

The New York City  
**Early Intervention  
Program**

For Babies and Toddlers With  
Developmental Delays or Disabilities

The Earlier The Better



New York City Department of Health and Mental Hygiene  
Revised August 19, 2011 (Revised Policies Reflect The New  
York Early Intervention System - NYEIS)

# Chapter 1: Referral

## New York City Early Intervention Program

<b>Policy Title:</b> <b>Referrals to NYC Early Intervention Program</b>	<b>Effective Date:</b> <b>2/28/2011 - NYEIS Implementation</b>
<b>Policy Number:</b> <b>1-A</b>	<b>Supersedes:</b> <b>N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>New York City Early Intervention Program Referral Form</b></li> <li>• <b>Fax Confirmation of Initial Service Coordinator and Important Dates</b></li> <li>• <b>Welcome Letter for Parents</b></li> <li>• <b>FAQ for Parents Regarding Eligibility</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> <li>• <b>Your Rights in Early Intervention - Spanish</b></li> </ul>	<b>Regulation/Citation:</b> Public Health Law (§ 2542.3) <i>10 NYCRR 69-4.3(c) Referrals</i>

### I. POLICY DESCRIPTION:

The earliest possible identification of infants and toddlers with disabilities is a primary Early Intervention Program objective. This policy clarifies the Public Health Law (Public Health Law (§ 2542.3) and program regulations *10 NYCRR §69-4.3(c)* for referral to Early Intervention Regional Offices or to the Developmental Monitoring Unit. The EIP Referral Form with directions for completion can be found on the New York City DOHMH website at: <http://www.nyc.gov/html/doh/downloads/pdf/earlyint/ei-referral-form.pdf>

### II. PROCEDURE:

Responsible Party	Action
<b>Primary Referral Source</b>	<p>1. <b>Required to refer to Early Intervention within two (2) working days</b> children, aged birth to 36 months, suspected of having a disability or who appear at risk for a developmental delay.</p> <p><b>Primary referral sources include:</b></p> <ul style="list-style-type: none"> <li>• Early Intervention provider agencies;</li> <li>• Hospitals;</li> <li>• Pediatric and/or primary healthcare providers;</li> <li>• Day care programs;</li> <li>• Local health units;</li> <li>• Local school districts;</li> <li>• Local social service districts (ACS);</li> <li>• Public health facilities;</li> <li>• Early Childhood Direction Centers;</li> <li>• Operators of any clinic approved under Article 28 of <u>Public Health Law</u>, Article 16 or 31 of the <u>Mental Hygiene Law</u>; and</li> <li>• (PHL § 2541(15), 10 NYCRR § 69-4.1(aj))</li> </ul>

**Note:**

- Parents may refer their children to EIP at any time.
2. Must refer to EI based on two categories :
- a. Suspected of having a delay - Children suspected of having a delay:
    - i. The child has a condition with a known likelihood of leading to a developmental delay such as Down syndrome, a birth weight of less than 1,000 grams (2.2 pounds), failure of two hearing screenings or a confirmed hearing or vision loss;
    - ii. Additional conditions provided at 10NYCRR §69-4.3 (e);
    - iii. The results of a developmental screening or diagnostic procedure(s), direct experience, observation, or impression of the child's developmental progress that suggests a possible delay;
    - iv. Parent/caregiver is requesting an evaluation, or has provided information indicating the possibility of delay or disability.


**Note:**

- Children who meet the above criterion should be referred to the Early Intervention Program where they will receive:
    - Initial Service Coordination (ISC),
    - Multidisciplinary Evaluation (MDE), and, if found eligible, an
    - Individualized Family Service Plan (IFSP),
      - i. All Early Intervention services are at no direct cost to the family.
- b. At risk for delay - Children at risk for delays/disabilities:
- i. "At risk" is defined as children who are not suspected of having a disability and do not have a diagnosed condition with a high probability of delay, but are at increased risk for developmental delay because of specific biomedical risk factors or other risk criteria (PHL §2541 (1), 10 NYCRR 69-4.3 (f));
  - ii. Children with substantiated abuse or neglect, in the ACS system;
  - iii. Children evaluated and found not eligible for Early Intervention.

**Note:**

- Children who meet the criteria (in b) should be referred to Developmental Monitoring (DM) where they will receive:
    - Monitoring of the child's progress using the Ages and Stages Questionnaires®. This is completed by mail or phone. If the screenings show atypical development, DM will transfer the child, with parental consent, for further assessment.
3. The primary referral source does not need written consent from the parent to make a referral to the EIP (see directions for completion of Early Intervention Program referral form). However, a referral cannot be made if the parent objects.
- a. If a parent objects to the referral, a referral source should:
    - i. Maintain written documentation of the parent's objection and follow-up actions;

	<ul style="list-style-type: none"> <li>ii. Provide the parent with the name of the EIP and information on how to make a referral if parent wishes to contact the program in the future;</li> <li>iii. Make reasonable efforts to follow-up with the parent <b>within two (2) months</b> and, if appropriate, refer the child at that time unless the parent objects.</li> </ul> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Referrals must be made to the borough of the child’s residence, the Developmental Monitoring Unit or via the ACS Referral Hotline.</li> </ul> <p>4. Referrals to the NYC EIP are made by :</p> <ul style="list-style-type: none"> <li>a. Faxing a <b>Referral Form</b> directly to the Regional Office (RO) in the borough of the child’s residence;</li> <li>b. Calling 311 and asking for “Early Intervention.”; or</li> <li>c. Calling the ACS Referral Hotline at 877-885-KIDZ (5439) <ul style="list-style-type: none"> <li>i. ONLY Employees of the Administration for Children’s Services (ACS) or agencies contracted with ACS can use this referral method.</li> <li>ii. All ACS referrals must be made using the designated hotline number.</li> <li>iii. Faxed forms are discouraged for ACS referrals.</li> </ul> </li> </ul> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>A faxed referral and a telephone referral should not be made on the same child.</b></li> </ul> <p>3. When making a referral for a child <u>suspected of having a disability</u>, a specific Initial Service Coordinator (ISC) or ISC agency may be requested when there is “an established relationship with the child or family” (PHL 25 Title II-A 69 -4.7 (a)) .</p> <ul style="list-style-type: none"> <li>a. Assignment is determined by the EIP RO at the time the referral is received.</li> </ul> <p>4. Primary referral sources should keep a copy of the faxed transmittal of the <b>Referral Form</b>.</p> <ul style="list-style-type: none"> <li>a. Primary referral sources are responsible for ensuring the confidentiality of all information transmitted at the time of the referral.</li> </ul>
<p><b>Early Intervention Regional Office-Referral Unit</b></p>	<ul style="list-style-type: none"> <li>1. Referrals will be processed within <b>twenty-four (24) hrs of receipt.</b></li> <li>2. Once the referral is processed, Early Intervention will: <ul style="list-style-type: none"> <li>a. Confirm the assignment of an ISC by faxing the <b>Fax Confirmation of Initial Service Coordinator and Important Dates Form</b></li> </ul> </li> <li>3. Sends the parent of the referred child a <b>Welcome Letter</b> describing the NYC Early Intervention Program, giving the name and telephone number of the ISC and basic information about the EI process, and including a copy of <b>Your Family Rights in Early Intervention.</b></li> </ul>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 1/21/11

## New York City Early Intervention Program

<b>Policy Title:</b> <b>Referrals to NYC Early Intervention Program (Post NYEIS)</b>	<b>Effective Date:</b> <b>For All New Referrals Starting Staten Island: 7/12/2011</b> <b>Bronx: 7/26/2011</b> <b>Manhattan: 8/9/2011</b> <b>Queens: 8/23/2011</b> <b>Brooklyn: 9/7/2011</b>
<b>Policy Number:</b> <b>1-A.1</b>	<b>Supersedes:</b> <b>N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>New York City Early Intervention Program Referral Form</b></li> <li>• <b>Fax Confirmation of Initial Service Coordinator and Important Dates (Form Eliminated by NYEIS)</b></li> <li>• <b>Welcome Letter for Parents</b></li> <li>• <b>FAQ for Parents Regarding Eligibility</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> <li>• <b>Your Rights in Early Intervention - Spanish</b></li> </ul>	<b>Regulation/Citation:</b> Public Health Law (§ 2542.3) 10 NYCRR 69-4.3(c) Referrals

### I. POLICY DESCRIPTION:

The earliest possible identification of infants and toddlers with disabilities is a primary Early Intervention Program objective. This policy clarifies the Public Health Law (Public Health Law (§ 2542.3) and program regulations 10 NYCRR §69-4.3(c) for referral to Early Intervention Regional Offices or to the Developmental Monitoring Unit. The EIP Referral Form with directions for completion can be found on the New York City DOHMH website at: <http://www.nyc.gov/html/doh/downloads/pdf/earlyint/ei-referral-form.pdf>.

#### NOTE:

- **Referrals made by NYC Early Intervention providers must be made via the New York Early Intervention System (NYEIS).**
- Instruction for navigating NYEIS are denoted in *italics* in the body of this Policy

### II. PROCEDURE:

Responsible Party	Action
<b>Primary Referral Source</b>	1. <b>Required to refer to Early Intervention within two (2) working days</b> children, aged birth to 36 months, suspected of having a disability or who appear at risk for a developmental delay. <b>Primary referral sources include:</b> <ul style="list-style-type: none"> <li>• Early Intervention provider agencies;</li> <li>• Hospitals;</li> <li>• Pediatric and/or primary healthcare providers;</li> </ul>

- Day care programs;
- Local health units;
- Local school districts;
- Local social service districts (ACS);
- Public health facilities;
- Early Childhood Direction Centers;
- Operators of any clinic approved under Article 28 of Public Health Law, Article 16 or 31 of the Mental Hygiene Law (PHL § 2541(15), 10 NYCRR § 69-4.1(aj))

**Note:**

- Parents may refer their children to EIP at any time.

2. Must refer to EI based on two categories :

- a. Suspected of having a delay
  - i. The child has a condition with a known likelihood of leading to a developmental delay such as Down syndrome, a birth weight of less than 1,000 grams (2.2 pounds), failure of two hearing screenings or a confirmed hearing or vision loss;
  - ii. Additional conditions provided at 10NYCRR §69-4.3 (e);
  - iii. The results of a developmental screening or diagnostic procedure(s), direct experience, observation, or impression of the child’s developmental progress that suggests a possible delay;
  - iv. Parent/caregiver is requesting an evaluation, or has provided information indicating the possibility of delay or disability.

**Note:**

- Children who meet the above criterion should be referred to the Early Intervention Program where they will receive:
  - Initial Service Coordination (ISC),
  - A Multidisciplinary Evaluation (MDE), and, if found eligible, an
  - Individualized Family Service Plan (IFSP).
  - i. All Early Intervention services are at no direct cost to the family.

- b. At risk for delay:
  - i. Children who are not suspected of having a disability and do not have a diagnosed condition with a high probability of delay, but are at increased risk for developmental delay because of specific biomedical risk factors or other risk criteria (PHL §2541 (1), 10 NYCRR 69-4.3 (f));
  - ii. Children with substantiated abuse or neglect, in the ACS system;
  - iii. Children evaluated and found not eligible for Early Intervention.

**Note:**

- Children who meet the criteria (in b) should be referred to Developmental Monitoring (DM) in Early Intervention where they will receive:
  - Monitoring of the child’s progress using the Ages and Stages Questionnaire®. The questionnaire is completed by mail or phone. If

the questionnaire suggests atypical development, DM will transfer the child, with parental consent, for further assessment.

3. The primary referral source does not need written consent from the parent to make a referral to the EIP (see directions for completion of Early Intervention Program referral form). However, a referral cannot be made if the parent objects.
  - a. If a parent objects to the referral, a referral source should:
    - i. Maintain written documentation of the parent's objection and follow-up actions;
    - ii. Provide the parent with the name of the EIP and information on how to make a referral if parent wishes to contact the program in the future;
    - iii. Make reasonable efforts to follow-up with the parent **within two (2) months** and, if appropriate, refer the child at that time unless the parent objects.

**Note:**

- Referrals must be made to the borough of the child's residence, the Developmental Monitoring Unit or via the ACS Referral Hotline.
4. Referrals by non Early Intervention provider referral sources are made to the NYC EIP by :
    - a. Faxing a **Referral Form** directly to the Regional Office (RO) in the borough of the child's residence;
    - b. Calling 311 and asking for "Early Intervention"; or
    - c. Calling the ACS Referral Hotline at 877-885-KIDZ (5439)
      - i. ONLY employees of the Administration for Children's Services (ACS) or agencies contracted with ACS can use this referral method.
        - All ACS referrals must be made using the designated hotline number.
        - Faxed forms are discouraged for ACS referrals.


**Note:**

- **A child's referral should be submitted via only one method, fax or phone, not both.**
5. If the **Referral Form** is faxed, the primary referral sources should keep a copy of the faxed transmittal of the **Referral Form**.
    - a. Primary referral sources are responsible for ensuring the confidentiality of all information transmitted at the time of the referral.
  6. Referrals made by NYC Early Intervention providers must be made via the New York Early Intervention System (NYEIS)
    - a. *From the Home Menu button - Click on Create Referral*
    - b. *Enter mandatory information*
      - i. *All mandatory fields are indicated by a yellow asterisk*
      - ii. *Primary Referral Source will be pre-populated with the provider agency name*
      - iii. *Status assigned field*
        - *Provider selects "Confirmed Diagnosed Condition" or Suspected of delay for the referral to be routed to*



	<p><i>the Regional office</i></p> <ul style="list-style-type: none"> <li>• <i>Selecting “at risk” or “failed Initial hearing screening” will cause the referral to be routed to Developmental Monitoring</i></li> </ul> <p>iv. <i>The fields in the section below "Informed Parental Consent – The provider agency must make a reasonable attempt to obtain informed parental consent to complete the remaining NYEIS fields under the following categories:</i></p> <ul style="list-style-type: none"> <li>• <i>Child Details</i></li> <li>• <i>Communication Exemption (only if applicable)</i></li> <li>• <i>Suspected Delay Referral Details</i></li> <li>• <i>At Risk and Failed Newborn Hearing Screening Referral Details</i></li> <li>• <i>Place of Birth</i></li> <li>• <i>Primary Care Physician</i></li> </ul> <p>v. <i>When making a referral for a child <u>suspected of having a disability</u>, a specific Initial Service Coordinator (ISC) or ISC agency may be requested when there is “an established relationship with the child or family” (PHL 25 Title II-A 69 - 4.7 (a)) .</i></p> <ul style="list-style-type: none"> <li>• <i>The request for a specific ISC or ISC agency must be made in the “Comments” section of the referral in order to be considered.</i></li> <li>• <i>Assignment is determined by the EIP Regional Office when the referral is received.</i></li> </ul> <p>c. <i>Save the referral</i></p> <p>d. <i>Select the option to “View and submit the child’s referral”</i></p> <p><b>Note:</b> From “My Shortcuts” select “My Provider Home Page”. Select “Referrals” from the Navigation Bar to view a complete list of referrals and their status.</p>
<p><b>Early Intervention Regional Office-Referral Unit</b></p>	<p>1. Referrals will be processed within <b>twenty-four (24) hrs of receipt.</b></p> <ul style="list-style-type: none"> <li>a. Any referral made 45 days or less before the child turns three years old is automatically closed in NYEIS (if submitted electronically). Or, will not be entered into NYEIS ( if called or faxed in).</li> </ul> <p>2. Once the referral is processed, Early Intervention will:</p> <ul style="list-style-type: none"> <li>a. <i>Assign an ISC Agency in NYEIS</i> <ul style="list-style-type: none"> <li>i. <i>Indicates specific ISC preference in the “ISC Authorization Page” comments section</i></li> </ul> </li> </ul>
<p><b>Initial Service Coordination Agency Supervisor</b></p>	<p>1. Required to check NYEIS for new request for ISC every business day.</p> <p>2. <i>From the Inbox Menu button- Click “Work Queues”</i></p> <ul style="list-style-type: none"> <li>b. <i>Select View: _ Service Authorization</i></li> <li>c. <i>Select the task ID of the case to accept/Reject Service Coordinator Service Authorization</i></li> <li>d. <i>Under Supporting Information, select Service Authorization Home Page</i> <ul style="list-style-type: none"> <li>i. <i>The Service Details section of the Service Authorization Home Page replaces the <b>Fax Confirmation of Initial Service Coordinator and Important Dates Form</b></i></li> </ul> </li> </ul>

	<p style="text-align: center;"><i>ii. Check the comments section for the municipal assignment of ISC</i></p> <p><i>e. Under Primary Action, select: Accept/Reject Service Authorization</i></p> <p style="padding-left: 40px;"><i>i. Enter Provider Name or % (Wildcard), then Search, Select a specific ISC</i></p> <ul style="list-style-type: none"> <li><i>• The caseload column listing the # of cases for person will be listed</i></li> </ul> <p>Note:</p> <ul style="list-style-type: none"> <li>• The Service Coordination supervisor must call the Regional Office in order to obtain approval to select an ISC other than the one designed in the comments section of the Service Authorization Home page.</li> <li>• ISC agencies are required to accept or reject ISC assignment within one business day of receiving the request.</li> </ul>
<p><b>Early Intervention Regional Office-Referral Unit</b></p>	<p>3. Send a <b>Welcome Letter</b> to the parent of the referred child welcoming the family to the NYC Early Intervention Program, giving the name and telephone number of the ISC and basic information about the EI process, and including a copy of <b>Your Rights in Early Intervention</b>.</p>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 6/29/2011



# Early Intervention Program Referral Form

FOR OFFICE USE ONLY

Date of Referral

Re-open

Employees of the Administration for Children's Services (ACS) or agencies contracted with ACS must Call the Citywide ACS Referral Hotline: (877)-885-KIDZ(5439) to make a referral to the Early Intervention Program

1. REQUIRED INFORMATION

<b>CHILD'S NAME:</b> (Last, First, Middle)		<b>DATE OF BIRTH:</b> (MM/DD/YY) ___/___/___	
<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>CHILD'S ADDRESS:</b> (Street, Apt. No)		<b>CITY:</b> _____
		<b>Zip Code:</b> _____	
<b>RACE (may select more than one if applicable):</b> <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian or Pacific Islander		<b>ETHNICITY:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
<b>MOTHER'S NAME:</b> (Last, First, Middle)		<b>TELEPHONE:</b>	
<b>Caregiver or Alternate Contact Name:</b> (Last, First)		<input type="checkbox"/> Home (____) _____ - _____	
<b>Telephone:</b> (____) _____ - _____		<input type="checkbox"/> Cell (____) _____ - _____	
<b>Relation to Child:</b> <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other, <i>Specify:</i>		<input type="checkbox"/> Work (____) _____ - _____	
<b>REASON FOR REFERRAL</b> (Check only one)		<b>Person Presenting Referral to Early Intervention</b>	
<input type="checkbox"/> <b>EARLY INTERVENTION: Child with a suspected or known developmental delay or disability.</b> Fax to the EIP Regional Office in the child's borough of residence: Bronx (718) 410-4504 Brooklyn (718) 722-2998 Manhattan (212) 487-7071 Queens (718) 271-6114 Staten Island (718) 420-5360		Name	
		Agency or Facility, if any	
		Address (Street, Apt. No)	
		City, State, Zip	
		Telephone F ax (____) _____ - _____ (____) _____ - _____	
		Referral Source Type: <input type="checkbox"/> Community Program or EI Agency <input type="checkbox"/> Parent/Family <input type="checkbox"/> Foster Care/Other ACS <input type="checkbox"/> PCP <input type="checkbox"/> Hospital <input type="checkbox"/> Other ( <i>Specify</i> ):	
<input type="checkbox"/> <b>DEVELOPMENTAL MONITORING: Child is developing typically but may be "at risk" for atypical development, or child missed or failed newborn hearing screening.</b> Fax to the Child Find Citywide Office: (212) 227-3642			
<b>Comments:</b>			

2. WITH INFORMED PARENTAL CONSENT

<b>MOTHER'S DATE OF BIRTH:</b> (MM/DD/YY) ___/___/___	<b>PRIMARY HOME LANGUAGE:</b>	<b>CHILD KNOWN TO ACS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CHILD'S DOCTOR:</b>	<b>DOCTOR'S TELEPHONE:</b> (____) _____ - _____	
<b>BIRTH HOSPITAL:</b>	<b>LOCATION:</b>	
<b>BIRTH WEIGHT:</b> Pounds: ___ Ounces: ___ <b>OR</b> Grams: _____	<b>Gestational:</b> Age: ___ weeks	<b>DIAGNOSIS:</b> if known:

3. REQUIRES PARENTAL SIGNATURE

**Consent to Release Information (Only this section requires written parental consent)**

I authorize for a copy of the Multidisciplinary Evaluation (MDE) to be sent to the above signed referring professional (ex: Primary Care Provider)

\_\_\_\_\_ Date \_\_\_\_\_

Parent Signature Date

Request for ISC		FOR OFFICE USE ONLY	
Requested ISC	SC ID No.	Assigned SC	ISC Request <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
Agency	ID No.	Agency	ID No.
Tel. (____) _____ - _____	Fax (____) _____ - _____	Tel. (____) _____ - _____	Fax (____) _____ - _____
Reason for ISC Request		Data Entry	Date ___/___/___

Questions? Dial 311 and ask for Early Intervention EIP 11/10

## Instructions for Completing the Early Intervention Program Referral Form

(Please do not fax with the referral form)

### NOTE TO REFERRAL SOURCE:

**ACS Referral Hotline: Child with a suspected of known delay OR Child is typically developing but may be “at risk” for atypical development AND is involved in the ACS Foster Care, Protective Services or Preventative services.** Early Intervention Specialists at the ACS Hotline will discuss appropriate Next steps in the Early Intervention process. **All ACS referrals must be called in using this designated hotline number.** Fax referrals are discouraged for ACS referrals.

Write legibly or type all referral information. The referral form is divided into three (3) sections.

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

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

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

**Section 3** - Contains information that requires a parent’s written signature on this Referral Form.

***Although Sections 2 and 3 require parental consent, the information contained in these sections is important for appropriate routing of the referral and assignment of Initial Service Coordinator (ISC). Therefore, it is recommended that all sections be completed if possible.***

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**Information on this form must be typed or printed legibly** (other than parent signature in Section 3).

### **Section 1**

1. Write the child’s full name, last name first. Write the child’s date of birth in two (2) digit month, day, and year (e.g., 03/25/09).
2. Check the box indicating the child’s gender and write the full address where the child resides, including the city (or borough) and the zip code.
3. **Race and Ethnicity.** Check the appropriate box for each section. *More than one racial designation for a child can be selected.*
4. Write the name of the child’s biological or adoptive mother, last name first. On the right side, write the telephone numbers where the mother can be contacted.
5. Write the name of an alternate caregiver (such as the foster parent) or contact person and that person’s telephone number. Check the appropriate box to indicate the relationship to the child and specify what that is if “other” is checked.
6. **Reason for Referral.** Check Early Intervention, Developmental Monitoring or ACS Hotline. If the child is being referred because there is a particular concern, write that information in the *Comments* box (See Appendix A). **All ACS referrals must be called in using the designated hotline number. Fax referrals are discouraged for ACS referrals.**
7. **Person Presenting Referral to Early Intervention.** Write the name, agency or facility (if any), address, telephone and fax numbers of the person referring the child to NYCEIP and completing this form. Check the appropriate box for *Referral Source Type* reflecting the person who is actually making the referral. For example, check the box for Community Program or EI Agency if the person making the referral represents an EI Provider Agency or a community agency (e.g., ECDC). Additional information can be added in the *Comments* box.

### **Section 2**

8. Write the mother’s date of birth in two (2) digit month, day and year (e.g., 11/10/82).
9. Write the primary language spoken at home. This information will assist in determining whether a bilingual ISC needs to be assigned.
10. Check the appropriate box to indicate whether the family is known to ACS.
11. Write the name of child’s primary health care provider and his/her telephone number.
12. Write the name of the hospital in which the child was born and the location, e.g., address, borough or city and state/country.
13. Write the child’s birth weight in pounds and ounces or grams. Include the gestational age in weeks, if known.
14. If the child has a known diagnosis, write that here (e.g., autism, Down syndrome, cerebral palsy, etc.). General concerns can be written in the *Comments* box.

### **Section 3**

15. Indicate if a copy of the Multidisciplinary Evaluation (MDE) should be sent to the referring professional *if the parent consents to the release of this information.* ***This section requires written parental consent on this form*** and no information should be provided without the parent’s signature.

### **Request for ISC**

16. If the person/agency making the referral is requesting a particular initial service coordinator (ISC), write the name of the Service Coordinator (SC), the SC’s ID number, the name and ID number of the service coordination agency, and the telephone and fax numbers for the agency. Include the reason for requesting initial service coordination. According to NYS law, a specific ISC or ISC agency can be requested when there is “an established relationship with the child or family.” However, the EI Regional Office (RO) determines the assignment of ISC and documents this in the bottom right box on the form.

Note: A specific ISC or ISC agency can be requested when there is an established relationship with the child or family, but assignment is at the discretion of the EI RO.

**NOTE:** If there are questions about completing the form or making the referral, call the EI RO in the borough where the child resides or call 311 and ask for “Early Intervention.”

**Appendix A- Reason for Referral Clarification**

**Section 1** contains the **REASON FOR REFERRAL** block. The individual referring the child must indicate whether the child is being referred to EIP in the child’s borough of residence, **Child Find Developmental Monitoring (DM) or the ACS Referral Hotline**. The following indicators should assist with deciding which **REASON FOR REFERRAL** box to check and where to send the referral.

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

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

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

**DEVELOPMENTAL MONITORING: Child is developing typically but may be “at risk” for atypical development, or child missed or a failed newborn hearing screening or re-screening (not re-screened within seventy-five (75) days).**

This referral is sent to the citywide Child Find - DM Office. Check this box for a child who missed or failed his/her newborn hearing screening and did not return for follow-up within seventy-five (75) days. Also, check this box for a child who meets one or more of the risk criteria listed below:

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
<ul style="list-style-type: none"> <li>• Birth weight 1,000 - 1,500 grams</li> <li>• Gestational age less than 33 weeks</li> <li>• NICU stay of ten (10) days or more</li> <li>• CNS insult/abnormality</li> <li>• Asphyxia (5 min APGAR less than 4)</li> <li>• Growth deficiency/nutrition problems (e.g., SGA)</li> <li>• Presence of Inborn Metabolic Disorder</li> <li>• Maternal prenatal alcohol abuse</li> <li>• Congenital malformations</li> <li>• Hyper- or hypotonicity</li> <li>• Hyperbilirubinemia (above 15 mg/d)</li> <li>• Hypoglycemia (serum glucose less than 20 mg)</li> <li>• Maternal prenatal abuse of illicit substances</li> <li>• Prenatal exposure to therapeutic drugs with known risk</li> <li>• Venous lead level more than 19 mcg/dl</li> <li>• HIV infection</li> <li>• Maternal PKU</li> </ul>	<ul style="list-style-type: none"> <li>• Parental developmental disability or mental illness</li> <li>• Suspected/family history of hearing impairment</li> <li>• Suspected/family history of vision impairment</li> <li>• Other risk criteria identified by referral source (describe)</li> <li>• Parental concern re: development</li> <li>• Questionable score on Developmental/sensory screen</li> <li>• Illness/trauma with CNS Implications and ICU more than ten (10) days</li> <li>• Serous Otitis Media within three (3) months</li> <li>• Growth deficiency/nutritional problems, F.T.T., iron deficiency</li> </ul>	<ul style="list-style-type: none"> <li>• No prenatal care</li> <li>• Homelessness</li> <li>• Questionable score on Developmental/Sensory screen</li> <li>• History of child abuse or neglect*</li> <li>• No well child care by six (6) months</li> <li>• Concern re: parenting due to poor bonding, impairment in psychological/ interpersonal functioning</li> <li>• Significant immunization delay</li> <li>• Parental drug or alcohol abuse</li> <li>• Perinatally/congenitally transmitted Infection (e.g., HIV, hepatitis B, syphilis)</li> <li>• Parental developmental disability or mental illness</li> <li>• Other risk criteria identified by referral source (describe)</li> </ul> <p>* Referrals of typically developing children in ACS Foster Care who have not been screened should be sent to DM</p>



## INSTRUCTIONS FOR USE

### FAX CONFIRMATION OF INITIAL SERVICE COORDINATION AND IMPORTANT DATES

This form is faxed to the Service Coordination (SC) Provider Agency to confirm the assignment of Initial Service Coordination (ISC) for a particular child or children. Each child is identified by EI number and initials to maintain confidentiality. Important dates are indicated:

- The date of the child's referral.
- The date by which the evaluation agency must submit the completed Multidisciplinary Evaluation to the EI Regional Office (RO) in the child's borough of residence. Per contractual obligations, this date is **thirty (30) calendar days from the date of the child's referral to EI.**
- The end date of the ISC authorization.
- The **45<sup>th</sup> day from the child's referral to EI**, which is the date by which the child's IFSP meeting should be held, per federal and state regulation.

The form also lists the name and SC ID number of the assigned ISC for each child. **If there is any change in ISC assignment by the provider agency, the provider agency must contact the RO immediately.**



Date: \_\_\_\_\_

Dear Parent/Guardian:

**Welcome to the New York City Early Intervention Program!** The Early Intervention Program (EIP) is a program for families of children under three years of age who have significant delays in development.

Your child: \_\_\_\_\_ was referred by: \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_.

### **What happens next in Early Intervention?**

The first person you will meet in Early Intervention is your **Initial Service Coordinator (ISC)**. Your Initial Service Coordinator is \_\_\_\_\_. S/he can be reached at: \_\_\_\_\_.

The ISC will contact you to set up an appointment. At this meeting your ISC will:

- Explain the Early Intervention (EI) process and answer your questions about the program.
- Explain your rights and responsibilities in Early Intervention.
- Give you a copy of The Early Intervention Program: A Parent's Guide for Children with Special Needs - Birth to Age Three. (on-line at: [www.health.state.ny.us/community/infants\\_children/early\\_intervention/parents\\_guide/index.htm](http://www.health.state.ny.us/community/infants_children/early_intervention/parents_guide/index.htm))
- Collect your child's insurance information or refer you to a Child Benefit Advisor if necessary.
- Help you choose an **Agency** to evaluate your child at no cost to you.

### **The Evaluation**

- Your child will have a complete evaluation to find out if s/he has a delay that meets the EIP's eligibility requirements. This is called a **Multidisciplinary Evaluation (MDE)**.
  - During the evaluation tell the evaluators what your child can do and what you would like him/her to learn.
- Your evaluation team will discuss the results of the evaluations with you. The EIP will review your child's evaluation to ensure quality and may ask the evaluators or you for more information. Children with mild delays are not eligible for Early Intervention.

### **The IFSP Meeting**

- If the evaluation shows that your child is eligible for the EIP, an **Individualized Family Service Plan (IFSP)** meeting will be held **within forty-five (45) days from referral**. Your ISC will call you to arrange a date, time and location that is convenient for you.
- The Early Intervention Official Designee (EIOD), and the rest of the team will meet with you to decide how EI will work with you to help your child develop in the best way that he or she can. Your child learns all day long, by doing everyday things. You can help your child during those times. EI is here to help you.
- You may also have the opportunity to meet with our Department's Child Benefit Advisors. They will talk to you about benefits available for your child including health insurance.

### **What should you do next?**

- It is very important to **keep all of your EI appointments**. Call your ISC if you cannot keep an appointment or if an evaluator misses an appointment. If you miss appointments and we don't hear from you, we may have to close your child's case.
- Have your child's doctor fill out the medical form that comes with this letter.
- Tell your ISC whenever there is a change in your contact information.
- Visit the NYC DOHMH Early Intervention Program website: Along with information about the Early Intervention Program, you can also find the list of agencies contracted with NYC to provide service coordination, evaluations, and services: <http://www.nyc.gov/html/doh/html/earlyint/earlydirectory.shtml>

**If you have questions your Service Coordinator cannot answer**, you need other help, or you do not receive A Parent's Guide call the Early Intervention Regional Office at 212-487-3920 or 212-487-3926 and ask for an Assistant Director. You can also call the Early Intervention Director of Consumer Affairs at 347-396-6828.

Sincerely,

Director, Regional Office



**NYC EARLY INTERVENTION PROGRAM**  
**INFORMATION FOR PARENTS ABOUT ELIGIBILITY**  
**QUESTIONS AND ANSWERS**

**Q: My child was found not eligible for the Early Intervention Program (EIP). S/he isn't doing things like other children his/her age. Why isn't s/he eligible?**

**A:** The Early Intervention Program, by law, only provides services for children who have significant delays in development.

It is normal for children to develop skills at different times and at their own pace. For example, one child may start to walk at 11 months while another child starts at 16 months.

Difficulties eating new foods and temper tantrums can also be a normal part of early child development.

These children are not eligible for Early Intervention.

**Q: The reports that I got said that my child has a delay. They recommended that s/he gets therapy. But I was told that s/he is not eligible for Early Intervention. How can that be?**

**A:** While your child might have a delay, it might not be significant enough for Early Intervention. According to the State Department of Health, a severe delay in communication may be seen when a child has:

- no single words at 18 months,
- fewer than 30 words at 24 months
- no two word combinations at 36 months.

The program does not serve children who are “late talkers” or “late walkers”.

Your child might still benefit from therapy. You can bring the reports to your doctor, and ask if your doctor could recommend therapy paid for by your health insurance.

Your Service Coordinator can also help you find low cost therapy services. Some graduate school programs have clinics that provide therapy on a sliding scale. These schools are listed below.

**Q: I am still concerned. What can I do?**

**A:** Ask your Service Coordinator for a referral to the EIP Developmental Monitoring. You will be contacted on a regular basis to complete an Ages and Stages Questionnaire (ASQ). This will tell you if your child is still developing within age limits or if he/she should be re-evaluated.

## **Resources for Parents**

**Low Cost Speech Services** - Many colleges and universities in NYC have free or low-cost speech clinics:

Brooklyn College – 718-951-5186  
Lehman College – 718-960-8138  
LIU – Brooklyn Campus – 718-780-4122  
New York University – 212-998-5230  
Queens College – 718-997-2930  
Touro College – 718-787-1602 x 200

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**Day Care Referrals** - If you are interested in finding day care services, you can call the numbers below:

**The New York City Child Care Resource and Referral Consortium:** 888-469-5999

**Child Care Inc.**

322 Eighth Avenue, 4th Floor  
New York, NY 10001  
212-929-7604  
212-929-5785 (Fax)

**Child Development Support Corporation**

352-358 Classon Ave, 2nd Fl  
Brooklyn, NY 11238  
718-230-0056  
718-398-6182 (Fax)

**Chinese-American Planning Council**

165 Eldridge Street  
New York, NY 10038  
212-941-0030 ext. 597  
212-343-9567 (Fax)

**Committee for Hispanic Children and Families**

110 William Street, Suite 1802  
New York, NY 10011  
212-206-1090  
212-206-8093 (Fax)

**Child Care Council of New York, Inc.**

12 West 21st Street , 3rd Floor  
New York, NY 10010  
212-206-7818  
212-206-7836 (Fax)

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**Early Head Start (EHS)** – A community based program for low income families with infants and toddlers and pregnant women. It seeks to enhance the development of very young children and promote healthy family functioning. To locate EHS programs in NYC go to: <http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices>

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**Early Childhood Direction Centers (ECDC)** - Provide information, referral and support to families and professionals working with children, both typically developing and those with special education needs, ages birth through five.

**Bronx Early Childhood Direction Center**

2488 Grand Concourse, Room 405  
Bronx, NY 10458  
718-584-0658  
718-584-0859 (Fax)

**Brooklyn Early Childhood Direction Center**

UCP of NYC, Inc.  
SHARE Center  
160 Lawrence Avenue  
Brooklyn, NY 11230  
718-437-3794  
718-436-0071 (Fax)

**Manhattan Early Childhood Direction Center**

New York Presbyterian Hospital  
435 East 70th Street, Suite 2A  
New York, NY 10021  
212-746-6175  
212-746-8895 (Fax)

**Queens Early Childhood Direction Center**

Queens Centers for Progress  
82-25 164th Street  
Jamaica, NY 11432  
718-374-0002 X 465  
718-969-9149 (Fax)

**Staten Island Early Childhood Direction Center**

Staten Island University Hospital  
242 Mason Avenue, 1st Floor  
Staten Island, New York 10305  
718-226-6670  
718-226-6385 (Fax)

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**Resources for Children with Special Needs** - Works for families and children with all special needs, across all boroughs, to understand, navigate, and access necessary services to ensure that all children have the opportunity to develop their full potential.

116 E. 16th Street - 5th floor  
New York, NY 10003  
212-677-4650  
212- 254-4070 (Fax)

## YOUR FAMILY RIGHTS IN EARLY INTERVENTION

The New York City Early Intervention Program (EI) recognizes that the family is an essential part of the early intervention team. The program will do its best to meet the needs of your family and your child. However, you may have concerns that you feel are not being addressed, or disagreements with decisions. Your family has rights that are guaranteed by the Individuals with Disabilities Education Act (IDEA):

- You have the right to say yes or no to having your child screened or evaluated.
- You have the right to choose the evaluator and on-going service coordinator.
- You have the right to say yes or no to any EI service without risking your right to other services.
- You have the right to look at and request a change to your child's written record.
- You have the right to keep information about your family private.
- You have the right to be told about and to appeal any possible changes to your child's evaluation or any other early intervention service before changes are made.
- You have the right to take part in – and ask other people of your choice to attend – all meetings where decisions will be made about changes in your child's evaluation or services.
- You have the right to an explanation of how your insurance may be used to pay for early intervention services.
- You have the right to due process (appeal) procedures mediation, impartial hearing or systems complaint to resolve concerns: (\*see below).
- You have the right to use due process procedures if your child is not found eligible for early intervention services.

**If you have concerns or do not agree with a decision.:**

- **First, discuss your concern or disagreement with your Service Coordinator. S/he will explain your options and rights in further detail.**
- **You can call the Early Intervention Official Designee (EIOD) or an Assistant Director in the Early Intervention Regional Office at the number below:**

<u>Brooklyn:</u> 718 722-3310	<u>Queens:</u> 718 271-1003	<u>Staten Island:</u> 718 420-5350
<u>Bronx:</u> 718 410-4110	<u>Manhattan:</u> 212 487-3920	
- **Or, you can call the EI Director of Consumer Affairs, Beverly Samuels, at (347) 396-6828.**

**Due Process** – If you still have a concern or disagreement, you can appeal the decision by requesting:

- **Mediation** – This is a way to discuss your concerns and reach agreement with a mediator and the Early Intervention Program. Your Service Coordinator can help request mediation, or you can send a letter to the address below.
- **Impartial Hearing** – This is another way to settle disagreements. It is more formal and carried out by hearing officers who are administrative law judges (ALJs) assigned by the NYS Department of Health. The ALJs make the final decision about the complaint. You can send a letter to address below.
- **Systems Complaints** – This is a way to request that the NYS Department of Health investigate how the Early Intervention Program is working. If you believe that your Early Intervention Official, service provider, or service coordinator is not doing their job under the law (IDEA), you can write to the address below.

### **Mediation Requests**

Director of Consumer Affairs  
NYC Early Intervention Program  
Gotham Center #12, 42-09 28th St., 18th Floor  
Queens, NY 11101  
347 396-6828 (Phone)  
347 396-6982 (Fax)

### **Impartial Hearing or Systems Complaints**

NYS Department of Health  
Bureau of Early Intervention  
Corning Tower, Empire State Plaza  
Albany, NY 12237  
518 473-7016 (Phone)  
518 486-4824 (Fax)

## Sus Derechos como Padres en el Programa de Intervención Temprana

El Programa de Intervención Temprana de la Ciudad de Nueva York (EI) reconoce que la familia es una parte esencial del equipo de intervención temprana. Mientras el programa tratará de hacer todo lo posible para satisfacer las necesidades de su familia y su hijo(a), usted pueda que tenga preocupaciones que sienta que no han sido resueltas. Su familia tiene derechos garantizados por el Acta de Educación de Individuos con Incapacidades (IDEA):

- Usted tiene el derecho de decir si o no a una evaluación o examen de su hijo(a)
- Usted tiene el derecho de escoger un evaluador y después que elegibilidad para el Programa sea establecido y un plan de servicios individualizado para su familia sea escrito, un coordinador de servicios
- Usted tiene el derecho de decir si o no, a cualquier tipo de servicio de intervención temprana sin arriesgar su derecho a otros tipos de servicios
- Usted tiene el derecho de examinar y modificar el registro escrito de su hijo(a) bajo el Programa de Intervención Temprana
- Usted tiene el derecho de mantener privada la información de su familia
- Usted tiene el derecho de ser informado de cualquier cambio posible en la evaluación u otros servicios de intervención temprana, antes de que se hagan los cambios.
- Usted tiene el derecho de participar y pedir a otros que participen en todas las reuniones donde se tomen decisiones acerca de los cambios en la evaluación o servicios de su hijo(a)
- Usted tiene el derecho de recibir una explicación de cómo se utilizará su seguro para pagar por los servicios de intervención temprana
- Usted tiene el derecho de usar el proceso debido para resolver quejas (apelación) a través de mediación, audiencia imparcial o quejas sobre el sistema (citados abajo)
- Usted tiene el derecho de apelar si su hijo(a) no es encontrado elegible para recibir servicios de intervención temprana

Si algo le preocupa o esta en desacuerdo con una decisión, hay varias entidades con quien puede hablar.

- **Primero, discuta su preocupación o de lo que esta en desacuerdo 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 (347) 396-6828.**

**Apelaciones** – Si todavía tiene preocupaciones o aun esta en desacuerdo con una decisión tomada, puede apelar la decisión mediante pedir:

- **Mediación** – Una forma de discutir sus preocupaciones y llegar a un acuerdo con un mediador y el Programa de Intervención Temprana. Su coordinador de servicios puede ayudarle a pedir mediación, o usted puede mandar una carta a la dirección alistada abajo.
- **Audiencia Imparcial** – Esta es otra forma de resolver desacuerdos. Es más formal y es llevado a cabo por un funcionario de audiencias quien es juez de ley administrativa (ALJ), asignado por el Departamento de Salud del Estado de Nueva York. Estos funcionarios toma la decisión final sobre la queja presentada. Usted puede mandar una carta a la dirección alistada abajo.
- **Quejas sobre el Sistema** – Esta es una forma de pedir que el Departamento de Salud del Estado de Nueva York investigue como el Programa de Intervención Temprana esta trabajando. Si usted cree que el oficial de Intervención Temprana, su proveedor de servicios, o su coordinador de servicios no esa haciendo su trabajo bajo la ley (IDEA), usted puede escribir a la dirección siguiente:

### **Mediación Request**

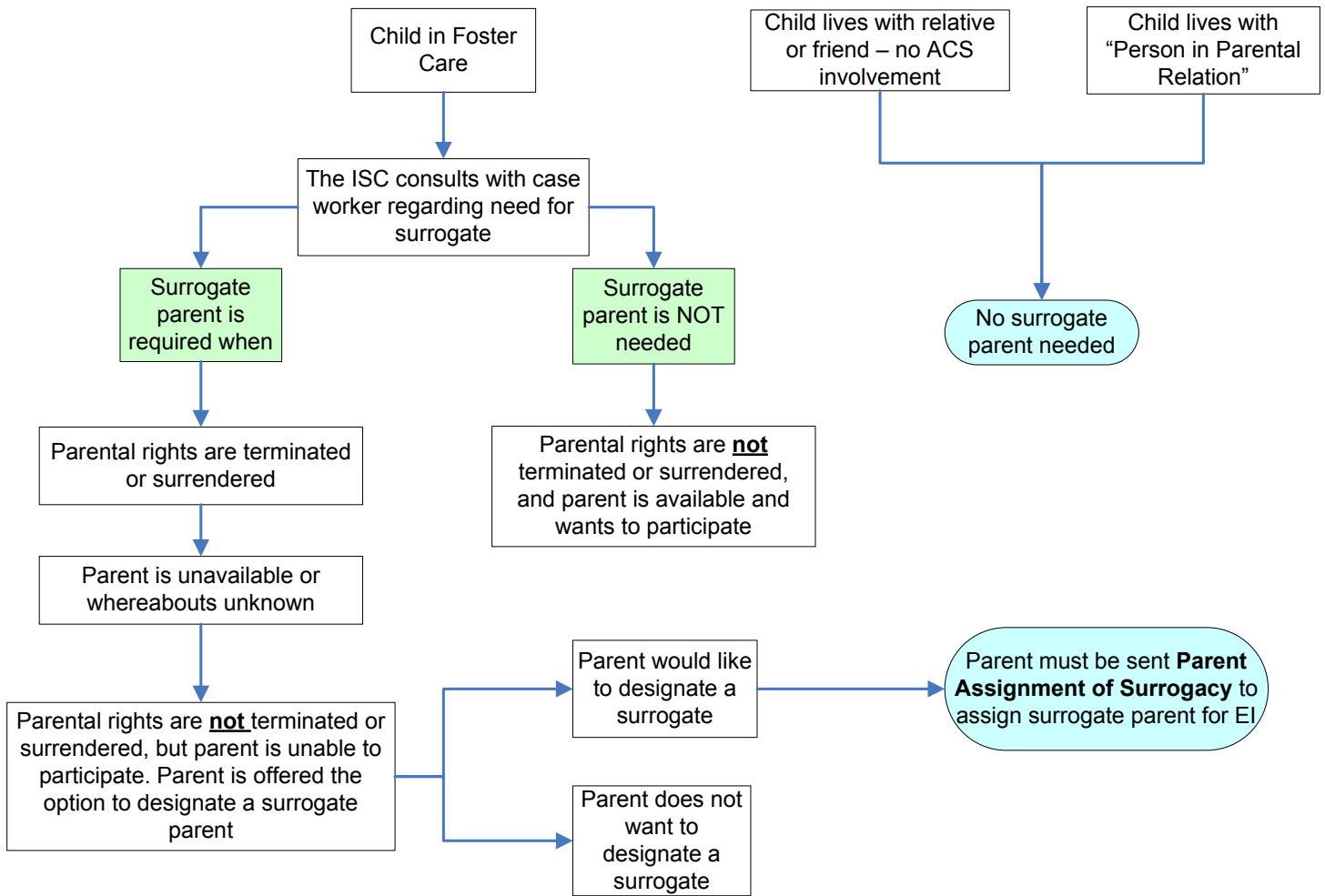
Director of Consumer Affairs  
NYC Early Intervention Program  
Gotham Center #12, 42-09 28th St., 18th Floor  
Queens, NY 11101  
347 396-6828 (Tel)  
347 396-6982 (Fax)

### **Impartial Hearing or Systems Complaint**

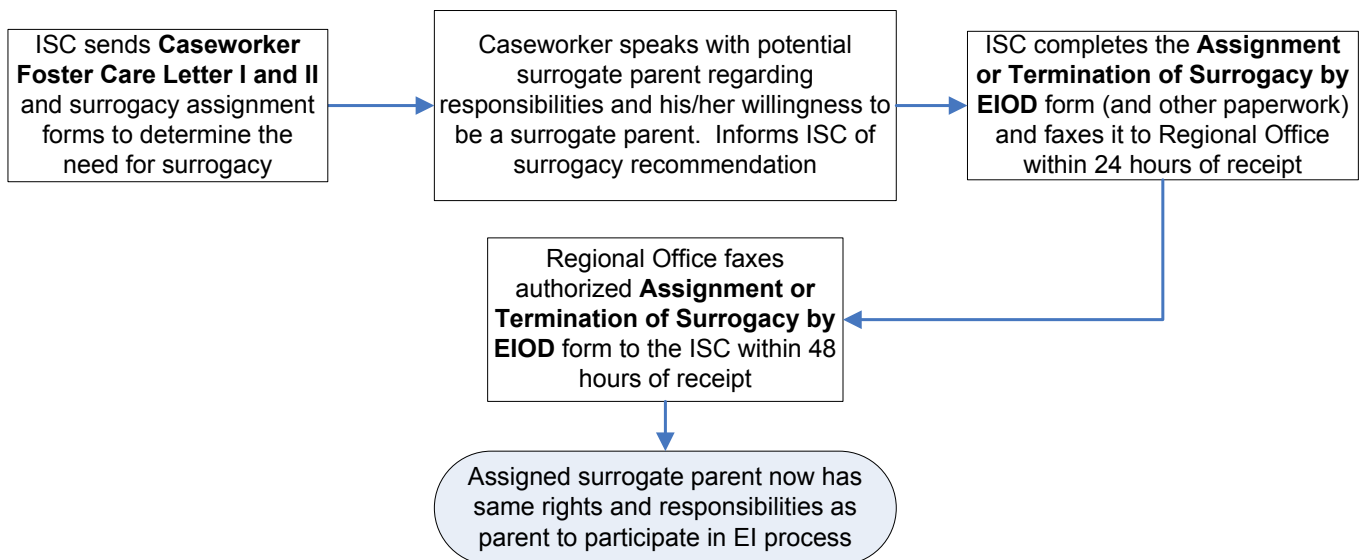
NYS Department of Health  
Bureau of Early Intervention  
Corning Tower, Empire State Plaza  
Albany, NY 12237  
518 473-7016 (Tel)  
518 486-4824 (Fax)

# 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

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

### 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:

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



- 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.

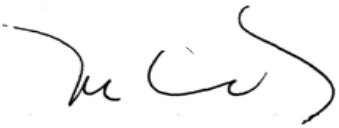
- b. For children **in foster care**, the steps described below should be followed in a timely manner.
- i. All steps must be thoroughly documented on the **Steps Taken to Determine Need for Surrogate Parent for Children in Foster Care Form**.

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

	<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"><li>a. If the parent would like to participate in EIP:<ol style="list-style-type: none"><li>i. Discusses the parent's role in the EI process.</li></ol></li><li>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"><li>i. Completes the <b>Surrogate Parent Designation by Parent Form</b> with the name provided by the parent (or by the caseworker on behalf of the parent); and</li><li>ii. Sends the form to the caseworker to complete with the parent; or</li><li>iii. Sends the <b>Surrogate Parent Designation by Parent Form</b> 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.</li></ol></li><li>c. If the parent notifies the caseworker that s/he objects to the child's participation in EI:<ol style="list-style-type: none"><li>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"><li>• Notifies the FCC that the parent continues to object or if the ISC was unable to reach the parent;</li><li>• Closes the Case (see Closure Policy).</li></ul></li></ol></li></ol>
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Approved By:   
Assistant Commissioner, Early Intervention

Date: \_\_\_\_\_ 4/28/2010 \_\_\_\_\_

## New York City Early Intervention Program

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

### 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:

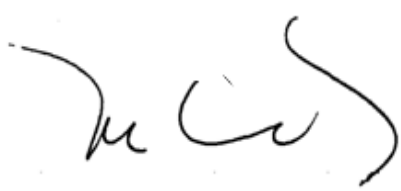
- screening, evaluation, and assessment of the child;
- development and implementation of the IFSP, including **six (6) month** and annual

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

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



Approved By:  
Assistant Commissioner, Early Intervention

Date: 4/28/2010

## New York City Early Intervention Program

<b>Policy Title: Foster Care Information in Child Records</b>	<b>Effective Date: July 1, 2010</b>
<b>Policy Number/Attachment: 2-C</b>	<b>Supersedes: N/A</b>
<b>Department/Unit: Bureau of Early Intervention</b>	<b>Regulation/Citation:</b> 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:

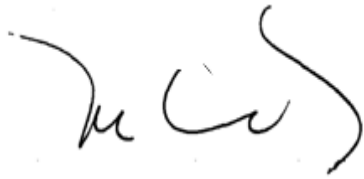
<b>Responsible Party</b>	<b>Action</b>
<b>Service Coordinators/ Regional Office Staff</b>	<p><u>Foster Care Information Maintenance</u></p> <ol style="list-style-type: none"> <li>1. Foster home contact information is maintained in EI files,               <ol style="list-style-type: none"> <li>a. Names, 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"> <li>i. <b>Referral form</b>;</li> <li>ii. All consent forms;</li> <li>iii. Initial, Review and Annual Individualized Family Service Plan (IFSP); and</li> <li>iv. The <b>Family Information Form</b> in the “Child Lives With” section.</li> </ol> </li> </ol> </li> <li>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"> <li>a. Agency name, address, telephone and fax numbers; and</li> <li>b. Caseworker name and telephone number.</li> </ol> </li> </ol>

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



## 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

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

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**

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

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**

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

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

<b>Policy Title: Initial Service Coordinator Responsibilities (Pre-NYEIS)</b>	<b>Effective Date: 10/12/10 - NYEIS Implementation</b>
<b>Policy Number: 3-A</b>	<b>Supersedes: N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>Consent to Initial Service Coordination Form</b></li> <li>• <b>Surrogate Parent Assignment by EIOD Form (if applicable)</b></li> <li>• <b>Consent to Release/Obtain Information Form</b></li> <li>• <b>Family Information Form</b></li> <li>• <b>Insurance Information Form</b></li> <li>• <b>Parent Refusal to Provide Insurance Information Form (if applicable)</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> <li>• <b>Reason for Delay in Evaluation Completion/MDE Submission Form (if applicable)</b></li> <li>• <b>Family Concerns, Priorities, and Resources Form</b></li> </ul>	<b>Regulation/Citation: NYCRR 69-4.7(a) (b)</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:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator (ISC)</b>	<ol style="list-style-type: none"> <li>1. Receives the <b>Referral</b> and <b>Fax Confirmation of Initial Service Coordinator and Important Dates Forms</b> from the Regional Office (RO);</li> <li>2. Contacts the parent/caregiver within <b>two (2) days of referral to the Early Intervention Program</b> in order to set up an appointment at a time and place convenient to the parent within <b>seven (7) calendar days</b> from referral.</li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p><b><u>Initial Meeting with the Parent(s)/Caregivers:</u></b></p>

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):
  - a. Provide a copy of **Your Family 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](http://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. Ensure that the **Parent Refusal to Provide Insurance Information Form** is completed when necessary.
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 **Social Security Documentation 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 **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. **Assignment or Termination of Surrogacy 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 in 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 EI/OD.
  - i. Assist the family in identifying their concerns, priorities, and resources by completing the **Family Concerns, Priorities and Resources (CPR) Form**.
  - ii. The **CPR Form** is brought to the IFSP meeting by the ISC to guide the development of IFSP outcomes and strategies.

**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: 11/8/10



## New York City Early Intervention Program

<b>Policy Title: Initial Service Coordinator Responsibilities- (Post NYEIS)</b>	<b>Effective Date: For All New Referrals Starting Staten Island: 7/12/2011 Bronx: 7/26/2011 Manhattan: 8/9/2011 Queens: 8/23/2011 Brooklyn: 9/7/2011</b>
<b>Policy Number: 3-A.1</b>	<b>Supersedes: N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>Consent to Initial Service Coordination Form</b></li> <li>• <b>Surrogate Parent Assignment by EIOD Form</b> (if applicable)</li> <li>• <b>Consent to Release/Obtain Information Form</b></li> <li>• <b>Family Information Form</b> (eliminated by NYEIS)</li> <li>• <b>Insurance Information Form</b> (eliminated by NYEIS)</li> <li>• <b>Information and Parental Consent for Use of Insurance to Cover Early Intervention Services (NEW)</b></li> <li>• <b>Parent Refusal to Provide Insurance Information Form</b> (if applicable)</li> <li>• <b>“Your Rights in Early Intervention”</b></li> <li>• <b>Reason for Delay in Evaluation Completion/MDE Submission Form</b> (if applicable)</li> <li>• <b>Family Concerns, Priorities, and Resources Form</b></li> </ul>	<b>Regulation/Citation: NYCRR 69-4.7(a) (b)</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).

**Note:**

- Instruction for navigating NYEIS are denoted in *italics* in the body of this Policy

### II. PROCEDURE:

Responsible Party	Action
<b>Initial Service Coordinator (ISC)</b>	<ol style="list-style-type: none"> <li>1. <i>Check NYEIS for new assigned cases every business day by clicking on the My Cases Menu Button – Click to select the “Case Reference” for the case you wish to work on.</i> <ol style="list-style-type: none"> <li>a. <i>Selecting the “Case Reference” will navigate to the “Integrated Case Home Page”</i> <ul style="list-style-type: none"> <li>• <i>Note the referral date (displayed as the “Child’s Integrated</i></li> </ul> </li> </ol> </li> </ol>

Case Start Date”)

- NYEIS automatically tracks the 45-day clock.
  - The end date of ISC service authorization is pre-calculated as the 45<sup>th</sup> day
- ii. Click on the “Case Reference” under the service coordination service authorizations section to see:
- ISC units authorized under the “Service Details Section”

Note: The **Assignment of Initial Service Coordinator and Important Dates Form** is eliminated by NYEIS

2. Contact the parent/caregiver within **two (2) days of the child’s referral to the Early Intervention Program** in order to set up an appointment at a time and place convenient to the parent. The appointment must take place within **seven (7) calendar days** from referral.

**Note:**

- In all contacts with the family, emphasizes 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.

**Initial Meeting with the Parent(s)/Caregiver(s):**

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):
  - a. Provides a copy of **Your Rights in Early Intervention**;
  - b. Informs parents of their rights and responsibilities in the EIP:
    - i. Explains 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](http://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. Completes the “Insurance Coverage” screen in NYEIS
    - i. Click on “My Cases” from the Menu Bar
    - ii. Select “Primary Client” in the case list
    - iii. Select “Insurance Coverage” from the navigation page

- iv. *Select any of the following insurance actions:*
  - *Enter new commercial insurance*
  - *Enter new Medicaid coverage, or*
  - *check Medicaid eligibility.*
- v. *When completing the “Commercial Coverage” screen, find the parent’s insurance provider by following the following steps:*
  - *Enter the wildcard “%” into the “Insurance Provider” field to obtain a complete list of insurers.*
  - *Select the correct insurer.*
  - *Click on the magnifying glass to select the correct address for the selected insurer.*
  - *Enter the Insurance Sequence Number to indicate whether this insurance should be billed first or*
    - *Commercial Insurance must be billed before Medicaid and therefore would be first.*

Note: **The Insurance Information Form** should only be used if the Insurance Provider Name cannot be found on the Insurance Provider search screen

- b. Ensure that the **Information and Parental Consent for Use of Insurance to Cover Early Intervention Services** or **Parent Refusal to Provide Insurance Information Form** is completed when necessary.
- 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 following fields in NYEIS to capture family information*
  - a. *From the Menu Bar – Click on “My Cases”*
  - b. *Select “Primary Client” in the case list*
  - c. *From the Child Homepage select “edit” and complete the fields in the following categories:*
    - i. *Child’s Information*
    - ii. *Family Information*
    - iii. *Insurance Information*
      - *Check this field ONLY when the refusal to provide insurance information form is attached to the child’s Integrated Case*
    - iv. *Primary Care Physician*
    - v. *Child’s Place of Birth*
    - vi. *Foster Care*
    - vii. *Click on “save” once information is complete*
  - d. *If the parent has a communication exception where one method of communication cannot be used, ensure it is documented by:*
    - i. *Selecting “Communication Exceptions” from the Child Homepage*
      - *Select “new”*
      - *Complete all the mandatory fields marked with an asterisk (\*)*

Note: The **Family Information Form** is eliminated by NYEIS.

- 9. If the child does not have health insurance, contact the DOHMH Office of Health 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. Attaches the following documents to the Child's Integrated Case in NYEIS
  - 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. **Information and Parental Consent for Use of Insurance to Cover Early Intervention Services or the Parent Refusal to Provide Insurance Information Form** ; and
  - e. **Reason for Delay in Evaluation Completion Form** (if applicable).
  - f. *Attach the documents in NYEIS by:*
    - i. *From the Inbox Menu Button – Click on “My Cases”*
    - ii. *Select the “Case Reference” will navigate to the “Integrated Case Home Page”*
    - iii. *Select “Attachments” and Select “New”*
    - iv. *On the Create Attachment screen:*
      - *Browse for the file to attach.*
        - *File size cannot be more the 1.5MB*
      - *Complete the fields under “File Details”*
      - *DO NOT enter any information in the location and Reference fields*
      - *Select the Document type*
        - *Document type for all documents above is “signature”*
      - *Receipt date must be the date that the attachment is made*
      - *Complete the Attachment Description field by listing the name of the form being attached*
      - *Click “Save” or “Save and New” to add additional*

*attachments*

3. Send the following documentation to the Evaluation Agency(ies):
  - a. **Consent to Release/Obtain Information Form**;
  - b. **Reason for Delay in Evaluation Completion Form** (if applicable).
4. 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 parent and the EIOD will make the final decisions about the services;
    - vii. Remind the parent/caregiver that their participation in the EIP is voluntary;
    - viii. Review the IFSP Screens in NYEIS 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 coordinator and the EIOD.
    - i. Assist the family in identifying their concerns, priorities, and resources by completing the **Family Concerns, Priorities and Resources (CPR) Form**.
    - ii. The **CPR Form** is attached to the Draft IFSP in NYEIS by the ISC to guide the development of IFSP outcomes and strategies.
      - Refer to the **Initial IFSP Policy** for details.

**Note:**

- Ensure that the Evaluation Site forwards the results of the evaluation to the parent(s).
- Ensure that Evaluation Agency completes and submits the MDE packet in NYEIS **within thirty (30) days of the referral to the EIP.**

4. 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. Calls the Service Provider agency(ies) to ensure that the following attachments are reviewed in NYEIS once the Service Provider agency(ies) located and assigned in NYEIS:
    - i. **Consent to Obtain/Release Information Form:**
      - *Attached to the IFSP in NYEIS*
        - *From the Inbox Menu Button – Click on “My Cases”*
        - *Select the “Case Reference” will navigate to the “Integrated Case Home Page”*
        - *Select the “Case Reference” for the IFSP which will take to the “IFSP Home Page”*
        - *Select Attachments*
        - *Click “View” to access the necessary attachment*
    - ii. **The evaluation packet:**
      - *Attached to the MDE attachment in NYEIS*
        - *From the Inbox Menu Button – Click on “My Cases”*
        - *Select the “Case Reference, which will navigate to the “Integrated Case Home Page”*
        - *Select “Child's Completed Evaluations” from the Navigation bar*
        - *Select “view” the accepted evaluation*
        - *Select “MDE Attachments”*
        - *Click “view” to access the necessary attachment*
    - iii. **The IFSP:**
      - *From the Menu Bar – Click on “My Cases”*
      - *Select the “Case Reference” will take you to “Integrated Case Home Page”*
      - *Select the “Case Reference” for the IFSP, which will take you to the “IFSP Home Page”*
      - *Scroll to the bottom of the “IFSP Home Page” and select each service authorization to access details.*
2. If the ISC was not named as the OSC:
  - a. Calls the OSC chosen by the parent(s) at the IFSP meeting to make sure he/she views the documents in NYEIS.

**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.

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

**Approved By:**  
**Assistant Commissioner, Early Intervention**

**Date: 6/29/11**

**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.

~~After~~ NYEIS implementation, this form is attached to the child's "Integrated Case Home Page". Refer to the ISC [Responsibilities Policy - Post NYEIS](#)

**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.



## INSTRUCTIONS FOR COMPLETION FAMILY INFORMATION FORM

The Initial Service Coordinator (ISC) must:

- Complete the **Family Information** form prior to the Initial IFSP.
- 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](http://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.

## Information and Parental Consent for Use of Private Insurance to Cover Early Intervention Services

When a child's parent has insurance that is subject to the New York State Insurance Law it is a required payment source for services provided under the Early Intervention Program. Private health insurance is used to help pay for early intervention services for children like yours who can be helped by these important services.

Under NYS Public Health Law and regulations:

1. Your Early Intervention Official (EIO) must collect information and documentation about your child's insurance coverage, including Medicaid and other government payers. Your service coordinator will collect this information and give it to your EIO. This information includes: the type of insurance policy or health benefits plan, the name of the insurer or plan administrator, the policy or plan identification number, the type of coverage in the policy and any other information needed to bill your insurance. Your service coordinator will explain your rights and responsibilities, and the protections that the law provides for families.
2. Your EIO must collect your social security number and your child's social security number.

**The early intervention services your child needs will be provided at no cost to your family.** You will not be required to pay any out-of-pocket costs, such as deductibles or co-payments, for services your child and family receive in the Early Intervention Program. In addition, New York State Insurance Law prohibits insurers from charging any benefits paid for early intervention services against any maximum annual or lifetime policy limits ("caps"). This means that any payment made by your insurance company for early intervention services will not decrease your family's total insurance coverage.

If the use of your private insurance would result in any cost to your family (such as if your employer is self-insured and not prohibited from applying early intervention payments against a policy cap), your insurance will not be billed without your informed consent. Incidental costs, such as the time needed to file an insurance claim or the postage needed to mail the claim, are not considered a cost to your family.

Your insurance will be billed unless you provide documentation that it is not subject to NYS Insurance Law.

If your insurance is NOT subject to Insurance Law you can choose to sign a special consent form to allow NYC EIP to bill your insurance anyway.

**The early intervention services available to your child and family will not be limited to what is covered by your insurance.** Your Early Intervention Official has to make sure that appropriate early intervention services are provided to your child, even if you have no insurance.

**ACKNOWLEDGEMENT OF NEW YORK CITY EI PROGRAM INTENT TO EXERCISE  
SUBROGATION RIGHTS**

I understand that the New York City Early Intervention Program intends to seek payment from third party payors covered by the New York State Insurance Law.

\_\_\_ 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.

\_\_\_ I understand that the New York City Early Intervention Program has the right to access my insurance information if my plan is subject to NYS insurance law

\_\_\_ My insurance is not covered by NYS law, but I give permission to the New York City Early Intervention Program 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.

\_\_\_\_\_  
*Policyholder Signature*

\_\_\_\_\_  
*Date*

**Information and Parental Consent for Use of Private Insurance to Cover Early  
Intervention Services**

**Instructions for Completion**

The Service Coordinator must review the information in this document when the child first enters the Early Intervention Program, and whenever the parent has questions about the use of insurance in the Early Intervention Program.

This form should also be used if the parent informs the Service Coordinator that there has been a change in their insurance company/policy that has changed their insurance status either making it subject or not subject to NYS Insurance Law.

If the parent refuses to provide the NYC Early Intervention Program with their insurance information, and they cannot provide evidence that their plan is NOT subject to NYS Insurance Law, they must complete the **Notice of Parent Refusal To Provide Insurance Information**. In this situation the parent must be informed that the NYC Early Intervention Program will attempt to access their insurance information as required by NYS laws and regulations.

If the parent has insurance that is not governed by NYS Insurance Law, they may give permission for the Early Intervention Program to access their insurance by signing this form.



**NYC EARLY INTERVENTION PROGRAM  
INSURANCE INFORMATION**

*Complete this form in its entirety and attached with and a copy of the insurance card(s) to the child's "Integrated Case Home Page" in the New York Early Intervention System (NYEIS). **This form should only be used when the insurance plan is not listed in the "Insurance Coverage Screen" in (NYEIS), or when the child is not in NYEIS.***

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: \_\_\_\_\_ Phon \_\_\_\_\_ e: ( \_\_\_\_\_ ) \_\_\_\_\_

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): \_\_\_\_ 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: \_\_\_\_\_ Ph \_\_\_\_\_ one: (\_\_\_\_\_) \_\_\_\_\_

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 to the extent that such payors are covered by NYS Insurance Law.

\_\_\_\_ 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.

\_\_\_\_ I was informed that the New York City Early Intervention Program will access my insurance if subject to NYS insurance law.

\_\_\_\_ I have provided the New York City Early Intervention Program with documentation that my insurance is not covered by NYS Insurance Law.

\_\_\_\_\_  
*Policyholder Signature*                      *Date*

FOR EIP OFFICE USE ONLY *EIP Data Entry*: \_\_\_\_\_ *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. This form should be used only when the insurance plan is **not** listed in the Insurance coverage screen in NYEIS

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.*"

Families must also be informed that the Early Intervention Official (EIO) must collect information and documentation about their child's insurance coverage, including Medicaid and other government payers.

### 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 policy holder 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 L    / / / / / / / /  
Letter N    umber    Number    Number Nu    mber Nu    mber Let    ter

**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

## NOTICE OF PARENT REFUSAL TO PROVIDE INSURANCE INFORMATION

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

1. 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.
2. The parent has not provided evidence that the insurance policy under which their child is covered is not governed under New York State laws and regulations.
3. The parent has been informed that the NYC Department of Health and Mental Hygiene has the right to access insurance information if the plan is subject to NYS Insurance Law.

Parent's Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Borough: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Home Phone: (    ) \_\_\_\_\_ Alternate Phone: (    ) \_\_\_\_\_

The parent 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 Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Initial/Ongoing Service Coordinator Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*EIOD Signature*

\_\_\_\_\_  
*Date*



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

Marie B. Casalino, MD, MPH  
Assistant Commissioner

NYC DOHMH  
Bureau of Early Intervention  
2 Gotham Center, CN 12  
42-09 28<sup>th</sup> St, 18<sup>th</sup> Floor  
Queens, NY 11101-4132

347 396-6828 tel  
347 396-6982 fax

## **FREQUENTLY ASKED QUESTIONS** **USE OF PRIVATE HEALTH INSURANCE IN EARLY INTERVENTION**

### **Why is my insurance being used? I was advised that Early Intervention is a free service.**

- Early Intervention services are at no cost to parents. Using private insurance to pay for services is required under the Early Intervention Program if such insurance is available and covered by NYS Insurance Law. Billing private insurance for your child's Early Intervention services is a normal part of helping to support the program. Parents are not required to pay co-pays or any other costs.
- Your insurance will be billed unless you provide documentation that it is not subject to NYS Insurance Law

### **Why am I receiving bills from my insurance company?**

- The forms you are receiving are not bills but Explanation of Benefit Statements (EOBs). When New York City submits a claim to your insurance company, the company is required to notify you.

### **The statement mentions that I am responsible for certain costs. Is that true?**

- New York City will pay any deductible or co-payment that your insurance imposes for Early Intervention services. In addition, you will not be required to pay any claims that are denied by your health insurance carrier due to lack of coverage, use of an out-of-network service provider, etc. **Parents are not responsible for any costs related to their child's services.**
- When you get a statement or EOB from your insurance company, remember that you are not responsible for any deductions or co-pays. The statements you receive are for your records. The forms you are receiving are not bills but Explanation of Benefit Statements (EOB). As the policy holder, you are notified of any claims being submitted to access your insurance **and should retain these documents for your records.**
- When New York City submits a claim to your insurance company, the company is required to notify you.

### **Will this affect any services that my family receives outside of Early Intervention that is claimed to my insurance company?**

- Under the New York State Insurance Law, payment for Early Intervention services **cannot** be applied to the lifetime

or annual monetary caps on the child/family's insurance policy. Use of third party insurance payment for Early Intervention services will not be applied against the lifetime or annual monetary limits specified in your insurance policy and will not reduce the number of visits otherwise available under the policy.

Please note that the New York City Early Intervention Program will bill only those insurance plans that are covered by New York State Insurance Law, unless you specifically consent to billing a non-covered insurance plan.

**My insurance company sent me a check. What should I do with it?**

- If your insurance company sends you a check, endorse it and send it to the Early Intervention Program to help pay for your child's services.

Send the check and EOB to the attention of:

Assunta Rozza  
Assistant Commissioner, Bureau of Finance and Revenues  
NYC Department of Health and Mental Hygiene  
Gotham Center, CN# 15-86  
42-09 28th Street  
Queens, New York 11101-4132

**DO NOT CASH OR DEPOSIT THE CHECK.**

**Whom can I contact if I have questions regarding use of my private health insurance coverage?**

There are many sources of information about the use of private health insurance in the Early Intervention Program. They include:

- ❖ The NYS Department of Health, Bureau of Early Intervention website:  
[http://www.health.state.ny.us/community/infants\\_children/early\\_intervention/memo03-2.htm#\\_toc42408102](http://www.health.state.ny.us/community/infants_children/early_intervention/memo03-2.htm#_toc42408102)
- ❖ NYC Call Center (311)
- ❖ Your Service Coordinator
- ❖ The NYC Department of Health and Mental Hygiene, Office of Early Intervention Consumer Affairs – Beverly Samuels (347) 396-6828



## FAMILY CONCERNS, PRIORITIES, & RESOURCES

Discuss the sections below after the child's eligibility has been established at the contact before the IFSP meeting.

<i>Family's Routine Activities</i> <i>(What is the activity?)<sup>1</sup></i>	<i>Currently Looks like</i> <i>(What happens during the activity?)</i>	<i>Would Like to Look Like<sup>2</sup></i> <i>(Learning Opportunities)</i>	<i>Family Priority<sup>2</sup></i> <i>(Why is it important?)</i>

Family's Strengths/Resources available to meet priorities:  Characteristics     Knowledge    Time    Strategies    Social Supports    Community Connections  
 Material Resources    Formal Supports    Other

Specify how their Strengths/ Resources will help:

Resources Needed help the family meet their priorities:  Information    Time    Strategies    Social Supports    Community Connections    Material Resources  
 Formal Supports    Other

Specify what: the family will need:

<sup>1</sup> IFSP page 3, #1  
<sup>2</sup> IFSP page 3, #2

## FAMILY CONCERNS, PRIORITIES, & RESOURCES INSTRUCTIONS FOR COMPLETION

**Purpose:** The service coordinator is responsible for assisting the family in identifying their concerns, priorities, and resources in order to guide the development of the IFSP. Complete this form after the MDE is completed and eligibility is established. **DO NOT COMPLETE THIS FORM** if eligibility has not been established.

- The attached Routine Activities Worksheet can guide your discussion.

1. **Family's Routine Activities:** Routine activities are what the child does during his/her day. Routine activities are individualized to each family, and identified by the family. Routine activities *might* include, but are not limited to, the Routine Activities specified on the Routine Activities Worksheet (feel free to use the family's own words). For children in child care (ex: day care), routine activities are what the child does during child care, as well as activities at home and in the community.
  - a. Ask the family to identify routine activities that are:
    - i. Enjoyable for the family/caregiver and child. These times are prime opportunities for learning as the child is already interested and engaged.
    - ii. Difficult for the family/caregiver or child. These times are important to make easier for families by supporting the child's development within them.
    - iii. New. These activities have not yet been tried by the family, but they are interested in attempting with the child.
  - b. Gather this information by asking questions like:
    - What are times of the day that are enjoyable for you and your child? What's your child's favorite time of the day?
    - What are times of the day that are hard for you and your child? What are your child's least favorite times of the day?
    - What else does your child do during the day?
    - What activities would you like to do with your child, but have not been able to yet?
    - You said you came to early intervention because you were worried about.... When are times during the day when your child needs to be able to...? (see response to "What brought you to Early Intervention?" to individualize question)

*NOTE: Families do not need to identify **all** the activities of the day; just those they feel are important to share. These activities can be documented in the sample attached Routine Activities Worksheet.*
  - c. Ask the family to identify which routine activities they might want to focus on in early intervention – times when they think (1) intervention support could be helpful and (2) the family has the time and can focus on the intervention both when the teacher/therapist is present, and when s/he is not. Document those identified in Noted Routine Activities.
2. **Currently Looks Like:** Family concerns and priorities emerge from a conversation around the identified routine activities. Gather this information by asking questions about what the activity *Currently Looks Like* **to understand what interventionists need to build on**. Ask questions like:
  - What does your child do now during the routine activity?
  - What is happening now?  
What are you (or other adults) doing?
3. **Would like to look like:** This question identifies how the activity could look different - what the family would like the child to be able to do. **This may become the behavioral part of an Outcome at the IFSP**. Ask questions like:

- What can your child learn during these times? [Consider prompting with, “Based on why you came to early intervention...”]
- What would you like to be happening instead?
- What would you like your child to be able to do then? What would that look like?

4. **Family Priority:** Why the learning opportunity is important to the family. For any learning opportunities identified (i.e., *Would like to look like*), ask the family to identify *why* it’s important to *them* that the child learn the outcome behavior.

*Note: During this conversation, families might change their mind regarding which routine activities to focus early intervention supports.*

5. **Strengths/Resources Available to meet priorities, and Needed to meet priorities:**

- Help the family identify the strengths and resources the family **already has available** that enhance their capacity to meet their priorities and concerns that are important to note for use in designing the intervention plan.
- Help the family identify the additional resources **needed** by the family to further meet those concerns and priorities.

These resources can be:

- Characteristics: Features internal to family members, (e.g., good at problem solving, communicating with others, or soothing the child)
- Knowledge/Information: Understanding the child, the child’s learning characteristics, the child’s diagnosis, how early intervention works, what other supports are available
- Time: To focus on supporting the child’s learning and development
- Strategies: To promote their child’s learning and development
- Social Supports: Family and friends
- Community Connections: Either community activities the family already participates in, or would like to participate in for the child to learn (e.g., library story time or a specific time parents gather in the park), or community resources for the family (e.g., parents with similar interests getting together)
- Material Resources: Including financial or objects/equipment
- Formal Supports: Agencies or programs designed to provide a specific service

- Check off any resource types discussed as available or needed. The same resource type can be checked as both available and needed.
- Describe the specific resources within the resource types checked off. Describe how the resources help/could help the family meet their priorities related to enhancing their child’s development.

## ROUTINE ACTIVITIES WORKSHEET

Routine Activities (RAs)	Specify Activity/ies	Is the Activity
1. Eating meals/snacks		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
2. Hanging out		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
3. Playing with others		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
4. Playing with objects		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
5. Playing outside		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
6. Engaging in nurturing, comforting		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
7. Dressing/Undressing/Diapering		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
8. Reading books		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
9. Going for a walk		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
10. Playing in community activities		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
11. Running errands		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
12. Participating in family outings		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
13. Transitioning between activities		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
14. Leaving the house		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
15. Getting ready for bed/Going to bed		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
16. Taking a bath		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
17. Completing morning routine		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
18. Doing chores		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
19. Traveling around in community		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
20. Competing disability needs*		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
21. Other:		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
22. Other:		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
23. Other:		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
24. Other:		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New
25. Other:		<input type="checkbox"/> Enjoyable <input type="checkbox"/> Difficult <input type="checkbox"/> New

\* Caretaking routines that are a result of the child's disability.

## New York City Early Intervention Program

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

### 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:

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

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

Approved By:   
Assistant Commissioner, Early Intervention

Date: 11/10/10



**NYC EARLY INTERVENTION PROGRAM  
(PRE-NYEIS) 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.

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**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.

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**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

<b>Policy Title:</b> <b>Choice of Evaluation Site (Post-NYEIS)</b>	<b>Effective Date:</b> <b>For All New Referrals Starting</b> <b>Staten Island: 7/12/2011</b> <b>Bronx: 7/26/2011</b> <b>Manhattan: 8/9/2011</b> <b>Queens: 8/23/2011</b> <b>Brooklyn: 9/7/2011</b>
<b>Policy Number: 3-B.1</b>	<b>Supersedes: N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>- <b>Active Providers: Language and Specialties List</b></li> <li>- <b>Reason for Delay in Evaluation Completion (Revised)</b></li> </ul>	<b>Regulation/Citation:</b> <b>10NYCRR69-4.1 (j);</b> <b>10NYCRR69-4.1 (k);</b> <b>10NYCRR69-4.1 (l).</b>

### 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.”

**Note:**

- Instruction for navigating NYEIS are denoted in *italics* in the body of this Policy

### II. PROCEDURE:

Responsible Party	Action
<b>Initial Service Coordinator (ISC)</b>	<ol style="list-style-type: none"> <li>1. Review the <b>Active Evaluation Providers: Language and Specialties List</b> with the parents, and assist them in selecting an Evaluation Agency:               <ol style="list-style-type: none"> <li>a. Service Coordinators (SC) must be familiar with specific information about each evaluator, including:                   <ol style="list-style-type: none"> <li>i. Available settings for evaluations (e.g. home vs. facility); and</li> <li>ii. Languages spoken:                       <ul style="list-style-type: none"> <li>• If upon review of the <b>Active Evaluation Providers:</b></li> </ul> </li> </ol> </li> </ol> </li> </ol>

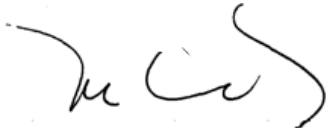
**Language and Specialties List**, an appropriate evaluation agency cannot be located, the ISC will inquire if the evaluation agency can find an interpreter;

- Refer to the **Bilingual Evaluations Policy**.
- iii. Types of evaluations performed;
  - iv. Expertise with special populations; and
  - 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).
2. Contact the Evaluation Agency to notify them that they have been selected as the evaluation site by the family.
  3. *Assign the Evaluation Agency in NYEIS*
    - a. *From the Inbox Menu Button – Click on “My Cases”*
    - b. *Select the “Case Reference” will navigate to the “Integrated Case Home Page”*
    - c. *Click on “Assign Evaluator for MDE” for the NYEIS navigation menu*
    - d. *Click New*
    - e. *Click on the magnifying glass to search for Evaluation Agency Name,*
    - f. *Enter Evaluation Agency Name or % (Wildcard), then Search,*
    - g. *Select an Evaluation Agency Name.*
    - h. *Enter Evaluation Due Date*
      - i. ***Due date must be 30 days from the referral to the Early Intervention Program (EIP)***
    - i. *Enter type of evaluation (initial or ongoing).*
    - j. *Save.*

**Note: Do not assign an Evaluation Agency in NYEIS before confirming the agency’s availability by phone.**

4. If a parent chooses an evaluator knowing that there is a waiting list for evaluations:
  - 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.
  - b. Document the family’s informed choice in the service coordination activity notes;
  - c. Complete the **Reason for Delay in Evaluation Completion Form**.
    - i. Obtain parent signature.
    - ii. Attach the form to the Child’s Integrated Case in NYEIS
      - Refer to the **ICS Responsibilities Policy** for a detailed walkthrough of attaching documents to the Child’s Integrated Case
5. If the parent has accessed an approved evaluator before being contacted by

	<p>the ISC:</p> <ol style="list-style-type: none"> <li>a. Contact the parent/caregiver to ensure that the parent has received information concerning other approved Evaluation Agencies; and</li> <li>b. Determine if the parent/caregiver needs assistance in the evaluation process.</li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• All of the above described activities must be clearly documented in the SC activity notes.</li> </ul>
<p><b>Evaluation Agency</b></p>	<ol style="list-style-type: none"> <li>1. <i>Accept MDE assignment in NYEIS</i> <ol style="list-style-type: none"> <li>a. <i>From the Inbox Menu Bar – Click on Work Queues</i></li> <li>b. <i>Select View: (Borough)_Evaluations work queue</i> <ol style="list-style-type: none"> <li>i. <i>Every action in NYEIS is assigned a Task ID #</i></li> </ol> </li> <li>c. <i>Select the Task ID of the case you wish to work on.</i></li> <li>d. <i>Under Primary Action, select: <b>Accept/Reject MDE</b></i></li> <li>e. <i>Click on <b>Accept</b>.</i></li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <i>If the Evaluation Agency selects “Reject MDE Assignment”, the case disappears form the Agency’s work queue and is automatically returned to the assigned EIOD</i></li> </ul> </li> <li>2. Notify parent and ISC if: <ol style="list-style-type: none"> <li>a. The evaluations cannot be completed within <b>thirty (30) days from the child’s referral</b> to the EIP.</li> <li>b. Explain the following to the parent: <ol style="list-style-type: none"> <li>i. The reason that evaluations will not be provided in a timely manner;</li> <li>ii. The right of the parent to choose another Evaluation Agency.</li> </ol> </li> <li>c. Enter the reason for delay in NYEIS: <ol style="list-style-type: none"> <li>i. From the Inbox Menu Bar – Click on Work Queues</li> <li>ii. Select View: (Borough)_Evaluations work queue</li> <li>iii. Every action in NYEIS is assigned a Task ID #</li> <li>iv. A task will appear titled “ Notice of Overdue Evaluation for (child name)” <ul style="list-style-type: none"> <li>• Select “View” and enter the reason for delay</li> </ul> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• The “Notice of Overdue Evaluation” will only be generated when the MDE has not been submitted within <b>thirty (30) days of referral</b>.</li> <li>• NYEIS will not allow the evaluator to submit an MDE if the “notice of overdue evaluation” is not resolved.</li> <li>• <b>Section II of the Reason for Delay in Evaluation Completion/ MDE Submission Form is eliminated by NYEIS.</b></li> </ul> </li> </ol>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 6/29/2011



**NYC EARLY INTERVENTION PROGRAM  
(POST-NYEIS) REASON FOR DELAY OF EVALUATION SUBMISSION FORM  
INSTRUCTIONS FOR COMPLETION**

***This form should only be completed if delays occur for any child in NYEIS***

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.

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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.

Complete this form 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.

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The Evaluation Provider Agency will document the reason for any delay in **completing or submitting the Multidisciplinary Evaluation (MDE)** in NYEIS.

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

## New York City Early Intervention Program

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

### I. POLICY DESCRIPTION:

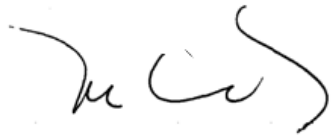
**Accurate Communications, Inc.** has been contracted by Department of Citywide Administrative Services to perform sign language interpretation for the Department of Health and Mental Hygiene. This is the only agency that the Department can reimburse for sign interpreting for the Early Intervention Program.

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:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator (ISC)</b>	<ol style="list-style-type: none"> <li>1. Contacts the Director of Consumer Affairs (DCA) or designee <b>no later than 48 hours</b> prior to IFSP meeting using the <b>Request for Sign Language Interpreter Form</b>:               <ol style="list-style-type: none"> <li>a. Requests only apply to <b>Initial</b> IFSP meetings.</li> </ol> </li> <li>2. Informs DCA at 347-396-6828 and Accurate Communications Inc. at 877-682-1333 if the IFSP meeting is cancelled for any reason:               <ol style="list-style-type: none"> <li>a. <b>Notifies the DCA of meeting cancellation by faxing the Request for Cancellation of Sign Language Interpreter Form no later than 48 hours</b> of scheduled meeting.</li> </ol> </li> </ol> <p><b>NOTE:</b></p> <ul style="list-style-type: none"> <li>• Initial Service Coordinators (ISCs) may not request a sign language interpreter directly from Accurate Communications, Inc.</li> </ul>
<b>Director of</b>	<ol style="list-style-type: none"> <li>1. Receives the completed <b>Request for Sign Language Interpreter Form</b>.</li> </ol>

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



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

<b>I. Individualized Family Service Plan (IFSP) Information</b>	
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:
<b>II. Child Information</b>	
Child's Name:	
EI ID Number:	DOB:
Name of Deaf Individual:	Relationship to child:
<b>III. Initial Service Coordinator (ISC) Information</b>	
ISC Name:	
ISC Agency:	
Telephone #:	Fax #:
<b>IV. Individual to be Contacted the Day of the IFSP Meeting</b>	
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 347-396-6828 AND Accurate Communications, Inc. at 877-682-1333.**

Fax this form to Beverly Samuels at 347-396-6982



## 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 347-396-6982. Please follow-up with a phone call to 347-396-6828 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  
Gotham Center, CN #12  
42-09 28th Street, 18th floor  
Queens, NY 11101-4132

347-396-6974 tel  
347-396-6982 fax

**TO:** \_\_\_\_\_, **Service Coordinator**

**AGENCY:**

**FAX:**

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

**PHONE:** **347-396-6828**

**TOTAL NUMBER OF PAGES (including cover): 3**

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**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 347-396-6828.

Interpreter's name:

- The Service Coordinator **MUST** fax the attached questionnaire **(Fax Confirmation of IFSP Meeting with Sign Language Interpreter)** to Beverly Samuels at 347-396-6982 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  
Gotham Center, CN #12  
42-09 28th Street, 18th floor  
Queens, NY 11101-4132

347-396-6974 tel  
347-396-6982 fax

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

**FAX:** 347-396-6982

**FROM:** \_\_\_\_\_, Initial Service Coordinator

**PHONE:**

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

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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:

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- 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: (347) 396-6828  
 Fax : (347) 396-6982  
 e-mail: bsamuel1@health.nyc.gov  
 Lori Gallo (347) 396-7049

**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:

## New York City Early Intervention Program

<b>Policy Title: Initial Service Coordinator Requests For Additional Units or Extension of Service Authorization (NYEIS Policy)</b>	<b>Effective Date:</b> <b>For All New Referrals Starting</b> <b>Staten Island: 7/12/2011</b> <b>Bronx: 7/26/2011</b> <b>Manhattan: 8/9/2011</b> <b>Queens: 8/23/2011</b> <b>Brooklyn: 9/7/2011</b>
<b>Policy Number:</b> <b>3-D</b>	<b>Supersedes:</b>
<b>Attachments: Regulation/Citation:</b>	

### I. POLICY DESCRIPTION:

Service Coordination (SC) units are approved by the Regional Office when a child first enters the Early Intervention Program and, at IFSP meetings. These units are based on the needs of the family and the amount of time a SC will need to assist the family throughout the authorization period. If it appears that the number of units authorized is not sufficient, the SC must submit a request for additional units prior to the end of the authorization period

**Please be advised that additional units can not be utilized without the formal approval of the EI/OD/Assistant Director.**

**Note:**

- Instruction for navigating NYEIS are denoted in *italics* in the body of this Policy

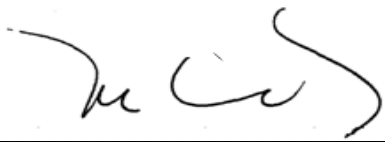
### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator</b>	<ol style="list-style-type: none"> <li>1. <i>Requests an extension of the authorization period for initial service coordination (ISC) in NYEIS when there is a delay in convening the IFSP meeting within 45 days of the date of referral:</i> <ol style="list-style-type: none"> <li>a. <i>From the Inbox Menu Bar – Click on “My Cases”</i></li> <li>b. <i>Select the “Case Reference” number for the case</i></li> <li>c. <i>The “Service Coordination Service Authorizations” section displays the Initial Service Coordination Service Authorization (SA)</i></li> <li>d. <i>Click the “Case Reference” link.</i></li> <li>e. <i>Under the Manage section, select “Extend”</i> <ol style="list-style-type: none"> <li>i. <i>Extending an SA adds 30 calendar days to the authorization period</i></li> </ol> </li> <li>f. <i>Select the appropriate reason under “Reason For Extension”</i></li> <li>g. <i>Select “Save”</i></li> </ol> </li> <li>2. Requests additional ISC units:</li> </ol>

- a. *Enter the request in NYEIS*
    - i. *From the Inbox Menu Bar – Click on “My Cases”*
    - ii. *Select the “Case Reference” number*
    - iii. *The “Service Coordination Service Authorizations” section displays the initial service coordination Service Authorization (SA)*
    - iv. *Click the “Case Reference” link.*
    - v. *Under the Manage section, select “Edit”*
    - vi. *On the “Amend Service Authorization” screen, under the amend details heading, select: “The Reason for Modification”*
    - vii. *Under the Service Details heading, modify the “Start” and/or “End” date, and/or the “Number of Units”.*
    - viii. *Click on “Submit”.*
    - ix. *“EIOD Review Required” will display as the SA status.*
  - b. *Complete a letter of justification on SC agency letterhead describing the reason for request of additional units. Justifications might include, but are not limited to:*
    - i. *Difficulty in determining surrogacy in Foster Care*
    - ii. *Family reasons*
  - c. *Attach the letter in NYEIS*
    - i. *From the Inbox Menu Bar – Click on “My Cases”*
    - ii. *Select the “Case Reference” number*
    - iii. *The “Service Coordination Service Authorizations” section displays the initial service coordination Service Authorization (SA) details*
    - iv. *Click the “Case Reference” link.*
    - v. *Select “Attachments”, then select “New”*
      - *On the Create Attachment screen:*
        - *Browse for the file to attach. File size cannot be more the 1.5MB*
      - *Complete the fields under “File Details”*
      - *DO NOT enter any information in the “Location” and “Reference” fields*
      - *Select the Document type*
        - *Document type for all documents above is “supporting documentation”*
      - *Receipt date must be the date that the attachment is made*
      - *Complete the Attachment Description field by listing the name of the document as “ Justification for increase in ISC units”*
      - *Click “Save”*
3. Requests must be submitted **no later than 1 week** prior to the end of the relevant authorization period
4. Additional units cannot be utilized without formal authorization in NYEIS by the EIOD/ AD
- Note:** The EIOD can enter these modifications directly into NYEIS by following the steps above

<p><b>Early Intervention Official Designee Assistant</b></p>	<ol style="list-style-type: none"> <li>1. Reviews request by: <ol style="list-style-type: none"> <li>a. <i>From the Menu Bar – Click on “Inbox”</i></li> <li>b. <i>Select “Assigned Tasks” and select the associated SA task.</i></li> <li>c. <i>Under the Primary Action heading, click on “Review SA Amendment”/ “Review SA Extension Details”.</i> <ol style="list-style-type: none"> <li>i. <i>If reviewing a request to extend the authorization period:</i> <ul style="list-style-type: none"> <li>• <i>Select Approve or Reject form the review screen</i> <ul style="list-style-type: none"> <li>○ <i>When approving, the EIOD Assistant can choose to enter comments related to the approval (comments on approval not mandatory)</i></li> </ul> </li> <li>• <i>If selecting “Reject”</i> <ul style="list-style-type: none"> <li>○ <i>Enter the rejection reason on the NYEIS screen that appears (“Confirm rejection of SA extension Request”)</i></li> </ul> </li> </ul> </li> <li>ii. <i>If reviewing a Service Authorization Amendment</i> <ul style="list-style-type: none"> <li>• <i>Review the request under the “Requested Amendments” heading</i></li> <li>• <i>From the Menu Bar – Click on “My Cases”</i></li> <li>• <i>Select the “Case Reference” number for the amendment request for the case. The “Service Coordination Service Authorizations” section displays the Initial Service Coordination Service Authorization (SA)</i></li> <li>• <i>Select the “Case Reference” link</i></li> <li>• <i>Select “Attachments”</i></li> <li>• <i>Review the attached justification for additional ISC units</i></li> </ul> </li> <li>iii. <i>After the justification has been reviewed:</i> <ul style="list-style-type: none"> <li>• <i>From the Inbox Menu Bar – Click on “Inbox”</i></li> <li>• <i>Select “Assigned Tasks” and selecting the associated SA task.</i></li> <li>• <i>Under the “Primary Action” heading, click on “Review SA Amendment”.</i></li> <li>• <i>Under the “Requested Amendments” Heading, check the appropriate box to approve individual amendments or click "Select All"</i></li> <li>• <i>Click on the “Save” or “Reject All” button,</i></li> <li>• <i>If “Save” is selected:</i> <ul style="list-style-type: none"> <li>○ <i>The “Save” button results in the creation of a new SA with “Approved” status reflecting the revised date ranges and number of units. The previous SA will now have a “Closed” status.</i></li> </ul> </li> <li>• <i>If “Reject All” is selected:</i> <ul style="list-style-type: none"> <li>○ <i>He/she must document the reason in the mandatory rejection comment box.</i></li> </ul> </li> </ul> </li> </ol> </li> </ol> </li> <li>2. The EIOD may request additional information if insufficient information was provided. <ol style="list-style-type: none"> <li>a. <i>The EIOD Assistant will request additional justification by “Rejecting” the request and indicating what additional</i></li> </ol> </li> </ol>
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	<p><i>documentation (ISC Notes) should be faxed to in the Regional Office in the "Rejection Reason"</i></p> <p>3. If the EIOD Assistant rejects the request, the EIOD Assistant will return the denied request to the Service Coordinator within 5 days of the rejection with an explanation.</p>
<p><b>Service Coordinator</b></p>	<p>1. <i>Alerted to the approval of the request to extend an authorization period/request for additional ISC units by:</i></p> <ul style="list-style-type: none"> <li>a. <i>A new SA with "Approved" status reflecting the revised date ranges and/or number of units will appear on the "Service Coordination Service Authorizations" section on the child's "Integrated Case Page"</i> <ul style="list-style-type: none"> <li>i. <i>From the Inbox Menu Bar – Click on "My Cases"</i></li> <li>ii. <i>Select the "Case Reference" number to view the "Integrated Home Page"</i></li> </ul> </li> <li>b. <i>The previous SA will now have a "Closed" status.</i></li> </ul> <p>2. <i>Rejections are visible by checking the Notes associated with the specific SA. To see these notes:</i></p> <ul style="list-style-type: none"> <li>a. <i>From the Menu Bar – Click on "My Cases"</i></li> <li>b. <i>Select the "Case Reference" number to view the "Integrated Home Page"</i></li> <li>c. <i>The "Service Coordination Service Authorizations" section displays the ISC SA</i></li> <li>d. <i>Click the "Case Reference" link.</i></li> <li>e. <i>Select "Notes" from the navigation bar</i></li> <li>f. <i>Read the rejection reason entered in this note section</i></li> </ul>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 6/29/2011



# Chapter 4: Evaluation and Eligibility

## New York City Early Intervention Program

<b>Policy Title: Screening</b>	<b>Effective Date For All Referrals Starting Staten Island: 7/12/2011 Bronx: 7/26/2011 Manhattan: 8/9/2011 Queens: 8/23/2011 Brooklyn: 9/7/2011</b>
<b>Policy Number/Attachment: 4-A</b>	<b>Supersedes:</b>
<b>Department/Unit: Bureau of Early Intervention</b>	<b>Regulation/Citation: 69-4 1(am), 69-4.8(a)2(iv); EI Memorandum 2005-2</b>

### II. POLICY DESCRIPTION:

According to 69-4 1(am) a *Screening* means a process involving those instruments, procedures, family information and observations, and clinical observations used by an approved evaluator to assess a child's developmental status to indicate what type of evaluation, if any, is warranted.

While parents always have the option to pursue a multidisciplinary evaluation for their child upon referral to the EIP, there are some circumstances when performance of a screening is appropriate. Screening tests are generally intended to be brief, easy to administer, and lead to a yes/no decision as to whether or not a developmental problem is likely and further in-depth assessment/evaluation is needed. The evaluator is responsible for determining what type of screening should be conducted (for example, whether a screening should address one or more domains of development, or if the screening should address a specific concern, such as potential hearing loss).

Circumstances under which it may be appropriate for an evaluator to conduct a screening include when there are concerns about only one area of development (e.g., communication development, physical development, etc.), or if there is a *generalized concern* about the child's development, a screening may be conducted to determine whether the child is typically developing or whether there are indications of problems that require further evaluation and assessment; or, very specific concerns for which procedures exist to clearly "rule out" or identify a problem (e.g., hearing loss).

The IFSP meeting must be convened ***within 45 days*** from the date the child was referred to the NYCEIP. In order for the meeting to be scheduled, the screening and multidisciplinary evaluation (if completed) must be completed and the necessary forms and reports, as described in this Policy, must be submitted through NYEIS, and the parent(s) ***within 30 days*** of the child's referral.

### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator (ISC)</b>	<ol style="list-style-type: none"> <li>1. At the Initial meeting with the parent(s)/caregiver(s)               <ol style="list-style-type: none"> <li>a. Explains the difference between the evaluations and screenings to the family</li> <li>b. Refer to the Initial Service Coordination Responsibilities Policy for additional explanation of the ISC role</li> </ol> </li> </ol>

<p><b>Evaluation Agency</b></p>	<ol style="list-style-type: none"> <li>1. At the initial meeting with the parent, explains the differences between screening and evaluation to the parent. <ol style="list-style-type: none"> <li>a. Refer to <i>Appendix A: Screening vs. Multidisciplinary Evaluation</i> in this chapter of the Manual.</li> <li>b. Screenings should not be done if: <ol style="list-style-type: none"> <li>i. The parent requests an evaluation</li> <li>ii. The child has a diagnosed condition with a high probability of developmental delay. <ul style="list-style-type: none"> <li>• (refer to SDOH <i>Memorandum 2005-2 Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the Early Intervention Program</i>)</li> </ul> </li> </ol> </li> </ol> </li> <li>2. If the parent agrees to a screening: <ol style="list-style-type: none"> <li>a. Screening must be completed in a timely manner as to ensure that the screening documentation and other MDE documentation or closure documents are submitted to the regional office within 30 days of the children referral to Early Intervention.</li> <li>b. If a screening indicates cause for concern, a MDE must be completed to determine whether child is eligible for the EIP</li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>- An approved evaluator may bill for both a screening and a Multidisciplinary evaluation for the same child only when the screening is performed in the child’s home or child care site.</li> <li>- When a screening and evaluation are performed at the approved evaluator’s site, the evaluator may bill only for the Multidisciplinary evaluation.</li> </ul> <ol style="list-style-type: none"> <li>3. Discusses the results of the screening with the parent, and at the parent’s request, the ISC. <ol style="list-style-type: none"> <li>a. Explains the results of the screening to the family. <ol style="list-style-type: none"> <li>i. If the child does not pass the screening: <ul style="list-style-type: none"> <li>• Discuss the composition of the evaluation team with parent</li> <li>• Complete a full Multidisciplinary evaluation. Refer to the Policy on <b>Multidisciplinary Evaluations</b></li> </ul> </li> <li>ii. If the child passes the screening <ul style="list-style-type: none"> <li>• If there are concerns about possible future delays, discusses with the parent a referral to the EIP Child Find Unit for ongoing developmental monitoring. <ol style="list-style-type: none"> <li>a. Inform the initial Service Coordinator if the parent/caregiver agrees</li> </ol> </li> </ul> </li> </ol> </li> </ol> </li> </ol> <p><b>Note:</b> The parent can request a full MDE at any point in the screening process.</p> <ol style="list-style-type: none"> <li>4. Submits the necessary screening and MDE (if necessary) documents via NYEIS no later than <b>30 calendar days after the child’s initial referral to EIP</b></li> </ol>
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	<p>a. Refer to the <b>Multidisciplinary Evaluations Policy</b> for a detailed walkthrough of submission requirements</p> <p><b>Note:</b> Copies of the screening report or MDE is sent to the child's primary health care provider only if the parent has signed the <b>Consent to Obtain/Release Information</b> form.</p>
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**Approved By:** \_\_\_\_\_  
**Assistant Commissioner, Early Intervention**

**Date:** 7/19/2011

## New York City Early Intervention Program

<b>Policy Title:</b> <b>Multidisciplinary Evaluations Policy</b>	<b>Effective Date:</b> <b>For All Referrals Starting</b> <b>Staten Island: 7/12/2011</b> <b>Bronx: 7/26/2011</b> <b>Manhattan: 8/9/2011</b> <b>Queens: 8/23/2011</b> <b>Brooklyn: 9/7/2011</b>
<b>Policy Number:</b> <b>4-B</b>	<b>Supersedes:</b>
<b>Attachments:</b> <b>Parental Consents for Evaluation and Screening</b> <b>Core Evaluation Data Entry Form (Eliminated by</b> <b>NYEIS)</b> <b>Multidisciplinary Evaluation Data Entry Form</b> <b>(Eliminated by NYEIS)</b> <b>Supplemental Evaluation Data Entry Form</b> <b>(Eliminated by NYEIS)</b> <b>MDE/Screening Summary</b> <b>Reason for Delay in Evaluation Completion/MDE</b> <b>Submission (Section II Eliminated by NYEIS)</b> <b>MDE Checklist</b>	<b>Regulation/Citation:</b> <b>10 NYCRR 69-4.1</b> <b>10 NYCRR 69-4.8</b> Memorandum 1999-2 Memorandum 2005-02

### I. POLICY DESCRIPTION:

A multidisciplinary evaluation shall be performed to determine the child's initial and ongoing eligibility for early intervention services...The evaluator shall obtain informed parental consent to perform the evaluation and screening prior to initiating the evaluation procedures. (10NYCRR69-4.8 (a) (2))

The IFSP meeting must be convened ***within 45 days*** from the date the child was referred to the NYCEIP. In order for the meeting to be scheduled, the multidisciplinary evaluation must be completed and the necessary forms and reports, as described in this Policy, must be submitted to the Regional Office through NYEIS, the parent(s), the child's primary care provider (with parental consent), and to the Administration for Children's Services (if applicable) ***within 30 days*** of the child's referral.

The MDE is necessary to:

- determine eligibility for the EIP
- assess the status of the child's physical, cognitive, communication, social-emotional and adaptive functioning
- identify areas of developmental strengths and needs
- determine and understand parent's resources, priorities and concerns

For a child who is eligible based on a diagnosed condition with a high probability of leading to a developmental delay/disability, an MDE is required to assist with the development of an

Individualized Family Service Plan (IFSP). An MDE may also be required to confirm on-going eligibility when considerable progress has been made and/or there is a question about the child's on-going eligibility.

Public Health Law defines an eligible child as an infant or toddler from birth through age two with a disability. A disability is defined as a developmental delay or diagnosed physical or mental condition with a high probability of resulting in developmental delay (**10NYCRR69-4.1 (h)**) e.g., low birth weight, Down Syndrome, sensory impairments.

A child is automatically eligible for the EIP where there is a confirmed diagnosis of a physical or mental condition with a high probability of the condition resulting in a developmental delay or disability ([Refer to Early Intervention Memorandum 1999-2 - Reporting of Children's Eligibility Status Based on Diagnosed Conditions with High Probability of Developmental Delay](#)). It is the responsibility of the evaluator to confirm that the child has the diagnosed condition and is therefore eligible for the Early Intervention Program. For children eligible on the basis of the diagnosed condition, the primary purpose of early intervention is to mitigate the impact of the condition on a child's developmental progress. **The child does not have to demonstrate a delay to receive early intervention services if he has a condition with a high probability of developmental delay.**

If a referred child does not have a confirmed diagnosis which would establish automatic eligibility in New York State ([refer to Memorandum 2005-02 - Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the Early Intervention Program](#)), consistent with federal regulations under Part C of IDEA, s/he must exhibit a significant developmental delay to be eligible for early intervention services. Developmental delay as defined by PHL 69-4 means that the child has not attained developmental milestones expected for the child's chronological age adjusted for prematurity in one or more of the following areas of development: cognitive, physical (including vision and hearing, oral motor feeding and swallowing disorders), communication, social/emotional or adaptive functioning as measured by qualified professionals using appropriate diagnostic instruments and/or procedures, and informed clinical opinion.

To be initially eligible for early intervention based upon a developmental delay, the following criteria must be met:

- A 12-month delay in one or more functional domains, or
- A 33% delay in one functional domain, or
- A 25% delay in **two** or more functional domains, or
- For children who have been found to have a delay only in the communication domain and if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department articulated in 10NYCRR69-4.23.

Or, when appropriate standardized tests are used:

- Two standard deviations (2.0SD) below the mean in one functional domain, or
- One and a half standard deviations (1.5SDs) below the mean in **two** or more functional domains.

The five functional domains include: cognition, communication, physical, adaptive and social/emotional.

Eligibility **cannot be** established based on isolated difficulties, e.g., feeding, sensory integration, articulation unless there is a significant impact on the child’s development in one or more of the five functional domains. This must be documented in the MDE report.

**Note:** An isolated feeding problem in and of itself may not be sufficient to establish a child’s eligibility for the Early Intervention Program. Feeding and swallowing problems often co-occur in children who have motor disorders, and may be an early indicator of a motor or other developmental health problem. Difficulties with feeding and swallowing are signs and symptoms, and it is important to determine the underlying cause. If the central concern for a child is feeding dysfunction, the MDE must provide sufficient evidence that the feeding problem is significantly impacting on the child’s developmental status. The nature of the feeding dysfunction must be documented in the MDE report, including the statement of the child’s eligibility for the Early Intervention Program. (Refer to Clinical Practice Guidelines Motor Disorders pgs. 66-77 for more in-depth information on the assessment of feeding disorders.)

Instruction for navigating NYEIS are denoted in *italics* in the body of this Policy and in the **NYEIS MDE Crosswalk**

**II. PROCEDURE:**

<b>Responsible Party</b>	<b>Action</b>
<b>Evaluation Agency</b>	<ol style="list-style-type: none"> <li>1. Notified by the ISC or parent/caregiver that they have been selected as the evaluation site by the family.</li> <li>2. Accepts the MDE assignment in NYEIS               <ol style="list-style-type: none"> <li>a. Refer to the <b>Choice of Evaluation Site Policy</b> for specific NYEIS directions</li> </ol> </li> <li>3. Evaluation/Screening process begins unless the child is awaiting surrogacy determination.               <ol style="list-style-type: none"> <li>a. The Evaluation or Screening process cannot begin until the evaluation agency receives <b>Surrogate Parent Assignment by EIOD Form</b> (if applicable).</li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• The ISC will send the Evaluation Site the <b>Consent to Obtain/ Release Information Form</b></li> <li>• Above forms must be kept in the child’s record</li> <li>• <b>Since all parent consent forms are now attached in NYEIS, it is NO LONGER the responsibility of the Evaluation Agency to submit any forms completed by the ISC since the ISC directly attaches the forms to the “Childs Integrated Home Page” NYEIS.</b></li> </ul>

I. First Contact with the Parent:

1. Determine if a screening is necessary before an MDE is conducted.
  - a. Refer to *Appendix A: MDE vs. Screening*
  - b. Refer to the **Screening Policy** in this chapter of this manual.
2. Determine the components of the MDE based on parent concerns.
  - a. Parent's primary concern should be part of the Core evaluation
3. Obtain parent/caregiver signature on the **Consent for Evaluation and Screening Form**.
  - a. One consent is signed for a Core Evaluation
  - b. One consent is signed for a Screening
  - c. Every Supplemental Evaluation must have a separate signed consent.
4. Ask the parent if a recent health assessment was conducted **and** if the parent has appropriate health assessment documentation from the child's primary care provider
  - a. If a recent health assessment was not conducted or health assessment documentation obtained:
    - i. Obtain parental signature on the **Consent to Obtain/Release Information**.
    - ii. Contact the child's physician to assist parent/caregiver with obtaining a health assessment and health assessment documentation.
    - iii. If the child does not have a primary care provider, a health assessment should be conducted as a supplemental physician evaluation

II. Multidisciplinary Evaluation (MDE) Components

1. An MDE is made up of a Core Evaluation (identified as the Developmental Assessment in NYEIS) and, when necessary, Supplemental Evaluation(s).
  - a. The MDE team is composed of at **least** two qualified personnel, one of whom is a specialist in the developmental area that is of concern for the child.
  - b. A MDE Core Evaluation consists of
    - i. An assessment of the five developmental domains: cognitive, physical (including vision and hearing, oral motor feeding and swallowing disorders), communication, social-emotional, and adaptive
    - ii. An assessment of the specific area of concern in development identified at the time of referral:
      - The qualified personnel who conduct the core evaluation should have sufficient expertise to assess the developmental area of the parent's primary concern/ reason for referral
    - iii. A review of pertinent records related to the child's current health status, developmental concerns and medical history is required.
      - Conducted with parental consent
    - iv. A parent interview about the family's resources, priorities,



and concerns related to the child's development and about the child's developmental progress.

- Parent interview may be incorporated as part of the core evaluation report or submitted as a standalone document. In either scenario the parent interview cannot be billed for separately.
- v. A separate family assessment focusing on the resources, priorities and concerns of the family related to enhancing the development of the child (optional on the part of the parent).
- A family assessment includes identifying formal and informal support services
  - Offered and conducted with parental consent
  - The family assessment cannot be billed for separately
- vi. An evaluation of the child's level of functioning and assessment of the unique needs of the child in each developmental domain.
- This includes the identification of services that may be appropriate to meet those needs
- vii. An evaluation of the transportation needs of the child, including:
- Parent/caregiver ability to provide transportation
  - Child's special needs related to transportation and safety issues
  - Parental concerns related to transportation
    - Refer to the **Assessing Transportation Needs Policy** in this chapter of the manual.

**Note:** In many cases, the Core Evaluation (Developmental Assessment), on its own, will contain sufficient information to determine if a child is eligible for EI services.

c. Supplemental Evaluations

- i. Supplemental evaluations are conducted based on the written justification of the core evaluation team.
- It is expected that, in most cases, the core team will be equipped to assess all five developmental areas, and will not need to seek an additional evaluator and supplemental evaluation.
  - Supplemental evaluations **should not** be routinely provided to all children in the EIP (NYS DOH EIP Memorandum 2005-02).
- ii. NYS Guidance Memorandum 2005-02 pp. 23-24 specify justifiable circumstance for recommending supplemental evaluations, including:
- If the MDE team identifies the need for an in-depth assessment of a child's strengths and needs in a

specific area. The supplemental evaluation may be necessary to provide direction as to the specific early intervention services that may be needed by the child.

- If, at the time of referral, a child has no established primary health care provider, a supplemental physician evaluation or non-physician evaluation may be used to complete the health assessment required as part of the child's physical development.
  - If, at the time of referral, a child is suspected of having a diagnosed condition with a high probability of developmental delay, which necessitated the involvement of an expert qualified to evaluate and diagnose the condition, a supplemental evaluator qualified to conduct an in-depth assessment resulting in a diagnosis may be considered.
- d. Supplemental evaluations may not be conducted before the Core evaluation is completed.
    - i. Supplemental evaluations must be recommended by the core evaluation team,
  - e. May also be conducted when authorized after the child's initial IFSP.

## II. Conducting the Multidisciplinary Evaluation

### *Parental Involvement*

1. The evaluation process, including clinical observation, should be conducted in an environment appropriate to the unique needs of the child, with consideration given to the preferences of the parent. Such settings may include:
  - a. Natural settings (e.g., the child's home or daycare setting)
  - b. Unstructured (e.g., play room)
  - c. Structured (e.g., clinic, office, foster care agency)
2. The child's parent(s) must be given the opportunity to be an active participant in the evaluation process, as should other family members and other individuals who care for the child (e.g., daycare, nanny, foster parent, guardian, and caregiver) with parental consent.
  - a. Recognizing the family as an integral member of the evaluation team ensures that parental concerns and priorities regarding the child's development remain the focal points.
  - b. Parent partnership validates the parents' understanding of the child's current functioning and his/her strengths and developmental needs.

### *Evaluation Procedures*

1. Evaluation procedures should be objective, professional, and individualized and consider each child's unique developmental strengths and needs.

2. MDEs should include *informed clinical opinion*, and employ age-appropriate instruments and procedures.
3. Nondiscriminatory evaluation and assessment procedures must be used in all aspects of the evaluation and assessment process. Evaluation and assessment procedures must be responsive to the *cultural and linguistic background of the family*. (Refer to the **Policy on Bilingual Evaluations** in this chapter of the Policy and Procedures Manual.)
4. *No single procedure or instrument* may be used as the sole criterion or indicator of eligibility.
  - a. The Multidisciplinary Team must rely on information from a variety of appropriate sources:
    - i. Standardized instruments and procedures whenever appropriate and possible,
    - ii. Observations of the child,
    - iii. Parent interviews,
    - iv. Informed clinical opinion, and
    - v. Any other sources of information about the child's developmental status available with parental consent. (Refer to Memorandum 2005-02)

*Assessment Instruments*

1. Standardized, norm-referenced evaluation assessment and/or diagnostic instruments should be used whenever possible unless such instruments are not appropriate for:
  - Child's age
  - Child's culture or language
  - Developmental status or concern
  - a. Results should be scored according to that instrument's guidelines for scoring and reporting, and in compliance with SDOH Memorandum 2005-02.
  - b. **Age equivalents from standardized tests should not be used for eligibility determination**, unless:
    - i. The manual for the instrument supports the use of age equivalents to establish eligibility.
2. Criterion-referenced tests can be helpful in evaluating children when norm-referenced tests are not available or appropriate due to the child's age, condition, language/culture, or other factors that influence test performance.
  - a. Criterion-referenced tests usually do not provide sufficient information to determine the extent of a child's developmental delay(s).
  - b. Criterion-referenced tests can be used in conjunction with other sources of information about a child's development, including informed clinical opinion, to establish a child's eligibility if eligibility is based on the level of developmental delay.
  - c. If criterion-referenced tests are used, the evaluator must:
    - i. Be aware of how the results or age ranges are to be interpreted.
      - This is usually described in the test's instruction

manual and must be discussed in the evaluation report.

3. The instruments used must be the most recent edition. Standardized tests must be reliable and valid, with appropriate sensitivity and specificity.

**Note:**

- A standardized instrument or instruments approved by the State Department of Health must be used when conducting an MDE.
  - The evaluator must provide a written justification in the evaluation report why such instrument or instruments are not appropriate or if an instrument is not available for the child, if an approved instrument is not used
- Refer to Memorandum 2005-02 p. 8-10 and Anderson, L. “Appropriate and Inappropriate Interpretation and Use of Test Scores in Early Intervention,” *Journal of Early Intervention*, 2004, Vol. 27, No. 1, p. 55-68 for further discussion.

*Prematurity and Age Adjustment*

1. When evaluating a child who was born prematurely (less than 37 weeks gestation) the evaluation team will decide whether to use adjusted age, as appropriate to the clinical situation and the test/diagnostic instrument being used in the evaluation process.
  - a. The evaluation report should clearly state the amount and type of adjustment that was made, if any.

**Note:** Ref: Memorandum 2005-02 (p.30) and Wilson, S.L. and Craddock, M. M. (2004) *Journal of Pediatric Psychology*, 29 (8): 641-649

*Informed Clinical Opinion*

1. Informed clinical opinion is “the best use of quantitative and qualitative information by qualified personnel regarding a child and family, if applicable. Such information includes, if applicable, the child’s functional status, rate of change in development, and prognosis.” 10 NYCRR §69-4.1(w)
  - a. Diagnostic instruments and informed clinical opinion must be used in combination to:
    - i. Interpret results of the MDE,
    - ii. Determine the degree of developmental delay, and
    - iii. Formulate a statement of “eligible” or “not eligible”, stating specifically why the child does or does not meet eligibility criteria
  - b. The use of informed clinical opinion is:
    - i. Required by federal regulations in evaluation and assessment procedures for eligibility purposes.
    - ii. A necessary safeguard against eligibility determination based upon isolated information or test scores alone.

**Note:** Refer to [Appendix C: Informed Clinical Opinion](#) of this chapter of the manual

### III. Immediately After an Evaluation is Complete

1. Individual evaluators should verbally share only preliminary results/impressions with the parent at the conclusion of each assessment session, explaining to the parent that the information yet to be compiled and eligibility for the Early Intervention Program is determined by the MDE team.
  - a. Evaluators should also explain that while a child may have a delay, it may not be severe enough for eligibility.
  - b. Individual evaluators should document in their reports that preliminary results were shared with the parent.

### IV. Completing and Submitting the Multidisciplinary Report

1. The evaluation team is responsible for preparing an evaluation report and written MDE Summary.
  - a. **Individual evaluations** must provide sufficient information to support the finding of “eligible” or “not eligible”, including an in-depth assessment of the child’s strengths and needs in the specific areas of development that were assessed.
    - i. Refer to [\*Appendix B: Best Practice Recommendations For Report Writing and Submission\*](#) of this chapter.
    - ii. Refer to the [\*\*Assessing Transportation Needs in The Multidisciplinary Evaluation\*\*](#) policy in this chapter of the manual.

#### **Note:**

- Evaluators may make recommendations about the **type(s)** of services that the child may need, **but evaluators may not make recommendations regarding the frequency, duration, and intensity of such services.**
  - c. The **MDE Summary**
    - i. Refer to the [\*\*MDE/Screening Summary Form\*\*](#) in this chapter of the policy and procedure manual.

**Note:** If a bilingual evaluation was conducted, the summary should also be provided in the parent’s dominant or preferred language or other mode of communication of the parent, if feasible (refer to the policy on *Bilingual Evaluation* in this chapter of the manual).

2. Completes the applicable NYEIS MDE screens when ready to submit the MDE to the Regional Office.

**Note:** The following forms have been eliminated by NYEIS:

- **Screening Data Entry Form**
- **Core Evaluation Data Entry Form**
- **Multidisciplinary Evaluation Data Entry Form**
- **Supplemental Evaluation Data Entry Form**

- a. *From the Inbox Menu Bar – Click on “Work Queues”*
- b. *Select View: (Provider ID) Evaluations work queue*

- c. *Select the “Task ID” of the case you wish to work on.*
- d. *Select “A Multidisciplinary Evaluation has been assigned to (your agency) for (child name)”*
  - i. *Select “Manage MDE” under Primary Action*
  - ii. *The complete data entry sections appear*

***e. Select “Screening” from the navigation bar***

**Note:**

- This section of NYEIS replaces the **Screening Data Entry Form**
- If the child was referred with a “confirmed eligibility diagnosis,” a screening is not permitted.
- If the child was referred with a “suspected delay”, the screening section must be completed.
  - i. *Select “New”*
  - ii. *In response to the question “Was a screening deemed necessary?”, choose either*
    - *“No” or “No with diagnosed condition”: once this is selected, the screening section is complete*
    - *“Yes”: the following screening sections must then be completed:*
      - *Evaluator Details*
      - *Screening Location*
      - *Screen Domains*
      - *Concern About Specific Domains*
      - *Reason for Screen*
      - *Parent Informed of Results*
      - *Screening Details*
        - a. *Refer to the **MDE crosswalk** for a more detailed explanation of fields*

***f. Select “Developmental Assessment” from the navigation bar***

**Note:** This section of NYEIS replaces the **Core Evaluation Data Entry Form**

- i. *Select “New” under the Qualified Personnel Involved*
- ii. *Enter “evaluator name” of % (wildcard)*
- iii. *Select the names of the staff who conducted the developmental assessment (a minimum of two people must be selected)*
  - *The staff member must be already entered as a Licensed/ Certified Professional in your agency’s “Employee/Contractor” section of NYEIS.*
  - *Repeat this step for each evaluator on the developmental evaluation team*
- iv. *Enter the Developmental Domain Results by selecting “View” next to each domain*
  - *Select the qualified personnel involved in the assessment of the selected domain*
  - *Select “Edit” and complete the “Domain Status”*

*field and the “Date Completed” field*

- *Repeat this procedure for each of the five domains assessed.*
- *If “Test Inadequately Represents Child’s Developmental Level” or “No Standardized Test Appropriate” is selected for the communication domain, the “evidence-based criteria” section must be completed*
- *Select “Save”*
- v. *Select “Location Type” from the drop-down menu*
  - *Enter location address if the location is other than the “Child’s Home”.*
- vi. *Enter Evaluation Diagnosis Results - all fields in this section are mandatory*
  - *Select an “EI Eligible Diagnosis Code” if the child has an auto-eligible condition for early intervention*
  - *Select an “Other Eligible Diagnosis Code” if the child is eligible based on delay. A justification statement is required if an ICD-9 code is selected from this category*
- vii. *Enter Evaluation Methods*
  - *If “standardized test” is selected, the test results and scores are required*
- ix. *Select the “New” button above the heading “Diagnostic Tests Administered” if a test was administered.*
  - *Enter the mandatory information: Test Name and Date administered plus test scores. Either “Save” the data or add sub-scores and then save all the data.*
  - *Select “Close”*
- j. *Select “Family Assessment” from the navigation bar*
  - i. *Select “Offered and Was Refused,” or “New” if accepted*
  - ii. *If “New” is selected, select “Edit” to complete each section*
  - iii. *Refer to the [MDE Crosswalk](#) for a detailed description of the NYEIS fields.*
  - iv. *Select “Close” once complete.*

***k. Select “Supplemental Evaluation” on the navigation bar (if applicable).***

**Note:** This section replaces the **Supplemental Evaluation Data Entry Form**

- i. *Enter evaluator name or % (wildcard) under Search Evaluator for Assignment*
  - *Select the assigned Employee/Contractor*
    - *The staff member(s) must be already*

*entered as a Licensed/ Certified Professional in your agency's "Employee/Contractor" section of NYEIS.*

- ii. Select "In-Depth Assessment" **OR** "Diagnostic Evaluation"*
- iii. Select "New" under the "Developmental Domain Results"*
  - Select the developmental domain*
    - Select "Save"*
  - Enter the "Domain Status" field and the "Date Completed" field*
    - Select "Save"*
- iv. For the remainder of the Supplemental NYEIS screen, follow the procedure under the Developmental Assessment section above starting from: 3.i.v Select "Location Type"*

**I. Select "External Evaluations" on the navigation bar (if applicable).**

**Note:**

- "If an "external evaluation" is performed on a child by a licensed professional, such as a physician or psychologist, who is not approved by the Department as qualified personnel under the EIP, or who is not under contract with the municipality, a multidisciplinary evaluation that is performed by an approved evaluator under contract with the municipality is still required to determine eligibility for the EIP. The evaluator may, with parental consent, review, verify and use the findings from such an "external evaluation", provided that it adheres to existing regulations for other evaluations [10 NYCRR §69-4.8(a)(5)].
- Evaluation results from an "external evaluation" cannot serve as the sole basis for the child's eligibility or for the sole assessment of one of the five developmental domains. Although the evaluator may use findings from an "external evaluation", the findings do not replace the multidisciplinary evaluation or the requirement that the evaluator determine the child's eligibility for the EIP. If a parent disagrees with the determination of the evaluator, the parent must be advised of their due process rights in accordance with PHL §2549(1)."

- i. Evaluator Details – All information in this section is mandatory:*
  - Evaluator Name*
  - Agency Affiliation Name*
  - Profession (drop down list)*
  - Date Evaluation Conducted*
- ii. Please Check All that Apply – Identify the sources used to determine the assessment results by checking the appropriate boxes.*
- iii. Select "In-Depth Assessment" **OR** "Diagnostic Evaluation" to specify the Type of Evaluation*
- iv. Approved Evaluation Team must certify:*



- *The procedures used by the external evaluator were performed in a manner consistent with EIP requirements*
  - *The findings were used to augment and not replace the evaluation to determine eligibility*
  - *There are no indications present which suggest the need to repeat the tests or procedures performed by the evaluator*
- v. *Health Assessment – Certification is necessary to confirm that the external health assessment was performed recently and accurately represents the child.*
- vi. *General Health Status – Information regarding the child’s health concerns/ issues may be included.*
- vii. *The evaluation diagnosis results are mandatory and must be completed as designated by the diagnosis headers and subsequent questions.*
- *If there has been a diagnosis established as a result of this external evaluation:*
    - *Select “Other Eligible Diagnosis Code” and search for the appropriate ICD-9 Code.*
    - *Multiple codes may be entered*
  - *Date completed is mandatory.*
  - *Indicate if the assessment was bilingual.*
- viii. *Enter Evaluation Methods*
- *If “standardized test” is selected, the test results and scores are required in the attached report*
- ix. *General Evaluation Comments*
- *Comments are not mandatory*
- x. *Select “Save” once completed*

***m. Select “MDE Home” from the navigation bar***

**Note:** This section of NYEIS replaces the **Multidisciplinary Evaluation Data Entry Form**

- i. *Select “View” under “MDE summary details”*
- ii. *Select “Edit”*
- iii. *Enter mandatory fields under “Eligibility”*
- *Select “Eligibility Status” from the drop-down list*
  - *Select “Date Eligibility Determined”*
    - *If the child is eligible because of a diagnosed condition, use the date of the evaluation that determined the condition.*
    - *If the child is eligible because of a developmental delay, use the date the evaluation summary is completed.*
  - *Enter “Date Full MDE Completed”*
  - *Parent(s) Received Summary of MDE - Select Yes or No.*

- *Parent must receive a copy of the MDE for the MDE to be submitted.*
- *Parent(s) Received Summary of MDE in Their Dominant Language - Select Yes or No.*
- *Parent(s) Received The Full Evaluation Report - Select Yes or No.*
- iv. *Enter mandatory fields under “Diagnosis Details”*
  - *EI Eligible Diagnosis Code - If a child has an automatic eligibility condition, the condition must be entered in this box.*
    - *NYEIS will generate a list that only includes the ICD - 9 codes entered in previous sections of the MDE*
  - *Date of Diagnosis - Provide the date that the diagnosis was made*
  - *Diagnosis Made By - Select from the drop - down list.*
  - *Other Eligible Diagnosis Code - The diagnosis (and ICD 9 code number) which makes the child eligible must be listed.*
    - *NYEIS will generate a list that only includes the ICD - 9 codes entered in previous sections of the MDE*
  - *If Other ICD Code, Justification - Provide a reason why the code was selected*
  - *Other Diagnosis Not Related to Eligibility - Select all other diagnoses as indicated from the developmental evaluation and supplemental evaluation(s).*
  - *Screening Only Diagnosis Code - Enter the appropriate “V” code*
- v. *Eligibility Statement - Indicate “MDE summary attached”*
- vi. *Child Transportation Needs - Select Yes or No.*
- vii. *Select “Save”*

3. Attaches the following documents to the “MDE Attachments” section in NYEIS **30 calendar days after the child’s initial referral to EIP:**

- **Consents for Evaluation/Screening** (one for the Core Evaluation and for each Supplemental Evaluation) signed and dated by the parent/surrogate parent
- **Health Assessment**
  - **Medical form** (or electronic medical record print-out signed by doctor)
- **MDE Summary** (and translation into the parent’s dominant/preferred language if applicable)
- Full evaluation reports including:

- **Developmental Assessment (including Parent Interview)**
- **Optional Family Assessment**
- **Supplemental evaluations(s) (if necessary)**
- **Attestation Statements** must be included in each report
- **Other sources of information** (w/ parent consent; ex: medical records)
- **Screening Summary** (if applicable)
- **Screening Report** (if applicable)
- **External Evaluation** (if applicable)

**Note:** Evaluation agencies can use the MDE Checklist to aid them in submitting completed MDE packets and to avoid rejection of the MDE packet by the Regional Office.

- a. *Select “MDE Attachments” on the navigation bar*
  - i. *Select “New” to add an attachment*
  - ii. *Select the “type of Attachment” under “Evaluation File”*
    - *Consents for evaluation and screening are attachment type “Evaluation Attachment”*
    - *Health Assessment is attachment type “Medical Form”*
    - *MDE Summary should be attachment type “Summary”*
    - *Developmental Assessment and parent Interview are attachment type “Developmental Assessment”*
    - *Family Assessment is attached as “Family Assessment”*
    - *Supplemental evaluations should be attached as “Supplemental Evaluations”*
    - *Other sources of information are attachment type “Evaluation Attachment”*
    - *Screening Summary and Screening report are attachment type “Screening”*
  - iii. *Select “Browse” to choose the file name*
    - *Attachments cannot be larger than 1.5MB each*
  - iv. *DO NOT enter any information in the “Location” and “Reference” fields*
  - v. *Complete the “Comments” field by listing the name of the document being attached*
  - vi. *Select “Save”*
    - *A “View” option appears where the attachment can be edited or deleted before it is submitted with the MDE screens to the Regional Office*
    - *Select “New” to attach another attachment*
  - vii. *Select “MDE Validation Errors” from the Navigation bar or select “Submit” from the “MDE Home” page*

	<ul style="list-style-type: none"> <li>• <i>NYEIS will generate a list of errors that will need to be corrected in order to submit the MDE</i></li> </ul> <p>viii. <i>Select submit from the “MDE Home” page</i></p> <p>4. <i>Full MDE packet is sent to the parent, including:</i></p> <ol style="list-style-type: none"> <li>a. <i>Evaluation reports</i></li> <li>b. <i>Summary</i></li> <li>c. <i>Print out of the information entered into NYEIS</i> <ol style="list-style-type: none"> <li>i. <i>Select “Print MDE” from the MDE Home page</i> <ul style="list-style-type: none"> <li>• <i>NYEIS generates a PDF summary document of all completed NYEIS MDE Screens.</i></li> </ul> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Parental questions based on statements or scores included in the written MDE should be addressed by the evaluation team prior to the IFSP meeting. <ul style="list-style-type: none"> <li>○ The parent <b>MUST</b> have the opportunity to discuss the evaluation results, with the evaluators or designated contact, including any concerns they may have about the evaluation process; and to receive assistance in understanding these results, and ensure the evaluation has addressed their concerns and observations about their child.</li> </ul> </li> <li>• Copies of the MDE or screening report is sent to the child’s primary health care provider if the parent has signed the <b>Consent to Obtain/Release Information form</b></li> <li>• Once an MDE is successfully submitted to the EI/OD, the evaluation must be approved before scheduling can begin. Refer to the <b>MDE Review Policy</b></li> </ul>
<p><b>Early Intervention Scheduler</b></p>	<ol style="list-style-type: none"> <li>1. <i>Select “Inbox” for the Menu Bar – Click on “Assigned Tasks”</i></li> <li>2. <i>Select the “Task ID” of the case you wish to work on</i></li> <li>3. <i>Under Primary action, select “Manage Submitted MDE”</i></li> <li>4. <i>Review the Submitted MDE.</i> <ol style="list-style-type: none"> <li>a. <i>Select MDE sections via the left Navigation bar.</i></li> </ol> </li> <li>5. <i>Review attachments in the Integrated home page</i> <ol style="list-style-type: none"> <li>a. <i>Select “My Cases” for the Menu Bar</i></li> <li>b. <i>Select the “Case Reference” of the case you wish to work on</i></li> <li>c. <i>Select “Attachments” for the navigation bar</i></li> <li>d. <i>Conduct a “Completeness Review” on the attachments based on the MDE Checklist</i></li> </ol> </li> </ol> <p><i>Note: The EI/OD view of NYEIS allows MDE attachments and attachments made to the integrated case to be viewed by selecting attachments from the integrated case homepage</i></p> <ol style="list-style-type: none"> <li>i. <i>If the MDE Submission is incomplete:</i> <ul style="list-style-type: none"> <li>• <i>Select “Inbox” for the Menu Bar – Click on “Assigned Tasks”</i></li> <li>• <i>Select the “Task ID” of the case you wish to work on</i></li> <li>• <i>Under Primary action, select “Manage Submitted MDE”</i></li> </ul> </li> </ol>

	<ul style="list-style-type: none"> <li>• Select “Reject” <ul style="list-style-type: none"> <li>○ Select the rejection reason code as “Incomplete”</li> <li>○ List the documents missing under “Rejection Reason”</li> </ul> </li> <li>ii. If the MDE Submission is complete and shows no quality issues <ul style="list-style-type: none"> <li>• Select “Inbox” for the Menu Bar – Click on “Assigned Tasks”</li> <li>• Select the “Task ID” of the case you wish to work on</li> <li>• Under Primary action, select “Manage Submitted MDE”</li> <li>• Select “Accept”</li> </ul> </li> <li>iii. If an Assistant Regional Director needs to review the MDE <b><u>prior to</u></b> “Accept MDE”(you must forward the Task and the case) <ul style="list-style-type: none"> <li>• From the Inbox Menu Button – Click on Assigned Tasks</li> <li>• Select the Task ID of the case you wish to work on. <ul style="list-style-type: none"> <li>○ Under the Manager action, Reserve the task, and then forward the task.</li> <li>○ On the Forward Task screen, click on the magnifying glass to search for the User to whom you will forward the case.</li> <li>○ On the “User Search” Screen, narrow the search to “Muni Names” only. <ul style="list-style-type: none"> <li>i. Enter a User First Name, Last Name or % (Wildcard),</li> <li>ii. Select Search, Select a User Name</li> <li>iii. Select Save</li> <li>iv. The task will be forwarded to the new User.</li> </ul> </li> </ul> </li> <li>• Assign the Case to the Assistant Director by: <ul style="list-style-type: none"> <li>○ From the Menu Bar – Click on “My Cases”</li> <li>○ Select the “Case Reference” number for the case you would like to assign</li> <li>○ Select “User Roles” for the Menu bar</li> <li>○ Select New EIOD</li> <li>○ Click on the magnifying glass to search for the User to forward the case to.</li> <li>○ On the User Search Screen, narrow the search to “Muni Names” only <ul style="list-style-type: none"> <li>i. Enter a User First Name, Last Name or % (Wildcard)</li> <li>ii. Select Search</li> <li>iii. Select a User Name</li> <li>iv. Select Save.</li> <li>v. The task will be forwarded to the new User</li> </ul> </li> </ul> </li> </ul> </li> </ul>
<b>Evaluation Agency</b>	1. Checks the “Evaluations Queue” daily to ensure that all MDE rejections are managed in a timely manner

	<ul style="list-style-type: none"><li>a. <i>From the Inbox Menu Bar – Click on “Work Queues”</i></li><li>b. <i>Select View: (Provider ID)_Evaluations Work Queue</i></li><li>c. <i>Select the “Task ID” of the case you wish to work on.</i><ul style="list-style-type: none"><li>i. <i>A rejected MDE task appears as: “Submitted Provider Evaluation for (child name), Case Reference (number) has been rejected. Review the rejection reason(s) and comments, make necessary corrections and re-submit the evaluation</i></li></ul></li></ul>
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**Approved By:** \_\_\_\_\_  
**Assistant Commissioner, Early Intervention**

**Date:** \_\_\_\_\_ 7/19/2011 \_\_\_\_\_

**NYC EARLY INTERVENTION PROGRAM**  
**CONSENT FOR EVALUATION AND SCREENING**

Child's Name: \_\_\_\_\_

Last

First

MI

EI #: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Referral \_\_\_\_/\_\_\_\_/\_\_\_\_

Dear Early Intervention Official Designee:

I authorize the evaluation of my child by: \_\_\_\_\_

Name of Evaluation Site

to determine my child's eligibility for the Early Intervention Program. I understand that several people will be involved in the evaluation process. I also understand that the evaluation site that I have selected will coordinate the evaluation(s) and is the only agency authorized to arrange an Early Intervention evaluation for my child.

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

\_\_\_\_\_  
Signature of Parent/Surrogate Parent

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date:

\_\_\_\_\_  
Signature of Evaluation Site Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date:

## INSTRUCTIONS FOR COMPLETION

### CONSENT FOR EVALUATION AND SCREENING

This form is to be signed by the birth/adoptive parent or the surrogate parent giving permission for an evaluation **before** any evaluation may be performed. A representative from the evaluation site must also sign this form. If several different EI agencies are participating in a child's evaluation, **each** agency needs a separate consent form.

It is expected that the evaluation site will clearly explain to parents their right to an evaluation within 30 days of the child's referral to the NYC Early Intervention Program, and that any evaluator accepting a child for an evaluation must make all attempts to conform to the contractual obligation of submitting a completed evaluation to the Regional Office via New York Early Intervention System (NYEIS) **within 30 days of the child's referral to the EIP.**

**This form is not to be used with a foster parent unless the NYC Early Intervention Program has assigned that person to be the surrogate parent** ([Refer to Chapter 2 – Foster Care & Surrogacy](#).) If the parent of a child who is in foster care is available and able to give informed consent for evaluation, that parent may sign this form.

The **Consent for Evaluation** form(s) with the appropriate signature must be submitted with the evaluation reports in NYEIS. Failure to obtain this consent from the parent, person in parental relationship, or assigned surrogate parent **prior** to the initiation of each evaluation **will affect payment for the evaluation.**

An evaluation can be reimbursed by the NYC Early Intervention Program **only** if the evaluator has a contract with NYC DOHMH and has submitted complete documentation to the Regional Office via NYEIS (i.e., **Summary of Multidisciplinary Evaluation**, and evaluation reports).



# NYC EARLY INTERVENTION PROGRAM

## SUMMARY OF MULTIDISCIPLINARY EVALUATION (MDE)

Screening  Evaluation

Child's Name: \_\_\_\_\_ Date of Evaluation: \_\_\_\_/\_\_\_\_/\_\_\_\_  
EI #: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### SIGNATURE OF PERSON COMPLETING SUMMARY:

I certify that the determination of eligibility and the summary of the multidisciplinary evaluation or screening is based upon an interview with the above-named child's parent/surrogate parent (or other guardian if there is no available parent), a general assessment of the child's level of functioning in each of the five developmental domains, and an in-depth assessment in the specific domain(s) in which there is a suspected delay. I further certify that to the best of my knowledge, age-appropriate instruments and procedures and informed clinical opinion were employed in such assessments.

\_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature

\_\_\_\_\_  
*Print name, title and license number*

### **Summary of Evaluation:**

- I. Name, title and disciplines of the persons performing the evaluation and assessment
- II. The child's health assessment (e.g., recent physical examination report, hospital discharge summary)  
- Describe the nature of any delay with obtaining Health Assessment Information from the child's primary care provider (if applicable)
- III. Summary of Parent Interview and optional Family Assessment
- IV. Description of the assessment process and conditions
- V. Measures and/or scores that were used, if any; and an explanation of these measures or scores
- VI. The child's responses and the family's belief about whether the responses were optimal
- VII. How informed clinical opinion was used by the evaluation team in assessing the child's developmental status and potential eligibility for the EIP
- VIII. The child's developmental status in the five developmental domains, including the unique strengths and needs in each area
- IX. A clear statement of the child's eligibility
- X. Nature of child's/family's transportation needs

If a bilingual evaluation is conducted, this summary should also be provided in the parent's dominant or preferred language or other mode of communication of the parent, if feasible.

## SUMMARY OF MULTIDISCIPLINARY EVALUATION (MDE)/SCREENING

### INSTRUCTIONS FOR COMPLETION

EIP regulations require the evaluation team to prepare a written summary integrating the results of all the evaluations (Core and Supplemental). Any discrepancies between the evaluations must be explained. To the extent feasible and within the parent's preference and consent regarding disclosure to the interpreter, and within confidentiality requirements, this summary should be provided in the dominant language or other mode of communication of the parent. The components of the MDE summary and reports are outlined in 10NYCRR69-4.8 (a) (9) (i-iii)

**NOTE:** If the evaluation found the child not eligible for Early Intervention services, the evaluation team remains responsible for completing the Summary of Multidisciplinary Evaluation/Screening.

- Check the appropriate box: **Evaluation** or **Screening** to indicate report type.
- Provide the requested identifying information for the child.

Write the date that the MDE Summary/Screening was completed.

- *The person writing the summary must, sign and date the attestation, printing his/her name, title and license number (if appropriate) below the signature.*

*Note: The person completing the summary must be a member of the IFSP team (10NYCRR 69-4.8(a) (9) (i))*

The Summary of the Multidisciplinary Evaluation/Screening is a narrative report containing the following information:

- I. List of the name, title, and discipline of all individuals involved in the evaluation and assessment of the child.
- II. The child's health assessment, which should include any relevant medical information, such as current health status and medical history, appropriate ICD-9 code for a diagnosed condition with a high probability of resulting in developmental delay, and any other information pertaining to the child's development.
  - a. Describe the Nature of Delay with Obtaining Health Assessment Information from the child's primary care provider (if applicable).
    - Describe the frequent and persistent attempts made to obtain health assessment information
- III. Summary of Parent Interview and optional Family Assessment:
  - a. Parent Interview: include information about the family's resources, priorities and concerns related to the child's development and developmental progress.
    - If the child is in foster care, the parent interview should include both the biological parent and foster parent with parental consent
  - b. Family Assessment (optional): identify formal supports and services available through the EIP or other service delivery systems (e.g., family training, family/parent support groups, services through the Office of People with Developmental Delays) that the family may want to access.

Identify informal supports and community resources available to the family (i.e. family and friends, playgroups that can assist the family in enhancing their child's development, etc.).

IV. Description of the assessment process and conditions:

- a. List the various types of information sources used to determine the child's developmental status (as required by regulation), such as:
  - Standardized or criterion referenced instrument(s) ( Detailed in item V)
  - Direct observation of the child (Detailed in item VI)
  - Qualitative criteria for communication only evaluations
  - Interview with parent to determine perceptions of the child's abilities and performance on date(s) of testing (findings detailed in item VI)
  - Informed clinical opinion (findings detailed in item VII)
  - Any other sources of information relevant to the eligibility determination, with parental consent (e.g., medical information, report from relatives or family members, family day care or child care provider, name of foster care agency).
- b. Describe the conditions of the evaluation (required by regulation to ensure the accuracy of the results.) Include the following:
  - The style of the evaluation (e.g., arena, individual)
  - How parent/caregiver was involved
  - The evaluation setting, noting any possible impact on the child's performance
  - The child's state at the time of the evaluation (e.g., tired, irritable, hungry, alert, active).
- c. Describe how the evaluation is responsive to the cultural and linguistic background of the family (to ensure discriminatory evaluation and assessment procedures are employed). This may include:
  - A statement of the extent to which the child was exposed to different languages;
  - Whether a bilingual evaluation was indicated and conducted;
  - Whether and how an interpreter was used (the name and relationship of the interpreter to the family, if any);
  - The methodology used to conduct the bilingual evaluation with or without an interpreter and the child's response; and
  - The repertoire of words or sounds in all languages of exposure.
    - The combined number of words in all languages that the child is exposed to need to be listed and considered together when making a determination regarding the child's developmental status.

V. Measures and/or scores that were used, if any; and an explanation of these measures or scores:

- a. Identify the instruments used and provide an explanation of the scores/ results obtained, including relevance to the child's level of functioning.
  - The instrument used must be from the SDOH preferred list of instruments
  - A justification must be provided if an instrument that is not on the preferred list is used
- b. This may include a discussion of the limitations of a tool when the evaluator has determined that the scores do not accurately reflect the child's level of functioning.
- c. For communication only where no norm referenced instrument is available or appropriate, use the qualitative criteria articulated in NYS 10NYCRR 69-4.23

VI. The child's response to the procedures and instruments used as part of the evaluation process, and the family's belief about whether the responses were optimal:

- a. Report on the child’s response to all evaluation procedures. This may include the child’s spontaneous response, elicited response, or facilitated response to the parent/caregiver or the evaluator, etc.
  - b. Report on family’s belief about whether the responses were optimal; provide individualized information.
- VII. How informed clinical opinion was used by the evaluation team in assessing the child’s developmental status and potential eligibility for the EIP. (As stated in Memorandum 2005-02, pg 10, and defined at 10NYCRR 69-4.1(w), informed clinical opinion, for the purposes of the EIP, is “the best use of quantitative and qualitative information by qualified personnel regarding a child, and family if applicable. Such information includes, if applicable, the child’s functional status and rate of change in development and prognosis.”)
- a. Based on the evaluators’ professional expertise, describe any qualitative factors impacting the child’s functioning.
  - b. Ensure that results of procedures and instruments used from all evaluations are integrated to address discrepancies between reports, and accurately determine child’s functioning ability in each developmental domain.
- VIII. Report of the child’s level of functioning in each of the five developmental domains; and report of the unique strengths and needs in each area.
- IX. A clear statement of the child’s eligibility:

If eligibility criteria are met	If eligibility criteria are not met
<ul style="list-style-type: none"> <li>• A statement documenting that the child is eligible for the EIP based on a diagnosed condition with a high probability of resulting in developmental delay and associated ICD-9 code; or</li> <li>• A statement of developmental delay consistent with NYCRR69-4.8(a)(9)(iii) (a statement describing “the child’s developmental status including objective and qualitative criteria in sufficient detail to demonstrate how the child meets the eligibility criteria for the program”) and associated ICD-9 code for developmental delay</li> </ul>	<p>A statement documenting reasons why the child is not eligible for the EIP. <u>Examples of reasons</u>: the child’s development is within acceptable limits; the child is not experiencing a developmental delay consistent with the State’s definition of developmental delay (NOTE: <i>It is possible for a child to have a developmental delay and not meet the eligibility criteria for the EIP</i>)</p>

As stated in the Memorandum 2005-02, “Eligibility cannot be made on the basis of isolated delays in specific skill areas. Rather, the MDE team must, using *their* informed clinical opinion, decide whether **composite evaluation findings, considered together**, are consistent with eligibility criteria for the EIP”

- X. Nature of child’s/family’s transportation needs:
- a. Information includes: parents’ ability or inability to provide transportation; the child’s special needs related to transportation; safety issues/ parental concerns related to transportation, etc.

## Your Agency Name/Logo

Your Agency Address and Contact information  
Phone and Fax Number of Agency

Regional Office:	Date:
Child's Name:	LHU:
Date of Birth:	Eligible? YES NO

**The following are required for the MDE:**

Checklist Before NYEIS Implementation	Checklist After NYEIS Implementation
<b>1. MDE Form (Multidisciplinary Evaluation Form)</b>	<i>Not required: Replaced by NYEIS</i>
<b>2. Medical Form/Health Assessment Information</b> Medical form or Electronic medical record print-out signed by doctor	Required as an "MDE Attachment" in NYEIS
<b>3. <u>Core</u> Evaluation Form</b>	<i>Not required: Replaced by NYEIS</i>
<b>4. Summary of MDE</b>	Required as an "MDE Attachment" in NYEIS
<b>5. Parent Interview</b>	Required as an "MDE Attachment" in NYEIS
<b>6. Parental Consent for Evaluation</b>	Required as an "MDE Attachment" in NYEIS
<b>7. Parental Consent to Initiate Service Coordination Agency</b>	Not required: attached to the "Child's Integrated Home Page" by the ISC Agency
<b>8. Parental Consent to <u>Release/Obtain</u> Information</b>	Not required: attached to the "Child's Integrated Home Page" by the ISC Agency
<b>9. Family Worksheet</b>	<i>Not required: Replaced by NYEIS</i>
<b>10. Insurance Information Form</b>	<i>Replaced by the <b>Information and Parental Consent for Use of Private Insurance to Cover Early Intervention Services</b></i> Attached to the "Child's Integrated Home Page" by the ISC Agency

**The following are required for the MDE if applicable:**

Checklist Before NYEIS Implementation	Checklist After NYEIS Implementation
<b>11. <u>Supplemental</u> Evaluation Form</b>	<i>Not required: Replaced by NYEIS</i>
<b>12. Supplemental(s):</b>	Required as an "MDE Attachment" in NYEIS
( ) Speech Therapist                      ( ) Special Educator                      ( ) Psychologist ( ) Physical Therapist                      ( ) Occupational Therapist                      ( ) Pediatrician or Physician ( ) Audiologist                      ( ) Other:	
<b>Language(s):</b>	
<b>13. Reason for Delay Form</b>	<i>Not required: Replaced by NYEIS</i>
<b>14. Family Assessment</b>	Required as an "MDE Attachment" in NYEIS
<b>15. Request for Additional Evaluations</b>	Required as an "MDE Attachment" in NYEIS
<b>16. Surrogate Parent Assignment by EIOD</b>	Not required: attached to the "Child's Integrated Home Page" by the ISC Agency
<b>17. Closure Form</b>	Required as an "MDE Attachment" in NYEIS
<b>Reason for Closure:</b>	

<b>Your Name:</b>	<b>Title:</b>
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**Appendix A: Multidisciplinary Evaluation (MDE) vs Screenings**

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

## Appendix B: Best Practice Recommendations for Report Writing and Submission

When preparing the MDE report and summary, take the following best practices into account. In addition, the report and MDE summary should:

*Explain any discrepancies or differences between individual evaluations, between parent report and test results, or between incidental observations of skills.*

1. Describe the child's medical history including:
  - a. Birth history
  - b. Diagnosed condition (ex: Reflux)
  - c. Medications
  - d. Hospitalizations and surgeries
2. Describe the child's **recent history** when significant (separation, placement in foster care, arrival of sibling, move, hospitalization, etc.) and discuss possible impact on functioning.
3. Describe the **conditions** of the evaluation:
  - a. Setting of evaluation
  - b. Factors affecting child on the day of evaluation (sleepy, hungry, awakening from nap, etc.)
  - c. Who was present including all evaluators, if arena-style evaluation was conducted and impact on child's functioning
  - d. How the evaluator established rapport with child
  - e. How the parent's participation was facilitated
  - f. Informal and incidental observations of the child's functioning
  - g. How the child and family were introduced to the formal aspects of the evaluation process
4. Describe the child's performance through **vivid and detailed vignettes of behavior**, which will include language and behavior samples, play-based assessments, interviews with parent(s) and, when appropriate, other caregivers, to determine the child's functional developmental status.
5. Report **the family's comments** about how the child's behavior during the evaluation compares to the child's usual behavior.
6. Describe the child's **emerging skills**.
7. **Use family-friendly language**. Explain professional terms if they must be used).
8. Describe the **child's strengths** as well as **needs**.
9. When the child demonstrates a delay, explain clearly what the deficit(s) is/are, both within the context of that developmental domain as well as its impact on the child's overall development.
10. Clearly distinguish whether the delay is due to immaturity and lack of exposure and is expected to disappear with age, or is a true developmental delay.
11. **Address parental concerns clearly and fully**.
12. **Report accurately** measures, scores and any other results from the instruments that were used.

13. Provide an **explanation** of these measures, scores or results in a manner easily understandable by parents and other professionals.
14. **Interpret and integrate** information from all sources (observation of play, parent reports, other evaluations, etc.) not just tests.
15. When describing what skills the child can and cannot do, only list developmentally expected/appropriate skills.
16. **Make use of relevant available medical information** about the child to assess functioning where applicable.
17. **Always include diagnostic information** (and ICD9 code).
18. Adhere to regulations requiring use of clinical opinion in addition to formal assessment, review of pertinent health records, observations, and parental report to arrive at a determination of the **child's functioning ability**.
19. **Clearly document clinical opinion** using, where applicable, the SDOH Clinical Practice Guidelines.
20. Recommend the **types of services** that are clinically appropriate and may be needed to meet the child's needs.
  - a. **Do not make recommendations regarding frequency, duration and intensity of specific services.**
21. Make appropriate recommendations for further evaluations when concerns are raised.
22. Individualize the report. Do not use language that is "canned," "stereotyped," or inappropriate or inapplicable to early intervention (ex: "this will impact vocational skills").
23. Do not make an unwarranted prognosis beyond professional scope or expertise.
24. When eligibility status changes for any reason, ensure that reports document why child is not eligible and that an explanation has been given to the parents.



## Appendix C: Informed Clinical Opinion

### **Developed in conjunction with the NYC Local Early Intervention Coordinating Council: Program and Services Committee (9.25.2009)**

Informed Clinical Opinion (ICO) refers to a professional's use of quantitative information (based on test instruments and/or other measurable indicators), qualitative information (based on observation and interviewing) and expertise in a particular area (obtained through professional training) in order to assess an individual's overall functioning. It offers the evaluator the opportunity to utilize his/her professional knowledge in a manner that is critical in providing a better understanding of the unique strengths and needs of the individual being evaluated. In the Early Intervention Program ICO is essential for substantiating the evaluator's recommendations and should be used in conjunction with all other available information in determining eligibility for the Early Intervention Program.

ICO is a required component of every Early Intervention evaluation and Multi-Disciplinary evaluation (MDE) summary. However, it is particularly important when discrepancies exist between an evaluator's clinical impression and any of the following:

- test scores
- caregiver concerns
- findings from other evaluators.

The MDE summary, with input from all evaluators, should explain and discuss areas of agreement as well as discrepancies in order to reach a conclusion regarding the child's overall functioning and eligibility.

New York State provides the following definition of ICO:

*Informed Clinical Opinion for the purposes of the Early Intervention Program is defined at 10NYCRR section 69.4.1 (w) as "the best use of quantitative and qualitative information by qualified personnel regarding a child and family, if applicable. Such information includes, if applicable, the child's functional status, rate of change in development and prognosis. When using clinical opinion the evaluator should take into consideration results of standardized instruments, clinical observation, interviews, other measures used, the concerns related to child and family and his/her own clinical background expertise."*

Although these regulations underscore the importance of clinical opinion, no specific guidance is provided on how to integrate ICO into both the evaluation report and the MDE in the most useful way. The purpose of this document is to provide a resource for using ICO in the most effective manner in order to ascertain functional status, rate of change in development and prognosis and to determine eligibility for the Early Intervention Program.

### **Critical Factors in Formulating Informed Clinical Opinion: Individual Evaluation**

## **Data collection**

Data regarding a child's functioning is ascertained from four different sources:

1. Caregiver interview
2. Evaluator observations
3. Test performance
4. Medical and/or other relevant evaluations

### 1. Caregiver Interview

A caregiver interview is essential in understanding the child's functioning. The evaluator should ask open ended, non-judgmental questions regarding the child's functioning in a variety of situations which include: sleeping and eating behaviors, interpersonal relatedness, communication, adaptive skills, child behaviors (tantrums, frustration tolerance) and play activities. The information obtained from the interview should provide very specific details e.g. not only what the child likes to play with, but how the child plays with the toy. The caregiver's concerns should be investigated and responded to in the summary section of the report.

### 2. Evaluator Observations

The evaluator's observations are critical when substantiating clinical opinion. The evaluator should use qualitative information to create a picture of the child and describe his/her salient characteristics in a way that might not be captured in the quantitative information alone. The following information should be described in detail:

- Child's ability to attend and focus
- Quality of child's interaction with caregiver and with the examiner
- Quality of the child's independent, non-structured play with toys
- Ability of the child to transition
- Quality of the child's ability to move about in his/her environment
- Behavioral attributes, e.g., activity level
- Child's desire to explore and demonstrate curiosity about his/her environment

Whether a child can or cannot complete a specific task is important; however, equally important is the manner in which a child executes the task. Therefore, a description of the quality of the response is essential in forming a clinical opinion. The focus should be on the manner in which the child was able to complete the task: did he/she perform this task deftly and in an age appropriate manner, what strategies did the child use (e.g., using both hands when the task requires only one hand or posturing his/her body in an atypical fashion). In addition, the evaluator must understand a child's functioning within the context of normal development. How does this child's abilities compare to what is expected for his/her age?

### 3. Test Performance

Whenever possible, a norm referenced assessment instrument should be used to evaluate the child's functioning. However, the test score alone cannot be used to determine eligibility. State regulations require that the MDE include ICO as one of the information sources upon which eligibility is based. Norm referenced and many criterion referenced tests are standardized and can be used for the purposes of documenting a child's strengths and needs; however, they do not provide sufficient information to determine eligibility for the Early Intervention Program. Evaluators should consider the strengths and weaknesses of any test instrument and whether the needs of a specific child are best served by the test. In addition, it is important to consider the psychometric properties of a test instrument and its applicability to a particular age group. Some issues to be aware of:

- Standardized tests may contain components that inherently limit their ability to accurately assess a child's functioning. For example, a test's age range may be too broad to be sufficiently sensitive for a specific age child. Or, the test may have a low item density at the younger ages, but a more adequate density for older age groups. A low density of items may not provide sufficient information regarding the child's functioning in a specific area or an instrument has a large standard error of measurement.
- Developmental assessment instruments base their scores on developmental milestones, not on the underlying factors related to development. In some cases this may limit their ability to fully assess the child's functioning. Developmental milestones do not occur in a vacuum. They consist of many precursors within a developmental trajectory. A description of this trajectory and whether it is developmentally appropriate is critical in describing a child's functioning. For example, the number of words a child uses may be an insufficient indicator of a child's language development when considered separately from other indicators. It is equally important to assess whether the child has developed abilities necessary to form words i.e appropriate oral-motor functioning and the ability to make a variety of sounds.
- The composite or standardized score of an administered test may be rendered as relatively meaningless due to significant intra-domain discrepancies. For example, in some developmental tests fine and gross motor skills are combined into one score. This single, combined score for physical development may demonstrate a significant delay. However, the fine or gross motor scores, individually, may not demonstrate a significant delay. In these cases, an assessment of how the particular delay impacts on other developmental domains should be assessed. For example, a significant delay in the fine motor area might impact on a child's cognitive or adaptive functioning. A child with poor fine motor functioning may not be able to manipulate items in a way that helps him/her learn about his environment, thus limiting acquisition of age appropriate skills. It is critical to examine and interpret these discrepancies. The child's development should be described in comparison to how typically developing children are functioning. Any atypical abilities should be described and interpreted.

#### 4. Medical and/or Other Relevant Evaluations

Parents may have obtained evaluations outside the EIP for their child, e.g., neurological or psychological evaluations. In addition, they may have pertinent medical records that can provide valuable information for the EIP. These evaluations cannot be used to supplant the Early Intervention Multi-Disciplinary evaluation; however, the information from these reports can and should be used to support informed clinical opinion.

### **Summary**

Each evaluator must take the information he or she has obtained through the caregiver interview, evaluator observations, test performance and other relevant evaluations and write an evaluation report that integrates and synthesizes this information. Through this process the evaluator can then describe the significance of the evaluation and provide an interpretation of the results in a manner that can help determine eligibility.

### **Critical Factors in Formulating Informed Clinical Opinion: MDE Summary**

The purpose of a multi-disciplinary evaluation is to assure that a child's functioning in all five domains is fully and accurately assessed to determine eligibility for the Early Intervention Program. ICO is a critical component in documenting eligibility in the MDE summary. ICO requires the integration, synthesis and interpretation of all evaluation findings. In some cases, all evaluations are in concordance and corroborate the parent's concerns. At other times, discrepancies arise among evaluations and/or the caregiver. It is the responsibility of the evaluation team to address and explain these discrepancies.

- The team should integrate information from both qualitative and quantitative data provided by each evaluator and determine the true level of functioning and address the possible reasons for the discrepancies.
- Information from the caregiver interview should be part of each separate evaluation and is an integral component in the overall assessment of the child. At times, the caregiver interview may yield discrepant information among evaluators. Each professional asks questions related to his/her field. It is not uncommon to see different perspectives of the child depending on the questions that were asked. It is the team's responsibility to review, interpret and synthesize information from the evaluators and the caregiver so that these discrepancies can be better understood and explained in the summary.
- Informed Clinical Opinion used within the context of the Team Summary can help provide information regarding how particular deficits, whether they are statistically significant or not, are impacting on the child's development across all domains and determines whether the child is eligible for therapeutic services.

## New York City Early Intervention Program

<b>Policy Title: Bilingual Evaluations</b>	<b>Effective Date:</b> <b>For All New Referrals Starting Staten Island: 7/12/2011</b> <b>Bronx: 7/26/2011</b> <b>Manhattan: 8/9/2011</b> <b>Queens: 8/23/2011</b> <b>Brooklyn: 9/7/2011</b>
<b>Policy Number: 4-C</b>	<b>Supersedes: N/A</b>
<b>Attachment (s): Active Providers: Language and Specialties</b>	<b>Regulation/Citation:</b> <b>10NYCRR69-4.1 (i);</b> <b>10NYCRR69-4.8 (a) (14);</b> <b>10NYCRR69-4.8 (6); 10NYCRR69-4.8 (a) (9) (v) (v); Memorandum 2005-02 FAQ 21</b>

### **POLICY DESCRIPTION:**

All aspects of the multidisciplinary evaluation, including any instruments, tests, and materials used in the evaluation process, must be administered in the child's dominant language unless it is clearly not feasible to do so and consider the unique characteristics of the child. In addition, nondiscriminatory evaluation and assessment procedures shall be employed in all aspects of the evaluation and assessment process. Responsiveness to the cultural background of the family shall be a primary consideration in all aspects of evaluation and assessment.

### **II. PROCEDURE:**

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator</b>	<ol style="list-style-type: none"> <li>1. ISC will review the <b>Active Providers: Language and Specialties</b> list and allow the parent to select an Evaluation Agency with evaluators who speak the language of the child and family.               <ol style="list-style-type: none"> <li>a. If upon review of the <i>Language and Specialties list</i>, an appropriate evaluation agency with an appropriate MDE team cannot be located, the ISC will inquire if the evaluation agency can find an interpreter.                   <ol style="list-style-type: none"> <li>i. The ISC assists the Evaluation Agency locate an interpreter if one cannot be located.</li> </ol> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Service Coordination notes must document the offer to family/caregiver to review the <b>Active Providers: Languages and Specialties</b> list in the SC notes and attempts to locate a bilingual evaluation team.</li> </ul>
<b>Evaluation Agency</b>	<ol style="list-style-type: none"> <li>1. Assesses the child's dominant language.               <ol style="list-style-type: none"> <li>a. Dominant language is defined as: the language or mode of communication used by parent or the potentially eligible child, including Braille, sign language, or other mode of communication (10 NYCRR §69-4.1(i))</li> <li>b. For the purposes of the evaluation, the dominant language of the child determines the language(s) of the evaluation. (Memorandum 2005-02 FAQ 21)</li> </ol> </li> <li>2. Determines the appropriate language or languages of the Multidisciplinary</li> </ol>

Evaluation (MDE).

3. When the child/family speaks a language other than English:
  - a. Evaluation agency is expected to locate an evaluator who speaks the language(s) of the child and family to ensure that:
    - i. The child's core evaluation and any necessary supplemental evaluation(s) are performed by one or more qualified personnel who are bilingual **and if possible** familiar with the child's cultural background.

**Note:**

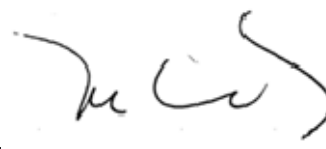
- A parent(s) **cannot** insist that the evaluation be conducted in English or refuse to have the evaluation conducted in the child's dominant language.
- If a parent does not consent to a multidisciplinary evaluation consistent with Federal and State requirements, eligibility cannot be established for the EIP and the municipality is not obligated to develop an IFSP and provide services to the child.

- b. When a bilingual Evaluator (s) is located:
  - i. Evaluator(s) should consider how the following socio-cultural factors impact the child's performance and developmental functioning:
    - Family's values, beliefs and practices
      - *Example: In some cultures, children are fed by the parent and do not have the opportunity to feed themselves until they are much older. This might look like a delay in feeding skills or adaptive development, however according to cultural practices this is the norm.*
    - Communication style
  - ii. When feasible, the evaluator should use tests that have been normed and standardized on the child's linguistic and cultural group.
  - iii. If a child is exposed to more than one language, the evaluation process must take the child's abilities to understand and use each language into account.
    - The receptive and expressive skills of children may develop at different rates in a bilingual/multilingual environment... Because some of the differences in language structure impact the way in which children learn the language, it may appear that a child learning English, who is also influenced by Spanish, is delayed in his language development when in fact it may be a normal variation in the learning process.  
(Communication Disorders: Clinical Practice Guidelines pg. 25)

**Note:** Exposure to another language does not necessarily require a bilingual evaluation. SDOH memorandum 2005-2 FAQ #22

- c. If the Evaluation Agency is unable to locate a bilingual evaluator:

	<ul style="list-style-type: none"> <li>i. Notifies the ISC and the parent that the evaluation cannot be done using a bilingual evaluation and that an interpreter must be located.</li> <li>ii. Locates an interpreter who is fluent in the language(s) of the family and familiar with the culture of the family</li> </ul> <p><b>Note:</b> Interpreter should receive information on the procedural aspects of the evaluation and how the interpretation should occur during the evaluation</p> <ul style="list-style-type: none"> <li>iii. Evaluation agency should document attempts made to locate an interpreter <ul style="list-style-type: none"> <li>• The evaluation agency bills for the multidisciplinary evaluation at the bilingual rate.</li> </ul> </li> <li>iii. When an interpreter is used, the evaluator should document how interpretation was provided during the evaluation and the way it may have affected the child's performance</li> </ul> <p>d. If the Evaluation Agency cannot locate a bilingual interpreter, a friend or acquaintance of the family who speaks both languages may be used.</p> <ul style="list-style-type: none"> <li>i. If the family is unable to locate someone who speaks the language, the parent may be used as a last resort. <ul style="list-style-type: none"> <li>• <b>Use of the parent or family member presents significant difficulties in the validity of the evaluation results.</b></li> </ul> </li> </ul> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Parent cannot <b>be required</b> to use family members/friends as interpreters.</li> <li>• Prior to using an interpreter for common languages (e.g. Spanish), the evaluation agency should contact the Regional Office or Program Monitoring and Quality Improvement for assistance in locating a bilingual evaluator.</li> </ul>
<b>Regional Office/ Program Monitoring and Quality Improvement</b>	1. Offer technical assistance to evaluation agencies in locating bilingual evaluators/interpreters
<b>Evaluation Agency</b>	Once the Evaluation is complete: 1. To the extent feasible and within the parent's preference: a. The <b>MDE Summary</b> and oral summary of the evaluation must be provided in the language or other mode of communication of the parent.

Approved By:   
Assistant Commissioner, Early Intervention

Date: 7/19/11

## New York City Early Intervention Program

<b>Policy Title: Assessing Transportation Needs in The Multidisciplinary Evaluation</b>	<b>Effective Date For All Referrals Starting Staten Island: 7/12/2011 Bronx: 7/26/2011 Manhattan: 8/9/2011 Queens: 8/23/2011 Brooklyn: 9/7/2011</b>
<b>Policy Number/Attachment: 4-D</b>	<b>Supersedes:</b>
<b>Department/Unit: Bureau of Early Intervention</b>	<b>Regulation/Citation: 10 NYCRR 69-4.8(a)(4)(v)</b>

### I. POLICY DESCRIPTION:

Evaluations conducted under the Early Intervention Program must address the issue of the transportation needs of the child, and include this information in the evaluation report without regard to the eligibility of the child for early intervention services at the time of the evaluation. The evaluation team must address the issue of transportation with parent(s) as detailed below, and document the family's responses. A discussion of the transportation needs may be incorporated into any evaluation report, or into the parent interview or family assessment, as determined by the evaluation team.

Consideration of this issue is mandated by Section 69-4.9(a)(4)(v) of the NYS Regulations, which provides that the evaluation shall include:

- (v) an evaluation of the transportation needs of the child, which shall include:
  - a) Parental ability or inability to provide transportation;
  - b) The child's special needs related to transportation; and
  - c) Safety issues/parental concerns related to transportation.

### II. PROCEDURE:

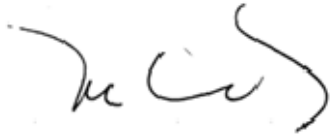
<b>Responsible Party</b>	<b>Action</b>
<b>Early Intervention Evaluator</b>	1. Assess the transportation needs for services outside the home with the parent during the course of the Multidisciplinary Evaluation. <ul style="list-style-type: none"> <li>a. The following continuum of transportation services should be discussed:               <ul style="list-style-type: none"> <li>i. No transportation needed</li> <li>ii. Parent/guardian may be able to transport child via public transportation or car</li> <li>iii. Parent /guardian unable to transport child – state reason</li> <li>iv. School bus/car service</li> <li>v. Special transportation due to child's medical needs</li> <li>vi. Other needs (e.g., which family members or a nurse will accompany child to services) – be specific.</li> </ul> </li> </ul>



- b. The evaluation report must address the following transportation issues:
- i. The child's history
    - Sufficient background and information must be given to justify a recommendation for the parent to accompany the child to group developmental services.
      - i. A conclusion that the parent should or should not accompany the child will not be considered sufficient.
  - ii. Medical needs of the child that would dictate a particular means of transportation. ( e.g. wheelchair bus)
  - iii. The need for specialized medical equipment or personnel to accompany the child should be cited.

Note:

- If there is no specified medical need for a certain kind of transportation, it is premature for the evaluation to recommend a particular type of transportation.
  - Transportation type will then be determined at the IFSP meeting when it is decided what services the child will be receiving and on what schedule.
2. Assessment of transportation need must be included in the evaluation report and the MDE summary when the full MDE packet is submitted to the Regional Office via NYEIS for review.
- a. Complete submission procedures are located in the **Policy on Multidisciplinary Evaluations** in this chapter of the manual.



Approved By: \_\_\_\_\_  
 Assistant Commissioner, Early Intervention

Date: 7/19/2011

# NYEIS Multidisciplinary Evaluation (MDE) Crosswalk

# NYEIS Multidisciplinary Evaluation Evaluation Crosswalk - Screening

7/2011

NY Early Intervention System  
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Screening Necessary: Savannah Claudio - 300348

Was a screening deemed necessary?:

Save Cancel

recent items

NY Early Intervention System  
 NYEIS  
 NYEIS Sandbox  
 (Practice use only - no real live data)

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navigation

Modify Screening: Savannah Claudio - 300348

Save Cancel

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241		

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Evaluator NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Evaluator Details**

Evaluator Name:	Qualified Personnel:
Evaluator NPI:	Date Assigned:

**Screening Location**

If selected location is other than "Child's Home", must enter "Location Address". If location is at a provider's site, must select the "Provider Location".

Location Type:

Location Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241	Provider Location:	
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**Screen Domains**  Domain  Adaptive  Cognitive

**Concern About Specific Domains**  Domain  Adaptive  Cognitive

# NYEIS Multidisciplinary Evaluation Crosswalk -Screening Cont.

7/2011

Reason for Screen (Choose all that apply)	
Concern about child's overall development?:	Yes <b>5</b>
Concern about child's hearing?:	No <b>6</b>
Concern about child's vision?:	No <b>7</b>
Performed specific diagnostic screening test?:	No <b>8</b>
If yes, which test?:	<b>9</b>
Parent Informed	
Was parent informed of results?:	Yes <b>10</b>
If yes, enter date informed:	7/28/20 <b>11</b>
Screening Details	
Date Screening Completed or Decision Not to Screen:	<b>12</b>
Screening Results:	Parent Request <b>13</b>

## NYEIS Multidisciplinary Evaluation: Instructions for Completion

**Note:** NYEIS navigation instructions appear in *italics*

**Screening** - This section in NYEIS replaces the Screening Data Entry Form

- *Select “Screening” from the NYEIS navigation bar*
- *Select “New”*

1. **Was a screening deemed necessary?** Select from the drop - down list:
  - a. No - Either the parent is requesting an evaluation, or the child is suspected of having a delay in one or more functional domains
  - b. Yes - The parent may be requesting a screening, or indicating that the child may appear to be slightly delayed
  - c. No - child w/ diagnosed condition - Children with a diagnosed condition that makes them automatically eligible for the EIP should not be screened, but should proceed to an MDE.

**Note:**

- If the child was referred with a “confirmed eligibility diagnosis,” a screening is not permitted.
- If the child was referred with a “suspected delay,” the screening section must be completed.

- *Select “Save” when the selection is complete*
- *If either “No” option is selected, the screening section is complete*
- *If “Yes” is selected, the NYEIS Screening page will appear. The fields below must be completed:*

2. **Location type** – Select the location from the drop - down list. If the location is other than “Child’s Home,” the “Location Address” must be entered. If location is a provider’s site, must select the “Provider Location.”
3. **Screen domains** - Select all areas that were screened. These areas must be reflected in the Screening report
4. **Concern about specific domains** - Select the area(s) for which the evaluator found a possible delay.
5. **Concern about child’s overall development?** - Select yes or no.
6. **Concern about hearing?** Select yes or no. If yes is selected, the MDE should address hearing
7. **Concern about vision?** Select yes or no. If yes is selected, the MDE should address vision
8. **Performed specific diagnostic screening test?** Select yes or no.
9. **If yes, which test?** Select the specific test from the drop - down.
10. **Was parent informed of the results?** - Select yes or no. The parent must be informed of the results
11. **Date informed** - Enter the date that the screening results were discussed with the parent
12. **Date screening completed or decision not to screen** - Enter the date that the screening was completed.
13. **Screening results** - Select from the drop - down list:
  - a. **Passed** - No MDE needed. Child scored within normal limits and the parent does not request further testing.
  - b. **Child needs MDE** - Child is showing a possible delay in one or more developmental domains
  - c. **Parent requests MDE** - Child does not show a possible delay, but the parent wants an MDE due to continued concerns.

- *Select “Save” to complete the Screening section*
- *The View Screening page will appear*
- *Select “Change/ Assign Rendering Provider” to document the qualified personnel who completed the screening*

- *Enter evaluator name or % (wildcard)*
- *Select the staff member conducting the screening*
- *The staff member must be already entered as a licensed/certified professional in your agency's "Employees/Contractor" section of NYEIS.*

**When screening is performed and an MDE does not need to be completed:**

- *From the MDE homepage select "View" under the "MDE Summary Details" section*
- *Select "Edit"*
  - *Under the Eligibility category*
    - *Eligibility Status - Select "No MDE, screening only."*
  - *Under the Diagnosis Details category*
    - *Screening Only Diagnosis Code - Enter the appropriate "V" code (usually V79.3)*
- *Enter "Save"*
- *Attach the screening summary and screening report in the "MDE Attachments" section*
  - *Refer to the **MDE Policy** for detailed attachment instructions*
  - *The screening can now be submitted in NYEIS.*

# NYEIS Multidisciplinary Evaluation Crosswalk – Developmental Assessment (Core)

7/2011

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navigation

**View Developmental Assessment: Savannah Claudio - 300348**

?

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241		

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Agency NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Qualified Personnel Involved**

Action	Date Assigned	Rendering Provider	Qualified Personnel

**Developmental Domain Results**

Action	Domain	Developmental Status	Discipline/QP	Date Completed
<a href="#">View</a> <a href="#">Cancel</a>	Adaptive			
<a href="#">View</a> <a href="#">Cancel</a>	Cognitive			
<a href="#">View</a> <a href="#">Cancel</a>	Communication			
<a href="#">View</a> <a href="#">Cancel</a>	Social/Emotional			
<a href="#">View</a> <a href="#">Cancel</a>	Physical			

**Location**

Location Type:	
Location Address:	Provider Location:

# NYEIS Multidisciplinary Evaluation Crosswalk – Developmental Assessment (Core)

7/2011

<b>Location</b>		
		Location Type:
Location Address:	Provider Location:	
<b>Evaluation Diagnosis Results</b>		
		EI Eligible Diagnosis Code:
		Other Eligible Diagnosis Code:
		If other ICD code, justification:
		Date of Diagnosis:
		Diagnosis Made By:
		Bilingual Evaluation?:
		If yes, language:
		If Other, description:
		Date Developmental Assessment Complete:
<b>Evaluation Methods</b>		<input type="button" value="New"/>
<u>Evaluation Method</u>	<b>Diagnostic Tests Administered</b> <span style="background-color: black; color: white; border-radius: 50%; padding: 2px 5px;">3</span>	
Standardized Test	Action	Test Name
		Date Test Administered
<b>General Evaluation Comments</b>		
<b>Parent Caregiver Report/Comments</b>		
		<input type="button" value="Edit"/> <input type="button" value="Close"/>



# NYEIS MDE Crosswalk – Developmental Assessment (Core)

7/2011

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**Modify Developmental Domain Details: Savannah Claudio - 300348**

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241		

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Agency NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Evaluator Details**

Evaluator Name:	Wendy Welch	Evaluator NPI:	331417
Qualified Personnel:	Speech Language Pathologist		

**Developmental Domain Details**

Developmental Domain:	Communication
Domain Status:	1
Date Completed:	2

**Evidence-Based Criteria** 3

If no test appropriate or test inadequately represents child's developmental level, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department. Please select all that apply.

Child younger than 18 months of age	Child 18 months of age or older
<input type="checkbox"/> <u>Criteria</u>	<input type="checkbox"/> <u>Criteria</u>
<input type="checkbox"/> Documentation that the child has attained none of the normal language milestones expected for children in the next younger age range, and none for the upper limit of the child's current chronological age range, and the presence of a preponderance of established prognostic indicators of communication delay that	<input type="checkbox"/> No single words by 18 months of age
	<input type="checkbox"/> Vocabulary of fewer than 30 words by 24 months of age
	<input type="checkbox"/> No two-word combinations by 36 months of age

**Comments** 4

# NYEIS Multidisciplinary Evaluation Crosswalk – Developmental Assessment (Core)

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**Modify Developmental Assessment: Savannah Claudio - 300348**

Save | Cancel

## Location

If selected location is other than "Child's Home", must enter "Location Address". If location is at a provider's site, must select the "Provider Location".

Location Type:

Location Address:

## Evaluation Diagnosis Results

EI Eligible Diagnosis Code:

Other Eligible Diagnosis Code:

If other ICD code, justification:

Date of Diagnosis:

Diagnosis Made By:

Bilingual Evaluation?:

If yes, language:

If Other, description:

Date Developmental Assessment Complete:

## Evaluation Methods

Evaluation Method

Clinical Assessment

Informed Clinical Opinion

Evaluator Observation

Parent/Caregiver Report

Standardized Test

Criterion Referenced Test

# NYEIS Multidisciplinary Evaluation Crosswalk – Developmental Assessment (Core)

7/2011

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NYEIS Sandbox:  
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Modify Developmental Assessment: Savannah Claudio - 300348

Save Cancel

General Evaluation Comments 12

Parent Caregiver Report/Comments 13

Save Cancel

## NYEIS Multidisciplinary Evaluation Instructions for Completion

**Note:** NYEIS navigation instructions appear in *italics*

**Developmental Assessment (Core)** - This section in NYEIS replaces the Core Evaluation Data Entry Form

- *Select “Developmental Assessment” from the NYEIS navigation bar*
- *Select “New”*
- *Select “Edit”*

**1. Qualified personnel involved** - Select “New”

- a. *Enter evaluator name or % (wildcard)*
- b. *Select the staff conducting each part of the developmental assessment (a minimum of two must be selected)*
  - i. *Only one staff member can be entered at one time. Repeat this step for each person who conducted the developmental assessment.*
- c. *The staff member must be already entered as a licensed/certified professional in your agency’s “Employees/Contractor” section of NYEIS.*

**2. Developmental domain results** - Select “View” to complete each domain

- a. *NYEIS will prompt the user to select the qualified personnel involved in the assessment of the selected domain*
- b. *Select “edit” to enter the developmental domain results*
- c. *The “Modify Developmental Assessment” screen will appear*
  - i. *Refer to the Modify Developmental Assessment Screen below on this page*

**3. Diagnostic test administered** - Select “New”

- a. *“Add Diagnostic Test Administered” will appear*
  - i. *Test Name* - *Select the test administered from the drop down list*
    - *The drop down list provided is the SDOH Preferred List of Tools*
  - ii. *If Other, enter test name – If a tool is used that is not on the preferred list, a justification must be provided*
    - *Justify why other test used*
  - iii. *Date Test Administered*
  - iv. *Standard Deviation*
  - v. *Percentile Rank*
  - vi. *Mean*
  - vii. *T - Score*
  - viii. *Z - Score*
    - *Complete only the necessary fields “ v – viii” according to the test manual.*

### Modify Developmental Domain Details

**1. Domain status** - Select from the drop - down list

- a. *No delay* - *development within acceptable ranges*
- b. *2.0+ SD below the mean* - *sufficient alone for eligibility*
- c. *1.5+SD below the mean* - *similar delay in another functional area needed to establish eligibility*
- d. *12 month delay* - *sufficient alone for eligibility*
- e. *33% or more delay* - *sufficient alone for eligibility*
- f. *25% or more delay* - *similar delay in another functional area needed to establish eligibility*
  - i. *For the communication domain:*

*If a test was not administered, or does not represent the child’s functioning, select one of the following options from the drop - down list:*

    - a. *No Standardized Test Appropriate, or*

b. Test Inadequately Represents Child’s Developmental Level

**Note:** The following options are used only to evaluate for on - going eligibility:

- SD or more below the mean
- Outside expected range

2. **Date completed** - The date the evaluation for this Domain is completed
3. **Evidence - based criteria** ( Communication Domain ONLY) - This section **must** be completed when the following options were chosen for the Communication Domain Status:
  - a. No Standardized Test Appropriate,
  - b. Test inadequately represents child’s developmental level.
    - i. Dependent on the child’s age (either younger or older than 18 months) select all applicable options in the list.

**Note:** The evidence - based criteria section **cannot** be completed if a numeric domain status was entered, (for example, 2.0 SD below the mean, etc.).

4. **Comments** - Comments are not mandatory, since the evaluation reports must be attached in the “MDE Attachments Section”
  - *Select “Save” once all of the information has been entered*
  - *Repeat the process to enter Developmental Assessment results for each developmental domain:*
    - *Complete the remaining Developmental Assessment fields by selecting “edit” from the “View Developmental Assessment” Screen*
    - *The “Modify Developmental Assessment” page will appear*

### **Modify Developmental Assessment**

1. **Location type** - Select the location from the drop down list. If the location is other than “Child’s Home,” the “Location Address” must be entered. If location is at a provider’s site, must select the “Provider Location.”
2. **EI eligible diagnosis code** - If a child has an automatic eligibility condition, the condition must be entered in this box. Click the magnifying glass to search for the applicable diagnosis
3. **Other eligible diagnosis code** - The diagnosis (and ICD 9 code number) which makes the child eligible must be listed. Click on the magnifying class to search for the appropriate code
4. **If other ICD code, justification** - Provide a reason as to why the code was selected
5. **Date of diagnosis** - Provide the date that the diagnosis was made
6. **Diagnosis made by** - Select from the drop - down list. If the diagnosis was made by an external source, documentation must be included in the MDE attachments section and the “External Evaluations” section must be completed.
7. **Bilingual evaluation** - Select Yes or No. Refer to the **Bilingual Evaluation Policy**
8. **If yes, language** - Select from drop - down list
9. **If other, description** - If language of evaluation is not found in the drop down list, please enter the name of the language.
10. **Date Developmental Assessment Complete** - Enter the date that the Core evaluation was completed.
11. **Evaluation methods** - Select all evaluation methods used for this child.
  - a. The developmental status should reflect an integration of test results, parent report, and informed clinical opinion.
    - i. If “standardized test” or “criterion referenced test” is selected, the “diagnostic test administered” must be entered from the “View Developmental Assessment screen”
12. **General evaluation comments and Parent/caregiver report comments** - Enter “No comments necessary – report attached”
  - *Select “Save”*

# NYEIS Multidisciplinary Evaluation Crosswalk – Supplemental Evaluation

7/2011

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**View Supplemental Evaluation: Savannah Claudio - 300348** Edit Close

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241		

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Evaluator NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Evaluator Details**

Evaluator Name:	Rachel Roundtree	Evaluator NPI:	446369
Qualified Personnel:	Teacher of Special Education	Date Assigned:	7/29/2011

**Type of Evaluation**

In Depth Assessment - Developmental Domain: Diagnostic Evaluation - General Area:

**Developmental Domain Results** 1

New

Action	Domain	Developmental Status	Qualified Personnel	Date Completed
--------	--------	----------------------	---------------------	----------------

**Location**

Location Type: Location Address: Provider Location:

**Type of Evaluation** 2

In Depth Assessment - Developmental Domain: Diagnostic Evaluation - General Area:

**Developmental Domain Results**

Domain	Developmental Status	Qualified Personnel	Date Completed
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**Location**

If selected location is other than "Child's Home", must enter "Location Address". If location is at a provider's site, must select the "Provider Location".

Location Type: Location Address: Provider Location:



## **NYEIS Multidisciplinary Evaluation Instructions for Completion**

**Note:** NYEIS navigation instructions appear in *italics*

**Supplemental evaluation** - This section in NYEIS replaces the Supplemental Evaluation Data Entry Form

- *Select “Supplemental Evaluation” from the NYEIS navigation bar*
- *Select “New”*
- *The “Search Evaluator for Assignment” screen will appear*
  - Enter evaluator name or % (wildcard) under “Search Evaluator for Assignment”
  - Select the assigned employee/contractor
    - The staff member(s) must be already entered as a licensed/certified professional in your agency’s “Employees/Contractor” section of NYEIS.

1. **Developmental domain results** - Select “New”

a. Select the developmental domain

i. Select “Save”

- Enter the “Domain Status” field and then refer to the description of “Domain Status and Date Completed” in Developmental Assessment section
- “Date Completed” - Enter the date that the supplemental evaluation was completed. **Supplemental evaluations CANNOT be conducted before the developmental assessment (core)**

2. Select “In - Depth Assessment” **OR** “Diagnostic Evaluation” to complete this section to explain the purpose for the external evaluation. If an in - depth assessment for a developmental domain was needed, select the domain for which the supplemental evaluation is being conducted; **OR** if there was an area of general concern, such as hearing or vision, select the **Diagnostic Evaluation – General Area**.

Refer to the Developmental Assessment instructions for all remaining NYEIS field under the Supplemental Evaluation category

# NYEIS Multidisciplinary Evaluation Crosswalk – Family Assessment

7/2011

NYEIS Sandbox: (Practice use only - no real live data)

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navigation

- MDE Home
- Screening
- Developmental Assessment
- Family Assessment**

**Family Assessment: Savannah Claudio - 300348**

New | Assessment Offered and Refused **1**

Action	Date Assigned	Date Completed	Qualified Personnel	Rendering Provider	Bilingual
--------	---------------	----------------	---------------------	--------------------	-----------

NYEIS Sandbox: (Practice use only - no real live data)

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navigation

recent items

**View Family Assessment: Savannah Claudio - 300348**

Edit | Close

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241	Status:	Assigned

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Evaluator NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

Change/Assign Rendering Provider

**Evaluator Details**

Evaluator Name:	Wendy Welch	Evaluator NPI:	331417
Qualified Personnel:	Speech Language Pathologist	Date Assigned:	7/29/2011

**Methods Used To Conduct Family Assessment**

Family Assessment Tool:	Tool name:
Other Method:	If "Other Method", describe:
Personal Interview:	

**Family Participants**

New **2**

Action	Name	Relationship
--------	------	--------------



# NYEIS Multidisciplinary Evaluation Crosswalk – Family Assessment

7/2011

Methods Used To Conduct Family Assessment			
Family Assessment Tool:	<input type="text" value="1"/>	Tool name:	<input type="text" value="2"/>
Other Method:	<input type="text" value="3"/>	If "Other Method", describe:	<input type="text" value="4"/>
Personal Interview:	<input type="text" value="5"/>		
Family Participants			
Name	Relationship		
I want to know more about	I want help for my family in the following areas		
<input type="checkbox"/> Select Area	<input type="checkbox"/> Select Area		
<input type="checkbox"/> Meeting with other families	<input type="checkbox"/> Coping with my child's disability/special needs		
<input type="checkbox"/> Housing, clothing, jobs, food, telephone	<input type="checkbox"/> Modifying our home environment to help our child		
<input type="checkbox"/> Finding/working with doctors/other specialists	<input type="checkbox"/> Help/training in helping my child grow/develop		
<input type="checkbox"/> Planning for the future, what to expect	<input type="checkbox"/> Integrating our child into community activities		
<input type="checkbox"/> My child's disability or area of need(s), what it means	<input type="checkbox"/> People who can help me care for my child		
<input type="checkbox"/> People who can help me care for my child	<input type="checkbox"/> Helping my child's siblings adjust		
<input type="checkbox"/> Ways to have fun as a family	Other: <input type="text"/>		
<input type="checkbox"/> Other kinds of help that might be available			
<input type="checkbox"/> Equipment/supplies			
<input type="checkbox"/> Ideas for brothers/sisters/friends, extended family			
Other: <input type="text"/>			
Comments			
<input type="text" value="8"/>			
Evaluation Details			
Date Family Assessment Completed:	<input type="text" value="9"/>		
Bilingual Evaluation?:	<input type="text" value="10"/>		
If yes, language:	<input type="text" value="11"/>		
If Other, description:	<input type="text" value="12"/>		
<input type="button" value="Save"/> <input type="button" value="Cancel"/>			

## **NYEIS Multidisciplinary Evaluation Instructions for Completion**

**Note:** NYEIS navigation instructions appear in *italics*

### **Family Assessment**

- *Select “Family Assessment” from the NYEIS navigation bar*

**Note:** A family assessment must be offered to all families. A family assessment is the family’s determination of their needs and strengths. A formal tool may be used, or the evaluator may use this page in NYEIS to guide a discussion with the parents. This information is used to assist in developing outcomes or service coordinator tasks for the child’s IFSP. The family assessment may be integrated into an evaluator’s report or written as an individual report.

1. **Select either: “Assessment Offered and Refused” or “New”**
  - a. *If selecting “Assessment Offered and Refused”*
    - i. *Confirm by indicating “Yes”*
  - b. *If choosing “New,” the “Search Evaluator for Assignment” screen will appear*
    - i. *Enter evaluator name or % (wildcard) under “Search Evaluator for Assignment”*
    - ii. *Select the assigned employee/contractor*
    - iii. *The staff member(s) must be already entered as a licensed/certified professional in your agency’s “Employees/Contractor” section of NYEIS.*
  - *Once the evaluator has been assigned, the “View Family Assessment” screen will appear*
2. **Family participants - Select “New”**
  - a. **Name** – Enter the name of the family member participants
  - b. **Relationship** – Select the relationship of the family participant
    - *Select “Save,” or “Save and New” to enter additional participants*
    - *Once the “Family Participants” section is complete, the “View Family Assessment” screen will appear*
    - *Select “Edit” to complete the remaining family assessment fields on the “Modify Family Assessment” page*

### **Modify Family Assessment**

1. **Family assessment tool** - Indicate whether a formal tool was used by selecting Yes or No.
2. **Tool name** - If a formal tool was used, indicate the name.
3. **Other method** - Select Yes or No.
4. **If other method, describe** - Enter how the family assessment was conducted.
5. **Personal interview** - Select yes or no.
6. **I want to know more about** - Indicate if there are other areas for which the parent needs more information.
7. **I want help for my family in the following areas** - Indicate if there are other areas in which the parent needs help
8. **Comments** - Enter any other comments or reference an evaluator’s report (for example “See social work report,” “Family assessment attached,” “Name of foster care agency involved in the evaluation,” etc.)
9. **Date family assessment completed** - Select date.
10. **Bilingual evaluation** - Select Yes or No. Refer to the [Bilingual Evaluation Policy](#)
11. **If yes, enter language** - Select the appropriate language from the drop - down list
12. **If other, description** - If language of evaluation is not found in the drop - down list, enter the name of the language.
  - *Select “Save”*

# NYEIS Multidisciplinary Evaluation Crosswalk – External Evaluations

7/2011

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**Create External Evaluation: Savannah Claudio - 300348**

Save | Cancel

**Child Details**

Name:	Savannah Claudio	Date of Birth:	12/23/2009
Primary Phone Number:	(123) 456	Evaluation Due By:	6/29/2011
Primary Address:	16 court street brooklyn (Kings (Brooklyn)) New York 11241		

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Agency NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Evaluator Details**

\*Evaluator Name:  1

\*Agency Affiliation Name:  2

\*Profession:  3

\*Date Evaluation Conducted:  4

**Please Check All That Apply** 5

- Obtained records with parental consent
- Reviewed child's records
- Consulted with external evaluator by phone or through correspondence
- Used results to establish eligibility - in-depth assessment
- Used results to establish eligibility - diagnostic evaluation
- Used results to meet requirements for the child's health assessment

**Type of Evaluation** 6

In Depth Assessment - Developmental Domain:

Diagnostic Evaluation - General Area:

# NYEIS Multidisciplinary Evaluation Crosswalk – External Evaluations

7/2011

## Approved Evaluator Team Must Certify That 7

The procedures used by the external evaluator were performed in a manner consistent with EIP requirements:

The findings were used to augment and not replace the evaluation to determine eligibility:



There are no indications present which suggest the need to repeat the tests or procedures performed by the evaluator:

## Health Assessment

If health assessment was performed, we certify that it was performed recently enough that a new assessment is not needed:  8

## General Health Status/Health Concerns 9

## Evaluation Diagnosis Result

Other Diagnosis Code:  10  

Other Diagnosis Code:   

Other Diagnosis Code:   

Date Completed:  11 

Bilingual Evaluation?:  12

If yes, language:  13

If Other, description:  14

## Evaluation Methods 15

- Evaluation Method
- Clinical Assessment
- Informed Clinical Opinion
- Evaluator Observation
- Parent/Caregiver Report
- Standardized Test
- Criterion Referenced Test

## General Evaluation Comments 16

Save

Cancel

## **NYEIS Multidisciplinary Evaluation Instructions for Completion**

**Note:** NYEIS navigation instructions appear in *italics*

**External Evaluations - Completed this section if a non-EI contracted evaluation is being included as part of the MDE.**


- *Select “External Evaluations” from the NYEIS navigation bar*
- *Select “New”*

1. **Evaluator name** - Enter the name of the evaluator
2. **Agency affiliation** - Enter the agency that the evaluator works for
3. **Profession** - Select from the drop down list
4. **Enter date of evaluation** - Select date from the calendar
5. **Please check all that apply** - Indicate the manner in which external evaluation sources were used to inform the MDE
6. Select “In - Depth Assessment” **OR** “Diagnostic Evaluation” to complete this section to explain the purpose for the external evaluation. If an in - depth assessment for a developmental domain was needed, select the domain assessed by the external evaluation; **OR** if there was an area of general concern, such as hearing or vision, select the **Diagnostic Evaluation - General Area**.
7. **Approved evaluator must certify the following regarding the use of the external evaluation:**
  - a. The procedures used by the external evaluator were performed in a manner consistent with EIP requirements
  - b. The findings were used to augment and not replace the evaluation to determine eligibility
  - c. There are no indications present which suggest the need to repeat the tests or procedures performed by the external evaluator
8. **Health assessment** - Complete this section if an external medical specialist (developmental pediatrician, nephrologist, audiologist, ENT, etc.) is used. When an external medical specialist is used, certify that the health assessment was performed recently enough that a new assessment is not needed
9. **General health status/health concerns** - Indicate that the relevant health assessment documentation is included in the MDE Attachments section
10. **Other diagnosis code** - Enter ICD code indicated as a result of the external evaluation
11. **Date completed** - Select date
12. **Bilingual evaluation** - Select Yes or No. Refer to the **Bilingual Evaluation Policy**
13. **If yes, enter language** - Select the appropriate language from the drop - down list
14. **If other, description** - If language of evaluation is not found in the drop - down list, enter the name of the language
15. **Evaluation methods** - Choose all methods used by the external evaluator
16. **General evaluation comments** - Indicate that the report is attached

- *Select “Save”*

# NYEIS Multidisciplinary Evaluation Crosswalk – MDE Summary

7/2011



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**navigation**

- [MDE Home](#)
- [Screening](#)
- [Developmental Assessment](#)
- [Family Assessment](#)
- [Supplemental Evaluations](#)
- [External Evaluations](#)
- [MDE Attachments](#)
- [MDE Validation Errors](#)

**recent items**

**Create MDE: Savannah Claudio - 300348**

Record results of the MDE using left hand navigation links prior to completing MDE Summary.

**Child Details**

Name: Savannah Claudio	Date of Birth: 12/23/2009
Primary Phone Number: (123) 456	Evaluation Due By: 6/29/2011
Primary Address: 16 court street brooklyn (Kings (Brooklyn)) New York 11241	Reason for Delay:

**Completed Sections**

Screening	No Screening Necessary
Developmental Assessment - Adaptive	Completed
Developmental Assessment - Cognitive	Completed
Developmental Assessment - Communication	Completed
Developmental Assessment - Social/Emotional	Completed
Developmental Assessment - Physical	Completed
Family Assessment	Offered and Refused

**MDE Summary Details**

1

Date Eligibility Determined:	Date Provider Completed:
Eligibility Status:	

**EIO/D Evaluation Rejection Reasons**

Rejection Date	Reason Code	Reason
<input type="button" value="Submit"/> <input type="button" value="Close"/> <input type="button" value="Print MDE"/>		



# NYEIS Multidisciplinary Evaluation Crosswalk – MDE Summary

7/2011

NYEIS (Practice use only - no real live data)

Home | Inbox | My Calendar | My Cases | Search | About | Log Out

**Modify MDE Summary: Savannah Claudio - 300348**

Save | Cancel

**Evaluator Agency Details**

Agency Name:	TIPSE - Toddlers and Infants Program for Special E	Agency State ID:	3076
Agency NPI:	4959414	Reviewer Name:	TIPSE - Toddlers and Infants Program for Special E

**Evaluators Assigned**

Evaluator Name	Affiliated Agency	Qualified Personnel	Individual NPI
TIPSE - Toddlers and Infants Program for Special E	TIPSE - Toddlers and Infants Program for Special E		4959414
TIPSE - Toddlers and Infants Program for Special E	TIPSE - Toddlers and Infants Program for Special E		4959414
Rachel Roundtree	TIPSE - Toddlers and Infants Program for Special E	Teacher of Special Education	446369
Rachel Roundtree	TIPSE - Toddlers and Infants Program for Special E	Teacher of Special Education	446369
Rachel Roundtree	TIPSE - Toddlers and Infants Program for Special E	Teacher of Special Education	446369
Rachel Roundtree	TIPSE - Toddlers and Infants Program for Special E	Teacher of Special Education	446369
Wendy Welch	TIPSE - Toddlers and Infants Program for Special E	Speech Language Pathologist	331417

**External Evaluators**















Evaluator Name	Agency Affiliation	Date of Evaluation	Profession
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**Eligibility**

Eligibility Status:	<input type="text" value=""/>	1
Date Eligibility Determined:	<input type="text" value=""/>	2
Date Full MDE Completed:	<input type="text" value=""/>	3
Parent(s) received summary of MDE?:	<input type="text" value=""/>	4
Parent(s) received summary of MDE in their dominant language:	<input type="text" value=""/>	5
Parent(s) received the full evaluation report:	<input type="text" value=""/>	6

# NYEIS Multidisciplinary Evaluation Crosswalk - MDE Summary Cont.

7/2011

Diagnosis Details	
EI Eligible Diagnosis Code:	<input type="text"/> <span>7</span>  
Date of Diagnosis:	<input type="text"/> <span>8</span> 
Diagnosis Made By:	<input type="text"/> <span>9</span> 
Other Eligible Diagnosis Code:	<input type="text"/> <span>10</span>  
If other ICD code, Justification:	<input type="text"/> <span>11</span>
Other Diagnosis not related to eligibility:	<input type="text"/> <span>12</span>  
Other Diagnosis not related to eligibility:	<input type="text"/>  
Other Diagnosis not related to eligibility:	<input type="text"/>  
Screening Only Diagnosis Code:	<input type="text"/> <span>13</span>  

Evaluation Methods Used	
Evaluation Name	Method Used
Developmental	
Supplemental	

Eligibility Statement
State the reason for the child's eligibility determination including evaluation methods and how informed clinical opinion was used to make this determination
<input type="text"/>

Child Transportation Needs
Is parent able to provide transportation?: <input type="text"/>
List any special needs, safety issues and parental concerns related to transportation
<input type="text"/>



## **NYEIS Multidisciplinary Evaluation Instructions for Completion**

**Note:** NYEIS navigation instructions appear in *italics*

**MDE Home (MDE Summary)** - This section of NYEIS replaces the MDE Summary Form

- *Upon completion of the MDE, select “MDE Home” from the navigation bar. The results from the Developmental Assessment (Core), Supplemental Evaluations, Screening, and Family Assessment will be automatically populated.*

1. **MDE summary details** - Select “View”
  - a. *The “View MDE Summary” page will appear*
    - i. *Select “Edit” to complete the MDE Summary*
    - ii. *The “Modify MDE Summary” page will appear*

### **Modify MDE Summary**

1. **Eligibility status** - Using the results of the evaluation, indicate the status from the drop - down list.
  - a. **Eligible - Developmental delay** - The child is eligible due to delay(s) determined through evaluation.
  - b. **Eligible diagnosed condition** - The child is automatically eligible due to a medically or clinically diagnosed condition with a high probability of developmental delay. The MDE report must include documentation that the diagnosis was made by an appropriately licensed/certified professional. Please refer to the guidance document from NYS DOH (**Early Intervention Memorandum 1999 – 2 - Reporting of Children’s Eligibility Status Based on Diagnosed Conditions with High Probability of Developmental Delay**) which defines each condition and the qualified personnel who can diagnose the condition.
  - c. **No MDE - Screening only** - Select if only a screening was conducted, no evaluation
    - i. A screening may not be conducted after eligibility has been determined.
    - ii. Refer to the [Screening Crosswalk](#) for detailed instructions of entering screening information into NYEIS
  - d. **Not Eligible - Statement required** - Attach evaluation report.

**Note:** Ensure that the eligibility status matches the information obtained from the developmental assessment and supplemental evaluation(s)

2. **Date eligibility determined**
  - a. If the child is eligible because of a diagnosed condition, use the date of the evaluation that determined the condition.
  - b. If the child is eligible because of a developmental delay, use the date the evaluation summary is completed.
3. **Date full MDE completed** - Indicate the date that the evaluation summary was completed.
4. **Parent(s) received summary of MDE** - Select Yes or No. Parent must receive a copy of the MDE for the MDE to be submitted.
5. **Parent(s) received summary of MDE in their dominant language** - Select Yes or No.
6. **Parent(s) received the full evaluation report** - Select Yes or No.
7. **EI eligible diagnosis code** - If a child has an automatic eligibility condition, the condition must be entered in this box.
  - a. *Click the magnifying glass*

- b. *NYEIS will generate a list that only includes the ICD - 9 codes entered in previous sections of the MDE*
8. **Date of diagnosis** - Provide the date that the diagnosis was made
  9. **Diagnosis made by** - Select from the drop - down list. If the diagnosis was made by an external source, documentation must be included in the MDE attachments section and the “External Evaluations” section must be completed.
  10. **Other eligible diagnosis code** - The diagnosis (and ICD 9 code number) which makes the child eligible must be listed.
    - a. *Click the magnifying glass*
    - b. *NYEIS will generate a list that only includes the ICD - 9 codes entered in previous sections of the MDE*
  11. **If other ICD code, justification** - Provide a reason why the code was selected
  12. **Other diagnosis not related to eligibility** - Select all other diagnoses as indicated from the developmental evaluation and supplemental evaluation(s).
  13. **Screening Only diagnosis code** - Enter the appropriate “V” code (usually V79.3)
  14. **Eligibility statement** - Indicate “MDE summary attached”
  15. **Child transportation needs** - Select Yes or No.
    - a. The Multidisciplinary Evaluation must indicate the transportation needs of the child.
      - i. Consideration shall first be given to provision of transportation by a parent of a child to early intervention services.
      - ii. Transportation may be provided or the parent may be reimbursed at a mileage rate authorized by the municipality for the use of a private vehicle or for other reasonable transportation costs, including public transportation, tolls, and parking fees.
      - iii. If the parent has indicated an inability to provide or access transportation, the evaluator must explain the reason.
      - iv. Refer to the **Assessing Transportation Needs Policy**
        - *Select “Save”*
        - *Select “Close”*

After all of the necessary NYEIS MDE screens are complete, attach the necessary MDE attachments and submit the MDE as per the **MDE Policy**.

# Chapter 5: Individualized Family Service Plan (IFSP)

## New York City Early Intervention Program

<b>Policy Title:</b> <b>Initial Family Service Plan Scheduling Policy</b>	<b>Effective Date:</b> <b>June 1, 2010</b>
<b>Policy Number:</b> <b>5-A</b>	<b>Supersedes:</b> <b>N/A</b>
<b>Attachments:</b> <b>1. IFSP Meeting Request and Confirmation Form</b> <b>2. Notice of IFSP Meeting (IFSP meeting notice for parents)</b>	<b>Regulation/Citation:</b> 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:

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

- 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:

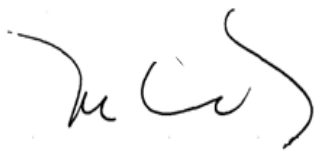
1. OSC will submit the **IFSP Meeting Request/Confirmation Form** to the RO within **48 hours** of verbal confirmation, and note if:
  - a. The parent would like to exercise the option of a paper review with correspondence.
  - b. The parent would like to exercise the option of a conference call
    - 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. <b>If an IFSP Review Meeting is scheduled as a Transition Conference, the EIOD must be present.</b></p> <p>5. The ISC/OSC must submit the <b>Consent for Transition Conference</b> form signed by the parent when requesting a transition conference with the <b>IFSP Meeting/ Confirmation Form</b>.</p> <p><b>Note: Participation in a Transition Conference is voluntary on the part of the parent.</b></p>
<p><b>Regional Office Scheduling Unit</b></p>	<p>1. Complete and fax Section II of the <b>IFSP Meeting Request/Confirmation Form</b>:</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 <b>IFSP Meeting Request/Confirmation Form</b>.</p> <p>c. If the IFSP can not be confirmed, the Scheduler will give a reason via phone or fax.</p>
<p><b>Initial/ Ongoing Service Coordinator</b></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 <b>Parent Notice of IFSP Meeting</b>.</p> <p>ii. Final <b>IFSP Meeting Request/Confirmation Form</b> 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;"><b>Or</b></p> <p>The ISC or OSC, Evaluation Representative, or Parent needs to reschedule:</p> <p>a. ISC/ OSC must submit a new <b>IFSP Request/Confirmation Form</b> with a new date and time.</p> <p>b. ISC/OSC must fill out section III of the <b>IFSP Request/Confirmation Form</b> with the new submission.</p> <p>c. Reason for IFSP meeting reschedule must be included.</p> <p><b>Note:</b> If an evaluation representative or interventionist is not available for the IFSP meeting, <b>24 hour advance notice</b> 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

**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  
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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

**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**

**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](http://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](http://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

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

### 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><b>Early Intervention Official Designee</b></p>	<p>The initial Individualized Family Service Plan (IFSP) meeting is convened at a time and place convenient to the family and <b>within 45 calendar days</b> 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"> <li>• 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.</li> <li>• 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.</li> <li>• Early Intervention Official Designee (EIOD): Facilitates and guides the meeting ensuring team participation; determines with the parent what services will be authorized.</li> <li>• Evaluator: Participates in the development of the IFSP by providing clinical input based on the Multidisciplinary Evaluation (MDE).</li> <li>• Advocate or person outside the family (if invited by the parent).</li> <li>• Foster care caseworker (if appropriate).</li> <li>• Committee of Pre-school Special Education (CPSE) administrator (if Initial IFSP is also a Transition Conference).</li> <li>• Service providers (as appropriate).</li> <li>• 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.</li> </ul> <ol style="list-style-type: none"> <li>1. The EIOD facilitates the IFSP meeting by:       <ol style="list-style-type: none"> <li>i. Introducing all members, reviewing parent rights;</li> <li>ii. Encouraging the active participation of the parent(s), the representative of the evaluation team, the ISC, and any other individual(s) present.</li> </ol> </li> <li>2. The EIOD determines if the parent(s):       <ol style="list-style-type: none"> <li>i. Received the written MDE report and summary, <b>Your Family Rights in Early Intervention</b>, and “A Parent’s Guide”           <ol style="list-style-type: none"> <li>a. If parent has not received a copy of “A Parent’s Guide”:               <ul style="list-style-type: none"> <li>• EIOD will provide a copy or weblink (with parental consent) to the guide by the end of the meeting.</li> </ul> </li> </ol> </li> <li>ii. Provided insurance information           <ol style="list-style-type: none"> <li>a. If the parent has not provided insurance information or has updates to the insurance information, the EIOD:               <ul style="list-style-type: none"> <li>• Informs the parent about the use of insurance information in EIP.</li> <li>• Completes the <b>insurance section on Page 5a of the IFSP:</b> <b>Service Authorization Data Entry Form.</b></li> </ul> </li> </ol> </li> <li>iii. Understands the results of the evaluation           <ol style="list-style-type: none"> <li>a. If parent has not received a written copy of the MDE and summary, the EIOD:               <ul style="list-style-type: none"> <li>• 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,</li> <li>• 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</li> </ul> </li> </ol> </li> </ol> </li> </ol>
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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"> <li>ii. Justification for the change is required. (See section on <i>Amendments</i> in this chapter.)</li> <li>iii. If the request is not approved by the EIOD, the parent will receive <b>Prior Written Notice</b> from the EIP</li> <li>iv. Parent has the right to accept or decline any EI service without jeopardizing other EI services.</li> <li>v. <b>No services can be provided without written parental consent.</b></li> <li>vi. Occupational Therapy, Physical Therapy, and Nursing services cannot begin without a prescription from a primary care provider.</li> </ul> <p>b. Parent signs to attest that:</p> <ul style="list-style-type: none"> <li>i. S/he understands his/her rights under EI</li> <li>ii. S/he agrees/ disagrees with the Plan:</li> </ul> <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"> <li>i. The IFSP is considered final and is signed by the EIOD and parent.</li> </ul> <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"> <li>i. The services that the parent and EIOD agree upon are to be implemented at the conclusion of the IFSP meeting;</li> <li>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,).</li> <li>iii. The EIOD will clearly document all services offered and those declined by the parent.</li> </ul> <p>4. EIOD must accurately complete the legally mandated components of the IFSP, including:</p> <ul style="list-style-type: none"> <li>• <b>Collection of Social Security Numbers</b> form;</li> <li>• <b>Consent to Release/Obtain Information</b> form, and when needed;</li> <li>• <b>Transportation Service Data Entry Form (if applicable);</b> and</li> <li>• <b>Assistive Technology Device Data Entry Form (if applicable).</b></li> </ul> <p>5. Completed IFSP package is copied, and all IFSP team members receive a copy:</p> <ul style="list-style-type: none"> <li>a. Copies of the <b>Transportation Services Data Entry Form(s)</b> and the <b>Assistive Technology Device Data Entry Form(s)</b> are distributed to Data Operations and provider agencies only:</li> <li>b. <b>Collection of Social Security Information</b> form is maintained in the RO and <b>NOT</b> given to providers or the OSC.</li> <li>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"> <li>i. The EIOD will ensure that the OSC gets copies of the IFSP document within one (1) week of the authorization.</li> <li>ii. OSC will ensure all other meeting participants receive a copy of the IFSP expeditiously, but no later than 48 hours after receipt.</li> </ul> </li> </ul>
<b>Regional Office Data Entry Staff</b>	<ul style="list-style-type: none"> <li>1. IFSP is checked for completeness.</li> <li>2. IFSP is scanned and given a barcode.</li> <li>3. IFSP is sent to EI Data Operations for entry into the KIDS system.</li> <li>4. After data entry, IFSP is returned to the RO to be filed.</li> </ul>

Approved By: 

Date: 4/26/2010

Assistant Commissioner, Early Intervention

## New York City Early Intervention Program

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

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

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

- 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:**

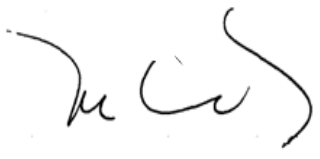
1. If the EIOD is not present at the review meeting:
  - a. The completed review IFSP is sent to the EIOD who reviews, stamps and signs the IFSP document.
    - i. If the IFSP review is incomplete, the EIOD will notify the OSC by phone or fax.
    - ii. The EIOD may send the six (6) month review back 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



<b>Office Data Entry Staff</b>	Central.
<b>Ongoing Service Coordinator</b>	<ol style="list-style-type: none"><li>1. Sends copies of the Six (6) Month Review to all providers of services and to the parents.</li><li>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>).</li></ol>



**Approved By:**  
**Assistant Commissioner, Early Intervention**

**Date:** 4/26/2010

## New York City Early Intervention Program

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

### 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:

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

<p><b>Service Coordinator</b></p>	<p>of the IFSP:</p> <ol style="list-style-type: none"> <li>a. Nine (9) and Twelve (12) month <b>Provider Progress Notes</b> from each interventionist for each service type; or             <ol style="list-style-type: none"> <li>i. Documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider.</li> </ol> </li> <li>b. Nine (9) and Twelve (12) month <b>Parent Progress Notes</b>, if the parent chooses to complete.</li> <li>c. Calendars or alternate tools completed by the parent, if available</li> <li>d. Supplemental Evaluations and/or Justifications for Changes in Services.</li> </ol> <ol style="list-style-type: none"> <li>2. Contact the Regional Office (RO) scheduling staff to arrange for the IFSP meeting. This should be done two <b>(2) weeks</b> before the end of the IFSP period.</li> <li>3. Submit the IFSP <b>Meeting Request/Confirmation Form</b> to the RO scheduling staff within 48 hours of verbal confirmation from the RO.             <ol style="list-style-type: none"> <li>a. Refer to the policy on <i>IFSP Scheduling</i>.</li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>- <b>Required participants for the Annual IFSP meetings must meet in-person.</b></li> <li>- If an Interventionist is unable to attend:             <ul style="list-style-type: none"> <li>• RO should be notified <b>24 hrs</b> before the scheduled meeting via fax by the provider agency.</li> <li>• That individual(s) should participate through a telephone conference call.</li> <li>• 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).</li> </ul> </li> </ul> <ol style="list-style-type: none"> <li>4. Submit the following documents to the RO <b>at least two (2) weeks prior to the expiration date of the current IFSP:</b> <ol style="list-style-type: none"> <li>e. Nine (9) and Twelve (12) month <b>Provider Progress Notes</b> from each interventionist for each service type; or                 <ol style="list-style-type: none"> <li>i. Documentation explaining the reason(s) that s/he has been unable to collect progress notes from any provider</li> </ol> </li> <li>f. Nine (9) and Twelve (12) month <b>Parent Progress Notes</b> (if parent has chosen to complete).</li> <li>g. Calendars or alternate tools completed by the parent (if available).</li> <li>h. <b>Supplemental evaluations and/or Justifications for Changes in Services</b> <ol style="list-style-type: none"> <li>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</li> </ol> </li> </ol> </li> <li>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"> <li>a. Private evaluations</li> <li>b. Updated medical information</li> </ol> </li> </ol>
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	<p><b>Note:</b></p> <ul style="list-style-type: none"> <li>- Missing <b>Progress Notes</b> will not prevent the convening of the Annual IFSP meeting</li> <li>- <b>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.</b></li> </ul>
<p><b>Regional Office Scheduling Staff</b></p>	<ol style="list-style-type: none"> <li>1. Collect <b>Progress Notes</b> sent by the OSC       <ol style="list-style-type: none"> <li>a. If progress notes are not received <b>two (2) weeks</b> prior to the scheduling of the IFSP meeting:           <ol style="list-style-type: none"> <li>i. RO will call the OSC to follow-up on the receipt of the progress notes.</li> <li>ii. If the OSC is unable to collect the <b>Progress Notes</b>:               <ul style="list-style-type: none"> <li>• Program Monitoring and Quality Improvement (PMQI) will be notified by the RO for follow-up action.</li> </ul> </li> </ol> </li> </ol> </li> </ol>
<p><b>Early Intervention Official Designee</b></p>	<ol style="list-style-type: none"> <li>1. Convene the meeting <b>at least two (2) weeks prior to the expiration date of the current IFSP</b>. The meeting must include the following individuals:       <ul style="list-style-type: none"> <li>• The parent(s);</li> <li>• The Early Intervention Official Designee (EIOD);</li> <li>• The Ongoing Service Coordinator (OSC);</li> <li>• The evaluator or interventionist(s) working with the child and family;</li> <li>• The foster care worker (if appropriate);</li> <li>• The Committee of Pre-school Special Education (CPSE) administrator, if IFSP meeting is combined with a transition conference.</li> <li>• Any other person whom the parent or the service coordinator, with the parent’s consent, invites.</li> </ul> </li> <li>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.</li> <li>3. Inform the parent of his/her rights, and give him/her <b>Your Family Rights in Early Intervention</b> fact sheet.</li> <li>4. Ask the parent if there are any changes in the child’s insurance coverage.       <ol style="list-style-type: none"> <li>a. Update Insurance Information on Page 5a (<b>Service Authorization Data Entry Form</b>) of the IFSP.</li> </ol> </li> <li>5. Facilitate a team review and discussion of:       <ul style="list-style-type: none"> <li>• The current needs of the child and family</li> <li>• Progress toward achieving outcomes</li> <li>• The effectiveness of strategies used during intervention sessions</li> <li>• Any needed modification of the outcomes or Early Intervention (EI) services</li> </ul> <ol style="list-style-type: none"> <li>a. The following new forms must be completed:           <ol style="list-style-type: none"> <li>i. All IFSP pages (See <i>Initial IFSP Policy</i>);</li> </ol> </li> </ol> <p><b>Note:</b> On Page 5a: <b>Service Authorization Data Entry Form(s)</b>, 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"> <li>ii. <b>Transportation Service Data Entry Form(s)</b> (if</li> </ol> </li> </ol>

	<p style="text-align: center;"><b>applicable).</b></p> <p style="text-align: center;">iii. <b>Parental Consent to Release/Obtain Information</b></p> <p><b>Note:</b></p> <p><b><u>Prescriptions</u></b></p> <ul style="list-style-type: none"> <li>- A new prescription from a physician is required for Physical Therapy, Occupational Therapy or Nursing services.</li> <li>- A current <b>Health Assessment Form</b> is required for a child attending group developmental services.</li> </ul> <p><b><u>Transition</u></b></p> <ul style="list-style-type: none"> <li>- 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"> <li>• The parent is responsible for making the referral to CPSE.</li> <li>• 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.)</li> </ul> </li> <li>- Combine an Annual meeting with a Transition Conference, when appropriate (See <i>IFSP Scheduling Policy</i>).</li> </ul> <p>6. Ensure that the completed IFSP is copied and distributed to all IFSP team members as appropriate:</p> <ul style="list-style-type: none"> <li>a. Copies of the <b>Transportation Service Authorization Form(s)</b> and the <b>Assistive Technology Service Authorization Form(s)</b> are distributed to Data Operations and provider agencies only:</li> <li>b. 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"> <li>i. The EIOD will ensure that the OSC gets copies of the IFSP document within one (1) week of the authorization.</li> <li>ii. OSC will ensure all other meeting participants receive a copy of the IFSP expeditiously, but no later than 48 hours after receipt.</li> </ul> </li> </ul>
<b>Regional Office</b>	1. Submit the approved <b>IFSP</b> and <b>Service Authorization Data Entry Form(s)</b> to Data Operations.
<b>Ongoing Service Coordinator</b>	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



## 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):

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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):

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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):

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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):

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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):

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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/C aregiver 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/C aregiver 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><b>1. Functional Outcome:</b></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><b>Progress Note Dates:</b></p>	<p><b>2. Functional Outcome:</b></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><b>Progress Note Dates:</b></p>
<p><b>3. Functional Outcome:</b></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><b>Progress Note Dates:</b></p>	<p><b>4. Functional Outcome:</b></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><b>Progress Note Dates:</b></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><b>1. SERVICE TYPE (Category A services)</b></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 dashed black; padding: 5px; margin-top: 10px;"> <p style="text-align: center;"><i>Assistive Technology and Transportation:</i></p> <p>Use the <b>AT Device</b> for AT equipment and <b>Transportation Service DE Forms</b> 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><b>2. PAYMENT RATE / METHOD TYPE</b></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><b>3. LOCATION TYPE</b></p> <p style="text-align: center;"><u><b>Group Service Codes:</b></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><b>Individual Service Codes:</b></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><b>4. &amp; 5. BEGIN &amp; END DATES</b></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><b>6, 7, &amp; 8. FREQUENCY AND DURATION CODES</b></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><b>9. UNITS: (Days x weeks for each service.)</b></p> <p>Service Coordination: Refer to the Units Table.</p> <p>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><b>Service Type Unit Table</b></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><b>10. WAIVER CODES</b> <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><b>NOTE:</b> 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><b>11. AMEND STATUS</b> <i>(Circle One)</i></p> <p><b>Add</b> – a new authorization</p> <p><b>End</b> – 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><b>12 &amp; 13 Provider instructions:</b></p> <p>12. <b>Bilingual Request-</b> 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 <b>Service Authorization Form</b> does not need to be resubmitted.</p> <p>13. <b>Prescription Needed-</b> 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: ____/____/____ <b>CHILD INFORMATION:</b> <b>CHILD EI #:</b> _____ <b>DOB:</b> ____/____/____ CHILD'S NAME: _____ (LAST) _____ (FIRST) (MIDDLE) <b>Borough:</b> _____	<b>PROVIDER INFORMATION</b> (USE ONE SHEET PER SERVICE PROVIDER) PROVIDER NAME: _____ PROVIDER EI #: _____ CONTACT PERSON: _____ CONTACT PERSON'S PHONE: (____) _____ CONTACT PERSON'S FAX: (____) _____ SC: _____ SC #: _____ PHONE: (____) _____ FAX: (____) _____	<b>TYPE OF IFSP</b> <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: ____/____/____
<b>NOTE:</b> 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 45<sup>th</sup> 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.



## 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 **bilingual 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 2<sup>nd</sup> 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 3<sup>rd</sup> 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 3<sup>rd</sup> 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.



## New York City Early Intervention Program

<b>Policy Title:</b> <b>Social Security Documentation</b>	<b>Effective Date:</b> <b>2/28/2011</b>
<b>Policy Number:</b> <b>5-E</b>	<b>Supersedes:</b> N/A
<b>Attachment:</b> • <b>Social Security Number Collection Form</b>	<b>Regulation/Citation:</b> NYCRR <b>Section 69-4.11(a)(5)(i)(a,b,c)</b>

### I. POLICY DESCRIPTION:

NYS Regulations Section 69-4.11 (5) requires that:

"(5)(i) The notice to the child's parent of the IFSP meeting shall also inform the parent of the following:

(a) parents are required to furnish their social security numbers and the social security number of their child to the early intervention official, in accordance with subdivision four of section 2552 of the Public Health Law, for the purposes of administration of the Early Intervention Program;

(b) parents shall provide their social security numbers and the social security number for their child at the time of the IFSP meeting; and

(c) social security numbers of the child and parent will be maintained in a confidential manner, will be used solely for the purpose of administration of the Early Intervention Program, and will not be re-disclosed to any party other than the Department."

The EIOD is responsible for collecting the Social Security Numbers of the child and his/her parent(s) at the Initial IFSP meeting and recording them on the [Social Security Number Collection Form](#).

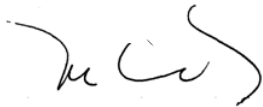
All Early Intervention child records are maintained in accordance with confidentiality requirements set forth in Federal IDEA, New York State Early Intervention Regulations, Federal Educational Rights and Privacy Act (FERPA) and The Department of Health and Mental Hygiene confidentiality policies.

Child records and other materials contained therein which are personally identifiable are confidential and may not be released or made available to persons other than those authorized.

### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Early Intervention Official Designee (EIOD)</b>	At the Initial IFSP meeting, the EIOD must inform the parent/guardian of the following: <ol style="list-style-type: none"> <li>1. Parents are required to provide EIP with their Social Security Numbers and the Social Security Number of their child.</li> <li>2. Social Security Numbers are being requested under authority granted at Section 2552 of the Public Health Law.</li> </ol>

	<p>3. The information will be used for the general administration of the program including, but not limited to, assisting in maximizing third party reimbursement for early intervention services.</p> <p>4. Information will be maintained by the NYC Early Intervention Program in a confidential manner and not disclosed to any party other than the NYS Department of Health.</p> <p>Social Security Information is collected at the beginning of the Initial IFSP meeting along with the <b>Identifying Information (page 1)</b>.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Foster Parents are not required to provide EIP with their SSN numbers. <ul style="list-style-type: none"> <li>○ The Child’s SSN should still be provided.</li> </ul> </li> <li>• The Early Intervention Program will provide services regardless of whether the parent provides Social Security Numbers.</li> <li>• EIODs must record Social Security Numbers on the <b>Social Security Number Collection Form</b>.</li> </ul>
<p><b>Early Intervention Regional Office</b></p>	<p>The <b>Social Security Number Collection Form</b> will become part of the child’s internal EI record.</p> <p>SSN documentation forms will not be made available to Service Coordinators, Evaluators or Service Providers</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• If a request for a copy of the child’s record is received from a non EI-staff person, the <b>Social Security Number Collection Form</b> must be removed from the file before copy is sent.</li> </ul>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 1/21/11

NYC EARLY INTERVENTION PROGRAM

**SOCIAL SECURITY NUMBER COLLECTION FORM**

**THIS FORM IS COMPLETED BY THE EIOD-DO NOT COPY THIS FORM**

The NYS Early Intervention Regulations (NYCRR 69-4.11(a)(5)(i) require the collection of Social Security Numbers of an eligible child and the child’s parents (except in the case of foster parents):

"(5)(i) The notice to the child's parent of the IFSP meeting shall also inform the parent of the following:

(a) parents are required to furnish their social security numbers and the social security number of their child to the early intervention official, in accordance with subdivision four of section 2552 of the Public Health Law, for the purposes of administration of the Early Intervention Program;

(b) parents shall provide their social security numbers and the social security number for their child at the time of the IFSP meeting; and

(c) social security numbers of the child and parent will be maintained in a confidential manner, will be used solely for the purpose of administration of the Early Intervention Program, and will not be re-disclosed to any party other than the Department."

CHILD’S NAME (Last, First and Middle): _____	
EI #: _____	DOB: ____/____/____
SS #: _____ - _____ - _____ <input type="checkbox"/> Individual does not have a Social Security Number	
Foster child: <input type="checkbox"/> Yes <input type="checkbox"/> No (Social Security Numbers are <u>not</u> required for foster parents)	
Mother’s/Guardian’s Name: _____	
SS #: _____ - _____ - _____ <input type="checkbox"/> Individual does not have a Social Security Number	
Father’s/Guardian’s Name: _____	
SS #: _____ - _____ - _____ <input type="checkbox"/> Individual does not have a Social Security Number	
<b>NOTE: The Early Intervention Program will provide services regardless of whether the parent provides Social Security Numbers. <i>If applicable, check box below:</i></b>	
<input type="checkbox"/> Parent has refused to furnish requested Social Security Numbers.	
Parent’s Signature: _____	Date: _____
EIOD Signature: _____	Date: _____

**INSTRUCTIONS FOR COMPLETION**

**SOCIAL SECURITY NUMBER COLLECTION FORM**

The EIOD is responsible for collecting the Social Security Numbers of the child and his/her parent(s) at the initial IFSP meeting and recording them on this form.

The EIOD must complete the information requested, checking the appropriate box if the child and/or parent(s) do not have a Social Security Number.

The Early Intervention Program will provide services for eligible children and their families regardless of whether the parent(s) and child have Social Security Numbers or whether the parent provides the Social Security Numbers.

Check the box if the parent refuses to furnish the requested Social Security Numbers and have the parent sign and date in the box.

The EIOD will sign and date this form.

# Chapter 6: Service Delivery

## New York City Early Intervention Program

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

### I. POLICY DESCRIPTION:

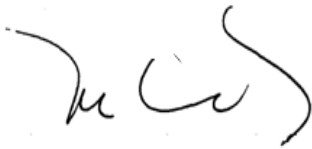
“Service Coordination shall be an active ongoing process that involves facilitating the timely delivery of available services (NYCRR 69-4.6 (b) (4)).”

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:

<b>Responsible Party</b>	<b>Action</b>
<b>Ongoing Service Coordinator (OSC)</b>	<ol style="list-style-type: none"> <li>1. Contacts the family and the service provider agency (agencies) <b>within one (1) week</b> of the IFSP meeting (Initial, Review, and Annual) date to determine if all authorized services have begun.</li> <li>2. For each authorized service type, confirms that the service has started and documents the start date on the <b>Status of Start Date of Services Form</b>.               <ol style="list-style-type: none"> <li>a. If all authorized services have begun <b>within two (2) weeks</b> of the authorized start date:                   <ol style="list-style-type: none"> <li>i. Completes the <b>Status of Start Date of Services Form</b> and keeps it as part of the Service Coordination record.</li> </ol> </li> <li>b. If any service(s) has not started <b>within two (2) weeks</b> of the authorized start date:                   <ol style="list-style-type: none"> <li>i. Contacts the Program Monitoring and Quality Assurance Unit (PMQI) at 347 396-6977 for assistance in locating a service provider.</li> <li>ii. When a service provider(s) has been identified:                       <ul style="list-style-type: none"> <li>• Completes the <b>Service Authorization Data Entry Form</b> and <b>Change in Services/Service Provider/Service Coordinator Form</b>, if appropriate, and submits to the EIOD for authorization.</li> <li>• Forwards copies of the authorized <b>Service Authorization Data Entry Form</b> and <b>Change in</b></li> </ul> </li> </ol> </li> </ol> </li> </ol>

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



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"/>	
			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"/>	
			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(cies) 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

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

### 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	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:

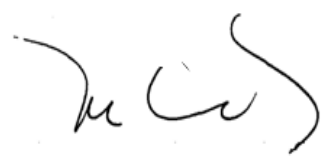
1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)	2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units
1: <u>TYPE SVC</u> <i>Code Letter</i>	<u>Speech/language</u> N	<u>Home/Community</u> A	1/1/10	6/30/10	30	2	26	52

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

## II. PROCEDURE:

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

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



**Approved By:**  
**Assistant Commissioner, Early Intervention**

**Date:** 09/17/10



## New York City Early Intervention Program

<b>Policy Title: Obtaining Prescriptions For Authorized Services</b>	<b>Effective Date: 10/17/2010</b>
<b>Policy Number: 6-C</b>	<b>Supersedes: N/A</b>
<b>Attachment:</b> <ul style="list-style-type: none"> <li>• <b>Request for Prescription for Services Form</b></li> </ul>	<b>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</b>

### 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:

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

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

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

### 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:


<b>Responsible Party</b>	<b>Action</b>
<b>Early Intervention Official Designee (EIOD)</b>	<ol style="list-style-type: none"> <li>1. Reviews the make-up policy with parents at conclusion of every IFSP meeting. (<b>IFSP Page 8: Attestations, Consent for Services</b>)               <ol style="list-style-type: none"> <li>a. Gives parent a copy of the <i>NYC EI Make-Up Policy – Information for Families</i>.</li> <li>b. Explains that:                   <ol style="list-style-type: none"> <li>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></li> <li>ii. While make-up sessions are not mandatory, providers are encouraged to make-up missed sessions.</li> <li>iii. Sessions can be made up <b>within two (2) weeks</b> after the missed session.</li> </ol> </li> </ol> </li> </ol>



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

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

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

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 347 396-6828.

Bronx: 718-410-4110  
Brooklyn: 718-722-3310  
Manhattan: 212-487-3920  
Queens: 718-271-1003  
Staten Island: 718-420-5350

## **PROGRAMA DE INTEVENCION 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 hija/hijo.

- 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 INTEVENCIÓN 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 (347) 396-6828

## New York City Early Intervention Program

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

### 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.

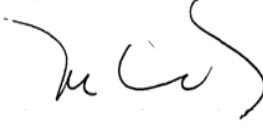
### II. PROCEDURE:

Responsible Party	Action
Service Provider Agency	<ol style="list-style-type: none"> <li>1. <b>At the start of services, informs the family to notify the Service Provider Agency when the family will be going on vacation.</b></li> <li>2. Informs family of the following: Anytime that a family will be going on vacation:               <ol style="list-style-type: none"> <li>a. Child's EI case may be kept open.</li> <li>b. The Service Provider Agency and/or therapist(s) currently providing services may not be available to serve the child upon their return.</li> <li>c. <b>Missed service sessions will not be made up.</b></li> <li>d. The family <b>must</b> give an anticipated return date.                   <ul style="list-style-type: none"> <li>• If the family does not return on the date indicated:                       <ul style="list-style-type: none"> <li>○ The Service Coordinator (SC) will close the case after making <b>three (3) documented unsuccessful attempts</b> to contact the family.</li> <li>○ 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.</li> </ul> </li> <li>• If the family does not give an anticipated return date:                       <ul style="list-style-type: none"> <li>○ The SC will attempt to contact the family after <b>three (3) weeks</b> of absence.</li> <li>○ The SC will close the case after making <b>three (3) documented unsuccessful attempts</b> to contact the family.</li> </ul> </li> </ul> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>Three (3) documented unsuccessful attempts</b> 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.</li> <li>• 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.</li> </ul> <ol style="list-style-type: none"> <li>3. Notifies the SC as soon as the family notifies the service provider agency of an upcoming vacation</li> </ol>



<p><b>Service Coordinator</b></p>	<ol style="list-style-type: none"> <li>1. Notified that the family will be going on vacation. <ol style="list-style-type: none"> <li>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"> <li>i. Documents the conversation in the SC notes.</li> </ol> </li> <li>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"> <li>i. A copy of that letter must be kept in the child’s SC file.</li> </ol> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• If the family is going on vacation within <b>two (2) weeks</b> 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.</li> </ul> <ol style="list-style-type: none"> <li>c. When the family does not give a return date: <ol style="list-style-type: none"> <li>i. Attempts to contact the family after <b>three (3) weeks</b> of absence.</li> <li>ii. Makes <b>three (3) documented unsuccessful attempts</b> to contact the family.</li> <li>iii. Submit a Closure Form and documentation of attempts to contact the family to the RO. <ul style="list-style-type: none"> <li>• The “effective date” of closure is not specified by the SC. The RO will enter the closure date after review of documentation.</li> </ul> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>Three (3) documented unsuccessful attempts</b> 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"> <li>○ The SC must submit a copy of the certified letter, certified label, and the <b>Closure Form</b> to the RO.</li> <li>○ <b>A copy of the Closure Form, certified letter, and other unsuccessful contact attempts must be documented in the child’s SC record.</b></li> </ul> </li> <li>• Refer to the <b>Closure Policy</b></li> <li>• The <b>Closure Form</b> must be submitted with a clear statement for the reason of closure.</li> </ul> <ol style="list-style-type: none"> <li>3. Notified that the family is planning to be away for an extended time period during the summer. <ol style="list-style-type: none"> <li>a. Informs the family of all of the above (as appropriate).</li> <li>b. Informs the family of the following: <ol style="list-style-type: none"> <li>i. The NYC EIP does not provide services outside of New York State.</li> <li>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"> <li>• NYC SC is responsible for coordinating services.</li> </ul> </li> <li>iii. Missed sessions will not be made-up.</li> </ol> </li> <li>c. Sends letter on service provider agency letterhead to the RO indicating</li> </ol> </li> </ol>
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	<p>the arrangements and that the family understands the above.</p> <ul style="list-style-type: none"> <li>i. A copy of this letter must be kept in the child’s case record and sent to family and all service provider agencies.</li> <li>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.</li> </ul>
<b>Regional Office (RO)</b>	<ol style="list-style-type: none"> <li>1. <b>Closure Forms</b> are routed to the assigned Early Intervention Official Designee (EIOD) for review.</li> <li>2. EIOD sends parents and the Ongoing Service Coordinator (OSC) <b>Prior Written Notice</b> <ul style="list-style-type: none"> <li>a. The “effective date” of closure is <b>three (3) weeks</b> after the last service date.</li> <li>b. If the parent does not respond within <b>ten (10) business days</b>, the <b>Closure Form</b> is signed and submitted by the RO as a separate document to the Data Operations for entry into KIDS.</li> <li>c. The RO must send a copy of the signed <b>Closure Form</b> to the SC <b>within two (2) weeks of receipt.</b></li> </ul> </li> </ol>
<b>Service Coordinator</b>	<ol style="list-style-type: none"> <li>1. Inform all service provider agencies (including transportation providers and respite providers when appropriate) by sending them a copy of the <b>Closure Form.</b></li> </ol>

Approved By:   
Assistant Commissioner, Early Intervention

Date: 09/17/10

## New York City Early Intervention Program

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

### 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:

<b>Responsible Party</b>	<b>Action</b>
<b>Provider Agencies</b>	<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"> <li>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"> <li>a. The NYC Early Intervention Program (NYCEIP) will reimburse the provider agency and service coordination agency for the services <b>as previously authorized</b> upon completion of the Six Month Review or Annual IFSP meeting.</li> <li>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"> <li>i. Refer to the detailed instructions on how to complete the Services Authorization Form in the <b>IFSP Review Policy</b></li> </ol> </li> </ol> </li> <li>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) <b>in writing</b> to allow the RO to contact the provider agency and SC before services are terminated.               <ol style="list-style-type: none"> <li>a. Notification of termination must be sent to the RO <b>at least two (2) weeks</b> prior to the authorization end date</li> </ol> </li> <li>3. If an amendment to a service that is currently on the IFSP has been requested:               <ol style="list-style-type: none"> <li>a. The service must continue to be provided <b>as currently authorized</b> until the SC and provider receive written authorization from the EIOD for the change.                   <ol style="list-style-type: none"> <li>i. Refer to the <b>Amendments Policy</b></li> </ol> </li> </ol> </li> </ol>

  
**Approved By:**  
**Assistant Commissioner, Early Intervention**

**Date:** 09/17/10

## New York City Early Intervention Program

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

### 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:

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

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

Approved By:   
Assistant Commissioner, Early Intervention

Date: 09/17/10

## New York City Early Intervention Program

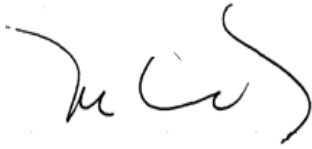
<b>Policy Title: Role of the Transportation Coordinator</b>	<b>Effective Date:</b> <b>10/17/2010</b>
<b>Policy Number: 6-H</b>	<b>Supersedes: N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>IFSP: Transportation Data Entry Form</b></li> <li>• <b>Transportation Attendance Sheet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

### 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
<b>Service Coordinator (SC)</b>	<ol style="list-style-type: none"> <li>1. Faxes a copy of the signed (authorized) <b>Transportation Data Entry Form</b> 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"> <li>a. Refer to the <b>Start Date of Services Policy</b>.</li> <li>b. <b>Transportation Service Data Entry Form</b> must be sent for the <i>correct bus company assigned to the EI provider</i> (not a subcontracted company).</li> </ol> </li> </ol>
<b>Transportation Coordinator (TC)</b>	<ol style="list-style-type: none"> <li>1. Receives the signed <b>Transportation Service Data Entry Form</b> from the provider agency.</li> <li>2. Forwards the Transportation Service Data Entry Form to the bus company.               <ol style="list-style-type: none"> <li>a. <b>The Transportation Data Entry Form</b> must be sent <b>at least six (6) calendar days</b> before the child can begin to ride the bus.</li> </ol> </li> <li>3. Ensures that the bus company received the signed <b>Transportation Service Data Entry Form</b>.</li> <li>4. Completes the <b>Transportation Attendance Sheet</b> monthly indicating the:               <ol style="list-style-type: none"> <li>a. Names of any companions; and</li> <li>c. Days that the companion was on the bus.</li> </ol> </li> <li>5. Sends the <b>Transportation Attendance Sheet</b> to the DOHMH Fiscal Unit within <b>seven (7) calendar days</b> after the end of the calendar month.               <ol style="list-style-type: none"> <li>a. Completed attendance sheets should be mailed or faxed to:                   <p style="text-align: center;">Erica Savarese Transportation Coordinator Early Intervention Fiscal Office Gotham Center 42-09 28th St., 16th Floor Queens, New York 11101</p> </li> </ol> </li> </ol>

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)																																		
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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)																																		
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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

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

### I. POLICY DESCRIPTION:

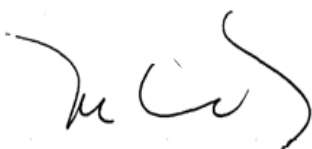
The New York City Department of Education, Pre-K Transportation contracts with bus companies to transport children to NYC Early Intervention (EI) provider agencies for services. Complaints about transportation providers must be directed accordingly.

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:

<b>Responsible Party</b>	<b>Action</b>
<b>Early Intervention Agencies, Service Coordinators (SCs), Parents</b>	<ol style="list-style-type: none"> <li>1. Direct inquiries or complaints regarding Pre-K Transportation to:               <ol style="list-style-type: none"> <li>a. The Department of Education Pre-K Customer Service hotline at <b>718-482-3800</b>. Agents are available to assist.</li> <li>b. <b>311</b>. Calls will be forwarded to someone who can assist.</li> </ol> </li> <li>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.</li> </ol>

  
**Approved By:**  
**Assistant Commissioner, Early Intervention**

**Date:** 09/17/10

## New York City Early Intervention Program

<b>Policy Title:</b> <b>Case Closure</b>	<b>Effective Date:</b> <b>2/28/2011</b>
<b>Policy Number:</b> <b>6-J</b>	<b>Supersedes:</b> N/A
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>Closure Form</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> </ul>	<b>Regulation/Citation:</b>

### I. POLICY DESCRIPTION:

New York State Department of Health/Early Intervention Program has defined those circumstances under which cases should be closed. It is the responsibility of the Municipality to track and report closure events to the New York State Department of Health.

When sending a **Closure Form** to a family, the Service Coordinator (SC) must always enclose a copy of **Your Family Rights in the Early Intervention Program**.


### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial Service Coordinator (ISC)</b>	<p>Submits <b>Closure Form to the Regional Office (RO)</b> and a copy of <b>Your Family Rights in Early Intervention to the parent/caregiver</b> when one of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. Upon the request of a parent/caregiver;</li> <li>2. Upon transfer of the case to a municipality/locality outside of NYC;</li> <li>3. After an agreed upon period of time by ISC and family following the death of a child (not to exceed <b>four (4) weeks</b>);</li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>Closure Form</b> is submitted within seven calendar days of the “effective date” of closure.</li> <li>• The “effective date” of closure is entered by the ISC in the above cases (1, 2, and 3 above).</li> <li>• The “effective date” of closure will be entered by the RO for all other scenarios (4, 5, 6, and 7 below).</li> <li>• The “effective date” of closure is the last day the ISC can bill for Service Coordination on a case.</li> </ul> <ol style="list-style-type: none"> <li>4. After <b>three (3) unsuccessful, documented</b> attempts by the assigned ISC to contact a family;</li> <li>5. When <b>three (3) scheduled</b> appointments for evaluation are missed;               <ol style="list-style-type: none"> <li>a. The evaluation agency must contact the ISC who will attempt to contact the family.</li> </ol> </li> <li>6. After <b>three (3) unsuccessful, documented</b> attempts to schedule an IFSP</li> </ol>

	<p>meeting where the family was unwilling or unable to attend.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>Three (3) documented unsuccessful</b> attempts to contact the family is defined as: attempts made on different days, to contact the family by phone, and in writing (at least one through a certified letter). The OSC must send a copy of <b>Your Family Rights in Early Intervention</b> when contacting the family by mail.</li> <li>• The ISC must submit a copy of the certified letter, certified label, and the <b>Closure Form</b> to the RO.</li> <li>• <b>A copy of the Closure Form, certified letter, and other unsuccessful contact attempts must be documented in the child’s SC record.</b></li> </ul> <p>7. After a family misses <b>two (2) successive</b> Initial IFSP meetings for which they have received notice without informing the ISC at least 24 hours before the scheduled meeting <b>AND</b> the ISC makes <b>three (3) documented</b> unsuccessful attempts to contact the family.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• When the family has an extenuating circumstance (ex: child or family illness), is unable to attend the Initial IFSP meeting at the time and place scheduled, and cannot give at least <b>24 hours</b> notice, the RO working with the ISC must reschedule the meeting at a time and place convenient to the family.</li> <li>• The ISC must document all attempts to schedule the initial IFSP in the child’s case record.</li> </ul>
<p><b>Ongoing Service Coordinator (OSC)</b></p>	<p>Submits <b>Closure Form to the RO</b> when one of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Upon the request of a parent;</li> <li>2. Upon transfer of the case to a municipality/locality outside of NYC;       <ol style="list-style-type: none"> <li>a. <b>Closure Policy</b> does not apply to cases where the family is on vacation. See <b>Vacation Policy</b>.</li> </ol> </li> <li>3. After an agreed upon period of time by OSC and family following the death of a child (not to exceed <b>four (4) weeks</b>);</li> <li>4. Upon a child’s transition or age - out of the Early Intervention Program (EIP).</li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• <b>Closure Form</b> is submitted <b>within seven (7) calendar days</b> of the “effective date” of closure.</li> <li>• The “effective date” of closure is entered by the Ongoing Service Coordinator (OSC) in the above cases (1, 2, 3, and 4 above).</li> <li>• The “effective date” of closure will be entered by the RO for all other scenarios (items 5 below).</li> <li>• The “effective date” of closure is the last day the OSC can bill for service coordination on a case.</li> </ul> <p>5. After a family misses <b>three (3) consecutive</b> scheduled intervention sessions for the same service without informing the OSC. When <b>three (3) consecutive</b> scheduled sessions are missed;</p>

	<p>a. Service provider agency must document in the child’s record their inability to provide services or locate the family.</p> <p>b. The service provider agency must contact the OSC who will attempt to contact the family by phone and mail.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• The OSC must make <b>three (3) documented unsuccessful</b> attempts to contact the family, defined as: attempts made on different days, to contact the family by phone, and in writing (at least one through a certified letter). The OSC must send a copy of <b>Your Family Rights in Early Intervention</b> when contacting the family by mail.</li> <li>• The OSC must submit a copy of the certified letter, certified label/return receipt, and the <b>Closure Form</b> to the RO.</li> <li>• <b>Copies of the Closure Form, certified letter, and other unsuccessful contact attempts must be documented in the child’s SC record.</b></li> </ul>
<p><b>Regional Office (RO)</b></p>	<p><b>Closure Forms</b> will be routed to the assigned Early Intervention staff (EIOD) for review and authorization.</p> <ol style="list-style-type: none"> <li>1. If the EIOD <b>does not</b> authorize closure, the <b>ISC/ OSC will be notified within two (2) weeks</b> of receipt via fax or letter.</li> <li>2. If the EIOD authorizes closure:       <ol style="list-style-type: none"> <li>a. EIOD checks if the <i>Closure Form</i> is signed by the parent           <ol style="list-style-type: none"> <li>i. <b>If signed, Prior Written Notice is <u>not</u> sent to Parent and OSC/ISC.</b></li> <li>ii. EIOD signs the <b>Closure Form</b> and submits to the Data Entry Unit for entry into KIDS.</li> <li>iii. The RO must send a <b>copy of the signed Closure Form to the SC within two (2) weeks</b> of receipt               <ul style="list-style-type: none"> <li>• SC forwards copies to all service provider agencies.</li> </ul> </li> </ol> </li> </ol> </li> <li>3. If the closure is authorized, but parent <b>did not</b> sign the <b>Closure Form</b>:       <ol style="list-style-type: none"> <li>a. EIOD sends parents and the ISC / OSC <b>Prior Written Notice Form</b> and a copy of <b>Your Family Rights in Early Intervention</b> when the reason for closure requires Prior Written Notice (<b>See Prior Written Notice Policy</b>).           <ol style="list-style-type: none"> <li>i. If the parent responds <b>within ten (10) business days</b> requesting due process, all services must remain in place until a resolution is reached.</li> <li>ii. If the parent does not respond <b>within ten (10) business days</b>, the <b>Closure Form</b> is signed and submitted by the RO as a separate document to Data Operations for entry into KIDS.</li> <li>iii. The RO must send a copy of the signed <b>Closure Form</b> to the SC <b>within two (2) weeks</b> of receipt               <ul style="list-style-type: none"> <li>• SC forwards copies to all service provider agencies.</li> </ul> </li> </ol> </li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• The effective date of closure reflected on the <b>Closure Form</b> must be the same date as the date that an action is considered final on the <b>Prior Written Notice Form</b>.</li> <li>• Effective date of closure is defined as the last date on which service coordination and services will be provided to a child/family, based on the reason for closure.</li> </ul>

	<ul style="list-style-type: none"> <li>• All child deaths must be reported immediately by the EIOD to SDOH at (518) 473-7016 (ext-2 Daniel Kellis or Robert Donnelly). <ul style="list-style-type: none"> <li>○ Parent Signatures on <b>Closure Forms</b> are not required in cases of child death.</li> <li>○ Regional Offices will <b>NOT</b> send <b>Prior Written Notice</b> in cases of child death.</li> </ul> </li> <li>• <b>If the OSC/ISC does not receive a signed Closure Form from the RO, the case will stay open.</b></li> </ul>
<b>Data Operations Staff</b>	<p><b>Closure Form</b> is initialed to validate that the <b>Closure Form</b> was entered, and all information entered in KIDS corresponds with the information on the <b>Closure Form</b>.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• If a closed case is re-opened to investigate a Turn Around Document (TAD) claim, the data entry staff/ claims analyst <u>must</u> close the case again in KIDS when the investigation is complete.</li> </ul>

**Approved By:**   
**Assistant Commissioner, Early Intervention**

**Date: 1/21/11**



## INSTRUCTIONS FOR COMPLETION CLOSURE FORM

The **Closure Form** may be completed by the Initial (ISC) or Ongoing Service Coordinator (OSC), EI/OD/RO staff, or Developmental Monitoring Specialist under the circumstances described below (See Appendix A).

The individual completing the form will:

1. Complete the identifying information.
2. Write the *Effective Date of Closure* and the *Date of Submission*, (dates do not have to be the same)
  - Provider agencies cannot bill for services or service coordination after the *Effective Date of Closure*.
  - The closure date should allow for any necessary activity on the case, such as *Prior Written Notice*, to have been completed.
3. Circle the correct designation (*SC/DM/RO*) and print his/her name.
4. If the SC is completing this form, the SC ID number must be specified.
5. Write telephone and fax numbers.
6. Check to indicate if the case is being closed in Early Intervention (EI) or Developmental Monitoring (DM).

When the **Closure Form** is completed and submitted by any of the parties listed, the appropriate staff in the RO or DM Unit will review the form and sign and date at the bottom.

Data Entry staff will sign and date the form to indicate that the information has been entered into KIDS.

### **Initial and Ongoing Service Coordinators:**

- Complete **Section I** of the **Closure Form** when any of the conditions listed in the box titled “Disposition” occurs (see Crosswalk of Instances of Closure and Disposition Codes).

**NOTE: This form should not be completed if a child will be leaving one EI Provider and continue to receive any services through another EI provider within the five boroughs of New York City.**

- Keep a completed copy of the **Closure Form** in the child’s service coordination case record.
- Send copies to the following: EI/OD (or appropriate EI Regional Office Director); the evaluation site (if prior to the IFSP meeting); and all service provider agencies, including respite and transportation providers, if authorized.
  - If the parent is unavailable for signature, attach the SC notes, certified letter (if applicable) and certified label (if applicable) documenting unsuccessful contact attempts and parent availability issues. For more information refer to the **Closure Policy**.
  - Parent signature is **NOT** necessary in cases of child death
- If a child is found not eligible for EI services, the SC should discuss referral to DM with the parents.
  - If parent agrees with referral to DM, check box “J” indicating the DM referral.

### **Regional Office Staff:**

- Complete Section I of the **Closure Form**:
  - Upon the conclusion of the evaluation process when the child is determined to be not eligible for EI, the family did not agree with the findings or did not sign the form, and a **Prior Written Notice Form** was sent.
  - After a child has been re-evaluated, found no longer eligible for EI services, and a **Prior Written Notice Form** was sent.
- Keep a completed copy of the **Closure Form** in the child’s municipal case record.
- Send copies to the following: ISC/ OSC, all service provider agencies, and Data Operations for entry into KIDS.

### **Developmental Monitoring Staff:**

- Complete Section II of the **Closure Form** when any of the conditions listed under “Disposition” occurs.
- Keep a completed copy of the **Closure Form** in the child’s municipal case record.
- Send a copy of the form to Data Operations for entry into KIDS.



<b>Appendix A: Closure Codes and Definition of Categories</b>	
<b>Closure Code</b>	<b>Definition of Category</b>
A- Delay condition resolved	The condition for which the child was receiving EI services has been resolved and the child no longer requires services.
B- Family Refused	Withdrawal by parent (or guardian) after the child has been evaluated.
C- Can't locate family	Attempts to reach the parent were unsuccessful. Category includes children at any stage in the EI process, and for whom personnel have been unable to contact or locate after repeated, documented attempts.
D- Transition to CPSE	Children who have been determined to be eligible for services by the Committee on Preschool Special Education.
E- Evaluated found not eligible	Children who have been evaluated and determined to be not eligible for EI services
G- Family moved out of NYC	The family moved out of NYC, but remains within NYS.
H- Family moved out of state	The family moved out of NYS.
I: Child Died	Case is closed due to child's death.
K- Refused Contact in 2 months	Parents withdraw from EIP before the Initial IFSP meeting occurs. The evaluation process may or may not have been initiated or completed.
L- Age out, not eligible for CPSE/ no referral	Children who have been determined to be not eligible for services by the CPSE and age out of EI with no referrals to other programs.
M- Age out, not eligible for CPSE/ referred to other programs	Children who have been determined to be not eligible for services by the CPSE and age out of EI with referrals to other programs such as: preschool learning center, Headstart, child care center, health and nutrition services.
N- Age out, unknown eligibility for CPSE/ process incomplete or parent refused	Children who have aged out of EI and for whom eligibility for services by the CPSE is unknown or the process is incomplete. Also include children for whom parents did not consent to transition planning or to referral to CPSE.
Z- Duplicate	Child is already active in KIDS with another ID number

**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. 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.

<b>1. IFSP Functional Outcome 1:</b> _____ _____	<b>Rate Progress in This Time Period</b>				
	No Progress <input type="checkbox"/>	Little Progress <input type="checkbox"/>	Moderate Progress <input type="checkbox"/>	Great Deal of Progress <input type="checkbox"/>	Outcome Achieved <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**

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

<b>Policy Title: Amendments</b>	<b>Effective Date: July 1, 2010</b>
<b>Policy Number: 7-A</b>	<b>Supersedes: N/A</b>
<b>Applicable Forms:</b> <ul style="list-style-type: none"> <li>- <b>Change in Services/Service Provider/Service Coordinator Form</b></li> <li>- <b>Justification for Change in Frequency, Duration or Method of Service Form</b></li> <li>- <b>Progress Notes</b></li> <li>- <b>IFSP Meeting Request/Confirmation Form</b></li> </ul> <b>IFSP Forms</b> <ul style="list-style-type: none"> <li>- Page 1: <b>Identifying Information</b></li> <li>- Page 4: <b>Functional Outcomes</b></li> <li>- Page 5: <b>Service plan: Service Setting and Incorporating Interventions into Natural Routines. (if applicable)</b></li> <li>- Page 5a: <b>Service Authorization Data Entry Form</b></li> <li>- Page 5b: <b>Co-visits (if applicable)</b></li> <li>- Page 6: <b>Transportation, Assistive Technology, and Respite Services (if applicable)</b></li> <li>- Page 7: <b>Service Coordination Activities</b></li> <li>- <b>Transportation Data Entry Form (if applicable)</b></li> </ul>	<b>Regulation/Citation:</b> 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
<b>Ongoing Service Coordinator (OSC)</b>	<ol style="list-style-type: none"> <li>1. Receives requests for changes (amendments) from the following individuals:               <ul style="list-style-type: none"> <li>• Parent/Caregiver;</li> <li>• Service provider; or</li> <li>• Foster care agency/Administration for Children’s Services (ACS).</li> </ul> </li> <li>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"> <li>a. There is a recommendation for a change in a <i>Service Type</i>, a <i>Method</i> by which a</li> </ol> </li> </ol>

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 Data Entry 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"> <li>i. <b>Change in Services/Service Provider/Service Coordinator Form;</b></li> <li>ii. Parent consent (signature) is required;</li> <li>iii. IFSP Page 5a: <b>Service Authorization Data Entry Form;</b></li> <li>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);</li> <li>v. <b>Justification for Change in Frequency, Duration or Method of Service Form.</b> <ul style="list-style-type: none"> <li>• Only questions 1, 2 and 5 of the justification should be addressed for termination of services.</li> </ul> </li> </ol> <p>e. Requests to change frequency, duration, or method of service delivery:</p> <ol style="list-style-type: none"> <li>i. <b>Change in Services/Service Provider/Service Coordinator Form;</b> <ul style="list-style-type: none"> <li>• Parent consent is required.</li> </ul> </li> <li>ii. Revised IFSP Forms; <ul style="list-style-type: none"> <li>• Required forms are listed under the “<i>Convening an Amendment Meeting</i>” section of this policy document.</li> </ul> </li> <li>iii. Copies of the most current <b>Provider Progress Notes</b> and <b>Calendars</b> (if completed); <ul style="list-style-type: none"> <li>• If a request is made prior to the (3) month progress note, <b>Session Notes</b> must be included instead of the Provider Progress Note(s).</li> </ul> </li> <li>iv. <b>Justification for Change in Frequency, Duration or Method of Service Form.</b></li> </ol> <p>f. Requests to add a new service type:</p> <ol style="list-style-type: none"> <li>i. <b>Change in Services/Service Provider/Service Coordinator Form;</b> <ul style="list-style-type: none"> <li>• Parent consent is required.</li> </ul> </li> <li>ii. Supplemental evaluation. <ul style="list-style-type: none"> <li>• Refer to the Policy on <b>Additional Evaluations</b> for requesting, completing and submitting additional evaluations.</li> </ul> </li> <li>iii. Revised IFSP Forms. <ul style="list-style-type: none"> <li>• Required forms listed under “<i>Convening an Amendment Meeting</i>” section of this policy document.</li> </ul> </li> <li>iv. Copies of the most current <b>Provider Progress Notes</b> and <b>Calendars</b> (if completed) from services currently being received. <ul style="list-style-type: none"> <li>• If a request is made prior to the three (3) month progress note, <b>Session Notes</b> must be included instead of the <b>Provider Progress Note(s)</b>.</li> </ul> </li> </ol> <p>g. Requests for additional Ongoing Service Coordination units:</p> <ol style="list-style-type: none"> <li>i. <b>Change in Services/Service Provider/Service Coordinator Form;</b> <ul style="list-style-type: none"> <li>• Parent consent is required.</li> </ul> </li> <li>ii. Brief explanation is required on agency letterhead, indicating; <ul style="list-style-type: none"> <li>• The reason(s) for the change in location (should be child-based and related to outcomes).</li> </ul> </li> <li>iii. IFSP Page 5a: <b>Service Authorization Data Entry Form;</b></li> </ol> <p><b>Note:</b> Requests for additional ISC are addressed in the <b>Changes in Initial Service Coordinator or Initial Service Coordination Units Policy.</b></p>
<p><b>Early Intervention Official</b></p>	<ol style="list-style-type: none"> <li>1. Reviews Amendment request within three (3) weeks of receipt in the RO: <ol style="list-style-type: none"> <li>a. EI/OD may schedule an amendment meeting after reviewing the amendment packet:</li> </ol> </li> </ol>

<b>Designee (EIOD)</b>	<ul style="list-style-type: none"> <li>i. Notifies the Scheduling Unit to set up an amendment meeting:; <ul style="list-style-type: none"> <li>• Refer to Policy on IFSP Meeting Scheduling in this chapter of the Policy and Procedures Manual.</li> </ul> </li> <li>b. EIOD may request additional information from the interventionist if insufficient information was provided.</li> <li>c. EIOD may authorize the amendment by: <ul style="list-style-type: none"> <li>i. Completing the submitted Service Authorization Data Entry Form: <ul style="list-style-type: none"> <li>• The <i>Begin Date</i> of the new service and the <i>End Date</i> of the old service must be completed;</li> <li>• EIOD must allow at least one week's notice to providers before any change goes into effect.</li> </ul> </li> <li>ii. Signing the <b>Change in Service/Service Provider/Service Coordinator Form.</b></li> </ul> </li> <li>b. If the EIOD denies the Amendment Request: <ul style="list-style-type: none"> <li>i. EIOD will return the denied request to the SC;</li> <li>ii. <b>Prior Written Notice</b> will be sent to the parent/caregiver by the EIOD detailing the reason for the denial: <ul style="list-style-type: none"> <li>• A written explanation will be sent to the service coordinator when a request for additional ongoing service coordination units is denied.</li> </ul> </li> </ul> </li> </ul> <p><b>Note:</b> 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>
<b>Ongoing Service Coordinator (OSC)</b>	<ul style="list-style-type: none"> <li>1. Gives a copy of the authorized amended IFSP to all service providers and the parent.</li> <li>2. Gives a copy of the approved amended IFSP packet to all service providers.</li> <li>3. If a new <b>Transportation Service Data Entry Form</b> was completed, the OSC must give a copy to the service provider's transportation coordinator, who <b>must</b> give a copy to the transportation provider and to the Department Of Education.</li> <li>4. Explains due process rights to parent if the Amendment request is denied.</li> </ul>



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).
<b>Date of Previous Justification(s) for Change in this Discipline:</b> If there were prior requests to amend this service, indicate the date of request.	
<b>Request for Change:</b> Indicate all changes to this service that are being requested at this time.	
<b>Required Justification Components:</b> For requests to <b>terminate services or decrease frequency</b> , complete questions 1, 2, and 5 only. For <b>all other requests</b> , answer questions 1 through 7.	

# Chapter 11: Procedural Safeguards

## New York City Early Intervention Program

<b>Policy Title: Procedural Safeguards Related to Early Intervention Records</b>	<b>Effective Date:</b> 2/28/2011
<b>Policy Number:</b> 11-A	<b>Supersedes:</b> N/A
<b>Attachments:</b> <ul style="list-style-type: none"><li>• <b>Consent to Obtain/Release Information Form</b></li></ul>	<b>Regulation/Citation:</b> 10 NYCRR69-4.17(c) – (e)

### I. POLICY DESCRIPTION:

All Early Intervention (EI) staff and provider agencies are subject to requirements pertaining to Early Intervention records in accordance with each of the following:

- Requirements relating to confidentiality/disclosure, access to records, and amendment of records contained in the Early Intervention Program regulations in 10 NYCRR 69-4.17 (c) – (e) under the heading **Procedural Safeguards**. The program regulations require each municipality and all Early Intervention providers to adopt procedures that meet the requirements in 34 CFR Part 99. (FERPA) and sections 34 CFR sections 300.560 through 300.576, with modifications specified in 34 CFR 303.5(b) to preserve the confidentiality of records on eligible children participating in the Early Intervention Program.
- Federal Family Educational Rights and Privacy Act (FERPA) and regulations (34 CFR Part 99). The Family Educational Rights and Privacy Act (FERPA) is the federal law that protects the privacy of student education records. FERPA protections apply to student special education records under IDEA *and* to Early Intervention records under Part C of IDEA. The State, municipalities and EI providers must comply with the requirements contained in FERPA. IDEA federal regulations in Section 300.560-300.576 relate to requirements under FERPA and also pertain to EI records
- Individuals with Disabilities Education Act (IDEA) and regulations (34 CFR 303; 34 CFR 300.560 through 300 576).
- Title II-A of Article 25 of PHL and 10 NYCRR69-4 Medical Assistance Program (Medicaid).

**Any breach of confidentiality (such as the loss or theft of records) must be reported to the Designated Confidentiality Coordinator of the Early Intervention Program no later than one (1) week post discovery.**


**Beverly Samuels, Director of Consumer Affairs**  
**New York City, Early Intervention Program**  
**Gotham Center #12**  
**42-09 28th Street, 18th Floor**  
**Queens, NY 11101**  
**Phone number: 347-396-6828**  
**Fax number: 347-396-6982**

## II. PROCEDURE:

Responsible Party	Action
<b>EI contracted agencies, NYC Bureau of Early Intervention</b>	<ol style="list-style-type: none"> <li>1. Required to develop policies/procedures regarding confidentiality pertaining to data, child records, personally identifiable information.</li> <li>2. Personally identifiable data, information, or records shall not be disclosed by the municipality, evaluator, service provider or service coordinator to any person other than the parent of such child. (Even if the child is no longer participating in EI).               <ol style="list-style-type: none"> <li>a. Only information appropriate to that request may be released.</li> <li>b. Extraneous information or sensitive information about the child and family must be protected.</li> <li>c. Any release of information for an individual child must contain information pertaining only to that child/family. Personally identifiable information about others must be redacted.</li> </ol> </li> <li>3. Prior to releasing records to any individual/agency outside the Early Intervention program (EIP) written consent must be obtained on the <b>Consent to Release/Obtain Information Form</b>.</li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• Parents must never be asked to sign a blank <b>Consent to Release/Obtain Information Form</b>.</li> </ul> <ol style="list-style-type: none"> <li>4. A record of any access to children’s EI records and the purpose for which the record was accessed must be kept in the child’s municipal/provider file (with the exception of the parent, employees of the municipality, Early Intervention providers, or Department staff or designees).</li> <li>5. All EI records containing personally identifiable information must be maintained in secure locations (e.g., in locked file cabinets).</li> <li>6. Staff who travel to a variety of locations must ensure the security and confidentiality of EI records that are off-site (e.g., EI records must be in a secure briefcase, file, etc.).</li> <li>7. All employees must be informed of, and adhere to, the policies and procedures regarding confidentiality.</li> <li>8. All employees must adhere to all legal requirements that protect EI records containing sensitive information (such as sexual or physical abuse, HIV status, treatment for mental illness, the child’s parentage, etc.).</li> <li>9. Employees of the New York State Department of Health, other State EI agencies, and municipalities may access any record pertaining to a child and the child’s family that are collected, maintained, or used for the purposes of the EIP.               <ol style="list-style-type: none"> <li>a. Staff must record the name of the individual accessing the record, the date of access and the purpose for which the party is authorized to use the record.</li> </ol> </li> </ol>
<b>Service Coordinators</b>	<p><b><u>Release of Information:</u></b>            EI/ODS/SC’s must:</p> <ol style="list-style-type: none"> <li>1. Offer parents the opportunity to sign selective releases that specify by name or category those individuals to whom information may be disclosed or from whom it is sought.</li> </ol>

	<ol style="list-style-type: none"> <li>2. Provide parents with the ability to revoke a release at any time and include a statement to this effect on any release forms used.</li> <li>3. Parents must be informed about the scope of information included in EI records that may be shared when they are asked to sign consent. When parents sign a consent they can specify limitations to the release of information, including: <ol style="list-style-type: none"> <li>a. Who can access information in their child’s EI records.</li> <li>b. What information in their child’s EI records can be released and to whom.</li> <li>c. Time period for which the consent to release information is applicable.</li> </ol> </li> </ol>
<p><b>NYC Bureau of Early Intervention Regional Office Assistant Director</b></p>	<p><b><u>Parental Requests for Amendments to Records:</u></b></p> <p>Parents have the right to request an amendment to any EI record pertaining to their child when the parent(s) believe(s) the information contained in the record is inaccurate, misleading, or violates the privacy or any other rights of the child.</p> <ol style="list-style-type: none"> <li>1. Request to amend or seal any EI record pertaining to a child are made to an Early Intervention Regional Office Assistant Director.</li> <li>2. Assistant Directors: <ol style="list-style-type: none"> <li>a. Inform parents about the procedures to be followed to request an amendment to EI records pertaining to their child and maintained by that Early Intervention Official or provider.</li> <li>b. Respond to a parent’s request to amend his/her child’s record <b>within ten (10) business days</b>.</li> <li>c. Notify the parent and the SC of the agreement to amend the record.</li> <li>d. Notify parents in writing if either the Early Intervention Official Designee (EIOD) or an EI service provider does not agree to a request to amend or seal the record. <ol style="list-style-type: none"> <li>i. If the EIOD or service provider do not agree with the request, the municipality: <ul style="list-style-type: none"> <li>• Informs the parent of the right to an administrative hearing.</li> <li>• Convene an administrative hearing to amend the record within a reasonable time after receiving a request from a parent for such a hearing.</li> <li>• Order any amendment the municipality determines to be appropriate to be made to the EI record in question. <ol style="list-style-type: none"> <li>○ Notify all appropriate parties of the ordered amendment (including individuals who have a copy); and, notifying the parent when the record has been amended</li> </ol> </li> <li>• Notify parents when a requested amendment is not ordered. <ol style="list-style-type: none"> <li>○ Inform parents of the right to include a statement in the record to be disclosed with the record reflective of their views, and</li> </ol> </li> </ul> </li> </ol> </li> </ol> </li> </ol>

	Notify the parent that the parental statement will be incorporated and disseminated as part of the record.
<b>NYC Bureau of Early Intervention and Provider Agency Staff</b>	<p><b><u>Parental Access to Their Children's Records:</u></b></p> <ol style="list-style-type: none"> <li>1. Parents must be given the opportunity to inspect and review all records pertaining to the child and the child's family that are maintained or used for the purposes of the EIP (unless the parent is prohibited such access under State or federal law or a court order).</li> <li>2. It should be presumed that the parent has the authority to inspect and review EI records pertaining to his or her child unless the EIP has been advised otherwise under applicable State law, regulations or court order related to guardianship and custody.</li> <li>3. If a record contains information on more than one child or on non-participants, only the portion of the record pertaining to the child's participation in the EIP may be accessed.</li> <li>4. Parents have the right to: <ol style="list-style-type: none"> <li>a. Receive an explanation about, and interpretation of information included in any EI record upon request.</li> <li>b. Obtain a copy of the requested EI record <b>within ten (10) business days</b> of receipt of the request by the EIOD or Early Intervention service provider.</li> <li>c. Obtain a copy of the requested EI record <b>within five (5) business days</b> if the request is made as a part of a mediation or impartial hearing.</li> <li>d. Have a representative review the record on the parent's behalf (with signed consent).</li> </ol> </li> <li>5. A fee may be charged to copy EI records upon parent request (not to exceed 10 cents per page for the first copy and 25 cents per page for additional copies), as long as the fee does not prevent the parent from inspecting and reviewing the record.</li> <li>6. No fees may be charged for records related to evaluations and assessments to which parents are specifically entitled (e.g., evaluation and assessment reports under 10 NYCRR 69-4.8) unless specifically permitted under PHL 18.</li> </ol>

**Approved By:**   
**Assistant Commissioner, Early Intervention**

**Date:** 1/21/11



## New York City Early Intervention Program

<b>Policy Title:</b> <b>Procedural Safeguards - Prior Written Notice</b>	<b>Effective Date:</b> <b>2/28/2011</b>
<b>Policy Number:</b> <b>11-B</b>	<b>Supersedes:</b> N/A
<b>Attachments:</b> <ul style="list-style-type: none"> <li>• <b>Prior Written Notice Form</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> </ul>	<b>Regulation/Citation:</b> <b>10NYCRR69-4.17 (b) (1),</b> <b>10NYCRR69-4.17 (b) (2),</b> <b>Procedural Safeguards</b>

### I. POLICY DESCRIPTION:

The Early Intervention Official Designee (EIOD) must give **prior written notice** to the parent of an eligible child **ten (10) working days** before the EIOD proposes or refuses to initiate or change the identification, evaluation, service setting, or the provision of the appropriate Early Intervention (EI) services to the child and the child's family. EI 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.

“The EIOD shall 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...”

### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Early Intervention Official Designee (EIOD)</b>	<p>Completes the <b>Prior Written Notice Form</b>, and sends a copy of <b>Your Family Rights in Early Intervention</b> to parents and ISC/OSC when:</p> <ol style="list-style-type: none"> <li>1. A decision regarding a case will go into effect <b>after ten (10) business days</b> of the notice for any of the following reasons:               <ol style="list-style-type: none"> <li>a. Request to add a service(s) is being denied;</li> <li>b. Request to increase service units is being denied;</li> <li>c. Service (s) is being terminated;</li> <li>d. Service (s) is being decreased in frequency;</li> <li>e. Request to change service setting is being denied.</li> <li>f. Request for an evaluation is being denied.</li> </ol> </li> </ol> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• If a parent requests due process (mediation or impartial hearing), all services must remain in place until a resolution is reached or the parent has exhausted his/her due process rights.</li> </ul> <ol style="list-style-type: none"> <li>2. A case will be closed <b>after ten (10) business days</b> for any of the following reasons:               <ol style="list-style-type: none"> <li>a. At the conclusion of the evaluation process when the child is determined to be not eligible for EI and the family agrees with the</li> </ol> </li> </ol>

findings.

**Note:**

- If the evaluation was not supported after being submitted to the EIP, ESU will send a **Ten (10) Day Notice Letter** to the family with a copy to the ISC and the Regional Office (RO).

b. After a child has been re-evaluated through the Multidisciplinary Evaluation (MDE) process, and found no longer eligible for EI services.

**Note:**

- EIOD must send **Prior Written Notice** and a completed and signed **Closure Form** to the SC if the parent has not contacted an Assistant Director at the RO or initiated due process.
- The effective date of closure reflected on the **Closure Form** must be the same date as the date that an action is considered final on the **Prior Written Notice Form**.

c. There have been **three (3) unsuccessful, documented** attempts to schedule an IFSP meeting where the family was unwilling or unable to attend;

**Note:**

- The ISC must document all attempts to schedule the IFSP in the child's case record.
- If the family has a valid reason for being unable to attend an IFSP meeting at the time and place scheduled, the RO working with the SC must continue to make efforts to reschedule the meeting at a time and place convenient to the family.

d. A family misses two (2) IFSP meetings without contacting the service coordinator 24 hours before the meeting, or responding to his/her **three (3) unsuccessful, documented** attempts to contact the family.

3. The ISC/ OSC submits a **Closure Form** that has not been signed by the parent.


**Note:** See [Closure Policy](#) for a full list of Closure events and procedure.

**Prior Written Notice Form** and **Closure Form** (if applicable) will be filed in both the municipal and provider records.

**Note:**

- If there is a disagreement at an IFSP meeting (ex: a request for additional evaluation has been denied):
  - IFSP Written Notice is given explaining the reason(s) for the decision.
  - This notice is part of the IFSP document, and will be given with **Your Family Rights in Early Intervention** to the parent.

<b>Initial and Ongoing Service Coordinator (ISC/OSC)</b>	<ol style="list-style-type: none"><li>1. Parent is not available to sign <b>Closure Form</b>:<ol style="list-style-type: none"><li>a. Submits SC notes, certified letter (if applicable) and certified label/ return receipt (if applicable) documenting unsuccessful contact attempts and parent availability issues.</li></ol></li><li>2. Ensures that the evaluation/ service agency is informed of any decision made by the EIP.</li></ol>
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**Approved By:**   
**Assistant Commissioner, Early Intervention**

**Date:** 1/21/11



## INSTRUCTIONS FOR COMPLETION

### PRIOR WRITTEN NOTICE FORM

Prior written notice is the responsibility of the Regional Office/EIOD.

EIODs must complete the **Prior Written Notice Form** when:

- a. Any of the circumstances outlined in the **Prior Written Notice Policy** occurs.
- b. A child was found ineligible for Early Intervention.
- c. A request for evaluation is denied.
- d. Changes in services are authorized with which the parent has not previously agreed.
- e. A request for an amendment in service units or types is being denied.
- f. A **Closure Form** that has not been signed by the parent is received from the Initial or Ongoing Service Coordinator (ISC/OSC).

The EIOD will check the appropriate box to indicate the reason for the **Prior Written Notice Form**. The EIOD must provide a specific explanation of the reason for denial of an evaluation, change to or denial of a service, or closure to minimize any confusion or misunderstanding.

The EIOD does not use this form when:

- a. A parent has already given written consent to a change (at an IFSP meeting, on a **Change in Services Form**, on a signed **Closure Form**, etc.) and the EIOD agrees with the change.
- b. A case is being closed because the child is transitioning or aging out of Early Intervention.

## Mediation versus Impartial Hearing

Mediation	Impartial Hearing
<b>Similarities:</b>	
❖ The basis of the dispute can be the same as it is for an impartial hearing.	❖ The basis of the dispute can be the same as it is for mediation.
❖ The goal is to achieve resolution of the disputed issues. A decision is not made by the mediator, but by the parties involved.	❖ The goal is to achieve resolution of the disputed issues. The impartial hearing officer makes the decision as to the resolution.
❖ A mediation meeting is conducted by a qualified and impartial mediator through an agency contracted by SDOH.	❖ A due process hearing is conducted by a qualified and impartial hearing officer (judge) employed by SDOH.
<b>Differences:</b>	
❖ Parties establish the ground rules.	❖ Ground rules are established by the hearing officer and federal and state law.
❖ The process is voluntary at every phase.	❖ Once one party initiates due process, all necessary parties must participate or they run the risk of the hearing officer ruling against them by default.
❖ The parties identify the potential solutions.	❖ Resolutions available are determined by the hearing officer in accordance with federal and state law and regulations.
❖ The mediator acts as a facilitator and does not pass judgment on specific issues.	❖ The hearing officer, while impartial, does make conclusions of fact and law and renders a legal judgment that may include specific resolutions.
❖ Only when resolution is achieved is a signed agreement between the parties developed.	❖ Parties do not have to agree for a hearing officer to make a decision that is binding for both parties
❖ Mediations are held in each borough at a time convenient to all parties.	❖ Hearings are held in Manhattan.
❖ Participants informally discuss the issues. Discussions during mediation and the contents of the signed settlement agreement are confidential.	❖ Participants are sworn in and testimony is given. The hearing may be open to the public and the decision, after deleting personally identifiable information, is available to the public.
❖ Although mediation is less formal, it must be available to families, and adhere to federal (IDEA) and state laws and regulations.	❖ A due process hearing is more formal and is a required step in the administrative process available under the IDEA to resolve disputes.

## New York City Early Intervention Program

<b>Policy Title: Mediation</b>	<b>Effective Date:</b> 2/28/11
<b>Policy Number:</b> 11-C	<b>Supersedes:</b> N/A
<b>Department/Unit: Bureau of Early Intervention</b> <ul style="list-style-type: none"> <li>• <b>Mediation Request Form</b></li> <li>• <b>Your Family Rights in Early Intervention</b></li> </ul>	<b>Regulation/Citation: NYCRR 10 69-4.17 (g)(1)-(14)Procedural Safeguards/ Mediation; NYCDOH Provider Contract</b>

### I. POLICY DESCRIPTION:

“Mediation services for the resolution of disputes regarding eligibility determinations or Early Intervention service delivery shall be available from community dispute resolution centers upon the written request of the parent and/or Early Intervention Official and the mutual agreement of the parent and the Early Intervention Official to participate in mediation. (NYCRR 10 69-4.17 (g) (2))”

By State and Federal regulations, requests for mediations must be responded to within two days of receipt by the EI Program. Additionally, all municipalities must forward copies of all mediation agreements with documentation to NYSDOH to demonstrate that agreements were carried out.

**“As provided by law, where a Parent has requested mediation or an impartial hearing with respect to a child for whom the Provider has provided Contract Services, the Provider shall cooperate with the Department representatives assigned to conduct such mediation or impartial hearing. Such cooperation shall include but not be limited to the following: (1) consultation with the appropriate Department representatives; and (2) after such consultation, provision of a witness or witnesses with either direct knowledge of the child sufficient knowledge of the child such that the witness or witnesses will effectively participate in the mediation or impartial hearing.” (DOHMH EI Provider Contract)**


### II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Initial and Ongoing Service Coordinators (ISC/OSC)</b>	<ol style="list-style-type: none"> <li>1. Parent has a concern regarding any aspect the of Early Intervention process               <ol style="list-style-type: none"> <li>a. Discuss the specific parental concern. If the service coordinator cannot address the concern:                   <ol style="list-style-type: none"> <li>i. Discuss the problem with the Regional Office (RO) or the Director of Consumer Affairs in order to resolve any parental issue or concerns.                       <ul style="list-style-type: none"> <li>• Brooklyn: 718-722-3310</li> <li>• Queens: 718-271-1003</li> <li>• Staten Island: 718-420-5350</li> <li>• Bronx: 718-410-4110</li> <li>• Manhattan: 212-487-3920</li> <li>• Director of Consumer Affairs, Beverly Samuels: 347-396-6828.</li> </ul> </li> </ol> </li> </ol> </li> </ol>

	<ol style="list-style-type: none"> <li>2. Parent has a concern that cannot be resolved informally by contacting the RO or Director of Consumer Affairs: <ol style="list-style-type: none"> <li>a. Explains the parent’s due process rights which include the right to mediation. <ol style="list-style-type: none"> <li>i. Provide parent/caregiver with a copy of <b>Your Family Rights in Early Intervention</b>.</li> </ol> </li> <li>b. Assists parent in completing the <b>Mediation Request Form</b>.</li> <li>c. Faxes the <b>Mediation Request Form</b> to the Director of Consumer Affairs (DCA).</li> </ol> </li> </ol> <p><b>Note:</b> Verbal requests for mediation cannot be accepted. The parent may request mediation via letter instead of the <b>Mediation Request Form</b>.</p>
<b>Director of Consumer Affairs(DCA)</b>	Immediately notifies the RO of the request for mediation.
<b>Regional Office (RO)</b>	Provides the following information to the DCA <b>within twenty-four (24) hours</b> of being notified of the request for mediation: <ol style="list-style-type: none"> <li>1. The RO staff who will attend the mediation.</li> <li>2. Child’s Evaluation Agency and Evaluator or Service Delivery agency (s) and interventionist (s) (depending on where the child is in the process).</li> <li>3. Agency for Service Coordination (SC) and name of SC if parent contacts DCA directly.</li> </ol>
<b>Director of Consumer Affairs (DCA)</b>	<b>Within two (2) calendar days</b> of receipt of mediation request: <ol style="list-style-type: none"> <li>1. Notifies Mediation Center/SC of request.</li> <li>2. Sends letter acknowledging receipt of request to parent including: <ol style="list-style-type: none"> <li>a. Information about mediation center,</li> <li>b. <b>A copy of Your Family Rights in Early Intervention</b>,</li> <li>c. Attendees who will be at mediation.</li> </ol> </li> <li>3. Sends letter to contracted providers (SC, Evaluation Agency, Service Provider) requiring their presence at the mediation <b>if</b> deemed appropriate by the Early Intervention Program (EIP).</li> <li>4. Sends copy of the documentation to RO.</li> </ol>
<b>Regional Office (RO)</b>	<ol style="list-style-type: none"> <li>1. Files documentation in child’s municipal chart.</li> <li>2. Notifies DCA of date of mediation and Mediation Center ID # for child.</li> </ol>
<b>Regional Office/Service Coordinator (RO/SC)</b>	Ensures that: <ol style="list-style-type: none"> <li>1. Case will not be closed until the parent has exhausted due process proceedings.</li> <li>2. All services currently on the child’s IFSP continue as written until the parent has exhausted their due process rights.</li> <li>3. Other services not in dispute by the parent and EIOD are added to the child’s current IFSP.</li> </ol>
<b>Regional Office Assistant Director (AD)</b>	<ol style="list-style-type: none"> <li>1. Notifies DCA if agreement is reached before date of mediation. <ol style="list-style-type: none"> <li>a. Assists parent in withdrawing request.</li> </ol> </li> <li>2. If no agreement is reached: <ol style="list-style-type: none"> <li>a. Ensures that the parent understands his/her continued due process rights to impartial hearing and/or systems complaint.</li> </ol> </li> <li>3. Attends mediation session. <ol style="list-style-type: none"> <li>a. If an agreement is reached: <ol style="list-style-type: none"> <li>i. Assistant Director (AD) ensures that the IFSP is amended to</li> </ol> </li> </ol> </li> </ol>



	<p>reflect the decision made at the mediation <b>within five (5) days</b> of the conclusion of the mediation session.</p> <p>ii. Sends the following documents to the DCA <b>within forty-eight (48) hours</b> after completed mediation:</p> <ul style="list-style-type: none"> <li>• Mediations held prior to Initial IFSP meeting: <ul style="list-style-type: none"> <li>○ Mediation agreement;</li> <li>○ Copy of authorization for additional evaluation form (when appropriate);</li> <li>○ Copy of actual evaluation;</li> <li>○ Copy of IFSP if child is subsequently found eligible;</li> <li>○ Other documentation referenced in the mediation agreement.</li> </ul> </li> <li>• Mediations held after an Initial IFSP meeting: <ul style="list-style-type: none"> <li>○ Mediation agreement;</li> <li>○ Copy of authorization for additional evaluation form (if appropriate);</li> <li>○ Copy of actual evaluation, when appropriate;</li> <li>○ Copy of subsequent IFSP or Service Authorization Form(s);</li> <li>○ Copy of progress report(s) and/or sessions notes relating to service(s) authorized (when applicable);</li> <li>○ Any other documentation referenced in the mediation agreement.</li> </ul> </li> </ul> <p>b. If no agreement is reached at the mediation and the parent chooses to request an impartial hearing:</p> <p>i. Ensures that Regional Director, Director of Early Intervention Services, and Director of Consumer Affairs are notified via Email;</p> <ul style="list-style-type: none"> <li>• Notes parent’s intent to file for impartial hearing. <ul style="list-style-type: none"> <li>○ Sends a complete copy of the child’s file to the Director of Consumer Affairs</li> </ul> </li> </ul> <p><b>Note:</b> All services currently on the IFSP must continue until after decision is made at the impartial hearing.</p> <p>3. Notifies SC of any necessary follow-up if the SC is not at the mediation session.</p>
<p><b>Initial and Ongoing Service Coordinator (ISC/OSC)</b></p>	<ol style="list-style-type: none"> <li>1. Attends the mediation session at the invitation of the parent.</li> <li>2. Ensures that any service added to the IFSP at the conclusion of the mediation session begins <b>within two (2) weeks</b> of the authorized start date as it appears on <b>IFSP page 5a: Service Authorization Data Entry Form</b>.</li> <li>3. Follows up on all other decisions reached at the mediation session.</li> </ol>

Approved by:   
Assistant Commissioner, Early Intervention

Date: 1/21/11

**NEW YORK CITY EARLY INTERVENTION PROGRAM  
REQUEST FOR MEDIATION AND PARENTAL CONSENT  
TO RELEASE INFORMATION**

Child's EI ID#: \_\_\_\_\_ Child' \_\_\_\_\_ s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_

\_\_\_\_\_  
City or Town State Zip Code

Home Phone :(\_\_\_\_) \_\_\_\_\_ Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_

Service Coordinator: \_\_\_\_\_ SC Agency: \_\_\_\_\_

Early Intervention Official Designee (EIOD): \_\_\_\_\_

I, \_\_\_\_\_, give the Early Intervention Program permission to release information concerning my mediation request to the mediator. This information shall include, but not be limited to, my name, my address and telephone number, and the nature of my complaint concerning the program.

**Signed:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Parent/Surrogate Parent

[ ] I will need someone to translate for me at the mediation meeting. (Please specify the language): \_\_\_\_\_

[ ] I am complaining about the following issue that I wish to have resolved: \_\_\_\_\_  
\_\_\_\_\_

[ ] Services that I wanted for my child were not included on the IFSP. These services are as follows: \_\_\_\_\_  
\_\_\_\_\_

[ ] Services that were on my IFSP are not being properly provided to my child. Explain: \_\_\_\_\_  
\_\_\_\_\_

[ ] There is a problem with the evaluation of my child, explain: \_\_\_\_\_  
\_\_\_\_\_

[ ] Other, explain: \_\_\_\_\_  
\_\_\_\_\_

Please send this form via fax to Early Intervention Program, attn: Beverly Samuels at 347-396-6982.

## New York City Early Intervention Program

<b>Policy Title: Impartial Hearings</b>	<b>Effective Date:</b> <b>2/28/2011</b>
<b>Policy Number:</b> <b>11-D</b>	<b>Supersedes: N/A</b>
<b>Attachments:</b> <ul style="list-style-type: none"><li><b>Your Family Rights in Early Intervention</b></li></ul>	<b>Regulation/Citation: NYS Regs. Sec.69-4.17(h); NYCDOH Provider Contract; NYS Consolidated Laws Title II-A Sec. 2549 7(b)</b>

### I. POLICY DESCRIPTION:

“The parent shall have the right to an impartial hearing which ensures the fair and prompt resolution of individual child disputes or complaints.”

Impartial hearings are carried out by hearing officers who are administrative law judges assigned by the New York State Department of Health (NYS-DOH).

“As provided by law, where a Parent has requested mediation or an impartial hearing with respect to a Child for whom the Provider has provided Contract Services, the Provider shall cooperate with the Department representatives assigned to conduct such mediation or impartial hearing. Such cooperation shall include but not be limited to the following: (1) consultation with the appropriate Department representatives; and (2) after such consultation, provision of a witness or witnesses with either direct knowledge of the Child sufficient Knowledge of the Child such that the witness or witnesses with effectively participate in the mediation or impartial hearing” (DOHMH EI Provider Contract)

“A parent who, after completing mediation, substantially prevails in an impartial hearing or a judicial challenge to an order or determination under this title shall be entitled to reimbursement for reasonable attorney’s fees incurred in such impartial hearing or judicial challenge provided, however, that the parent shall only be entitled to reimbursement for such fees for prevailing in an impartial hearing if the municipality was represented by an attorney at such impartial hearing.”

**“As provided by law, where a Parent has requested mediation or an impartial hearing with respect to a child for whom the Provider has provided Contract Services, the Provider shall cooperate with the Department representatives assigned to conduct such mediation or impartial hearing. Such cooperation shall include but not be limited to the following: (1) consultation with the appropriate Department representatives; and (2) after such consultation, provision of a witness or witnesses with either direct knowledge of the child sufficient knowledge of the child such that the witness or witnesses will effectively participate in the mediation or impartial hearing.” (DOHMH EI Provider Contract**

## II. PROCEDURE:

<b>Responsible Party</b>	<b>Action</b>
<b>Service Coordinator (SC)/ EIOD</b>	<ol style="list-style-type: none"> <li>1. Explains the parents' rights to request an impartial hearing.</li> <li>2. Informs families how to send a request in writing to the NYS Department of Health, Early Intervention Bureau.</li> </ol>
<b>Parent</b>	<ol style="list-style-type: none"> <li>1. Contacts the NYS Department of Health in writing to request an impartial hearing.               <ol style="list-style-type: none"> <li>a. Sample letter is located in <b>The Early Intervention Program: A Parent's Guide</b>.</li> </ol> </li> </ol>
<b>Director of Consumer Affairs</b>	<ol style="list-style-type: none"> <li>1. Notifies the following staff when a hearing date is received from SDOH:               <ol style="list-style-type: none"> <li>a. Assistant Commissioner;</li> <li>b. Agency Legal Council;</li> <li>c. Director of EI Services;</li> <li>d. Medical Director (when appropriate);</li> <li>e. Director of Regional Office; and</li> <li>f. Director of Program Monitoring and Quality Improvement.</li> </ol> </li> </ol>
<b>Director of Consumer Affairs</b>	<ol style="list-style-type: none"> <li>1. Requests complete municipal file from the Regional Office (RO) which includes but is not limited to:               <ol style="list-style-type: none"> <li>a. All relevant documents related to any mediation proceedings including:                   <ol style="list-style-type: none"> <li>i. EIOD/AD/RD notes on any contacts prior to, and post mediation session;</li> <li>ii. A chronology of events in the case; and</li> <li>iii. Documentation that parents were informed of their rights to an impartial hearing, and that the document <b>Your Family Rights in Early Intervention</b> was given to the parents at the mediation session;</li> <li>iv. All IFSPs, evaluations, requests for changes in services, correspondence, etc. prior to and post mediation.</li> </ol> </li> </ol> </li> </ol>
<b>Regional Office</b>	<ol style="list-style-type: none"> <li>1. Requests provider and service coordination files from all agencies involved in the care of the child.</li> </ol>
<b>Director of Consumer Affairs</b>	<ol style="list-style-type: none"> <li>1. Forwards complete files (municipal and agency) to Agency Legal Counsel.</li> </ol>
<b>All Pertinent EI Staff</b>	<ol style="list-style-type: none"> <li>1. Participates in planning for hearing and obtaining additional information as requested by Agency Counsel.</li> </ol>
<b>All Pertinent EI Staff</b>	<ol style="list-style-type: none"> <li>1. Participates in planning for hearing and providing additional information as requested by Agency Counsel.</li> </ol>
<b>All Pertinent EI Staff</b>	<ol style="list-style-type: none"> <li>1. Attends hearing as requested by Agency Counsel.</li> </ol>

Approved By:   
 Assistant Commissioner, Early Intervention

Date: 1/21/11

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).

<b>CATEGORY</b>	<b>BILLABLE SC ACTIVITIES</b>	<b>NONBILLABLE SC ACTIVITIES</b>
<b>Surrogacy</b>	<p>Discussing the following with foster care caseworkers:</p> <ul style="list-style-type: none"> <li>• The selection of a surrogate parent when necessary.</li> </ul>	
<b>Contacts</b>	<ul style="list-style-type: none"> <li>• Speaking with parent/guardian when he/she responds to the SC’s message(s).</li> <li>• 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.)</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Receiving a voicemail message.</li> <li>• Leaving a voicemail message</li> <li>• Travel</li> </ul>
<b>Meetings</b>	<ul style="list-style-type: none"> <li>• Meeting with the family in the office.</li> </ul>	<ul style="list-style-type: none"> <li>• Waiting for a parent who fails to keep appointments; waiting for other EI personnel when unaccompanied by parent.</li> </ul>
<b>Providing Information to Families</b>	<ul style="list-style-type: none"> <li>• Discussing with parents, both in person and on the phone, such topics as: <ul style="list-style-type: none"> <li>○ Overview of Early Intervention (EI) and role of Service Coordinator (SC) (Initial and Ongoing);</li> <li>○ Family rights (including due process) and responsibilities under the Early Intervention Program (EIP) and review of the EI handbook: <b>A Parent’s Guide;</b></li> <li>○ Evaluation process, including voluntary family assessment, and the parent’s role in the evaluation, and eligibility criteria;</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Writing notes in child’s case record;</li> <li>• 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);</li> <li>• Providing clinical counseling services to parents.</li> </ul>

	<ul style="list-style-type: none"> <li>○ The parent’s primary area(s) of concern;</li> <li>○ Natural environments or other settings for service delivery;</li> <li>○ Services available in EI;</li> <li>○ 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;</li> <li>○ Ascertaining any current receipt of case management services or other services from public or private agencies;</li> <li>○ The IFSP process including members of the team, and the rights of parents to chose an On-going SC;</li> <li>○ Showing the parent the IFSP forms and discussing the IFSP process.</li> <li>● Informing the parent that the child’s and parent’s social security information will be requested at the IFSP meeting.</li> <li>● 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;</li> <li>● Explaining the use of third party insurance.</li> <li>● Providing families with the list of EI evaluation sites, and assisting families with choosing an appropriate evaluation agency.</li> <li>● Assisting families w/locating a Primary Care Provider.</li> </ul>	
<b>Information Gathering</b>	<ul style="list-style-type: none"> <li>● Obtaining various parental consents necessary for participation in EI services.</li> <li>● Obtaining insurance information from parent/caregiver. Explaining to parent/caregiver how the information will be used.</li> </ul>	
<b>Referrals</b>	<ul style="list-style-type: none"> <li>● Making referrals to non-EI services.</li> </ul>	

<b>Administrative Tasks</b>	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: <ul style="list-style-type: none"> <li>• Xeroxing;</li> <li>• Filling out billing forms;</li> <li>• Scheduling evaluators who are employed by the same EI provider as the SC;</li> <li>• Organizing paperwork</li> <li>• Mailing, faxing, or receiving a letter or form.</li> <li>• Asking the Regional Office for forms or how to fill out forms</li> <li>• Completing EI forms</li> <li>• Completing and sending form letters ( ex: introductory letters about the agency or SC)</li> </ul>
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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).

<b>CATEGORY</b>	<b>BILLABLE SC ACTIVITIES</b>	<b>NONBILLABLE SC ACTIVITIES</b>
<b>Contacts</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.)</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Receiving a message.</li> <li>• Leaving a message on voicemail</li> <li>• Writing notes or letters to a child's health care provider about the child.</li> </ul>
<b>Meetings</b>	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"> <li>• Supervisory conferences;</li> <li>• Team meetings;</li> <li>• Trainings and other conferences sponsored by their agency.</li> </ul>
<b>Gathering Information</b>	Making telephone calls to ensure that evaluation site has conducted the evaluation.	

<p><b>Providing Information to Families</b></p>	<ul style="list-style-type: none"> <li>• Ensuring that parent/guardian has received copies of the MDE and discussing parental/guardian reaction to the MDE.</li> <li>• Facilitating a meeting between the evaluation agency and parent as necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Discussing evaluation results with the parent or the child’s medical provider (this is the evaluation team’s responsibility).</li> <li>• 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).</li> <li>• Writing notes in child’s case record.</li> <li>• Providing clinical counseling services to parents.</li> <li>• Providing written notice to parents to families regarding denial of eligibility.</li> </ul>
<p><b>Administrative Tasks</b></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"> <li>• Xeroxing;</li> <li>• Filling out billing forms;</li> <li>• Scheduling evaluators who are employed by the same EI provider as the SC;</li> <li>• Organizing paperwork;</li> <li>• Mailing, faxing, or receiving a letter or form;</li> <li>• Asking the Regional Office for forms or how to fill out forms;</li> <li>• Completing EI forms;</li> <li>• Completing and sending form letters (introductory letters about the agency or SC).</li> </ul>
<p><b>Due Process</b></p>	<ul style="list-style-type: none"> <li>• Attending mediations, if invited.</li> <li>• Attending impartial hearings, if required.</li> </ul>	

**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).

<b>CATEGORY</b>	<b>BILLABLE SC ACTIVITIES</b>	<b>NONBILLABLE SC ACTIVITIES</b>
<b>Meetings</b>	<ul style="list-style-type: none"> <li>• Scheduling IFSP meetings (e.g., speaking with the participants on the phone).</li> <li>• Participating in meeting to develop IFSP.</li> </ul>	<ul style="list-style-type: none"> <li>• Traveling to and from IFSP meeting.</li> <li>• Time spent waiting for any individual who is late or fails to keep an appointment.</li> <li>• Sending out written IFSP meeting invitations.</li> </ul>
<b>Gathering Information</b>	<ul style="list-style-type: none"> <li>• Prior to IFSP date, meeting with the family to discuss community resources and natural routines to prepare for the IFSP.</li> </ul>	<ul style="list-style-type: none"> <li>• 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).</li> </ul>
<b>Administrative Tasks</b>	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"> <li>• Xeroxing;</li> <li>• Filling out billing forms;</li> <li>• Scheduling evaluators who are employed by the same EI provider as the SC;</li> <li>• Organizing paperwork;</li> <li>• Mailing, faxing, or receiving a letter or form;</li> <li>• Asking the Regional Office for forms or how to fill out forms;</li> <li>• Completing EI forms;</li> <li>• Completing and sending form letters (introductory letters about the agency or SC).</li> </ul>
<b>Due Process</b>	<ul style="list-style-type: none"> <li>• Attending mediations, if invited.</li> <li>• Attending impartial hearings, if required.</li> </ul>	

**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
<b>Contacts</b>	<ul style="list-style-type: none"> <li>• Speaking with parent, EI/OD, 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.</li> <li>• Leaving one (1) or more messages in the same day for a parent, an EI/OD, 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.)</li> </ul>	<ul style="list-style-type: none"> <li>• Billing for contacts that takes less than five (5) minutes (e.g. leaving a message for a parent, an EI/OD, 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).</li> <li>• Receiving a message, leaving a message on voicemail.</li> <li>• Providing counseling or other clinical services to parents.</li> </ul>
<b>Meetings</b>	<ul style="list-style-type: none"> <li>• 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.).</li> <li>• Participating in Six (6) Month Reviews, Annual Reviews, or meetings to amend IFSP.</li> </ul>	<ul style="list-style-type: none"> <li>• Traveling to and from IFSP meetings.</li> <li>• Time spent waiting for any individual who is late or fails to keep an appointment</li> </ul>
<b>IFSP Follow-up</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>	<ul style="list-style-type: none"> <li>• Performing any Service Coordination activity by the OSC on or before the day of the Initial IFSP.</li> </ul>
<b>Delivery of Services</b>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Assisting families in obtaining EI services by contacting service provider agencies or service provision coordinators.</li> <li>• At the parent's request, contacting any therapists working with the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Meeting/speaking with interventionist which does not eventually result in conveying information back to parent.</li> <li>• Faxing and mailing forms</li> </ul>

	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Contacting the Regional Office if there are problems with service delivery that the SC cannot resolve.</li> <li>• Ensuring that providers receive information about closed cases and cancelled services.</li> <li>• Attending mediations, if invited; impartial hearings, if required.</li> </ul>	
<b>Providing Information to Families</b>	<p>Explaining to parents, both in-person and on the phone, such topics as:</p> <ul style="list-style-type: none"> <li>• Family’s rights and responsibilities under the Early Intervention Program (EIP);</li> <li>• Family’s due process rights;</li> <li>• Parents’ satisfaction with the Early Intervention (EI) services child/family is receiving.</li> </ul> <p>Contacting parent when there are issues of child’s availability for services</p>	<ul style="list-style-type: none"> <li>• 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);</li> <li>• Providing clinical counseling to parent(s).</li> <li>• Writing notes in child’s case.</li> <li>• Traveling to and from home visit or any other destination.</li> </ul>
<b>Gathering Information</b>	<ul style="list-style-type: none"> <li>• Updating Insurance Information obtained from parent/caregiver.</li> <li>• Assisting parent in requesting and/or arranging additional core and/or supplemental evaluations (after Initial IFSP).</li> <li>• Securing progress reports from provider agencies.</li> </ul>	
<b>Assistive</b>	Providing information about the AT process,	

<b>Technology (AT)</b>	and monitoring receipt as authorized in IFSP or amendment to the IFSP.	
<b>Transportation</b>	Reporting a transportation problem for a specific child at the request of the parent.	<ul style="list-style-type: none"> <li>• Escorting child from bus.</li> <li>• Coordinating the arrival and dismissal of children by school bus.</li> <li>• Attending field trips.</li> </ul>
<b>Transition</b>	<p>Transition out of EI: (Refer to Transition out of Early Intervention Chapter):</p> <ul style="list-style-type: none"> <li>• At the parent’s request, assisting in making a referral to the Committee of Pre-school Special Education (CPSE);</li> <li>• 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;</li> <li>• Participating in the development of a Transition Plan;</li> <li>• Implementing the Transition Plan;</li> <li>• Ensuring that EI receives a copy of required CPSE paperwork to extend services.</li> <li>• Attending the CPSE meeting if invited by the parent.</li> </ul>	<ul style="list-style-type: none"> <li>• Faxing and mailing forms.</li> <li>• Accompanying parents to tour or visit special education programs that the child may be transitioning to under the CPSE.</li> </ul>
<b>Administrative Tasks</b>	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"> <li>• Xeroxing;</li> <li>• Filling out billing forms;</li> <li>• Scheduling evaluators who are employed by the same EI provider as the SC;</li> <li>• Organizing paperwork;</li> <li>• Mailing, faxing, or receiving a letter or form;</li> <li>• Asking the Regional Office for forms or how to fill out forms;</li> <li>• Completing EI forms;</li> <li>• Completing and sending form letters (introductory letters about the agency or SC).</li> </ul>

<b>Due Process</b>	<ul style="list-style-type: none"><li>• Attending mediations, if invited.</li><li>• Attending impartial hearings, if required.</li></ul>	
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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.)

## New York City Early Intervention Program

<b>Policy Title: Requirements for Early Intervention Program Employment of Department of Education Employees</b>	<b>Effective Date: January 1, 2011</b>
<b>Policy Number: 13-A</b>	<b>Supersedes: N/A</b>
<b>Attachments: Applicable Forms:</b> <ul style="list-style-type: none"><li>• <b>Notification to the Department of Health and Mental Hygiene of the Employment of a Department of Education Employee by an Early Intervention Provider</b></li><li>• <b>Release to Receive EI Services from a DOE Employee</b></li></ul>	<b>Regulation/Citation: N/A</b>

### **I. POLICY DESCRIPTION:**

The NYC Conflicts of Interest Board has approved a waiver allowing Department of Education (DOE) employees to be employed by Early Intervention (EI) agencies. DOE employees may work for EI agencies, providing service coordination, evaluation, or services, with the following caveats and requirements:

1. The ruling applies only to DOE employees working as salaried employees or under contract/subcontract to EI agencies. It does not apply to DOE employees who function as principals, stockholders, or directors of EI agencies. Persons in those positions must seek determinations from the DOE ethics officer. If a DOE employee is working in an EI agency without having a Department of Health and Mental Hygiene (DOHMH) waiver in place or in progress, DOHMH will have to terminate its contract with the agency, unless the individual resigns from either the DOE or the EI agency. DOE employees should direct questions on these issues to the DOE Office of Ethics and Conflict of Interest.
2. DOE employees may not also be employed by CPSE programs, since these programs contract with the DOE. Thus, a release form has been developed to ensure that parents realize that if and when a child transitions to CPSE, a DOE employee may not provide services to the child. This release form must be signed by every parent whose child receives EI services from a DOE employee and kept on file by both the EI agency and the DOE employee.

All EI agencies are required annually to submit to DOHMH a list of DOE employees that they employed or subcontracted with in the previous year. The deadline for 2011 submission is March 1, 2011. In following years (2012 and forward) the deadline will be February 1.

**II. PROCEDURE:**

Responsible Party	Action
<b>DOE Employee</b>	Complete the <b>Notification to the Department of Health and Mental Hygiene of the Employment of a Department of Education Employee by an Early Intervention Provider</b> and submit it to the following address/email: Office of Early Intervention Contracts 42-09 28th St., 18th Floor Queens, NY 11101 Email: EIContracts@health.nyc.gov Subject: DOE Waiver
<b>Office of Early Intervention Contracts</b>	<ol style="list-style-type: none"> <li>1. Files the form.</li> <li>2. Sends an email to the DOE employee confirming that s/he is approved to provide EI services for that agency.</li> </ol>
<b>DOE Employee</b>	<ol style="list-style-type: none"> <li>1. For each child to which s/he provides EI services, obtains the parent's signature on the <b>Release to Receive EI Services from a DOE Employee</b>.</li> <li>2. Makes a copy of the <b>Release</b> and gives it to the employing EI agency.</li> <li>3. Keeps the original <b>Release</b> in her/his own files.</li> </ol>
<b>EI Agency Employing the DOE Employee</b>	<ol style="list-style-type: none"> <li>1. Keeps all signed <b>Releases</b> in the employee file.</li> <li>2. By March 1 of 2011, and by February 1 of each year thereafter, submits a list of the DOE employees which it employed or subcontracted with in the previous calendar year to the following address/email:            Office of Early Intervention Contract            Office of EI Contracts            42-09 28th St., 18th Floor            Queens, N.Y. 11101            Email: EIContracts@health.nyc.gov            Subject: DOE Waiver</li> </ol>
<b>Office of Early Intervention Contracts</b>	Files the list.

Approved By:   
 Assistant Commissioner, Early Intervention

Date: January 25, 2011

**NOTIFICATION TO  
THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
OF THE EMPLOYMENT OF A DEPARTMENT OF EDUCATION EMPLOYEE  
BY AN EARLY INTERVENTION PROVIDER  
PURSUANT TO NYC CONFLICTS OF INTEREST BOARD RULING 2000-234**

TO: NYC DOHMH Office of Early Intervention Contracts  
42-09 28th St., 18th Floor  
Queens, N.Y. 11101  
Subject: DOE Waiver

Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

Your DOE File #: \_\_\_\_\_

Name and Address of your DOE work location:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

El Agency employing you: \_\_\_\_\_

Address of El Agency employing you: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

**This form must be filled out by any Department of Education employee who is also employed by an Early Intervention agency, and provided to the Department of Health and Mental Hygiene at the time the individual is hired/subcontracted by the EI agency.**

[EI Agency Letterhead]

**RELEASE TO RECEIVE EI SERVICES  
FROM A DEPARTMENT OF EDUCATION EMPLOYEE**

Name of Department of Education Employee: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

EI ID #: \_\_\_\_\_

I understand that \_\_\_\_\_ will be providing service to  
(DOE Employee's Name)

\_\_\_\_\_ pursuant to a contract between  
(Child's Name)

the Agency and the New York City Department of Health and Mental Hygiene's Early Intervention Program. I understand that the Department of Education Employee will not be permitted to provide services to my Child when and if my Child becomes eligible for preschool services through the Department of Education, except and unless my Child attends a Department of Education-operated program.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent: \_\_\_\_\_

**A copy of this release shall be maintained in the Child's  
file at the EI Agency and by the Employee.**