “No Data Entry” column.</p>	<p>11. AMEND STATUS <i>(Circle One)</i></p> <p>Add – a new authorization</p> <p>End – an existing authorization</p>											
1 x 26 weeks = 26 units	2 x 26 weeks = 52 units																		
3 x 26 weeks = 78 units	4 x 26 weeks = 104 units																		
5 x 26 weeks = 130 units																			
<p>12 & 13 Provider instructions:</p> <p>12. Bilingual Request- Check if bilingual is preferred by the IFSP team. If bilingual services can not be located, a monolingual therapist is acceptable. Please notify the EIOD. The Service Authorization Form does not need to be resubmitted.</p> <p>13. Prescription Needed- If Occupational Therapy (OT), Physical Therapy (PT), or Nursing was authorized at the IFSP, check to indicate that services cannot begin until a prescription from a physician is received.</p>																			

INSTRUCTIONS

SERVICE AUTHORIZATION DATA ENTRY FORM

This form records the information necessary for data entry into the KIDS system of the services authorized for the child and family through the Early Intervention Program. Indicate all authorized services, including service coordination, assistive technology services, respite services, special instruction, family support and therapeutic services. Indicate transportation services on the **Transportation Service Data Entry Form**. Indicate specific assistive technology **devices** on the **Assistive Technology Device Data Entry Form**. (NOTE: This form may be completed by the Assistive Technology Unit.)

Document authorizations for *each* provider on a *separate* **Service Authorization Data Entry Form**. For example, if occupational therapy will be delivered through ABC agency and speech services and service coordination will be delivered through DEF agency, complete two **Service Authorization Data Entry Forms**, each with the appropriate *Provider Information*.

1. **Child Information** – The child’s EI number, name, and date of birth as recorded in all other places on the IFSP.
2. **Effective Date of IFSP** – For an initial IFSP, this is the date that the IFSP meeting takes place. (NOTE: If the meeting was convened but the IFSP was not completed at that meeting, use the date that the first meeting took place.)

For a Six Month Review or Annual IFSP, the effective date is the day after the end date of the existing IFSP.

For an amendment to an IFSP, use the effective date of the *current* IFSP.

3. **End Date of IFSP** - 26 weeks after the effective date of the IFSP **unless the child turns 3 before that date:**

If a child turns 3 before the 26 week end date of IFSP, the end date of the IFSP must be the day before the child’s third birthday. For example, the effective date of IFSP may be 1/1/10, and the end date of a 26 week IFSP would be 6/30/10. However, if the child’s third birthday is 4/15/10, the end date of IFSP would be 4/14/10.

If the child has been found eligible for services by the Committee on Preschool Special Education (CPSE) and an IEP form is presented at the IFSP meeting, the end date of the IFSP may be 26 weeks after the begin date if the parent requests that the child remain in EI. Under no circumstances, however, can the child continue to receive services beyond August 31 (for children turning 3 between January 1 and August 31) or December 31 (for children turning 3 between September 1 and December 31). A child may not receive services from both EI and CPSE at the same time. (For further information, see the policy on *Transition*).

If the child is found eligible for services by the CPSE after the begin date of IFSP, but before the child’s third birthday, and the parents wish to continue EI services until the age-out date, a new **Service Authorization Data Entry Form** must be written to extend the service from the third birthday to the age-out date. In the example above, if the services end 4/14/10 because the child turns 3 on 4/15/10, the new form will *add* the service from 4/15/10 until 6/30/10. **Note that under no circumstance can the service extend beyond the 26 week end date of the IFSP.** If the parent chooses to remain in EI until the child ages out on 8/31/10, services can be continued at the next IFSP from 7/1/10 to 8/31/10.

4. **Type of IFSP** – Check the appropriate box to indicate if the IFSP is an interim, initial, 6 month or annual IFSP. If the IFSP is a 6 month or annual, also check the appropriate month (6, 18 or 30 month or 12, 24, or 36 month).

If this is an amended IFSP, check **both** the appropriate box indicating the type of IFSP **and** the box indicating amendment to IFSP. Write the **effective date of the amendment**. For example, if an initial IFSP dated 1/1/09 is being amended on 5/20/09, check the box for *Initial* and the box for *Amendment to IFSP* and write 5/20/09 next to *Dated*.

5. **Provider Information** – For all types of IFSPs, each provider agency that will provide services to the child or family must have a separate **Service Authorization Data Entry Form**. For each provider, include the following information:
 - The Provider Agency Name and Provider EI Number as listed in the Provider Directory
 - The name of the contact person at the provider agency who can respond to questions about the child’s program and his/her telephone and fax numbers
 - The name of the child’s currently assigned OSC, the SC’s #, telephone and fax numbers.

6. **Service Provider not identified at time of IFSP for the following services (Pended)** - List all the services where a provider was not identified during the IFSP meeting. The Frequency (how often) and duration (how long) should be included. Write the date by which the OSC will identify the provider. The date must be within 2 weeks of the IFSP date.

7. **EIOD Signature and Name** – The EIOD’s signature, printed name, and the date s/he actually signed the form. This date may be different from the *Effective Date of IFSP*. **No payment can be made by the Early Intervention Program to a service provider if the Service Authorization Data Entry Form is not signed by the EIOD.**

8. **Insurance Information**- Medicaid or private insurance information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child’s Medicaid number, as well as insurance Company Information.

9. **Services** – Refer to the **Service Authorization Data Entry Key** for instructions on the codes. **No information should be written in this section other than the specific information indicated.** List each service type to be provided by the service provider agency indicated in *Provider Information*. There are five numbered “service lines” on each **Service Authorization Data Entry Form**. Only one *Service Type* may be written on each service line. Therefore, if more than five services are to be offered by a given provider, use additional forms. Each service line contains the following information:
 1. **Service Type and Code Letter** – The name of the *Service Type* and its corresponding *Code Letter* as listed.
 2. **Method** – The *Method* by which the service is delivered and its corresponding *Code Letter* as listed.
 3. **Location** – The *Location* of the service and its corresponding *Code Letter* as listed.
 4. **Begin** – The date that each service is authorized to start. The *Begin* date can be any date **after** the *Effective Date* of IFSP for an initial IFSP or any date **on or after** the *Effective Date* of IFSP for a 6 or 12 month IFSP. The *Begin Date* should reflect the actual date that the service is expected to begin. **NOTE: A provider will not be reimbursed for any service delivered prior to the *Begin Date*.**
 5. **End** – The date on which the service will end. If the service is to be delivered for the duration of the IFSP, write the same date as the *End Date of IFSP*. If the service is to end before the *End Date of IFSP*, write the actual date the service will end. **NOTE: A provider will not be reimbursed for any service delivered after the *End Date*.**
 6. **Mins (Minutes)** – How long each session/visit is expected to last, e.g., 30 minutes, 45 minutes, etc.
 7. **Days** – The number of days per week the service will be provided. (**NOTE:** If the frequency is less than weekly, e.g., every two weeks or once a month, write this across the days and weeks boxes, e.g., 2xmonth, 1xmonth. If a particular number of units is authorized for the duration of the IFSP, indicate that clearly, e.g., 8 units during 26 week IFSP)
 8. **Weeks** – The number of weeks the service will be provided, not to exceed the total number of weeks in the IFSP.

9. **Units** – The total number of units authorized for the service type, determined by multiplying the number of days by the number of weeks, e.g., 2x26=52 units, or 1x month=6 units. The number of units may also be the total number of units agreed upon in the *Service Plan*, such as 8 units of Social Work during the IFSP period.

For **Service Coordination**, do not fill in columns *Method*, *Location*, or *Days*. Write the number of minutes authorized per week in *Mins* (Column 7), e.g., 30 minutes. A unit of service coordination is equal to 15 minutes. Calculate the number of units by multiplying the number of minutes divided by 15 times the number of weeks, e.g., 30/15=2x26=52 units. Consult the **Service Authorization Data Entry Key**.

10. Waiver Code –

- a. For Initial and Annual IFSPs: If the line of service violates a billing rule and requires a waiver, write the appropriate Waiver Code. More than one Waiver Code can be placed in a box if the authorization on the service Authorization violates more than one billing rule. EIOD must approve the use of the waiver by initialing the waiver box and inserting the start date of the waiver.

Note: This column replaces the former Waiver Form. No additional form is needed to indicate a waiver of the billing rules.

b. For Review and Amendment IFSP (a waiver has been added to an existing service authorization): the EIOD will write the start date for the waiver on the **Service Authorization Form**, check the box on the top for *Amendment* and put in the date of the amendment, and sign with his/her initials. This situation may occur when a new service is authorized for a child resulting in a violation of the billing rules. For example, a child may already have a PT, OT, and special instructor providing services on the day the parent is available. If ST is added, all four services must be given a waiver of the billing rules, which in this case would be *waiver code #1*. If there is room on the original **Service Authorization Data Entry Form** to add the new service for the same provider agency, the EIOD will indicate the new start date(s), waiver code(s), and initial the *Waiver Code* box.

11. **Status** – Check **Add** if the service line is being added; check **End** if the service line is being terminated. It is **necessary** to check the appropriate box for authorizations at every IFSP period.
12. **Bilingual Request**- Check if bilingual is preferred by the IFSP team. If bilingual services can not be located, a monolingual therapist is acceptable. Please notify the EIOD. The **Service Authorization Form** does not need to be resubmitted.
13. **Prescription Needed**- If Occupational Therapy (OT), Physical Therapy (PT), or Nursing was authorized at the IFSP, check to indicate that services cannot begin until a prescription from a physician is received.

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 5B)
Service plan: Co-Visits (Use ONLY if co-visits are authorized)

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____ / ____ / ____
Today's Date: ____ / ____ / ____

Check the purpose of co-visit(s):

- Provide co-treatment for child targeting an area of child need in which 2 or more qualified personnel are providing different interventions.
 - Enable professionals and parents/caregivers to work together to assess child progress and problem-solve on emerging issues related to child and family needs across the areas of needs that are being addressed by differently qualified personnel.
- OR**
- Provide education, training, and instruction to the parent/designated caregiver in use and integration of particular techniques and strategies to enhance the child's development and functioning in the area of need being addressed by the professionals.
(NOTE: Checking this box requires the use of Family Training as the service type.)

Functional outcome(s) addressed by co-visit: _____

Participants: Parent/Caregiver ST PT OT SI SW Other _____
 FT (Indicate number and disciplines of participants) _____

Method: Office/Facility Individual/Collateral Basic Home/Community Individual/Collateral Extended Home/Community Individual/Collateral

Location: Home Center Other _____ **Frequency:** _____

Authorization: Use existing authorized units Additional units to be authorized Waiver needed? Yes No

Comments:

NOTE:
If one or more of the interventionists involved in a co-visit is unable to participate in a scheduled visit, s/he is responsible for contacting the Service Coordinator to request that the co-visit be rescheduled.

The Ongoing Service Coordinator should review the IFSP and, if co-visits are authorized, contact parents and interventionists to coordinate the co-visits.

INSTRUCTIONS FOR IFSP PAGE 5B

CO-VISIT

Page 5A documents required information when a co-visit is authorized. This page is for documentation purposes only and is *not* used for data entry. Co-visits may be authorized at an IFSP or as an amendment to the IFSP. **In most cases, the EIOD will complete this page.** To request authorization of a co-visit as an amendment, the SC should follow amendment procedures and include Page 5A completed through *Frequency*. The EIOD will check the appropriate *Authorization* box.

- 1. Check the purpose of co-visit(s)** - Check all that apply. If the third box is checked, *Family Training* must be authorized as the service type. This will usually involve authorizing additional lines of service.
- 2. Participants** – Check boxes to indicate all participants in the co-visit. Note that the parent or caregiver will always be a participant if the service is home/community or if the second or third boxes are checked. (Co-treatment in an EI center does not require the presence of the parent/caregiver.) Use the **Other** box to indicate the discipline of any other interventionist who may attend the co-visit.

Indicate the number of providers in the same discipline. For example, if there are two Special Instructors who will be attending the co-visit list it as: **SI 2**

NOTE: If two interventionists of the same discipline are attending the co-visit, *even if no additional units are required*, a waiver of the billing rules must be given. Indicate this on the **Service Authorization Data Entry Form** by writing the correct *Waiver Code*.

If Family Training is authorized for the co-visit, check FT and indicate the number and disciplines of the participants. For example, check FT – 4 SI, 1 ST, and 1 OT.

- 3. Method** – Check the box for the method that will be used for the co-visit.
- 4. Location** – Check if the co-visit will take place in the home, center or other location (specify).
- 5. Frequency** – Describe the frequency for which the co-visit is authorized. This can be the number of co-visits per month, bi-monthly, once every three months, etc.
- 6. Authorization** – Check the appropriate box to indicate if interventionists will use their existing authorized units for the co-visits or if additional units will be authorized. Indicate if a waiver of the billing rules is required by checking “yes” or “no”. If “yes” is checked, remember to write the *Waiver Code* on the **Service Authorization Data Entry Form**.
- 7. Comments** – Use this space to describe any other factors relevant to the co-visit.

NOTE: Co-visits do not necessarily require additional service authorizations. An interventionist can use a session from an existing line of service in collaboration with another interventionist. For example, the IFSP may authorize one visit per week for PT and one visit per week for SI and a monthly co-visit with the child and family. In this case, the PT and SI bill under the code for their own service when billing for the co-visit.

NOTE: In all situations, each interventionist must write his/her own **Co-Visit Session Note**, and include information about the co-visit in the **Progress Note** for the respective service.

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 6)
SERVICE PLAN: TRANSPORTATION, ASSISTIVE TECHNOLOGY AND
RESPIRE SERVICES

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____
Today's Date: ____/____/____

Transportation

Transportation services are authorized to enable an eligible child and the child's family to receive Early Intervention services. As per New York State Early Intervention Program Regulations at 10NYCRR, Sec 69-4.19 (b). "...consideration shall first be given to provision of transportation by a parent of a child..." **Transportation options are evaluated in the following order.**

- No transportation needed.
- Caregiver will transport child either by: Public Transportation Private car **Is reimbursement being requested?** Yes No
- If the Caregiver is unable to transport the child state the reason: _____

The Early Intervention Program will provide transportation by:

- School bus
- Car Service. If requesting this mode please state reasons why other forms of transportation are not appropriate:

Are there any other needs (e.g., nurse on bus)? _____

Assistive Technology Device Needs:

Names/categories of AT equipment: _____

Reason AT device needed to achieve functional outcome. _____

- Form attached Form to be completed Continued assessment needed Child currently has AT equipment Not applicable

Respite Services

Respite is short term, temporary care provided by a trained respite worker or nurse. It is intended to provide support to parents and caregivers who may otherwise be overwhelmed by the intensity and constancy of caregiving responsibilities for their child with special needs. Respite is not a substitute for daycare and the need for childcare is not sufficient alone to justify respite services. *The New York City Early Intervention Program determines the need for respite services based upon the individual needs of the child and family with consideration given to New York State Public Health Laws.*

Does the family express the need for respite services? Not at this time Yes Application attached Application to be submitted

Has the family applied for other sources of respite? Not eligible No *Explain why not.* _____

Yes Give source, date of application and current status. _____

INSTRUCTIONS FOR IFSP PAGE 6

SERVICE PLAN: TRANSPORTATION, ASSISTIVE TECHNOLOGY, AND RESPITE SERVICES

These are additional services that may be required by the family and may not necessarily involve an interventionist. These needs include transportation, assistive technology, and respite services. The need for any of these services should be reviewed at *every* IFSP meeting.

1. **Transportation** - The team should review the family's transportation needs related to implementation of the service plan and check the appropriate box. **NOTE:** As per NYS DOH regulations, consideration shall first be given to provision of transportation by the parent of a child.

The IFSP team should explore all options **in the order they are listed**. Is transportation needed at all? If so, is the caregiver able to transport the child either by public transportation or by private car? If the family is requesting reimbursement for public transportation or for mileage accrued, note as such.

If the caregiver is unable to transport the child to the location of service provision, **the reason for this inability must be clearly documented on this page**. For example, "The family/caregiver works during the day, the child stays at the home of a caregiver who cannot leave the building to transport the child to the location of service." "The family does not have a car or other means to transport the child to the EI center." The EIOD should determine the validity of the reason and proceed to consider whether a school bus or car service is an appropriate option.

If car service is authorized, a responsible adult must accompany the child. Any special transportation needs (such as a nurse accompanying the child) must be noted; these needs should be supported by and described in the MDE summary as well as in written documentation supplied by one of the child's medical providers.

2. **Assistive Technology** - The team should discuss and review the need for AT devices and/or services as per the evaluations and MDE summary and include in the plan as needed. Children with visual and hearing impairments and/or motor delays should *always* be considered for AT equipment.

List the names or categories of AT equipment that may assist the child in using EI services to achieve his/her outcomes. Specific devices may include hearing aids, orthotics, or adaptations to commercially available equipment, such as an infant seat or chair for a child with severe tone or muscle issues.

Explain how the AT device will assist in achieving the functional outcome. When specific types of equipment (make, model #) are determined, a request with documentation as outlined in the Policy on *Assistive Technology* must be submitted to the EIOD in the Regional Office or the Assistive Technology Unit.

Check the appropriate box to indicate the status of the child's need or potential need for assistive technology. Check the box "Not applicable" if there is no need for assistive technology.

- 3. Respite Services** - The team should review the statement defining respite services with the family, emphasizing that respite is a temporary service. (If the family needs ongoing or long-term services, the OSC should assist them in accessing other supports in the community.) Check the appropriate category indicating whether a parent/guardian has expressed a need for EI respite services. Note here whether the respite application is attached or whether the application is to be submitted at a later date. Respite applications should be sent to the EI Regional Office of the borough in which the child resides.

Indicate whether the family is eligible or has applied for other sources of respite, such as through OMRDD. If the family has applied, give the date of the application and current status.

NOTE: The OSC is responsible for obtaining the services specified on page 6 and ensuring that the rest of the IFSP is implemented as agreed upon by the participants at the IFSP meeting.

NYC EARLY INTERVENTION PROGRAM

A.T. DEVICE DATA ENTRY FORM

FOR OFFICE USE ONLY

EFFECTIVE DATE OF IFSP: ____/____/____ END DATE OF IFSP: ____/____/____ CHILD INFORMATION: CHILD EI #: _____ DOB: ____/____/____ CHILD'S NAME: _____ (LAST) _____ (FIRST) (MIDDLE) Borough: _____	PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER) PROVIDER NAME: _____ PROVIDER EI #: _____ CONTACT PERSON: _____ CONTACT PERSON'S PHONE: (____) _____ CONTACT PERSON'S FAX: (____) _____ SC: _____ SC #: _____ PHONE: (____) _____ FAX: (____) _____	TYPE OF IFSP <input type="checkbox"/> Interim <input type="checkbox"/> Initial <input type="checkbox"/> 6 Month ____6 ____18 ____30 <input type="checkbox"/> Annual ____12 ____24 ____36 <input type="checkbox"/> Amendment to IFSP Dated: ____/____/____
NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.		EIOD NAME: _____ DATE: ____/____/____ EIOD SIGNATURE: _____

<i>Vendor:</i>		<i>Catalog:</i>		<i>Dispensary:</i>				
1: CATEGORY/ CODE	2: CPT/HCPCS CODE	3: AT ITEM/ DEVICE DESCRIPTION	4: BEGIN DATE	5: END DATE	6: QUANTITY	7: COST	8: TOTAL COST	9: STATUS
1-CATEGORY ----- CODE	Asst. Tech ----- I							ADD END
2-CATEGORY ----- CODE	Asst. Tech ----- I							ADD END
3-CATEGORY ----- CODE	Asst. Tech ----- I							ADD END
4-CATEGORY ----- CODE	Asst. Tech ----- I							ADD END
5-CATEGORY ----- CODE	Asst. Tech ----- I							ADD END

Data Entry Signature: _____ Date: ____/____/____

INSTRUCTIONS
ASSISTIVE TECHNOLOGY DEVICE
DATA ENTRY FORM

This form records the information necessary to authorize assistive technology *devices*. (**NOTE:** Assistive Technology *services* are authorized on the **Service Authorization Data Entry Form.**) This signed form authorizes payment for the assistive technology (AT) device(s) to the contracted provider agency, who will in turn reimburse the AT vendor. In addition, this form identifies the codes necessary for medical insurance billing.

This form is completed by an EIOD in the Assistive Technology Unit or the Regional Office who authorizes the device(s) after receiving and approving a completed Assistive Technology Specification Request. A copy of the signed **Assistive Technology Device Data Entry Form** must be sent to the provider agency, the service coordinator and the Regional Office for filing in the child's case record.

1. **Effective Date of IFSP** – For an interim or initial IFSP, this is the date that the IFSP meeting takes place. For a Six Month Review or Annual IFSP, the effective date is the day after the end date of the existing IFSP. For an amendment to an IFSP, use the effective date of the *current* IFSP.

2. **End Date of IFSP** - 26 weeks after the effective date of the IFSP **unless the child turns 3 before that date.**

NOTE: This date should be the same as the end date of IFSP on the **Service Authorization Data Entry Form**. See Instructions for that form. For an interim IFSP, the end date of IFSP is 45 days from the date of the child's referral to EI, even though the end date of the authorization (see # 11 below) may be different.

3. **Child Information** – The child's EI number, name, and date of birth as recorded in all other places on the IFSP. Include the child's borough of residence.

4. **Provider Information** – For each provider, include the following information:

- The provider agency name and Provider EI Number as listed in the Provider Directory.
- The name of the contact person at the provider agency who can respond to questions about the child's program and his/her telephone and fax numbers.
- The name of the child's currently assigned OSC, SC ID #, telephone and fax numbers.

5. **Type of IFSP** – Check the appropriate box to indicate if the IFSP is an interim, initial, 6 month or annual IFSP. If the IFSP is a 6 month or annual, also check the appropriate month (6, 18 or 30 month or 12, 24, or 36 month).

If this is an amended IFSP, check **both** the appropriate box indicating the type of IFSP **and** the box indicating amendment to IFSP. Write the **effective date of the amendment**. For example, if an initial IFSP dated 1/1/09 is being amended on 5/20/09, check the box for *Initial* and the box for *Amendment to IFSP* and write 5/20/09 next to *Dated*.

6. **EIOD Signature and Name** – The EIOD's printed name, signature and the date s/he actually signed the form. This date may be different from the *Effective Date of IFSP*. **No payment can be made by the Early Intervention Program to a service provider if the AT Device Data Entry Form is not signed by the EIOD.**

7. **Vendor, Catalog or Dispensary** – The name of the vendor, catalog or dispensary from whom the device will be ordered.

8. **Category/Service Code** – The *category* is Assistive Technology and the *Service Code* is I for all AT devices. Thus this section has already been completed.

9. **CPT/HCPCS Code** – CPT- 4 codes are used to describe medical procedures and are maintained by the American Medical Association. HCPCS codes are established by the Centers for Medicare and Medicaid Services to identify items, supplies and non-physician services not identified within the CPT- 4 coding system. Refer to the reference manuals published by these institutions for the correct coding.
10. **AT Item/Device Description** – The generic or commercial name of the device and components that are authorized for purchase.
11. **Begin and End Dates** – The *Begin* and *End* dates enclosing the period during which the device is to be delivered to the child/family.

NOTE: Although services authorized at an Interim IFSP meeting, including AT services, must end on the 45th day after the child’s referral to the EI Program, AT devices may be authorized for a period of 6 months to allow sufficient time for delivery.
12. **Quantity** – The number of component parts needed for the completed device (e.g., 2 for bilateral orthotics).
13. **Cost** – The discrete cost of each component needed for the completed, assembled device which is included in the listed price on the ordering invoice as quoted by the vendor. The cost for “for profit” agencies may include taxes or surcharges; however, these charges are usually exempted. Shipping and handling may be included as a *separate* item.
14. **Total Cost** – The total cost is the listed price on the ordering invoice which includes all component costs and the base unit comprising the completed, assembled device.
15. **Status** - Circle *Add* if the AT Item/Device is being added for the first time at an initial, 6 or 12 month or amended IFSP. Circle *End* if it is being terminated from the IFSP.

<p>CHILD'S NAME:</p> <p>_____</p> <p>Last First MI</p> <p>EI # _____</p> <p>DOB ____/____/____</p>	<p>IFSP: [] Initial [] 6-Month [] Annual</p> <p> [] Amended [] Interim</p> <p>Effective date of IFSP: ____/____/____</p> <p>End date of IFSP: ____/____/____</p> <p>EIOD (print): _____</p> <p>EIOD signature _____</p> <p>Date: ____/____/____</p>	<p>TRANSPORTATION PROVIDER INFORMATION</p> <p>Transportation Provider Name: _____</p> <p>Provider EI # _____</p> <p>Contact person: _____</p> <p>Phone: (____) _____</p> <p>Fax: (____) _____</p>
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<p>DESTINATION INFORMATION</p> <p>Agency name: _____</p> <p>Agency EI#: _____</p> <p>Site address: _____</p> <p>_____</p> <p>Trans. Coord.: _____</p> <p>Phone: (____) _____</p> <p>Fax: (____) _____</p>	<p>Service Coordinator:</p> <p>Name (print): _____</p> <p>SC ID #: _____</p> <p>Agency Name: _____</p> <p>Agency #: _____</p> <p>Phone: (____) _____</p> <p>Fax: (____) _____</p>	<p>Data Entry Unit Only - For Bus Contract Change</p> <p>Prior Bus Effective End Date is: ____/____/____</p> <p>New contracted bus transportation name: _____</p> <p>Provider EI # _____</p> <p>Contact person: _____</p> <p>New Contract Date -</p> <p>Begin: ____/____/____ End: ____/____/____</p> <p># Weeks: _____ Total # Units: _____</p> <p>Phone: (____) _____</p> <p>Fax: (____) _____</p>
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Service Type: Bus <input type="checkbox"/> Other <input type="checkbox"/>	Begin Date	End Date	Days per week	# Weeks	# Units (bus only)	Status
Name Companion(s): 1. _____	Child	Child	M T W Th Fri Total # days per week: _____	Child	Child	[] Add
2. _____						[] End
Reason (bus only) :	Companion (bus only)	Companion (bus only)	M T W Th Fri Companion Total # days per week: _____	Companion (bus only)	Companion (bus only)	[] Add
						[] End

IF ANY OF THE INFORMATION BELOW CHANGES THE EIOD MUST BE NOTIFIED IN WRITING

<p>Parents/Guardians Name(s):</p> <p>_____</p> <p>_____</p> <p>Home #: (____) _____</p> <p>Work #: (____) _____</p> <p>Cell #: (____) _____</p> <p>Address (if different from pick up): _____</p>	<p>Pick up address/ phone:</p> <p>_____</p> <p>_____</p> <p>Drop off address/phone:</p> <p>_____</p> <p>_____</p> <p>Child travels with the following equipment: _____</p>	<p>Emergency Contact Name(s):</p> <p>1. _____</p> <p>Relation: _____</p> <p>Home #: (____) _____</p> <p>Work #: (____) _____</p> <p>Cell #: (____) _____</p>	<p>Check as appropriate:</p> <p>[] Ambulatory</p> <p>[] Non-ambulatory</p> <p>[] Wheelchair vehicle</p> <p>[] Needs special safety seat</p> <p>[] Other (specify) _____</p>
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EIP Data Entry: _____ Date: _____

INSTRUCTIONS

TRANSPORTATION SERVICE DATA ENTRY FORM

This page documents the discussion and authorization of transportation to a service delivery site for child and/or caregiver, if needed. There must be a separate Transportation Service Data Entry Form prepared for each provider (unless there is a bus company contract change, see #6 below) that will indicate an amount to be reimbursed for a transportation-related service. For example, if a child will be transported by a school bus provided by the transportation vendor, Smith Bus Company, and if, in addition, the child's father will be reimbursed by the Early Intervention service provider, LMN Developmental Center, for subway fare when he attends a weekly family support group, two **Transportation Service Data Entry Forms** must be completed. One form will be filled out for the bus company and another for the EI service provider.

1. **Child's Name, EI #, DOB** – Write the identifying information for the child as it appears on all other IFSP pages.
2. **IFSP:** Check the appropriate box for type of IFSP and write in the *Effective* and *End* dates of the IFSP period. **The EIOD will print his/her name, sign and date this form upon completion, indicating that the service is authorized.**
3. **Transportation Provider Information** – Either the bus company or the service provider agency that receives payment for car service, mileage, or public transportation and reimburses the family/caregiver. Include the provider name, provider EI contract # (as listed in the provider directory), agency contact person, and telephone and fax numbers of the transporting agency.
4. **Destination Information** - The name of the agency of destination, i.e., where the child/family is to be transported, agency EI contract #, site address, name of transportation coordinator, telephone and fax numbers.
5. **Service Coordinator** - Provide the SC information as indicated.
6. **Data Entry Unit Only – For Bus Contract Change** – This section will be completed by Data Operations staff when there is a change in the bus contract information that does not involve a change in the authorized service. The SC should **not** submit a new **Transportation Service Authorization Data Entry** form. No action is required by the SC or the EIOD/Regional Office.
7. **Transportation Service Type** – Check the box for *Bus* or *Other*. Write the code for the mode of transportation to be reimbursed.
 - 1 = Public Transportation
 - 2 = Taxi/Car Service
 - 3 = Mileage
 - 4 = Parking
 - 5 = Toll
 - 7 = School Bus
 - 8 = Nurse Accompaniment
 - 9 = Other
8. **Companion Accompanying Child** – If authorized, write the name of the person(s) who will accompany the child on the school bus or car service. Indicate the reason for accompaniment on the school bus. (***The parent or another adult over age 18 must accompany the child for car service.***)_The other information in this section applies to parents/caregivers who will:
 - always accompany their child on the bus, or
 - accompany their child on a school bus to an EI facility for the first few days of the child's attendance at the center, or
 - **occasionally but regularly** accompany the child on the bus in order to attend a Family Support Group, Parent-Child Group, or participate in a session at the EI facility.

**INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE COORDINATION ACTIVITIES (Page 7)**

Child's Name: (Last) _____ (First) _____

EI #: _____ DOB: ____/____/____

Today's Date: / /

SC Primary Roles:

- Coordinate and monitor the delivery of all services.
- Assist families in obtaining EI and non-EI services.
- Facilitate reviews of IFSP every 6 months.
- Inform caregivers of their rights and procedural safeguards under the Early Intervention Program.
- Obtain and update insurance information and explain to parents how information will be used by EI.
- Discuss transition from EI when the child is 24 or more months old.

I have been given the option of choosing an ongoing service coordinator (OSC) and I have selected:

Name of OSC _____ **SC ID #** _____

Tel. No. _____ **Ext.** _____ **Email** _____

Provider Agency _____ **Provider #** _____

Parent's signature _____

Ongoing SC should:

Assist family in identifying and applying for Public Programs (e.g., Child Health Plus, Medicaid, Medicaid Waiver, WIC, Lead Program, housing). **List the programs:**

Assist family in identifying and applying for other non-EI services needed by child/family (e.g., child care, counseling, recreation services). **List the services:**

Coordinate **co-visits**; reschedule if necessary.

Locate **lingual services**. If unavailable, contact EIOD to discuss alternatives.

Assist family with **transition**; complete pages 7A and 7B if child is 2 years or older.

Primary Health Care Provider: _____ Name of Medical Center/Facility _____

Address: _____ Phone #: (____) _____ Fax #: (____) _____

I give permission for my service coordinator to send a copy of the IFSP and evaluation reports to my child's primary health care provider

I do not give permission.

Signed: _____ **Date:** ____/____/____

If Parent/Guardian/Surrogate chooses to send the IFSP to others working with their child, such as Early Head Start, or Child Care Providers, complete "Parental Consent to Release/Obtain Information" form.

Additional Concerns: Describe below any concerns (from any members of the IFSP team) that may need follow-up.

Any further evaluations needed? Yes No **Specify what type and why:**

INSTRUCTIONS FOR IFSP PAGE 7
SERVICE COORDINATION ACTIVITIES

The Service Coordination section includes a list of regularly performed tasks for the Ongoing Service Coordinator (OSC) and the family's/caregiver's selection of an OSC. If additional follow-up activities are required of the OSC, check the applicable boxes.

1. **Service Coordinator Information** – The name of the OSC, SC ID number assigned by NYC EIP, telephone number, email address and name and number of provider agency by whom the SC is employed, as selected by the parent from the list of choices presented at the IFSP meeting.

If an OSC provider has not been identified by the end of the initial IFSP meeting (i.e., services are pending), the family/caregiver may select the ISC as the OSC to help locate a provider(s). Once a provider is located, the family/caregiver may wish to change service coordinators. If the parent selects a new OSC, follow the EIP procedure for changing the SC.

The parent must sign on this page to indicate that s/he has been given options and has selected the OSC.

NOTE: Before a SC can be designated or assigned, s/he must have applied for and received a SC ID number from the Early Intervention Program. In addition, a provider will not be reimbursed by the EIP for the services of the OSC until the *Start Date* for Service Coordination listed on the **Service Authorization Data Entry Form**.

2. **Ongoing SC should** - Check the applicable boxes for OSC F/u activities.
 - a. **Assist family in identifying and applying for Public Programs** – List the programs for which the family may be eligible, such as Child Health Plus or other medical insurance programs offered through Health Care Access and Improvement (HCAI), WIC, Lead program, housing etc.
 - b. **Assist family in identifying and applying for other non-EI services needed by child or family** – List other services that may be needed to support the child and family outcomes, e.g., “work with the local interchurch council to seek funds for child care so that mother can return to work part-time.”
 - c. **Coordinate co-visits; reschedule if necessary** – Check this box if co-visits are authorized. The OSC has the responsibility to coordinate co-visits and to assist in rescheduling as necessary.
 - d. **Locate bilingual services** – If bilingual services have been requested for any of the services authorized, the OSC must make diligent efforts to locate such services. If the OSC is unable to find a provider for the requested bilingual service, s/he must contact the EIOD to discuss alternatives. A monolingual service should not be substituted without the approval of the EIOD.
 - e. **Assist family with transition** – The OSC must assist the family in developing a transition plan for the child whenever a child exits the Early Intervention Program. This includes leaving the program when EI services are no longer needed or when the family moves to another county or state. In these situations, the OSC should help the family access services in the new location. If the child is 2 years old or older, this box must be checked and the OSC must complete pages 7A and 7B.
2. **Primary Health Care Provider** – Name of Primary Health Care Provider, name of Medical Center/Facility, address, telephone and fax numbers.
3. **Permission to Release Copy of IFSP**– The parent will indicate whether s/he wishes to have a copy of the IFSP shared with the child's Primary Health Care Provider by checking the appropriate box, signing and dating the form.
4. **Additional Concerns** – Any concerns discussed at the IFSP meeting (by any participants) that may need follow-up should be described in this section. If billing rules are waived, describe the reasons and specify the circumstances of the waiver(s). If services have been recommended but rejected by the parent, list these services and describe the reason for the parent's rejection of them.
5. **Any further evaluation needed?** – If during the IFSP meeting it becomes evident that another evaluation is needed for additional information, a Supplemental Evaluation can be requested by anyone present. If requested, indicate by checking *yes* and specify what type of evaluation is requested. Explain the reason for the request. A **Request for Additional Evaluation** form should be completed and attached to the IFSP. The OSC must follow-up to assist the family in scheduling the evaluation and ensuring that it takes place in a timely manner.

**INDIVIDUALIZED FAMILY SERVICE PLAN
Transition Plan (Page 7A):**

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____
Today's Date: ____/____/____ Child's Age: _____

INFORMATION REGARDING TRANSITION: Pages 7A and B must be completed for any child leaving EI, regardless of his/her age. These pages must be filled in at the IFSP closest to the child's 2nd birthday and updated at each subsequent IFSP. For children entering the EIP after age 2, these pages must be completed at the initial IFSP.

1. Children who complete their IFSP outcomes or no longer require EI services may exit EIP at any time prior to the third birthday. My service coordinator is responsible for helping me identify, locate, and provide access to other early childhood programs when appropriate.
2. If the parent is considering CPSE services, the following steps will need to be taken:
 - a. **NOTIFICATION:** I understand that I will need to give written consent to notify the CPSE of my child's potential eligibility. Notification must occur by ____/____/____ to Region/ District _____.
 - b. **TRANSITION CONFERENCE:** I understand that if I choose to request that my EIOD arrange a transition conference with my service coordinator and the chair of the CPSE or designee, I will need to give written consent for a transition conference which will be held by ____/____/____.
 - c. **REFERRAL:** I understand that it is my responsibility to refer my child to the CPSE. My service coordinator can assist me if I ask. Any delays on my part to refer my child may potentially interfere with the ability of the CPSE to establish eligibility before my child's third birthday. Referral must occur by ____/____/____.
3. I am aware that all EI services will end on the day before my child's 3rd birthday: ____/____/____, if my child is not found eligible for CPSE services. If my child does not need preschool special education programs and services, or if I choose not to refer my child to the CPSE, my service coordinator is responsible for helping me identify, locate and access other early childhood programs.

The above information has been explained to me. **Parent's signature:** _____ **Date:** ____/____/____

Parent has chosen NOT to: (initial as appropriate):

- Send Notification to the CPSE
 Consent to a transition conference.
 Refer child to the CPSE at this time.

I understand that all EI services will end the day before my child's 3rd birthday: ____/____/____

Parent's signature: _____ **Date:** ____/____/____

INSTRUCTIONS FOR IFSP PAGE 7A

TRANSITION PLAN

This page and Page 7B must be completed for any child leaving EI, regardless of his/her age. If the child remains in EI, these pages must be filled out at the IFSP closest to the child's second birthday and updated at each subsequent IFSP review. For a child entering EI after age 2, these pages must be completed at the initial IFSP and any subsequent reviews.

- 1. Information regarding transition** – The parent will sign and date in this box after the information has been explained. If the child no longer requires EI services, the Ongoing Service Coordinator (OSC) will assist the parent to access other early childhood programs as appropriate. If the parent is considering CPSE services, the steps to be taken must be explained and the dates for *Notification*, *Transition Conference* and *Referral* filled in. In addition, write the number of the Department of Education Region and District in which the child resides.

It is important that the parent understand that it is the parent's responsibility to refer the child to the CPSE for initial evaluations. The OSC should assist the family by helping them write the referral letter and mailing or faxing it to the CPSE. The OSC may, if asked by the parent, assist the family with follow-up. The parent must be informed that his/her child will no longer be eligible for EI services after turning 3 unless the child has been found eligible for services by the CPSE. **Include the date on which the child's services will end, i.e., the day before the child's third birthday, in #3 of this section.**

At the parent's request, the service coordinator may attend the CPSE meeting to determine the child's eligibility for preschool special education services.

- 2. Parent has chosen not to** – The parent must indicate by initialing on the appropriate line which steps toward transition s/he has refused. **Include the date, i.e., the day before the child's third birthday, on which the child's EI services will end.** The parent must sign and date in this box if referral to the CPSE has been refused.

**INDIVIDUALIZED FAMILY SERVICE PLAN
Transition Plan (Page 7b)**

Child's Name: (Last) _____ (First) _____
EI #: _____ DOB: ____/____/____
Today's Date: ____/____/____ Child's Age: _____

TRANSITION PLAN:

1. What types of setting/services are being considered? Discuss various options for programs and/or services when the child exits EI, such as home, Early Head Start, Head Start, child care, private preschool, play group, preschool special education programs and services through CPSE, OMRDD, etc. **At this time we are interested in the following options:**

2. Date by which steps to prepare the child and family to adjust to a new setting should begin ____/____/____
(6 mo. prior to discharge or when child is leaving EI before his/her third birthday)

3. Describe steps to be taken to ensure a smooth transition? (Visit Early Head Start, day care centers, private preschools, etc.)

4. Who will assist?

My child is leaving EI before the third birthday for the following reason(s): _____.

I am aware that I may re-refer my child to EI before his/her third birthday if I have concerns about his/her development.

I am aware that I can refer my child to CPSE after his/her third birthday if I have concerns about his/her development.

Parent's Signature _____ **Date** ____/____/____

NOTE: Update this section at every IFSP meeting.

Notification sent to the CPSE on: ____/____/____

Transition conference was held on: ____/____/____

Child was referred to the CPSE on: ____/____/____

CPSE meeting is scheduled for: ____/____/____

CPSE meeting was held on: ____/____/____

Child was found **eligible** for preschool special education programs and services.

Last day of EI services: ____/____/____

Projected date of preschool services: ____/____/____

Child was found **not eligible**. Last day of EI services: ____/____/____

INSTRUCTIONS FOR IFSP PAGE 7B

TRANSITION PLAN

This is the second page of required documentation for children leaving EI for any reason and for children who are 2 years of age or older.

1. **What types of setting/services are being considered?** – List the options that have been discussed with the parent and in which the parent shows interest. These may include both government sponsored (e.g., CPSE, OMRDD, Head Start) and private alternatives (e.g., child care, preschool, playgroups).
2. **Date by which steps to prepare the child and family to adjust to a new setting should begin** - Complete the date, either 6 months prior to the child's discharge or when the child is leaving EI before his/her third birthday.
3. **Describe steps to be taken to ensure a smooth transition** –What steps can be taken to assist the transition and the child and family's adjustment to a new setting? For example, SC and interventionists may begin talking to the child and family about changes in services and settings; provide referrals and literature to the family; suggest visiting possible sites or contacting community agencies.
4. **Who will assist?** – List the names of those who might assist, such as current interventionists, staff at the provider agency, community agencies (e.g., ECDC).
5. **Parent's Signature** – The parent should:
 - Complete this part of the form by indicating why the child is leaving EI before the 3rd birthday (e.g., family is relocating, child no longer needs services),
 - Understand the options to refer the child to EI or CPSE depending on the child's age,
 - Sign and date the form.
6. **Update** –At each subsequent IFSP meeting, update the status of the child's progress toward transition by filling in the date on the appropriate line. Refer to the policy on *Transition* for further information.

**INDIVIDUALIZED FAMILY SERVICE PLAN
ATTESTATIONS, CONSENT FOR SERVICES
(Page 8)**

Child's Name: (Last) _____ (First) _____
 EI #: _____ DOB: ____ / ____ / ____
 Today's Date: / /

- I received a copy of *A Parent's Guide* when my child was referred to Early Intervention. I understand my rights and I have received a verbal and written description of *My Family Rights* at this IFSP meeting.
- I understand that :
 - I 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 early intervention 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 fair 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 to help my child achieve our IFSP outcomes.
- I have been given a copy of the *EIP Policy on Make-up Sessions* and I understand when make-up sessions can be provided.

Parent's Signature

Parent's Signature

____ / ____ / ____
Date

- I (We) have participated in the development of this IFSP, and agree to all parts of this plan. I (we) give permission to the NYC Early Intervention Program to implement this plan with my family.
- I (We) do not agree with some aspects of this plan. I (We) understand that I (we) have due process rights that are described in the *Parent's Guide* and that have been explained to me(us) at this meeting. I understand that disagreeing will not affect the other EI services. This is what I (we) do not agree with:

Parent's Signature

Parent's Signature

____ / ____ / ____
Date

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 and the discussion that took place at this IFSP meeting as documented in the IFSP.

EIOD STAMP:

INSTRUCTIONS FOR IFSP PAGE 8

ATTESTATIONS, CONSENT FOR SERVICES

1. **First Parent's Signature** – Signature of the parent/guardian(s) indicating s/he has read the bulleted points in the box below the child's identifying information and understands his/her rights and responsibilities. *The EIOD must ensure that the parent understands his/her rights in the Early Intervention Program and has received copies of My Family's Rights and the EIP Policy on Make-up Sessions.*
2. **Second Parent's Signature, Agreement with Plan** – Indication of 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 parents 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 parents/guardians may exercise their due process rights to resolve the disputed areas. The EIOD and SC must ensure that the parents/guardians understand their due process rights to request mediation or an impartial hearing. The parents/guardians should be referred to the Early Intervention Program's "A Parent's Guide" for information on mediation/due process forms and procedures.

3. **Attestations and Signatures** – The evaluation representative and the EIOD must sign and date the IFSP attestation at the initial IFSP meeting. The EIOD will use the official NYCEIP stamp and sign and date this page for each IFSP, indicating authorization of the plan.

Chapter 6: Service Delivery

New York City Early Intervention Program

Policy Title: Start Date of Services	Effective Date: 10/17/2010
Policy Number: 6-A	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> • IFSP Page 5a : Service Authorization Data Entry form • Status of Start Date of Services Form • Change in Services/Service Provider/Service Coordinator form 	Regulation/Citation: Early Intervention Administrative contract with New York State Department of Health; NYCRR 69-4.6 (b) (4).

I. POLICY DESCRIPTION:

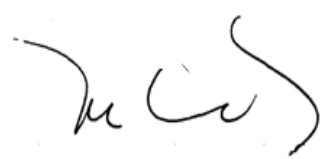
“Service Coordination shall be an active ongoing process that involves facilitating the timely delivery of available services (NYCRR 69-4.6 (b) (4)).”

The Early Intervention Service Coordination Agency must ensure that ongoing service coordination services are provided and that ongoing service coordinators appropriately monitor services and implement the IFSP so that services contained in the IFSP begin within two (2) weeks of the IFSP meeting and are provided continuously for the entire period covered by the IFSP.

II. PROCEDURE:

Responsible Party	Action
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. Contacts the family and the service provider agency (agencies) within one (1) week of the IFSP meeting (Initial, Review, and Annual) date to determine if all authorized services have begun. 2. For each authorized service type, confirms that the service has started and documents the start date on the Status of Start Date of Services Form. <ol style="list-style-type: none"> a. If all authorized services have begun within two (2) weeks of the authorized start date: <ol style="list-style-type: none"> i. Completes the Status of Start Date of Services Form and keeps it as part of the Service Coordination record. b. If any service(s) has not started within two (2) weeks of the authorized start date: <ol style="list-style-type: none"> i. Contacts the Program Monitoring and Quality Assurance Unit (PMQI) at 212 788-7622 for assistance in locating a service provider. ii. When a service provider(s) has been identified: <ul style="list-style-type: none"> • Completes the Service Authorization Data Entry Form and Change in Services/Service Provider/Service Coordinator Form, if appropriate, and submits to the EIOD for authorization. • Forwards copies of the authorized Service Authorization Data Entry Form and Change in

	<p>Services/Service Provider/Service Coordinator Form, if appropriate, to the provider agencies.</p> <ul style="list-style-type: none"> Documents all attempts to locate service providers and includes copies of all documents in the child's service coordination record. <p>Note:</p> <ul style="list-style-type: none"> The Service Authorization Data Entry Form and Change in Services/Service Provider/Service Coordinator Form are only completed when there is a change in service provider agency NOT Interventionist.
Early Intervention Official Designee (EIOD)	<ol style="list-style-type: none"> Approves Service Authorization Data Entry Form(s) and Change in Services/Service Provider/Service Coordinator Form(s), if appropriate Returns signed, authorized Service Authorization Data Entry Form(s) and Change in Services/Service Provider/Service Coordinator Form(s) to the OSC for distribution to the provider agencies. Keeps copies of all forms as part of the child's municipal record.
Program Monitoring and Quality Assurance (PMQI)	<ol style="list-style-type: none"> Provides technical assistance in locating a provider.



Approved By:
Assistant Commissioner, Early Intervention

Date: 09/17/10

**NEW YORK CITY EARLY INTERVENTION PROGRAM
STATUS OF START DATE OF SERVICES FORM**

Child's Name: _____ EI ID#: _____

Ongoing Service Coordinator (OSC): _____

SC #: _____

Date of IFSP: _____ IFSP Type: _____

Service Type	IFSP Begin Date	Authorized EI Agency	Have Services Started?	Actual Service Start Date *
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
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			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	
			Y <input type="checkbox"/> / N <input type="checkbox"/>	

* For any service that has not started **within two (2) weeks** of the IFSP, attach relevant service coordination notes. Include the service type, start date, reason for delay in start of service, all agencies contacted, contact name and date of contact, of all agencies contacted to secure a new service provider.

OSC Signature: _____ Date: _____

**NEW YORK CITY EARLY INTERVENTION PROGRAM
STATUS OF START DATE OF SERVICES
INSTRUCTIONS FOR COMPLETION**

This form must be completed by the Ongoing Service Coordinator (OSC) **within two (2) weeks** of the IFSP meeting (includes Initials and Reviews), forwarded to the appropriate Regional Office (RO) and retained in the child's case record.

The OSC must contact the family and/or the service provider agency to inquire whether all IFSP authorized services have begun, **within one (1) week** of the IFSP date.

For each IFSP authorized service type, the Service Coordinator (SC) must confirm that the service has started and indicate the actual start date of each service.

If any service has not started **within two (2) weeks** of the authorized start date, the OSC must inform the family of their rights and inform them that EI can select another service provider to deliver services.

The SC must send the "Status of Start Date of Services" form and his/her service coordination notes to the NYC EIP RO (Assistant Director or EIOD) when services do not begin **within two (2) weeks** of the authorized start date for any reason.

The **OSC must document the service type, reason for any delay in the starts of service(s) and his/her attempts to locate other services** (including agency(ies) contacted, contact name, and date of contact).

The OSC must sign and date **Status of Start Date of Services Form** when the form is completed.

Note: The SC should contact the Program Monitoring and Quality Assurance Office (PMQI) as well as the RO when assistance is needed in locating a provider. These contacts should be noted in the service coordination notes.

New York City Early Intervention Program

Policy Title: Error Submission	Effective Date: 10/17/2010
Policy Number: 6-B	Supersedes: N/A
Attachment: <ul style="list-style-type: none"> Error Submission Transmittal Form IFSP Page 5a: Service Authorization Data Entry Form 	Regulation/Citation:

I. POLICY DESCRIPTION:

All **Service Authorization Forms (Page 5a of the IFSP)** must be reviewed by the service provider agency for accuracy. Any form with an obvious error* may be sent to attention of the Assistant Regional Director (AD) within **ten (10) business days** of receipt of the IFSP.

Any error discovered **after ten (10) business days** must be reported through the Turn Around Document (TAD) process by the service provider agency.

* Examples of Obvious Errors:

1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)	2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	
1: <u>TYPE SVC</u> <i>Code Letter</i>	<u>Speech/language</u> M	<u>Home/Community</u> B	<u>Home</u> E	1/1/10	6/30/10	30	2	26	26

Wrong Code for SVC Type. Submit to change code to "N"

Wrong code for Method. Submit to change code to "A"

Incorrect total number of units. Submit to change units to "52"

Examples of Not Obvious Errors:

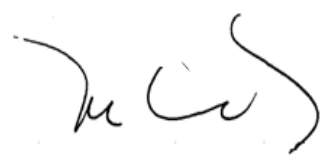
1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)	2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	
1: <u>TYPE SVC</u> <i>Code Letter</i>	<u>Speech/language</u> N	<u>Home/Community</u> A	<u>Home</u> E	1/1/10	6/30/10	30	2	26	52

Cannot locate SLP. Submit to change to SVC Type TSLD Code "M"

II. PROCEDURE:

Responsible Party	Action
EI Provider Agencies	<ol style="list-style-type: none"> 1. Reviews all IFSP documents immediately upon receipt. 2. Submits a request for correction of Service Authorization Form(s) by: <ol style="list-style-type: none"> a. Highlighting the error(s) on the current Service Authorization Form; b. Completing new Service Authorization Form(s): <ol style="list-style-type: none"> i. Ensure that the <i>Early Intervention Official Designee (EIOD) Name and Signature section</i> and the <i>Services sections</i> are left blank; and ii. Write the word “CORRECTION” and the date that the form was submitted to the Regional Office (RO) on the bottom of the new Service Authorization Form(s). c. Writing a letter on agency letterhead that fully explains the error(s). d. Completing and attaching the Error Submission Transmittal Form to the entire group of packets for submission to the RO. <p>NOTE:</p> <ul style="list-style-type: none"> • Errors should be submitted in batches to the RO. <ol style="list-style-type: none"> 1. Mails or faxes the error submission packet to the AD: <ol style="list-style-type: none"> a. Initial or Annual authorizations must be postmarked or date stamped: <ol style="list-style-type: none"> i. Within ten (10) business days of the IFSP meeting date. b. Paperwork IFSP submissions must be postmarked: <ol style="list-style-type: none"> ii. Within ten (10) business days of the date the EIOD faxed/returned the paperwork to the Ongoing Service Coordinator (OSC). 2. Mails or faxes a copy of the error submission to the Service Coordinator (SC). <p>NOTE:</p> <ul style="list-style-type: none"> • If the service provider discovers an error <i>after ten (10) business days</i>, a Turnaround Document (TAD) must be submitted (refer to Turnaround Document Policy). • Incomplete packets or forms will be returned to the service provider.
Regional Office (RO)	<ol style="list-style-type: none"> 1. Reviews the error submission packet to ensure completeness and accuracy. <ol style="list-style-type: none"> a. Complete error submission packets are date stamped and given to the appropriate AD. b. Incomplete or inaccurate error submission packets are returned to the service provider agency. 2. Error submission packets are processed within three (3) business days of receipt in the RO by the AD or designated EIOD. 3. The reviewer: <ol style="list-style-type: none"> a. Completes and signs the Service Authorization Form (s); b. Attaches the Error Submission Transmittal Form, indicating the date completed; c. Faxes the batch to the provider agency; and

	d. Forwards the batch for data entry.
EI Service Provider Agency	<ol style="list-style-type: none"> 1. Keeps a copy of the completed error submission packet in the child's file. 2. Faxes a copy of the packet to the SC.
Service Coordinator	<ol style="list-style-type: none"> 1. Receives a copy of the corrected error submission packet 2. Faxes a copy of the packet to the relevant service provider agency (ies). 3. Keeps a copy of the completed error submission packet in the child's file.



Approved By:
Assistant Commissioner, Early Intervention

Date: 09/17/10

New York City Early Intervention Program

Policy Title: Obtaining Prescriptions For Authorized Services	Effective Date: 10/17/2010
Policy Number: 6-C	Supersedes: N/A
Attachment: <ul style="list-style-type: none"> • Request for Prescription for Services Form 	Regulation/Citation: Early Intervention Program Guidance Memorandum 2003-01 Footnote 13; Responses to Technical Assistance Questions from Municipalities Regarding NYSAC-DOH Training Sessions On Early Intervention Guidance Memorandum 2003-01

I. POLICY DESCRIPTION:

The Service Provider Agency must obtain a physician's or nurse practitioner's order prior to the initiation of services pertaining to those Early Intervention (EI) services which require such an order. The Ongoing Service Coordinator (OSC) is responsible for this activities only if it listed as an OSC follow-up activity on the Individualized Family Service Plan (IFSP).

II. PROCEDURE:

Responsible Party	Action
Service Provider Agency	<ol style="list-style-type: none"> 1. Obtains separate physician or nurse practitioner prescription for each of the following services before service delivery can begin: <ol style="list-style-type: none"> a. Nursing; b. Physical therapy; and c. Occupational therapy. <ol style="list-style-type: none"> i. Requests prescriptions using the <u>sample language</u> in the Request for Prescription for Services Form. 2. Obtains new prescriptions when an amendment to a service is made changing the frequency/duration stated in the current order(s). 3. New prescriptions are not necessary for the six (6) month review of the IFSP, if frequency and duration of the specific service is not changed. 4. Obtains new prescription at the time of annual review even if there has been no change in frequency/duration. <p>Note:</p> <ul style="list-style-type: none"> • Prescriptions should not be obtained prior to the IFSP meeting. • It is sufficient for a prescription to say 'on as needed basis' if no time frame or frequency is indicated. • If feeding services are authorized, obtains written medical clearance from the child's physician indicating that there are no contraindications. <ol style="list-style-type: none"> 5. Faxes the prescription to the Service Coordinator whenever there is change to the service on the IFSP. 6. Provides a copy of the prescription to all relevant therapists.
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. A copy of the prescription is kept in the service coordination file.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 09/17/10

**NYC EARLY INTERVENTION PROGRAM
REQUEST FOR PRESCRIPTION FOR SERVICES**

Child's Name: _____ DOB: _____
EI #: _____ Date: _____

Dear Physician/Nurse Practitioner,

At the request of the parent, we are writing to inform you that your patient has been found eligible for the NYC Early Intervention Program (NYCEIP). The NYC Early Intervention Program provides educational and therapeutic services to children with developmental delays and disabilities and supports families/caregivers, using everyday routines to promote development.

The NYC EIP staff met with the family on (date) _____, and discussed the parents' concerns, priorities and resources in order to develop the Early Intervention Individualized Family Service Plan (IFSP).

Based on the IFSP meeting, your patient will receive the following services:

Speech Therapy: _____ (per week / month)
*Occupational Therapy: _____ (per week / month)
*Physical Therapy: _____ (per week / month)
*Feeding Therapy _____ (per week / month)
Special Education: _____ (per week / month)
Other: _____ (per week / month)

* Based on the New York State Practice Acts, Occupational Therapy (OT), Physical Therapy (PT), and Nursing services require a prescription. The prescription can specify the above frequency or say "As per the IFSP." A separate prescription is needed for OT and PT services. Please attach a prescription if you agree with the plan.

Are there any medical concerns about this child participating in a therapy program?
If yes, please let us know of the limitations of his/her participation, (e.g., cardiac or respiratory disease, etc.).

There are no restrictions There are restrictions (**Attach specific medical clearance**)

The service plan will be reviewed by the NYCEIP every six (6) months and adjustments to the plan will be made based on the child's progress. With parent permission, please keep us updated on any medical information or diagnoses that may impact his/her interventions within the NYCEIP.

If there are any questions about this request, please contact me at the below number/address:

Provider Contact (print name): _____ Title: _____
Address: _____
Phone: _____ Fax: _____
Email (optional): _____
Signature: _____

New York City Early Intervention Program

Policy Title: Make-up Sessions	Effective Date: 10/17/2010
Policy Number: 6-D	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> • IFSP Page 8: Attestations, Consent for Services • NYC EI Make-up Policy – Information for Families • Service Authorization Data Entry Form 	Regulation/Citation: NYCRR 69-4.9 (g)(2)(i); NYCRR 69- 4.9 (g)(2)(ii); NYCRR 69- 4.9 (g)(2)(i)(a)

I. POLICY DESCRIPTION:

“Providers shall make reasonable efforts to notify the child’s parent within a reasonable period prior to the date and time on which a service is to be delivered, of any temporary inability to deliver such service due to circumstances such as illness, emergencies, hazardous weather, or other circumstances which impede the provider’s ability to deliver the service.

Providers shall notify the child’s parent and service coordinator **at least five (5) days** prior to any scheduled absences due to vacation, professional activities, or other circumstances, including the dates for which the provider will be unable to deliver services to the child and family in conformance with the Individualized Family Service Plan and the date on which services will be resumed by such provider.

Missed visits may be rescheduled and delivered to the child and family by such provider, as clinically appropriate, agreed upon by the parent and in conformance with the child’s and family’s IFSP.”

Sessions delivered in excess of the authorized frequency per week/month to compensate for a prior missed session (make-up) may be rescheduled by the service provider according to the procedure indicated below.

II. PROCEDURE:

Responsible Party	Action
Early Intervention Official Designee (EIOD)	<ol style="list-style-type: none"> 1. Reviews the make-up policy with parents at conclusion of every IFSP meeting. (IFSP Page 8: Attestations, Consent for Services) <ol style="list-style-type: none"> a. Gives parent a copy of the <i>NYC EI Make-Up Policy – Information for Families</i>. b. Explains that: <ol style="list-style-type: none"> i. Make-up sessions are delivered to compensate for one or more missed sessions in excess of the authorized frequency (per week/month). <i>Example: A child is authorized to receive Speech Therapy once a week. In a particular week, no session was delivered. In a future week, two (2) sessions were delivered; the second is a “make-up” for the missed session of the earlier week.</i> ii. While make-up sessions are not mandatory, providers are encouraged to make-up missed sessions. iii. Sessions can be made up within two (2) weeks after the missed session.

	<p>iv. Interventionist(s) will notify the child’s parent and Service Coordinator (SC) at least five (5) days prior to any scheduled absences.</p> <p>Note:</p> <ul style="list-style-type: none"> • If the family has circumstances that may result in many missed sessions, those circumstances should be documented in the IFSP, if known. • The Ongoing Service Coordinator (OSC) is responsible for monitoring delivery of services.
<p>Service Provider Agency</p>	<ol style="list-style-type: none"> 1. Does not provide individual and/or group (Group Developmental, Parent/Child Group, Family/Caregiver Support Group) make-up sessions under the following circumstances: <ol style="list-style-type: none"> a. While the services are being located, not to exceed fourteen (14) calendar days. <ol style="list-style-type: none"> i. Refer to Start Date of Service Policy. b. During family vacations: <ol style="list-style-type: none"> i. Service Provider must document such occurrence (s) in the Session Notes. ii. Refer to Family Vacation Policy. c. If parent/child displays a pattern of missed sessions (three (3) consecutive missed scheduled sessions) that was not agreed to by the interventionist and the parent. <ol style="list-style-type: none"> i. This does not apply to waived services. d. Provider agency must document such occurrences in the Session Notes. e. Refer to Closure Policy. 2. Provides individual and/or group make-up sessions within two (2) weeks of the missed session within the existing IFSP period, if the following conditions are met: <ol style="list-style-type: none"> a. The session is not medically or therapeutically contraindicated, as indicated by the child’s record b. The make-up session cannot be on the same day as a regularly scheduled service of the same type. <p>Note:</p> <ul style="list-style-type: none"> • For service with a billing waiver, therapeutic sessions cannot exceed the frequency of services authorized on the IFSP or the number of sessions waived on the IFSP. • Waivers are not given to address missed sessions. • Make-up sessions may not take place in advance of a missed session. <ol style="list-style-type: none"> c. Scheduling of the make-up session does not violate any New York State Department of Health billing rules for a particular day: <ol style="list-style-type: none"> i. Home/Community, Individual/Collateral Visit - Basic and Extended: Up to three (3) per day. The three (3) visits may include only one (1) visit per discipline per day. ii. Office/Facility Individual/Collateral Visit: Up to three (3) per day. The three (3) visits may include only one (1) visit per discipline per day. iii. Group developmental visits and parent-child group – No

	<p>more than one (1) per day</p> <ul style="list-style-type: none"> iv. Family/caregiver group – No more than two (2) per day. v. Regularly scheduled Early Intervention therapy sessions may not be extended for the purpose of making up a missed session. <p>d. Group sessions can be made up if all of the conditions above are met and:</p> <ul style="list-style-type: none"> i. An appropriate group is available ii. An appropriate teacher or therapist is available iii. The transportation company can accommodate the child on an existing route (if transportation has been authorized) or the parent can provide transportation for the child for the make-up session. <p>3. Provider agencies must plan as far in advance as possible for absences known ahead of time.</p> <ul style="list-style-type: none"> a. Provider agencies must give families a calendar with scheduled agency closures at the initiation of service and yearly thereafter. b. Provider agencies must notify the child’s parent and SC at least five (5) days prior to any scheduled absences due to vacation, professional activities, or other circumstances c. If missed sessions are due to a prolonged absence by an interventionist (absence of more than fourteen (14) calendar days since the last intervention session), a new interventionist should be assigned by the service provider with parent/caregiver consent. d. If the parent consents to a new interventionist but the provider agency cannot locate a new therapist within three (3) business days, the provider agency must immediately contact the parent and service coordinator. e. If the parent/caregiver chooses to wait for the interventionist to return (not to exceed three (3) weeks): <ul style="list-style-type: none"> i. The agency must notify the OSC. ii. The agency must document parent/caregiver choice in the child’s record. <p>Note: The provider agency must ensure that the parents and the OSC are fully aware of the days when the agency or individual therapists cannot provide services due to scheduled vacations or agency closures.</p>
<p>Ongoing Service Coordinator (OSC)</p>	<p>1. OSC must locate another interventionist/service provider when s/he becomes aware of any interventionist vacation lasting longer than fourteen (14) calendar days.</p> <ul style="list-style-type: none"> a. Notifies the EI/OD/Assistant Regional Director (AD). b. Completes the Change in Services/Service Provider/ Service Coordinator Form and new Service Authorization Data Entry Form and submit it to the RO for approval (applicable if changing provider agency). c. No parent signature is required when changing service providers but the OSC must notify the parent of the change. d. SC must document all attempts to locate a new interventionist/service provider and include a copy of the Change in Services/Service Provider/Service Coordinator Form (if applicable) in the child’s case record.

	<p>2. If the parent/caregiver chooses to wait for the interventionist to return:</p> <ol style="list-style-type: none"> OSC must document parental choice in the SC notes. OSC must review the make-up policy with the parent. A child cannot go without services for more than three (3) weeks. <p>Note: If a prolonged absence is due to a delay in initiation of services that exceeds fourteen (14) days see Start Date of Services Policy.</p>
<p>Early Intervention Official Designee</p>	<ol style="list-style-type: none"> Reviews and approves the Change in Services/Service Provider/Service Coordinator Form and new Service Authorization Data Entry Form within two (2) weeks of receipt. Ensures that arrangements for additional sessions are authorized for missed intervention sessions, if appropriate. If the EIOD determines that a provider has not delivered services for an excessive period of time (more than four (4) weeks), and a new provider for those services is located: <ol style="list-style-type: none"> An increased frequency may be added to the new provider's Service Authorization Data Entry Form to the extent that the sessions are clinically appropriate and feasible. <ol style="list-style-type: none"> A note will be made on the form and in the IFSP that "[X] number of sessions are being added for services not delivered as authorized." Sessions can be added to either the current or subsequent IFSP service authorizations. (This determination is made after consultation with the AD.) <p>Note:</p> <ul style="list-style-type: none"> How changes in frequency are scheduled will be addressed on a case-by-case basis depending on the new provider's ability to accommodate increased sessions. Authorization for services not delivered as authorized by the previous provider will be documented as such in the IFSP and on a Service Authorization Data Entry Form. <ul style="list-style-type: none"> Authorization will include the frequency and duration of the therapy. Refer to the Obtaining Prescriptions for Authorized Services Policy for information regarding changes to frequency. If the EIOD determines that a provider agency is at fault of extended periods of services not being delivered as authorized, the AD will notify Program Monitoring and Quality Improvement (PMQI).
<p>Program Monitoring and Quality Improvement (PMQI)</p>	<ol style="list-style-type: none"> PMQI will investigate the reasons for services not being delivered as authorized and determine if a Corrective Active Plan or further sanctions are warranted.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 9/17/10

NYC EARLY INTERVENTION PROGRAM

MAKE-UP POLICY - INFORMATION FOR FAMILIES

Your child's services should begin within two (2) weeks (14 days from the date of the IFSP authorization). Make-up sessions will not be provided from the date that services are authorized to the date that they begin.

Make-up sessions are not mandatory. The NYC Early Intervention Program expects that a make-up session will be held within **two (2) weeks** of the missed session. A session can only be made-up if medically or therapeutically appropriate for your child.

- Special child/family circumstances will be considered by the Early Intervention Official Designee (EOID).

Services can be made-up in the following ways:

1. When the make-up session is on a different **day** than a regularly scheduled visit.
(Example: If a visit is on Tuesday, the make-up session can happen on any day except Tuesday).
2. If the make-up session does not break any New York State billing rules. Talk to your service provider about how often services can be provided.
3. Group sessions may be made-up only if:
 - a. An appropriate group is available. Your service provider will need to make sure that the group is appropriate for your child.
 - b. An appropriate teacher or therapist is available. If the teacher or therapist does not know your child, s/he may not know how to work with him/her.
 - c. The bus company has room for you and your child.

Not all groups are right for all children, the needs of each child must be considered.

Services cannot be made-up in the following ways:

1. A session cannot be made longer to make-up for missed sessions. For example, if speech therapy is approved for a half-hour, it cannot be made-up as an hour session.
2. Sessions cannot be made-up before they are missed.
3. Sessions will not be made-up for family vacations.
4. Missed services cannot be made-up for scheduled agency closings. The agency providing services to your child should give you a copy of their calendar indicating the days that they will be closed.

NYC EARLY INTERVENTION PROGRAM

MAKE-UP POLICY - INFORMATION FOR FAMILIES

Therapist Absences

The therapist or the agency that s/he works for must tell you if a therapist will **NOT** able to provide your child with services for more than **14 days (two (2) weeks)**. You can choose to ask for a new therapist or to wait for him/her to come back as long as your child does not go without services for more than three (3) weeks. You should call your Service Coordinator if this happens.

You should also tell your Service Coordinator if your child's therapist or teacher:

- a. Keeps changing the schedule;
- b. Misses a lot of sessions;
- c. Asks you to combine services, (for example, a service is authorized two (2) times a week for 30 minutes. The therapist wants to come one (1) time a week for 60 minutes. This is not allowed);
- d. Asks you to sign session notes that are blank or are written for days that s/he did not give services to you or your child.

Remember: If you want to change the way that services are delivered (for example, you prefer one (1) time a week for 60 minutes week instead of two (2) times a week for 30 minutes) talk to your Service Coordinator. Changes to service authorizations can only happen after the IFSP team has been consulted. Ask your Service Coordinator for more information about this process.

If you have questions or concerns about services, call your service coordinator. If you still have concerns, call the Regional Office at the numbers below and ask for the EIOD or Assistant Director. You can also call Beverly Samuels, Director of Consumer Affairs at 212 219-0392.

Bronx: 718-410-4110

Brooklyn: 718-722-3310

Manhattan: 212-487-3920

Queens: 718-271-1003

Staten Island: 718-420-5350

PROGRAMA DE INTEVENCIÓN TEMPRANA

POLIZA PARA RE-EMPLAZO DE SERVICIOS- INFORMACION PARA FAMILIAS

Los servicios autorizados para su hijo/hija deben comenzar dentro de dos semanas (14 días de la fecha que se aprobaron). No habrán sesiones para re-emplazar aquellas que no ocurren de la fecha que se autorizaron hasta que comiencen.

Sesiones de re-emplazo no son mandatorias. El programa de intervención temprana recomienda que sesiones de re-emplazo ocurran dentro de (2) dos semanas de la que se cancelo. Una sesión puede ser re-emplazada solo si es médicamente o terapéuticamente apropiada para su hijo/hija.

- Circunstancias especiales e individuales de su hijo/a o la familia serán consideradas por el Oficial que aprueba los servicios.

Servicios pueden ser re-emplazados de las siguientes maneras:

1. Cuando la sesión de re-emplazo se realiza en un día diferente al que regularmente ocurre. (Ejemplo: La visita siempre son los martes y la de re-emplazo es cualquier día menos el martes.)
2. Si la sesión de re-emplazo no viola ningunas de las leyes de cobro. Hable con la agencia que provee lo servicios para mas información acerca de cada que tiempo los servicios pueden ocurrir.
3. Sesiones de grupo solo se pueden re-emplazar si:
 - a. Un grupo apropiado esta disponible. Su proveedor de servicios debe asegurar que el grupo es apropiado para su hijo/a.
 - b. Un terapeuta o maestra apropiado esta disponible. (Si el terapeuta o maestra no conoce su hijo/a talvez no sabrá trabajar con el/ella.
 - c. La compañía de transporte vía autobús tiene cupo para su hijo/hija.

No todos los grupos son apropiado para todos niños, así es que las necesidades de su hijo/a tienen que ser consideradas.

Servicios no pueden ser re-emplazados en las siguientes maneras:

1. Una sesión no puede ser mas larga para reemplazar otra. (Ejemplo: si la sesión del habla es por media hora, no puede ser extendida hasta una hora para re-emplazar otra.
2. Sesiones no pueden ser re-emplazadas antes de que se cancele una.
3. Sesiones no serán re-emplazadas por vacaciones familiares.
4. No se re-emplazan sesiones por días que la agencia este cerrada. La agencia otorgando los servicios le debe dar un calendario indicando las fechas que están cerradas.

PROGRAMA DE INTEVENCION TEMPRANA

POLIZA PARA RE-EMPLAZO DE SERVICIOS- INFORMACION PARA FAMILIAS

Ausencia del Terapeuta:

El terapeuta o la agencia para quien trabaja deben notificarle si el terapeuta estará ausente por más de catorce (14) días. Usted puede pedir otro terapeuta o esperar que regrese siempre y cuando no pasen más de tres (3) semanas sin que su hijo/a reciba el servicio. Debe comunicarse con su coordinador/a de servicios si esto sucede.

También debe dejarle saber a su Coordinador/a si el terapeuta o maestra:

- a. Cambia mucho el horario.
- b. Falta a muchas sesiones.
- c. Le pide combinar las horas de servicio. (ejemplo: un servicio es autorizado dos veces por semana por 30 minutos y el terapeuta o maestra quiere venir una vez por 60 minutos, esto no es permitido)
- d. Le pide que firme notas de sesiones en blanco o tienen la fecha de sesiones que no ocurrieron.

Recuerden: Si desea cambiar la manera en que se dan las sesiones (por ejemplo, prefiere una vez por semana por 60 minutos y no dos veces por 30 minutos) hable con su Coordinador/a de Servicios.

Si algo le preocupa, hay varias entidades con quien puede hablar.

- Primero, discuta su preocupación con su coordinador de servicios. El/Ella le explicará sus opciones y derechos con mayor detalle.
- Usted puede llamar al Oficial Designado de Intervención Temprana (EIOD) o a un Asistente de Director en la oficina Regional de Intervención Temprana, del condado donde reside, a uno de los números siguientes:

Brooklyn:

718 722-3310

Queens:

718 271-1003

Staten Island:

718 420-5350

Bronx:

718 410-4110

Manhattan:

212 487-3920

- O puede llamar a la Directora de Asuntos de Consumidores, Beverly Samuels, al (212) 219-0392.

New York City Early Intervention Program

Policy Title: Family Vacations	Effective Date: 10/17/2010
Policy Number: 6-E	Supersedes: N/A
Attachments:	Regulation/Citation:

I. POLICY DESCRIPTION:

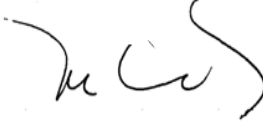
Families must contact the Early Intervention (EI) service provider agency when they will be unable to receive services for an extended period of time.

II. PROCEDURE:

Responsible Party	Action
Service Provider Agency	<ol style="list-style-type: none"> 1. At the start of services, informs the family to notify the Service Provider Agency when the family will be going on vacation. 2. Informs family of the following: Anytime that a family will be going on vacation: <ol style="list-style-type: none"> a. Child’s EI case may be kept open. b. The Service Provider Agency and/or therapist(s) currently providing services may not be available to serve the child upon their return. c. Missed service sessions will not be made up. d. The family must give an anticipated return date. <ul style="list-style-type: none"> • If the family does not return on the date indicated: <ul style="list-style-type: none"> ○ The Service Coordinator (SC) will close the case after making three (3) documented unsuccessful attempts to contact the family. ○ Informs the parents that the case can be re-referred by calling 311 when the family returns if the child remains age-eligible for EI services. • If the family does not give an anticipated return date: <ul style="list-style-type: none"> ○ The SC will attempt to contact the family after three (3) weeks of absence. ○ The SC will close the case after making three (3) documented unsuccessful attempts to contact the family. <p>Note:</p> <ul style="list-style-type: none"> • Three (3) documented unsuccessful attempts to contact the family is defined as: attempts made on different days to contact the family by phone, in writing (at least one through a certified letter), and in person. • Informs the parents that the case can be re-referred by calling 311 when the family returns if the child remains age-eligible for EI services. <ol style="list-style-type: none"> 3. Notifies the SC as soon as the family notifies the service provider agency of an upcoming vacation

<p>Service Coordinator</p>	<ol style="list-style-type: none"> 1. Notified that the family will be going on vacation. <ol style="list-style-type: none"> a. Ensures that the family understands the Vacation Policy as it is written in the Service Provider section of this document. <ol style="list-style-type: none"> i. Documents the conversation in the SC notes. b. Sends a letter on service coordination agency letterhead to the Regional Office (RO) and service provider agency (ies) documenting that the family has been informed of the information above. <ol style="list-style-type: none"> i. A copy of that letter must be kept in the child’s SC file. <p>Note:</p> <ul style="list-style-type: none"> • If the family is going on vacation within two (2) weeks of the expiration of the IFSP, an IFSP meeting may be held before the family goes away to facilitate continuity of services when the family returns from vacation. <ol style="list-style-type: none"> c. When the family does not give a return date: <ol style="list-style-type: none"> i. Attempts to contact the family after three (3) weeks of absence. ii. Makes three (3) documented unsuccessful attempts to contact the family. iii. Submit a Closure Form and documentation of attempts to contact the family to the RO. <ul style="list-style-type: none"> • The “effective date” of closure is not specified by the SC. The RO will enter the closure date after review of documentation. <p>Note:</p> <ul style="list-style-type: none"> • Three (3) documented unsuccessful attempts to contact the family is defined as: attempts made on different days to contact the family by phone, in writing (at least one through a certified letter), and in person. <ul style="list-style-type: none"> ○ The SC must submit a copy of the certified letter, certified label, and the Closure Form to the RO. ○ A copy of the Closure Form, certified letter, and other unsuccessful contact attempts must be documented in the child’s SC record. • Refer to the Closure Policy • The Closure Form must be submitted with a clear statement for the reason of closure. <ol style="list-style-type: none"> 3. Notified that the family is planning to be away for an extended time period during the summer. <ol style="list-style-type: none"> a. Informs the family of all of the above (as appropriate). b. Informs the family of the following: <ol style="list-style-type: none"> i. The NYC EIP does not provide services outside of New York State. ii. Services <u>may be</u> provided in a county outside NYC by a NYC contracted provider <u>if therapist(s) are readily available</u>: <ul style="list-style-type: none"> • NYC SC is responsible for coordinating services. iii. Missed sessions will not be made-up. c. Sends letter on service provider agency letterhead to the RO indicating
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	<p>the arrangements and that the family understands the above.</p> <ul style="list-style-type: none"> i. A copy of this letter must be kept in the child’s case record and sent to family and all service provider agencies. d. If the family moves their primary residence to another county, the SC is responsible for transferring the case to the new county, notifying all NYC EIP providers and closing the case in NYC.
Regional Office (RO)	<ol style="list-style-type: none"> 1. Closure Forms are routed to the assigned Early Intervention Official Designee (EIOD) for review. 2. EIOD sends parents and the Ongoing Service Coordinator (OSC) Prior Written Notice <ul style="list-style-type: none"> a. The “effective date” of closure is three (3) weeks after the last service date. b. If the parent does not respond within ten (10) business days, the Closure Form is signed and submitted by the RO as a separate document to the Data Operations for entry into KIDS. c. The RO must send a copy of the signed Closure Form to the SC within two (2) weeks of receipt.
Service Coordinator	<ol style="list-style-type: none"> 1. Inform all service provider agencies (including transportation providers and respite providers when appropriate) by sending them a copy of the Closure Form.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 09/17/10

New York City Early Intervention Program

Policy Title: Continuation of Services	Effective Date: 10/17/2010
Policy Number: 6-F	Supersedes: N/A
Attachments:	Regulation/Citation:

I. POLICY DESCRIPTION:

Six Month Review and Annual Individualized Family Service Plan (IFSP) meetings should be held prior to the expiration of the current IFSP. It is recognized, however, that circumstances may interfere with the timely scheduling of these meetings and authorization of services.

II. PROCEDURE:

Responsible Party	Action
Provider Agencies	<p>When a Review or Annual IFSP meeting is not held prior to the expiration date of the authorization:</p> <ol style="list-style-type: none"> 1. Authorized services will continue to be provided past the expiration date of the IFSP until new services are authorized unless the provider agency notifies the Regional Office (RO). <ol style="list-style-type: none"> a. The NYC Early Intervention Program (NYCEIP) will reimburse the provider agency and service coordination agency for the services as previously authorized upon completion of the Six Month Review or Annual IFSP meeting. b. If changes to the IFSP are authorized, they will take effect as of the date of the IFSP meeting. <ol style="list-style-type: none"> i. Refer to the detailed instructions on how to complete the Services Authorization Form in the IFSP Review Policy 2. If the current provider agency does not agree to continue services without signed authorization, the provider must notify the RO and Service Coordinator (SC) in writing to allow the RO to contact the provider agency and SC before services are terminated. <ol style="list-style-type: none"> a. Notification of termination must be sent to the RO at least two (2) weeks prior to the authorization end date 3. If an amendment to a service that is currently on the IFSP has been requested: <ol style="list-style-type: none"> a. The service must continue to be provided as currently authorized until the SC and provider receive written authorization from the EIOD for the change. <ol style="list-style-type: none"> i. Refer to the Amendments Policy


Approved By:
Assistant Commissioner, Early Intervention

Date: 09/17/10

New York City Early Intervention Program

Policy Title: Extension of Services for Six Month and Annual Reviews (Formerly the GAP Procedure)	Effective Date: 10/17/2010
Policy Number: 6-G	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> • IFSP Page 1: Identifying Information • IFSP Page 5a: Service Authorization Data Entry Form • IFSP Page 7a and 7b: Transition • IFSP Page 8: Attestations, Consent for Services • Provider Progress Note • Closure Form 	Regulation/Citation:

I. POLICY DESCRIPTION:

When a child is aging out of the NYC Early Intervention Program (NYCEIP), there may be a gap between the date that the service authorization ends and the date that the child transitions out of EI. The Extension of Services Policy will be applied to all children when:

- Exiting the NYCEIP in 60 days or less beyond the existing authorized Individualized Family Service Plan (IFSP)

AND

- No changes to the existing IFSP are being requested.

Examples of children that meet Extension of Services Policy requirements:

1. *“Jane” has been found eligible for services from the Committee on Pre-school Special Education (CPSE). Her EIP Forms have been submitted to the Regional Office (RO). Jane has an active IFSP for the period 2/5/09 to 8/5/09. Her next review would be due 8/6/09 which is less than 60 days from the effective date of her transition out of EI, which is 8/31/09. Her current services can be extended from 8/6/09 to 8/31/09.*
2. *“Tamara” has been found to not be eligible for services from the CPSE. She has an IFSP for the period 12/3/09 to 6/4/09. Her DOB is 8/1/09. A Service Authorization Data Entry Form can be written to extend the existing services from 6/5/09 to 7/31/09, the day before her third birthday.*

To reduce the need for an IFSP meeting to extend services for a very short time frame (60 days or less), the following procedures will be followed:

II. PROCEDURE:

Responsible Party	Action
Ongoing Service Coordinator (OSC)	Six Month or Annual Review: <ul style="list-style-type: none"> • Child will transition out of EI in sixty (60) calendar days or less from the expiration of the IFSP and, • No changes to the existing IFSP are being requested. The following documents must be submitted to the RO at least two

	<p>(2) weeks before the end date of the authorization period:</p> <ol style="list-style-type: none"> 1. IFSP Page 1: Identifying Information 2. IFSP Page 5a: Service Authorization Data Entry Form(s) <ol style="list-style-type: none"> a. <u>The start date</u> of the IFSP period will be the day after the end date of the last IFSP; and b. <u>The end date</u> of the IFSP will be the last day the child will receive EI services (either the day before the child’s third birthday, August 31, December 31, or the day before the child begins CPSE services.) 3. IFSP pages 7a and 7b: Transition 4. IFSP Page 8: Attestations, Consent for Services 5. Provider Progress Notes <ol style="list-style-type: none"> a. Progress notes must be provided for each discipline. 6. IEP Forms <ol style="list-style-type: none"> a. Applicable if the Referral to CPSE was made and a determination of eligibility has been made (Please refer to the chapter on Transition). 7. Closure Form <ol style="list-style-type: none"> a. The “effective date” of Closure is the day after the end date of the IFSP listed on the Service Authorization Data Entry Form; b. Parental Signature is required on the Closure Form; and c. The Service Coordinator (SC) must send the Closure Form to all service providers, including respite and transportation providers (if applicable). <p>Note:</p> <ul style="list-style-type: none"> • Children staying in EI for more than sixty (60) days from the expiration of the IFSP or for who changes to the existing plan are being requested must have an IFSP <u>meeting</u>. • Children who are aging out of EI, have been referred to CPSE, and whose eligibility for services from the CPSE have not yet been determined, are not appropriate candidates for the <i>Extension of Services Policy</i>. • Children who have not been referred to CPSE or have been found not eligible for services from the CPSE must exit EI the day before their third birthday.
<p>Early Intervention Regional Office (RO)</p>	<ol style="list-style-type: none"> 1. If the paperwork is complete and accurate, the EIOD authorizes services and returns signed paperwork to the SC. 2. If the paperwork is not complete or accurate, the EIOD will: <ol style="list-style-type: none"> a. Contact the SC within one (1) week for information needed, or revisions as appropriate; and b. Contact Program Monitoring and Quality Improvement immediately for assistance with obtaining missing Progress Notes. 3. Paperwork is then sent to EI Data Operations for entry into the KIDS system.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 09/17/10

New York City Early Intervention Program

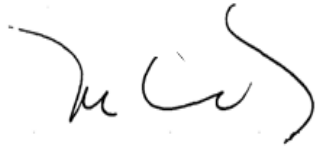
Policy Title: Role of the Transportation Coordinator	Effective Date: 10/17/2010
Policy Number: 6-H	Supersedes: N/A
Attachments: <ul style="list-style-type: none"> • IFSP: Transportation Data Entry Form • Transportation Attendance Sheet 	Regulation/Citation:

I. POLICY DESCRIPTION:

NYC Early Intervention (EI) provider agencies that use bus transportation to bring children and their parents on-site for services must designate a staff member as the **Transportation Coordinator (TC)**. **The TC may be a staff person who acts as the point of contact for all transportation responsibilities as part of other job responsibilities. The staff person who acts as the TC does not have to be dedicated to only transportation issues.**

II. PROCEDURE:

Responsible Party	Action
Service Coordinator (SC)	<ol style="list-style-type: none"> 1. Faxes a copy of the signed (authorized) Transportation Data Entry Form with the IFSP packet to the agency providing group developmental/individual facility based services as soon as the agency is located. <ol style="list-style-type: none"> a. Refer to the Start Date of Services Policy. b. Transportation Service Data Entry Form must be sent for the <i>correct bus company assigned to the EI provider</i> (not a subcontracted company).
Transportation Coordinator (TC)	<ol style="list-style-type: none"> 1. Receives the signed Transportation Service Data Entry Form from the provider agency. 2. Forwards the Transportation Service Data Entry Form to the bus company. <ol style="list-style-type: none"> a. The Transportation Data Entry Form must be sent at least six (6) calendar days before the child can begin to ride the bus. 3. Ensures that the bus company received the signed Transportation Service Data Entry Form. 4. Completes the Transportation Attendance Sheet monthly indicating the: <ol style="list-style-type: none"> a. Names of any companions; and c. Days that the companion was on the bus. 5. Sends the Transportation Attendance Sheet to the DOHMH Fiscal Unit within seven (7) calendar days after the end of the calendar month. <ol style="list-style-type: none"> a. Completed attendance sheets should be mailed or faxed to: <p style="text-align: center;">Joann Scaramuzzino Transportation Coordinator Early Intervention Fiscal Office 42 Broadway Suite 1611 New York, New York 10004</p>

A handwritten signature in black ink, appearing to be 'MCS'.

Approved By:
Assistant Commissioner, Early Intervention

Date: 09/17/10

NEW YORK CITY DOHMH EARLY INTERVENTION PROGRAM
TRANSPORTATION COMPANION ATTENDANCE SHEET

Transportation Contractor Name: _____

Transportation Provider EI#: _____

Month: _____

Year: _____

Program /School's Name: _____

Address: _____

Program Provider EI#: _____

EI #	DOB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total			
Child's Name (Last, First)																																				
Companion's Name (Last, First)																																				
Companion's Name (Last, First)																																				

EI #	DOB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total			
Child's Name (Last, First)																																				
Companion's Name (Last, First)																																				
Companion's Name (Last, First)																																				

EI #	DOB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total			
Child's Name (Last, First)																																				
Companion's Name (Last, First)																																				
Companion's Name (Last, First)																																				

EI #	DOB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total			
Child's Name (Last, First)																																				
Companion's Name (Last, First)																																				
Companion's Name (Last, First)																																				

I certify that the above EI child(ren) and authorized companion(s) were actually transported to receive services at the program on the above dates. I understand that any misrepresentation of fact provided by me on this form may result in criminal action.

Print Name/telephone #: _____ Signature of Authorized Program/School Official: _____ Date: ____ / ____ / ____

Transportation Companion Attendance Sheet Instructions

- 1) **Transportation Contractor Name** - Enter company's name (not subcontractor)
- 2) **Transportation Provider EI #** - Enter your five-digit Early Intervention number
- 3) **Month** - Enter the month of service (should be spelled out) and Year
- 4) **Program/School Name** - Enter Program/School name exactly as it appears on your contract
- 5) **Address/Site** - Enter site address of Early Intervention Program/School
- 6) **Provider EI #** - Enter provider Early Intervention five-digit number
- 7) **EI #** - Child's 7- digit Early Intervention number
- 8) **DOB** – Child's date of birth (MM/DD/YY) format
- 9) **Child's Name** – Enter the child's name in the Last Name, First Name Columns
- 10) **Companion Name** – If parent/guardian or other companion is authorized on the child's IFSP to accompany the child when traveling, enter the authorized companion's name last name and first name. You must enter companion name under authorized child's name. Multiple companions can continue on next line as long as the child's ID is also entered.
- 11) **Day of Trip** - Put an "x" in the box for the date child was transported/attended and "x" for each companion in boxes below for same date.
- 12) **Signature** - Please sign and indicate telephone # of Transportation Coordinator.

New York City Early Intervention Program

Policy Title: Complaints Regarding Bus Transportation	Effective Date: 10/17/2010
Policy Number: 6-I	Supersedes: N/A
Attachments: • Transportation Service Data Entry Form	Regulation/Citation:

I. POLICY DESCRIPTION:

The New York City Department of Education, Pre-K Transportation contracts with bus companies to transport children to NYC Early Intervention (EI) provider agencies for services. Complaints about transportation providers must be directed accordingly.

Bus transportation may be authorized for a child receiving services at an EI provider site. Transportation needs are discussed and documented in the IFSP. The EIOD will authorize bus transportation, if warranted, by completing a **Transportation Service Data Entry Form**. If companions are authorized to accompany the child, their names are listed on the form.

Providers should alert the EI Regional Office (RO) to any ongoing concerns or complaints about bus transportation.

II. PROCEDURE:

Responsible Party	Action
Early Intervention Agencies, Service Coordinators (SCs), Parents	<ol style="list-style-type: none"> 1. Direct inquiries or complaints regarding Pre-K Transportation to: <ol style="list-style-type: none"> a. The Department of Education Pre-K Customer Service hotline at 718-482-3800. Agents are available to assist. b. 311. Calls will be forwarded to someone who can assist. 2. EI agencies and SCs should also contact the EI Regional Office (Assistant Director or Regional Director) when there are any ongoing concerns or complaints about bus transportation.

Approved By: 
Assistant Commissioner, Early Intervention

Date: 09/17/10

NYC EARLY INTERVENTION PROGRAM

SESSION NOTE

Child's Name: _____ (Last) (First) _____ DOB: _____ EI #: _____

Interventionist's Name: _____ Discipline: _____ Location of Service: _____

Date: ____/____/____ Time: From ____ To ____ Service Type: ____ Date note written: ____/____/____

CPT Code: _____ ICD-9 Code: _____

IFSP Outcome(s) Addressed: _____ Session cancelled /not held write reason below (indicate make-up date):

Progress by child/family related to outcomes:

Worked with parent/caregiver and child together Worked with parent/caregiver alone Worked with child alone

Activity During Session:

Activity with parent/caregiver (check all that apply)

Parent/caregiver tried activity, therapist assisted Discussed session activity with parent/caregiver Showed parent/caregiver activity

Collaborated with parent to meet family needs Reviewed communication tool with parent (calendar, notebook etc.)

Parent/caregiver unable to participate Parent/caregiver unavailable

List family activity for next week:

Services were provided according to the frequency and duration stated in the IFSP.

Parent/Caregiver Signature: _____ Relationship to child: _____

Interventionist Signature: _____ Credential: _____

Date: ____/____/____ Time: From ____ To ____ Service Type: ____ Date note written: ____/____/____

CPT Code: _____ ICD-9 Code: _____

IFSP Outcome(s) Addressed: _____ Session cancelled /not held. Write reason below (indicate make-up date):

Progress by child/family related to outcomes:

Worked with parent/caregiver and child together Worked with parent/caregiver alone Worked with child alone

Activity During Session:

Activity with parent/caregiver (check all that apply)

Parent/caregiver tried activity, therapist assisted Discussed session activity with parent/caregiver Showed parent/caregiver activity

Collaborated with parent to meet family needs Reviewed communication tool with parent (calendar, notebook etc.)

Parent/caregiver unable to participate Parent/caregiver unavailable

List family activity for next week:

Services were provided according to the frequency and duration stated in the IFSP.

Parent/Caregiver Signature: _____ Relationship to child: _____

Interventionist Signature: _____ Credential: _____

NYC Early Intervention Program Session Note Instructions

1. A Session Note must be completed for each session.
2. Complete all areas as follows:
 - **Child's Name, DOB, and EI number:** Make sure this information is consistent with the information in the EI system (do not use nicknames).
 - **Interventionist's Name:** The individual providing the intervention.
 - **Discipline:** The appropriate discipline of the interventionist (e.g., PT, ST).
 - **Location of Service:** Where the session took place, e.g., home, center-based program, community location.
 - **Date and Time:** The date and time during which the session took place.
 - **Service Type:** The service type as listed on the IFSP, such as Speech Therapy or Family Training.
 - **CPT Code:** The relevant CPT code as indicated by the interventionist's professional association.
 - **ICD-9 Code:** The relevant ICD-9 code as indicated on the child's evaluation.
 - **Date Note Written:** The date the session note was completed (should be the same as the date of service).
 - **IFSP Outcome(s) Addressed:** The target outcome(s) from the IFSP, which was/were the focus of that session's intervention.
 - **Session Cancelled:** Check this off when the session is cancelled/not held and describe the reason why.
 - **Outcome(s) Addressed** section. Have the parent sign off on the cancelled session note and indicate the date of the makeup session.
 - **Progress by child/family related to outcomes:** Brief description of progress toward reaching the outcomes listed, including achievements and/or obstacles. Indicate if any IFSP objectives are met.
 - **Worked with parent/caregiver and child together...:** Check the appropriate box indicating those involved in this session (child/family/caregiver)
 - **Activity During Session:** Brief description of the intervention activity during the session.
 - **Activity with parent/caregiver:** The activities done with the parent/caregiver. Check all that apply. Note that family needs are defined as anything that keeps the family from having the time, energy and focus to help meet IFSP outcomes (e.g. guidance on handling tantrums, etc.). In the activity section, please describe the family need and how it was addressed.
 - **List family activity for next week:**
 1. Indicate the one or more activities agreed upon by the interventionist and the parent/caregiver that will be used during daily routines in the coming week(s).
 2. If this session was a co-visit, list the family plan on the session note as agreed upon at the co-visit.
 3. Indicate how the interventionist is helping the parent/caregiver document the activities to help his/her child during the daily routine. For example, if the objective is for the child to roll, the interventionist could write: "At bath or change time, the parent will use a towel or diaper to gently lift one side of the child to assist in beginning to roll." Parent will record progress in parent/therapist notebook/calendar, etc.
 4. Activities for parents are expected to span a minimum of one week. However, a therapist may see the child/family more than once per week; or activities may be recommended for multiple weeks. Indicate in this section if you are continuing to work on an activity from the previous Session Note.
 - **Verify that the session was provided at the frequency and duration stated in the IFSP.**
 - **Parent/Caregiver Signature and Relationship to Child:** The parent/caregiver who was present during the session signs and indicates his/her relationship to the child (not required for Facility-based services).
 - **Provider's Signature and Credential:** The interventionist's signature and credentials.
3. Keep the Session notes in child's file at the provider site. The Session notes may be reviewed or requested by the parents; therapist supervisor; NYC DOHMH EIP's various departments such as the Regional Office and Program Monitoring and Quality Improvement; and NYS DOH IPRO audit.

NYC EARLY INTERVENTION PROGRAM

Provider Progress Note Page 1 (Circle 3, 6, 9, 12)

Complete this progress report and review with the parent. Submit the completed report to the service coordinator **no later than 2 weeks** prior to the 6 month (submit 3 and 6 month notes) or annual review (submit 9 & 12 month notes). All questions must be answered or the report will be returned. Use additional pages if needed. Typed reports are preferred. Illegible hand written reports will be returned.

Child's Name: _____ EI #: _____ DOB: ____/____/____

IFSP Period: From: _____ To: _____ Provider Agency Name: _____

Provider Agency ID #: _____ Print Name of Interventionist: _____

Discipline: _____ Service Type: _____ Interventionist's Phone Number: _____

Date reviewed with parent: _____ Parent's Signature: _____

Authorized Frequency? _____ Date you started working with this child: ____/____/____

Where have services been delivered? _____

Has the parent(s) been present for the sessions, if not, how have you communicated with the family?

If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s).

List the child's medical diagnosis(es) (if any):

Is the child using assistive technologies? Yes No Is a new AT Device being requested? Yes No

If yes, identify the Functional Outcome (from the IFSP) and specify how the device is helping (or will help) to achieve the Outcome.

1. IFSP Functional Outcome 1: _____ **Rate Progress in This Time Period**

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

1a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.			
1. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
2. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
3. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
4. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
5. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>

1b. State changes/modifications made to objectives in order to facilitate developmental progress. Be specific.

1c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

1d. What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name: _____ IFSP Period: From: _____ To: _____

2. IFSP Functional Outcome 2: _____

Rate 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"/>

2a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.

Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
1. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2b. State changes/modifications made **to objectives** in order to facilitate developmental progress. Be specific.

2c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

2d. What changes were made if the routine **activities or the strategies/methods approaches were** ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name: _____ IFSP Period: From: _____ To: _____

3. IFSP Functional Outcome 3: _____

Rate 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"/>

3a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.

Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
1. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3b. State changes/modifications made to **objectives** in order to facilitate developmental progress.
Be specific.

3c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities? Which family member(s) have you been working with?

3d. What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

(Circle 3, 6, 9, 12)

Note: Questions 4, 5, and 6 do **NOT** need to be answered separately for each outcome

Child's Name: _____ IFSP Period: From: _____ To: _____

4. In addition, to working with the family, describe all collaborative efforts made to address the IFSP outcomes of this child. (Examples: Interactions with outside medical providers (with written parent permission), other EI therapists, day care staff, other caregivers, community resources).

5. Based on your ongoing assessment of the child's progress, what is the child's current level(s) of functioning?

In addition, for the 6 and 12 month progress note, please estimate the percentage of delay.
 Percent Delay: _____
 Provide an explanation of how the percentage delay was determined (e.g. standardized instrument and/or informed clinical opinion). If an instrument was administered, please report the results according to the instrument's manual.

6. What can the child do now, that he/she was previously unable to do (child's strengths). Address each functional outcome.

Note: If the interventionist has additional comments or observations, please attach additional documentation.

I certify that I have received & reviewed a copy of the child's IFSP and evaluation/progress notes prior to starting services, have provided services in accordance with the IFSP service's specified frequency and duration, and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of therapist completing report: _____
***License number:** _____ **Print Name:** _____
Date Report Was Completed: ____/____/____

*If certified, write "certified" and do not indicate number.

**NYC EARLY INTERVENTION PROGRAM
INSTRUCTIONS FOR COMPLETION
PROGRESS NOTES**

GENERAL DIRECTIONS

The therapist/teacher must complete this form at the 3, 6, 9, and 12 month interval after a child's initial IFSP meeting.

- The 3 and 6 month progress note is to be submitted at least two (2) weeks prior to the 6 month review.
- The 9 and 12 month progress note is to be submitted at least two (2) weeks prior to the Annual Review.

At the top of each page, please circle the IFSP interval that this progress note covers.

DEMOGRAPHIC/AUTHORIZATION INFORMATION

Child's Name:	Information must be the same as the EI record, (do not use nickname).
EI # and DOB:	Make sure that all identifying information is correct.
IFSP Period:	This is the term of the current IFSP, (not the recording quarter).
Provider Agency Name and ID#:	Agency and identification number of the agency for which the interventionist works.
Interventionist Name:	Print the name of the interventionist who is completing this form.
Discipline:	Interventionist's discipline, e.g. speech therapist, special educator, etc.
Service Type:	IFSP authorized service delivered by the interventionist, e.g. Speech, Physical Therapy.
Interventionist's Phone Number:	Direct number (cell, etc.) at which the interventionist can be reached if there are questions about the report. Do not use the provider agency's number.
Date Reviewed with Parent/Parent Signature:	The interventionist must review the report with the parent prior to submission and document such review.
Authorized Frequency:	How often the service was authorized at the IFSP (Ex: 1 x 30)
Date you started working with the child	State the date that you delivered the first intervention session.
Where have the service been delivered?	Location of services, e.g. parent's home, babysitter's home, day care center, agency location
How have you communicated with the parent when they were not present during sessions?	Describe your method of communication with the family. (Ex: Phone calls, meetings at work, notebook left in the parent's home or day care center, etc.).
If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s)	Explain the reason for, and length of, any gaps, whether make-up sessions were delivered, whether there was a gap between your service delivery to the child and that of the previous interventionist, etc.
List the child's medical diagnosis(es)	List all diagnoses. Indicate if any diagnoses are newly identified.
Is the child using assistive technologies (AT)	Check Yes or No
Is a new AT device being requested?	Check Yes or No
Indicate the type of device, and how the device is helping (or will help) to achieve an IFSP Functional Outcome?	If the child is currently using an AT device, or if an AT device is being requested, indicate type of device and how the device will help achieve an IFSP outcome. State which functional outcome(s) in particular. Refer to the AT Chapter for directions on requesting AT devices.

Clarification of Terms:

Functional Outcome: A practical result that reflects the family's priorities, is developmentally and individually appropriate, and considered critical for the child's participation in daily activities. The outcome should include a measurable skill targeted for a child to achieve in the next 6 months through Early Intervention supports and services. The functional outcome **MUST** be written in parent friendly language. All clinical terms must be avoided.

Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome. These small steps should be specific and measurable and written in parent friendly language.

Activities: Routine activities are those that occur within the child's day (ex: bedtime, snack time, time at the playground) and provide opportunities to learn and practice objectives with family members.

Strategies/methods/approaches: Ways that the family and therapist support the child's learning in routine activities.

Description of Progress in IFSP Outcomes: Pages 1, 2, and 3:

IFSP Functional Outcome: Indicate, on separate pages, each IFSP functional outcome, and the child's progress during the time period covered by this report. **Note: The functional outcomes listed in the progress notes MUST be the same functional outcomes that were agreed to in the IFSP. Attach additional functional outcome sheets if necessary.**

1a. Break down each functional outcome into short-term objectives that have been, and are currently being worked on. These objectives must be same as those that are listed on Page 4 of the IFSP.

Example: IFSP Functional Outcome: Ida will be able to pick up small objects, such as raisins or Cheerios, with either hand using the thumb and index figure without resting her arm on the table so that she can begin feeding herself everyday during meal time.

Objective 1: Ida will pick up a Cheerio with fingers/scraping movement.

Objective 2: Ida will pick up a Cheerio with side of finger and thumb.

For each objective listed, check the appropriate box to indicate if the objective has been achieved (Y), is not present (N), or is Emerging (E) – the skill has started to develop but has not been incorporated into all aspects of the child’s routine.

1b. **State changes/modifications made to objectives in order to facilitate developmental progress. Be specific.** - List changes made to the short term objectives during this IFSP period to facilitate achievement of the functional outcome.

Example: An additional outcome can be added to build upon Ida’s progress and achievement of the functional outcome: Objective 3: Ida will pick up a Cheerio with tip of finger and thumb while her arm is on the table.

1c. **What routine activities are you and the family/caregivers using to achieve each objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into routine activities. Which family member(s) have you been working with?** - Indicate what specific routine-based activities the family used to achieve each objective. Include the family’s feedback as to how well these activities worked when you were not present.

Example: Objectives 1, 2, and 3: During mealtime, Ms. I presents Ida with small bits of foods on a flat surface (ex: Ida’s favorite flat plate); these include peas, diced cooked carrots, and Cheerios. Ms. I picks up one cheerio at a time on Ida’s high chair tray to show Ida what to do.

Objectives 2 and 3: Ms. I encourages Ida to turn the pages of a book with thin paper during story time.

1d. **What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?** - Explain how you changed your approach or activities when you did not see progress.

Example of a change to an activity: Because Ida prefers to use all her fingers in a raking motion when presented with a plate of Cheerios, Ms. I started presenting Ida with one Cheerio at a time in the palm of her hand to encourage the use of Ida’s thumb and index finger. In addition, throughout the day, Ms. I started encouraging Ida to turn a wall light switch on and off.

Example of a change to intervention approach: I found that Ida was tired at the time of my scheduled visit. We switched the time to after her nap and had better success.

NOTE: Questions below (4, 5, and 6) do not need to be answered separately for each outcome being worked on.

4. **Describe all collaborative efforts made to address the IFSP outcomes for this child-** Describe communication with the other EI therapists and how you worked with them to achieve the functional outcomes. With parental consent, have you communicated with relevant medical providers? At the parent’s request, how have you assisted the family in finding other resources (e.g. books, articles)? Have you communicated with day care staff, taught techniques to grandparents, nannies, etc

5. **Based on your ongoing assessment of the child’s progress, what is the child's current level(s) of functioning?** – Document the child’s current functioning, including the use of standardized instruments (if the therapist chooses to administer) and informed clinical opinion. For 6 month and 12 month progress notes, estimate the percent of delay according to the NYS Guidance Memorandum (Memorandum 2005-02 – Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the Early Intervention Program).

Note: If an instrument is administered, report the results according to the instrument’s manual.

6. **What can the child do now that he/she was unable to do previously (child’s strengths)-** Provide an overall picture of how the child is functioning within daily routines and how the learned skills have been incorporated.

Certification: Sign, date, provide license number and print name. If a certified professional, indicate “certified” and do not write number.

Chapter 7: Amendments

New York City Early Intervention Program

Policy Title: Amendments	Effective Date: July 1, 2010
Policy Number: 7-A	Supersedes: N/A
Applicable Forms: <ul style="list-style-type: none"> - Change in Services/Service Provider/Service Coordinator Form - Justification for Change in Frequency, Duration or Method of Service Form - Progress Notes - IFSP Meeting Request/Confirmation Form IFSP Forms <ul style="list-style-type: none"> - Page 1: Identifying Information - Page 4: Functional Outcomes - Page 5: Service plan: Service Setting and Incorporating Interventions into Natural Routines. (if applicable) - Page 5a: Service Authorization Data Entry Form - Page 5b: Co-visits (if applicable) - Page 6: Transportation, Assistive Technology, and Respite Services (if applicable) - Page 7: Service Coordination Activities - Transportation Data Entry Form (if applicable) 	Regulation/Citation: 10 NYCRR §69-4.11; 10 NYCRR §69-4.17(b)

I. POLICY DESCRIPTION:

“The IFSP shall be reviewed at six (6) 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.”

“The EIO must make reasonable efforts to ensure the parent receives written notification about the right to due process and the method by which mediation and an impartial hearing can be requested at the following times: upon denial of eligibility; upon disagreement between the EIO and the parent on an initial or subsequent IFSP or proposed amendment to an existing IFSP; and, upon request from the parent for such information.” 10 NYCRR §69-4.17(b)

II. PROCEDURE:

Responsible Party	Action
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. Receives requests for changes (amendments) from the following individuals: <ul style="list-style-type: none"> • Parent/Caregiver; • Service provider; or • Foster care agency/Administration for Children’s Services (ACS). 2. Processes requests for changes at the Six (6) Month or Annual Review or at any other time when: <ol style="list-style-type: none"> a. There is a recommendation for a change in a <i>Service Type</i>, a <i>Method</i> by which a

service is delivered, the *Location* of the services, or the *Frequency/Duration* of a service type;

- b. There is a recommendation for an increase in ongoing service coordination units;
 - c. There is a recommendation for termination of a *Service Type*;
 - d. A new *Service Type* is being recommended;
 - e. There is a change in *Service Provider* for any of the *Service Types* or *Service Coordinator* (SC) on the **Service Authorization Form(s)**;
 - f. There is an authorized change in transportation provider on the **Transportation Service Authorization Form** (e.g., a change to a new bus company, parent reimbursement for mileage, etc.); or
 - g. A request to add a co-visit has been made.
3. Submits the proposed amended IFSP or required paperwork to the Early Intervention Official Designee (EIOD) as soon as it is completed. Do not wait for the Six (6) Month Review or Annual Review to submit the paperwork.

Convening the Amendment Meeting:

1. When the parent would like a face-to-face meeting with the EIOD:
 - a. Submits an **IFSP Meeting Request/Confirmation Form** with the justification packet and/or supplemental evaluation.

Note: If parent does not consent to termination of service, an amendment meeting must be convened with the EIOD present.

2. The Amendment meeting must be convened by the SC (regardless of whether the EIOD is present) for:
 - a. Changes to location of service;
 - b. Requests to increase frequency of service(s);
 - c. Requests to change duration of services(s);
 - d. Requests to change method of service delivery; and
 - e. Termination of service(s) (when the parent agrees to the termination).
3. The service provider(s) should be invited to attend this meeting:
 - a. In the rare instance that the interventionist is unable to attend the meeting s/he may participate via conference call.
 - i. Interventionist(s) participating through a conference call should be available for the pertinent portion of the meeting as required by the EIOD/SC (at a minimum: the discussion of child progress, outcome determination and recommendations for services).
4. Complete new/revised **IFSP Forms**, as appropriate for the requested change:
 - a. New Page 1: **Identifying Information, Signatures** includes:
 - i. Signature of all parties present;
 - ii. Indicate on this page if anyone is present by telephone;
 - iii. The type of IFSP is "Amendment."
 - b. New or Revised Page 4: **Outcomes**
 - i. Continuing services are indicated on the current **Outcomes** page; or
 - ii. Revised/new outcomes must be listed on a new **Outcomes** page.
 - c. New Page 5: **Service Setting**
 - i. Page should only be included if the service setting is changing.
 - d. New Page 5a: **Service Authorization Data Entry Form**.
 - i. New form must be completed for all revised, added, or terminated services. (Any service(s) that will not change should not be included on this form.);
 - ii. The *Effective Date of IFSP* and the *End Date of IFSP* should be copied from the top of the current **Service Authorization Data Entry Form**.

- iii. The box indicating the *Type of IFSP* (amendment) in the upper left hand corner must be checked with the date of the IFSP Amendment meeting written in.
 - iv. The *Begin Date* of the new service and the *End Date* of the old service must be left blank. The EIOD who reviews the paperwork will enter these dates, allowing for at least one week's notice to providers before any change is to take effect.
 - v. If a Service Type which is currently on the **Service Authorization Data Entry Form** is to be terminated, copy the *Service Type, Method, Location, and Begin Date* (columns 1-4). The EIOD will write the *End Date* when s/he authorizes the change(s).
 - e. New Page 5b: **Co-Visits**, if a request has been made to add a co-visit.
 - f. New Page 7: **Service Coordination Activities**.
 - i. The participants should discuss the reason(s) for termination of the service(s) and these reasons as indicated by the provider/parent should be documented by the service coordinator under the *Additional Concerns* section.
5. **New Transportation Service Data Entry Form (if applicable).**

Submitting the Amendment Justification Packet:


- 1. The OSC must submit the following documentation when requesting an amendment to a current service plan:
 - a. Requests to change service provider:
 - i. **Change in Services/Service Provider/Service Coordinator Form;**
 - Parent notification is required (no parental consent (signature) is required);
 - Parent notification should be documented in the SC notes.
 - ii. IFSP Page 5a: **Service Authorization Data Entry Form;**
 - iii. Brief explanation on provider agency letterhead is required explaining the reason for the change in service provider agency.
 - b. Requests to change the OSC:
 - i. **Change in Services/Service Provider/Service Coordinator Form;**
 - Parent consent (signature) is required.
 - ii. IFSP Page 5a: **Service Authorization Data Entry Form;**
 - Must be submitted when the reason for the SC change is due to a change in the Service Coordination Agency.
 - iii. Brief explanation on provider agency letterhead is required explaining the reason for the change in service coordinator/agency.

Note: Requests to change ISC are addressed in the **Changes in Initial Service Coordinator or Initial Service Coordination Units Policy.**

- c. Requests to change location of service (i.e. home to facility):
 - i. **Change in Services/Service Provider/Service Coordinator Form;**
 - Parent consent (signature) is required.
 - ii. Brief explanation is required on agency letterhead, indicating:
 - The reason(s) for the change in location (should be child-based and related to outcomes).
 - iii. IFSP Forms;
 - Required forms are listed under “*Convening an Amendment Meeting*” section of this policy document.

	<p>d. Requests to Terminate a Service:</p> <ol style="list-style-type: none"> i. Change in Services/Service Provider/Service Coordinator Form; ii. Parent consent (signature) is required; iii. IFSP Page 5a: Service Authorization Data Entry Form; iv. Current Progress Notes indicating developmental status as reason for termination. (Note: Parent request may also be considered as a reason for termination of service); v. Justification for Change in Frequency, Duration or Method of Service Form. <ul style="list-style-type: none"> • Only questions 1, 2 and 5 of the justification should be addressed for termination of services. <p>e. Requests to change frequency, duration, or method of service delivery:</p> <ol style="list-style-type: none"> i. Change in Services/Service Provider/Service Coordinator Form; <ul style="list-style-type: none"> • Parent consent is required. ii. Revised IFSP Forms; <ul style="list-style-type: none"> • Required forms are listed under the “<i>Convening an Amendment Meeting</i>” section of this policy document. iii. Copies of the most current Provider Progress Notes and Calendars (if completed); <ul style="list-style-type: none"> • If a request is made prior to the (3) month progress note, Session Notes must be included instead of the Provider Progress Note(s). iv. Justification for Change in Frequency, Duration or Method of Service Form. <p>f. Requests to add a new service type:</p> <ol style="list-style-type: none"> i. Change in Services/Service Provider/Service Coordinator Form; <ul style="list-style-type: none"> • Parent consent is required. ii. Supplemental evaluation. <ul style="list-style-type: none"> • Refer to the Policy on Additional Evaluations for requesting, completing and submitting additional evaluations. iii. Revised IFSP Forms. <ul style="list-style-type: none"> • Required forms listed under “<i>Convening an Amendment Meeting</i>” section of this policy document. iv. Copies of the most current Provider Progress Notes and Calendars (if completed) from services currently being received. <ul style="list-style-type: none"> • If a request is made prior to the three (3) month progress note, Session Notes must be included instead of the Provider Progress Note(s). <p>g. Requests for additional Ongoing Service Coordination units:</p> <ol style="list-style-type: none"> i. Change in Services/Service Provider/Service Coordinator Form; <ul style="list-style-type: none"> • Parent consent is required. ii. Brief explanation is required on agency letterhead, indicating; <ul style="list-style-type: none"> • The reason(s) for the change in location (should be child-based and related to outcomes). iii. IFSP Page 5a: Service Authorization Data Entry Form; <p>Note: Requests for additional ISC are addressed in the Changes in Initial Service Coordinator or Initial Service Coordination Units Policy.</p>
<p>Early Intervention Official</p>	<ol style="list-style-type: none"> 1. Reviews Amendment request within three (3) weeks of receipt in the RO: <ol style="list-style-type: none"> a. EI/OD may schedule an amendment meeting after reviewing the amendment packet:

Designee (EIOD)	<ol style="list-style-type: none"> i. Notifies the Scheduling Unit to set up an amendment meeting:; <ul style="list-style-type: none"> • Refer to Policy on IFSP Meeting Scheduling in this chapter of the Policy and Procedures Manual. b. EIOD may request additional information from the interventionist if insufficient information was provided. c. EIOD may authorize the amendment by: <ol style="list-style-type: none"> i. Completing the submitted Service Authorization Data Entry Form: <ul style="list-style-type: none"> • The <i>Begin Date</i> of the new service and the <i>End Date</i> of the old service must be completed; • EIOD must allow at least one week's notice to providers before any change goes into effect. ii. Signing the Change in Service/Service Provider/Service Coordinator Form. b. If the EIOD denies the Amendment Request: <ol style="list-style-type: none"> i. EIOD will return the denied request to the SC; ii. Prior Written Notice will be sent to the parent/caregiver by the EIOD detailing the reason for the denial: <ul style="list-style-type: none"> • A written explanation will be sent to the service coordinator when a request for additional ongoing service coordination units is denied. <p>Note: The amended IFSP is considered to be in effect after the EIOD reviews the documentation and returns the signed and approved IFSP form(s) to the OSC.</p>
Ongoing Service Coordinator (OSC)	<ol style="list-style-type: none"> 1. Gives a copy of the authorized amended IFSP to all service providers and the parent. 2. Gives a copy of the approved amended IFSP packet to all service providers. 3. If a new Transportation Service Data Entry Form was completed, the OSC must give a copy to the service provider's transportation coordinator, who must give a copy to the transportation provider and to the Department Of Education. 4. Explains due process rights to parent if the Amendment request is denied.



Approved By:
Assistant Commissioner, Early Intervention

Date: 5/28/2010

NYC EARLY INTERVENTION PROGRAM
CHANGE IN SERVICE(S)/SERVICE PROVIDER/SERVICE COORDINATOR

Child's EI ID Number: _____ Child's DOB: ____/____/____
Child's Name: (Last) _____ (First) _____ (MI) _____
Service Coordinator: _____ SC ID #: _____
SC Agency Name: _____ Tel. # _____ Fax # _____

“X” ALL BOXES THAT APPLY – COMPLETE SECTIONS ACCORDINGLY

***SECTION I: SERVICE PROVIDER** (See Note for documentation requirements)

FROM: _____ TO: _____

Provider Name: _____
Provider EI No: _____
Anticipated Date: ____/____/____

***SECTION II: SERVICE COORDINATOR** (See Note for documentation requirements)

FROM: _____ TO: _____

Name: _____
SC ID #: _____
Provider #: _____
Anticipated Date: ____/____/____ Check one: Initial Ongoing

***SECTION III: CHANGE IN SERVICES**

A separate form for each service must be completed when:

- A request is being submitted to change a service type currently on the IFSP (Method, Location, Frequency can all be requested on one form for the same service type.)
- A request to add Ongoing Service Coordination units is being made.
- A request to add a service type is being made.
- A request to terminate a service type is being made

Add Service Type Method Location Termination of Service Frequency/Duration (Mins./Days/Weeks) Add Ongoing Service Coordination Units

Anticipated Date: ____/____/____ Service Type: _____

I have been consulted about the above changes and approve of those changes

Parent/Guardian Signature: _____ Date: ____/____/____

*** Note:** *The service coordinator must do the following:*

1. Providers who are requesting a **termination of a service/ increase in frequency or intensity/change of method** must complete the *Justification for Change in Frequency, Duration, or Method of Services form*.
2. Attach new **IFSP Service Authorization** form reflecting only the amended Service Type(s).
3. If the ongoing service coordination/service provider agency will change, attach a new **IFSP Services Authorization** form.
4. Send the above forms to the EIOD. Changes **are not** official until approved and signed by the EIOD.
5. **All proposed changes, except a change in initial service coordination and a change in provider of services already on an IFSP, must have written parental consent.**

The EIOD will send a copy of the approved form to the current service coordinator (and newly assigned service coordinator, if applicable).

EIOD Section (For Office Use Only): Status of Request

SC agency: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Service Provider: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Add Service Type: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Method: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Location: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Terminate Service Type: Approved Denied (Prior Written Notice Attached) Effective Date of Change (if approved): ____/____/____
Frequency/Duration Approved Approved in Part (Specify): _____ Denied (Prior Written Notice Attached)
Effective Date of Change (if approved): ____/____/____
Add OSC Units: Approved Denied Effective Date of Change (if approved): ____/____/____
EIOD Name (Print): _____ EIOD Signature: _____ Date Signed: ____/____/____

**NYC EARLY INTERVENTION PROGRAM INSTRUCTIONS FOR COMPLETION
CHANGE IN SERVICE(S)/SERVICE PROVIDER/SERVICE COORDINATOR INSTRUCTIONS**

GENERAL DIRECTIONS:

The Service Coordinator (SC) must complete this form when there is a proposed change in Service(s), Service Provider, or Service Coordinator* (refer to **Note** on bottom of page). After completing the identifying information about the child and the currently assigned service coordinator, please "X" the appropriate section and complete/attach the relevant information. Once the parent has indicated his/her agreement with the proposed changes by signing the form (a change in provider of services and initial service coordination do not need parent's signature), the SC should send the completed form along with the appropriate documentation to the appropriate Early Intervention Official Designee (EIOD).

SECTION I - SERVICE PROVIDER

Complete with the Provider Name(s) and Provider Early Intervention Number(s) of the current service provider and the new service provider. Attach a letter explaining the reasons for the change, and a new **Service Authorization Data Entry Form** reflecting the new Provider information and relevant service changes, particularly new *Begin* dates for each service line. Include the anticipated date of change. The reason for the change must be documented on agency letterhead. Please note that a change in provider agency does not require a parent signature.

SECTION II - SERVICE COORDINATOR

Indicate the names and SC ID Numbers of the current and proposed SCs. Attach appropriate documentation indicating the reason(s) for the change. An **IFSP Service Authorization Data Entry Form** must be completed if there is a change in service coordination agency. The reason for the change must be documented on agency letterhead.

Although a change in the Initial Service Coordinator (ISC) should be discussed with the parent, the parent does not need to give consent. However, the parent's written consent is necessary when there is a change in the Ongoing Service Coordinator (OSC). The reason for the change must be documented on agency letterhead.

SECTION III - CHANGE IN SERVICES

A separate form for each service must be completed when:

- A request is being submitted to change a service type currently on the IFSP (Method, Location, Frequency can all be requested on one form for the same service type.)
- A request to add Ongoing Service Coordination units is being made.
- A request to add a service type is being made.
- A request to terminate a service type is being made

This form must be submitted to the EIOD along with a new **IFSP Service Authorization Data Entry Form** reflecting only the Service Type being changed or the service type being added and the **Justification for Change in Frequency, Intensity, or Method of Services** form, progress notes, recent evaluations and the required justification. Refer to the policy on Amendments in the IFSP Chapter of the Policy and Procedures Manual for instructions on completing the Service Authorization form and requesting an addition to ongoing service coordination units.

PLEASE NOTE:

To request a change in Initial Service Coordination Units refer to the **Changes in Initial Service Coordinator or Initial Service Coordination Units Policy**.

***All proposed changes, except a change in the ISC, and a change in the provider of services already on an IFSP must have written parental consent.**

Changes are not official until approved by the EIOD. Once the change has been authorized by the EIOD, the SC must retain a copy in the child's case record and send a copy to the EI service provider(s).

NYC EARLY INTERVENTION PROGRAM

JUSTIFICATION FOR CHANGE IN FREQUENCY, INTENSITY OR METHOD OF SERVICES

Child's EI ID Number: _____ Child's DOB: ____/____/____
 Child's Name: Last _____ First _____
 Name of Provider: _____ Discipline: _____
 Therapist Phone Number: (____) _____ Agency Name: _____
 Name of Supervisor: _____ Supervisor Phone Number: (____) _____
 Date of Submission to OSC: _____

Authorization Information: All areas must be completed on this form or it will be returned as incomplete.

IFSP Start Date: ____/____/____ IFSP End Date: ____/____/____ Authorized Service: _____

of sessions authorized: _____

of sessions delivered by provider prior to this **Justification for Change:** _____

of sessions missed (due to either provider or parent reasons): _____

Date(s) of any **Previous Justification for Change** in this Discipline: ____/____/____

Request for Change (Complete all that apply): Termination of Service Increase/Change in Service

Frequency: From: _____ times per _____ To: _____ times per _____

Duration: From: _____ minutes To: _____ minutes

Method: From: _____ To: _____

Required Justification Components: Justifications will be returned if all questions are not answered. Responses must be numbered and addressed in the below order. For termination of service(s), complete sections 1, 2, and 5 only.

1. Current Function:
 - a. What is the child's current level of function?
 - b. If an evaluation was administered, provide the name of the test and the score, unless this information is included in an evaluation report.
 - c. What was the child's level of function at the last IFSP?
 - d. What can the child do now, that he/she was unable to do previously (give skill-based examples).
2. Service(s) Provided to Date:
 - a. When did you begin delivery of the service?
 - b. Did a different provider deliver these services before you were assigned?
 - c. Did service(s) begin on time?
 - d. Explain any gaps in service(s) including: missed sessions, frequent illness, vacations etc. Include both provider and family reasons when available.
3. Family Involvement:
 - a. Describe how you are supporting the family and/or caregivers in integrating suggested activities into the child's and family's daily routines (Describe specific activities).
 - b. What successes or difficulties has the family had in integrating these activities?
 - c. When suggested activities were integrated into everyday activities, what changes in the daily routines have you observed?
4. Service Plan Coordination
 - a. Have you coordinated with other team members to achieve IFSP outcomes?
 - b. Have you addressed the same or different IFSP outcomes as other therapists? Explain.
5. IFSP Outcomes:
 - a. What is/are the functional outcome(s) that you are currently working on as stated in the IFSP?
 - b. What are the short term objectives that you are currently working on to reach the functional outcome(s)?
 - c. What progress has the child made toward the IFSP outcomes since initiation of this service plan?
 - d. What alternate strategies have you used to replace ineffective strategies? Have they been effective?
6. What will the recommended change offer that the present plan does not?
 - a. Does the proposed plan recommend a new functional outcome?
 - b. What new, short term objectives are being proposed to reach the functional outcomes?
 - c. What are the new strategies being proposed to achieve the short term objectives?
 - d. Will the new plan involve strategies and methods that cannot be reinforced by activities that are part of the child's daily routine? If yes, describe why and indicate if changes in the daily routine are possible.
7. List any changes in the child's medical diagnoses, conditions or medications since the last IFSP which may have an impact on the child's reaction to EI Services. Describe how a change in the child's medical condition or medications will affect the service delivery plan.

**NYC EARLY INTERVENTION PROGRAM
JUSTIFICATION FOR CHANGE
IN FREQUENCY, INTENSITY OR METHOD OF SERVICE**

GENERAL DIRECTIONS

This form is to be used for a change(s) in a **service already on an IFSP**, not to request a new service or a change to service coordination units.

- The therapist/teacher must complete this form and submit it to the Ongoing Service Coordinator (OSC) when there is a proposed termination to, or change in frequency, duration or method of a service currently on an IFSP.
- The OSC must submit this form to the Regional Office with other required paperwork whenever there is a request for a change in frequency, intensity or method of a service in the IFSP, (please refer to Amendment Policy in this chapter).

DEMOGRAPHIC INFORMATION

Please fill out this section in its entirety. The name and contact information of the therapist’s supervisor must be indicated.

AUTHORIZATION INFORMATION

This section **must** be completed in its entirety. Incomplete **Justifications** will be returned to submitter.

1. IFSP Start Date: ____/____/____ IFSP End Date: ____/____/____	Copy the Begin and End dates from the upper left hand corner of the IFSP being amended.
2. Authorized Service:	Indicate IFSP service type being amended.
3. # of sessions authorized:	Copy the # of session units authorized from the IFSP.
4. # of sessions completed by Provider:	Provide the total number of sessions that were delivered (include any make-up sessions).
5. # of sessions missed (due to either provider or parent reasons):	Indicate the number of any sessions missed, (exclude any sessions that were made-up).
Date of Previous Justification(s) for Change in this Discipline: If there were prior requests to amend this service, indicate the date of request.	
Request for Change: Indicate all changes to this service that are being requested at this time.	
Required Justification Components: For requests to terminate services or decrease frequency , complete questions 1, 2, and 5 only. For all other requests , answer questions 1 through 7.	

Chapter 12:
Billable and Non-Billable
Service Coordination
Activities

New York City Billable AND Non-Billable Service Coordination Activities

Service Coordination activities are cumulative on a daily basis.

12-A. AFTER REFERRAL (INITIAL SERVICE COORDINATION)

Please Note: Detailed information about the role and responsibilities of the Initial Service Coordinator (ISC) can be found in the NYS Early Intervention Program Regulations, 10NYCRR 69-4.7 (a) – (p).

CATEGORY	BILLABLE SC ACTIVITIES	NONBILLABLE SC ACTIVITIES
Surrogacy	<p>Discussing the following with foster care caseworkers:</p> <ul style="list-style-type: none"> • The selection of a surrogate parent when necessary. 	
Contacts	<ul style="list-style-type: none"> • Speaking with parent/guardian when he/she responds to the SC’s message(s). • Leaving one or more messages in the same day for a parent/guardian or evaluation site where the total time spent is five (5) minutes or more. (You may consolidate activities for the same child done on the same day that together add up to a full unit of service coordination – e.g., three (3) phone calls at two (2) minutes each; two (2) or more activities that together total at least five (5) minutes.) 	<ul style="list-style-type: none"> • Billing for contacts that take less than five (5) minutes (e.g. leaving a message for a parent, an EIOD, a provider, or other person involved with the child/family) when the total time spent on the child for that day is less than 5 minutes. • Receiving a voicemail message. • Leaving a voicemail message • Travel
Meetings	<ul style="list-style-type: none"> • Meeting with the family in the office. 	<ul style="list-style-type: none"> • Waiting for a parent who fails to keep appointments; waiting for other EI personnel when unaccompanied by parent.
Providing Information to Families	<ul style="list-style-type: none"> • Discussing with parents, both in person and on the phone, such topics as: <ul style="list-style-type: none"> ○ Overview of Early Intervention (EI) and role of Service Coordinator (SC) (Initial and Ongoing); ○ Family rights (including due process) and responsibilities under the Early Intervention Program (EIP) and review of the EI handbook: A Parent’s Guide; ○ Evaluation process, including voluntary family assessment, and the parent’s role in the evaluation, and eligibility criteria; 	<ul style="list-style-type: none"> • Writing notes in child’s case record; • Billing for SC delivered to more than (1) child/family during the same period of time (In the event of multiple births or two (2) or more EI children in the same family, the SC time should be divided among the children and billed accordingly or can be billed to one (1) child but not the others. Ex: 32 min split between 2 or more children cannot result in more than 3 units in total); • Providing clinical counseling services to parents.

	<ul style="list-style-type: none"> ○ The parent’s primary area(s) of concern; ○ Natural environments or other settings for service delivery; ○ Services available in EI; ○ Family priorities and needs (housing, food, primary, health care, etc.). Provide assistance with accessing services; the need for consent before information can be shared regarding the child and family; ○ Ascertaining any current receipt of case management services or other services from public or private agencies; ○ The IFSP process including members of the team, and the rights of parents to chose an On-going SC; ○ Showing the parent the IFSP forms and discussing the IFSP process. ● Informing the parent that the child’s and parent’s social security information will be requested at the IFSP meeting. ● Upon parent request, helping the parent to make a direct referral to CPSE for children who are 2 ½ years or older at the time of referral; ● Explaining the use of third party insurance. ● Providing families with the list of EI evaluation sites, and assisting families with choosing an appropriate evaluation agency. ● Assisting families w/locating a Primary Care Provider. 	
Information Gathering	<ul style="list-style-type: none"> ● Obtaining various parental consents necessary for participation in EI services. ● Obtaining insurance information from parent/caregiver. Explaining to parent/caregiver how the information will be used. 	
Referrals	<ul style="list-style-type: none"> ● Making referrals to non-EI services. 	

Administrative Tasks	<p>At the parent's request, writing a letter on behalf of the child/family (for example, to the Housing Authority regarding the child's special needs).</p>	<p>Performing administrative/clerical activities, including:</p> <ul style="list-style-type: none"> • Xeroxing; • Filling out billing forms; • Scheduling evaluators who are employed by the same EI provider as the SC; • Organizing paperwork • Mailing, faxing, or receiving a letter or form. • Asking the Regional Office for forms or how to fill out forms • Completing EI forms • Completing and sending form letters (ex: introductory letters about the agency or SC)
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New York City Billable AND Non-Billable Service Coordination Activities

Service Coordination activities are cumulative on a daily basis.

12-B. EVALUATION PROCESS (INITIAL SERVICE COORDINATION)

Note: Detailed information about the Initial Service Coordinator (ISC) 's responsibilities to assist the family in arranging an evaluation to determine the child's eligibility and in understanding the results of the evaluation can be found in the NYS Early Intervention Program Regulations, 10NYCRR 69-4.7(j) - (n).

CATEGORY	BILLABLE SC ACTIVITIES	NONBILLABLE SC ACTIVITIES
Contacts	<ul style="list-style-type: none"> • Speaking with parent, EIOD, provider, or any other person involved with the child/family on the phone when he/she responds to the Service Coordinator (SC)'s message. • Leaving one (1) or more messages in the same day for a parent, an EIOD, a provider, or other person involved with the child/family where the total time spent is five (5) minutes or more. (You may consolidate activities for the same child done on the same day that together add up to a full unit of service coordination – e.g., three phone calls at two (2) minutes each; two (2) or more activities that together total at least five (5) minutes, etc.) 	<ul style="list-style-type: none"> • Billing for contacts that takes less than five (5) minutes (e.g. leaving a message for a parent, an EIOD, a provider, or other person involved with the child/family) when the total time spent on the child for that day is less than 5 minutes. • Receiving a message. • Leaving a message on voicemail • Writing notes or letters to a child's health care provider about the child.
Meetings	Attending the child's evaluation and/or other meetings, upon parental request and, if appropriate, (ISC cannot bill simultaneously for both ISC and translator functions).	Participating in general meetings, such as: <ul style="list-style-type: none"> • Supervisory conferences; • Team meetings; • Trainings and other conferences sponsored by their agency.
Gathering Information	Making telephone calls to ensure that evaluation site has conducted the evaluation.	

<p>Providing Information to Families</p>	<ul style="list-style-type: none"> • Ensuring that parent/guardian has received copies of the MDE and discussing parental/guardian reaction to the MDE. • Facilitating a meeting between the evaluation agency and parent as necessary. 	<ul style="list-style-type: none"> • Discussing evaluation results with the parent or the child’s medical provider (this is the evaluation team’s responsibility). • Billing for SC delivered to more than (1) child/family during the same period of time (In the event of multiple births or two (2) or more EI children in the same family, the SC time should be divided among the children and billed accordingly or can be billed to one (1) child but not the others. Ex: 32 min split between 2 or more children cannot result in more than 3 units in total). • Writing notes in child’s case record. • Providing clinical counseling services to parents. • Providing written notice to parents to families regarding denial of eligibility.
<p>Administrative Tasks</p>	<p>At the parent’s request writing a letter on behalf of the child/family (for example, to the Housing Authority regarding the child’s special needs).</p>	<p>Performing administrative/clerical activities including, but not limited to:</p> <ul style="list-style-type: none"> • Xeroxing; • Filling out billing forms; • Scheduling evaluators who are employed by the same EI provider as the SC; • Organizing paperwork; • Mailing, faxing, or receiving a letter or form; • Asking the Regional Office for forms or how to fill out forms; • Completing EI forms; • Completing and sending form letters (introductory letters about the agency or SC).
<p>Due Process</p>	<ul style="list-style-type: none"> • Attending mediations, if invited. • Attending impartial hearings, if required. 	

New York City Billable AND Non-Billable Service Coordination Activities

Service Coordination activities are cumulative on a daily basis.

12-C. IFSP PROCESS (INITIAL SERVICE COORDINATION)

Please Note: Detailed information about the Initial Service Coordinator (ISC)’s responsibilities to assist the family in understanding the IFSP process can be found in the NYS Early Intervention Program Regulations, 10NYCRR 69-4.7(o) – (p) and 4.11(a) - (c).

CATEGORY	BILLABLE SC ACTIVITIES	NONBILLABLE SC ACTIVITIES
Meetings	<ul style="list-style-type: none"> • Scheduling IFSP meetings (e.g., speaking with the participants on the phone). • Participating in meeting to develop IFSP. 	<ul style="list-style-type: none"> • Traveling to and from IFSP meeting. • Time spent waiting for any individual who is late or fails to keep an appointment. • Sending out written IFSP meeting invitations.
Gathering Information	<ul style="list-style-type: none"> • Prior to IFSP date, meeting with the family to discuss community resources and natural routines to prepare for the IFSP. 	<ul style="list-style-type: none"> • Billing for SC delivered to more than (1) child/family during the same period of time (In the event of multiple births or two (2) or more EI children in the same family, the SC time should be divided among the children and billed accordingly or can be billed to one (1) child but not the others. Ex: 32 min split between 2 or more children cannot result in more than 3 units in total).
Administrative Tasks	At the parent’s request, writing a letter on behalf of the child/family (for example, to the Housing Authority regarding the child’s special needs).	Performing administrative/clerical activities including, but not limited to: <ul style="list-style-type: none"> • Xeroxing; • Filling out billing forms; • Scheduling evaluators who are employed by the same EI provider as the SC; • Organizing paperwork; • Mailing, faxing, or receiving a letter or form; • Asking the Regional Office for forms or how to fill out forms; • Completing EI forms; • Completing and sending form letters (introductory letters about the agency or SC).
Due Process	<ul style="list-style-type: none"> • Attending mediations, if invited. • Attending impartial hearings, if required. 	

New York City Billable AND Non-Billable Service Coordination Activities

Service Coordination activities are cumulative on a daily basis.

12-D. POST IFSP MEETING (ONGOING SERVICE COORDINATION)

Please Note: Detailed information about the Ongoing Service Coordinator (OSC)'s responsibilities after the Initial IFSP meeting can be found in the NYS Early Intervention Program Regulations, 10NYCRR 69-4.6 and 4.11(a) – (b).

CATEGORY	BILLABLE SC ACTIVITIES	NONBILLABLE SC ACTIVITIES
Contacts	<ul style="list-style-type: none"> • Speaking with parent, EIOD, provider, or any other person involved with the child or family on the phone when he/she responds to the Service Coordinator (SC)'s message. • Leaving one (1) or more messages in the same day for a parent, an EIOD, a provider, or other person involved with the child/family where the total time spent is five (5) minutes or more. (You may consolidate activities for the same child done on the same day that together add up to a full unit of service coordination – e.g., three phone calls at two (2) minutes each; two (2) or more activities that together total at least five (5) minutes.) 	<ul style="list-style-type: none"> • Billing for contacts that takes less than five (5) minutes (e.g. leaving a message for a parent, an EIOD, a provider, or other person involved with the child/family) when the total time spent on the child for that day is less than five (5) minutes). • Receiving a message, leaving a message on voicemail. • Providing counseling or other clinical services to parents.
Meetings	<ul style="list-style-type: none"> • Scheduling Six (6) Month Reviews, Annual Reviews, or meetings to amend Individualized Family Service Plan (IFSP) (e.g., speaking with the participants on the phone, writing letters to participants.). • Participating in Six (6) Month Reviews, Annual Reviews, or meetings to amend IFSP. 	<ul style="list-style-type: none"> • Traveling to and from IFSP meetings. • Time spent waiting for any individual who is late or fails to keep an appointment
IFSP Follow-up	<ul style="list-style-type: none"> • Following up on all issues assigned to the OSC at the Individualized Family Service Plan (IFSP) meeting (such as referrals needed by the family to non-EI services) 	<ul style="list-style-type: none"> • Performing any Service Coordination activity by the OSC on or before the day of the Initial IFSP.
Delivery of Services	<ul style="list-style-type: none"> • Ensuring that the family/guardian and service providers listed on the IFSP are notified after the Initial IFSP, six (6) month and annual reviews, and any subsequent amendments • Assisting families in obtaining EI services by contacting service provider agencies or service provision coordinators. • At the parent's request, contacting any therapists working with the child. 	<ul style="list-style-type: none"> • Meeting/speaking with interventionist which does not eventually result in conveying information back to parent. • Faxing and mailing forms

	<ul style="list-style-type: none"> • Locating other EI service providers when a parent is dissatisfied with the current provider or when a service agreed to in the IFSP is not being delivered. • Speaking with parents on a regular basis to ensure that the IFSP is being implemented as written, e.g. the service is being delivered at the agreed upon frequency, intensity, and duration. • Contacting the Regional Office if there are problems with service delivery that the SC cannot resolve. • Ensuring that providers receive information about closed cases and cancelled services. • Attending mediations, if invited; impartial hearings, if required. 	
Providing Information to Families	<p>Explaining to parents, both in-person and on the phone, such topics as:</p> <ul style="list-style-type: none"> • Family’s rights and responsibilities under the Early Intervention Program (EIP); • Family’s due process rights; • Parents’ satisfaction with the Early Intervention (EI) services child/family is receiving. <p>Contacting parent when there are issues of child’s availability for services</p>	<ul style="list-style-type: none"> • Billing for SC delivered to more than (1) child/family during the same period of time (In the event of multiple births or two (2) or more EI children in the same family, the SC time should be divided among the children and billed accordingly or can be billed to one (1) child but not the others. Ex: 32 min split between 2 or more children cannot result in more than 3 units in total); • Providing clinical counseling to parent(s). • Writing notes in child’s case. • Traveling to and from home visit or any other destination.
Gathering Information	<ul style="list-style-type: none"> • Updating Insurance Information obtained from parent/caregiver. • Assisting parent in requesting and/or arranging additional core and/or supplemental evaluations (after Initial IFSP). • Securing progress reports from provider agencies. 	
Assistive	Providing information about the AT process,	

Technology (AT)	and monitoring receipt as authorized in IFSP or amendment to the IFSP.	
Transportation	Reporting a transportation problem for a specific child at the request of the parent.	<ul style="list-style-type: none"> • Escorting child from bus. • Coordinating the arrival and dismissal of children by school bus. • Attending field trips.
Transition	<p>Transition out of EI: (Refer to Transition out of Early Intervention Chapter):</p> <ul style="list-style-type: none"> • At the parent’s request, assisting in making a referral to the Committee of Pre-school Special Education (CPSE); • With parental consent, scheduling a Transition Conference with the parent, EIOD, CPSE designee, and ACS/Foster Care Case worker (if applicable) at the IFSP closest to the child’s second birthday; • Participating in the development of a Transition Plan; • Implementing the Transition Plan; • Ensuring that EI receives a copy of required CPSE paperwork to extend services. • Attending the CPSE meeting if invited by the parent. 	<ul style="list-style-type: none"> • Faxing and mailing forms. • Accompanying parents to tour or visit special education programs that the child may be transitioning to under the CPSE.
Administrative Tasks	At the parent’s request writing a letter on behalf of the child/family, (e.g., to the Housing Authority regarding the child’s special needs).	<p>Performing administrative/clerical activities including, but not limited to:</p> <ul style="list-style-type: none"> • Xeroxing; • Filling out billing forms; • Scheduling evaluators who are employed by the same EI provider as the SC; • Organizing paperwork; • Mailing, faxing, or receiving a letter or form; • Asking the Regional Office for forms or how to fill out forms; • Completing EI forms; • Completing and sending form letters (introductory letters about the agency or SC).

Due Process	<ul style="list-style-type: none">• Attending mediations, if invited.• Attending impartial hearings, if required.	
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Chapter 13: Additional Forms and Procedures

**New York City Early Intervention Program
CHILD INFORMATION CHANGE FORM**

Please Print

CHILD'S NAME (Last, First and Middle): _____

EI # _____ **DOB:** ____/____/____ **Date Information Changed:** ____/____/____

Service Coordinator: _____ **SC ID #:** _____

SC Provider Agency: _____ **Agency EI #:** _____

CHANGES OF CHILD AND/OR FAMILY INFORMATION

A. CHANGE OF TELEPHONE NUMBER – Indicate Home or Work number: Home Work

From: (_____) _____

To: (_____) _____

B. CHANGE OF NAME (OR SPELLING OF NAME)

From: _____
Last, First & Middle

To: _____
Last, First & Middle

Documentation is requested, see instructions. If not available, attach letter explaining reason.

C. CHANGE OF ADDRESS FOR CHILD

From: _____ Apt. # _____

To: _____ Apt. #: _____

D. CHANGE OF CAREGIVER/PARENT

From: _____ Relationship: _____

To: _____ Relationship: _____

Attach any available legal documentation.

E. CHANGE DATE OF BIRTH - Documentation requested, see instructions

From: ____/____/____ To: ____/____/____

EIP Data Entry: _____ *Date:* _____

**New York City Early Intervention Program
CHILD INFORMATION CHANGE FORM INSTRUCTIONS**

GENERAL DIRECTIONS:

The service coordinator completes this form whenever a child's personally identifiable information in the Early Intervention (EI) system has been identified as incorrect (with the exception of insurance), e.g., name change, wrong date of birth, address change, etc. Indicate with a check the information that is being changed and complete the requested section(s) for this child. In all cases, "from" should be the information currently in the EI system and "to" should be the new information being submitted.

NOTE: IS THERE A CHANGE OF INSURANCE INFORMATION?

If yes, complete the *Insurance Information* form and attach a copy of the new insurance card with the form.

The Initial/Ongoing Service Coordinator must keep a copy of this form in the child's case record and must send a copy to the Regional Office and to all evaluator(s)/service provider(s).

Complete the following:

- **CHILD'S NAME (Last, First and Middle):** The child's complete legal name (no nicknames), last name, followed by first and middle names. Verify correct spelling.
- **EI ID #:** The unique identification number assigned to this child by the NYC Early Intervention Program (EIP).
- **DOB:** Child's date of birth, in month, day and (four digit) year order.
- **Date Information Changed:** The effective date of change for this information (rather than the day the form was completed).
- **Service Coordinator & Service Coordination #:** The service coordinator name and associated NYC EIP assigned identifier number.
- **Provider Agency & Agency EI #:** The employing service coordination agency name and associated EI contract number.

CHANGES OF FAMILY AND CHILD INFORMATION

A. CHANGE OF TELEPHONE NUMBER: The former and current telephone numbers of the child's caregiver/parent.

B. CHANGE OF NAME (OR SPELLING OF NAME): The current legal name of the child (no nicknames). Verify correct spelling. Documentation of the correct name/spelling (birth certificate, Medicaid card, etc.) must be attached. If documentation is not available, attach a letter of explanation.

C. CHANGE OF ADDRESS FOR CHILD: The former and current addresses of the child. Be sure to include the Apt. No. and Zip Code. If the child is moving out of the borough, ensure that appropriate notification has been made to the EI Program office in that area.

D. CHANGE OF CAREGIVER/PARENT: The former and current name of the caregiver/parent. Attach any available legal documentation. **Surrogate Parent:** Attach a letter of explanation and/or any additional information available. The service coordinator also needs to complete a new Surrogate Parent Assignment by EIOD form and submit it to the EIOD for approval.

E. CHANGE DATE OF BIRTH: The child's date of birth as it appears in EI records and the corrected date of birth. A copy of the child's birth certificate or Medicaid card must be attached to this form when indicating the change. (If documentation is not available, attach a letter of explanation.)