DBHDS

Virginia Department of Behavioral Health and Developmental Services

Infant & Toddler Connection of Virginia Practice Manual 2026

A Note About References to TRAC-IT in the Practice Manual

TRAC-IT (Tracking, Reporting and Coordinating for Infants and Toddlers) is Virginia's statewide early intervention data system. The Practice Manual generally assumes early intervention steps are being completed directly in TRAC-IT. However, references to "completing" a task in TRAC-IT allow that it may be completed through direct data entry or an electronic health record (EHR) upload. The Practice Manual is not a complete guide to using TRAC-IT, even for the sections in which specific tasks are referenced, and it does not replace the TRAC-IT User Guide as the primary reference for TRAC-IT information and instructions.

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Chapter 1: Mission, Purpose and Key Principles of Part C Early Intervention

Mission

Part C early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

Purpose

1. To enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings – in their homes with their families; in childcare, preschool or school programs; and in the community.
2. To enable families to provide care for their child and have the resources they need to participate in their own desired family and community activities.

Key Principles

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
2. All families, with the necessary supports and resources, can enhance their children's learning and development.
3. The primary role of a service provider in early intervention is to work with and support family members and caregivers in children's lives.
4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs.
5. IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
6. The family's priorities, needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

Source: Work Group on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings. (2008, March). *Agreed upon mission and key principles for providing early intervention services in natural environments.*

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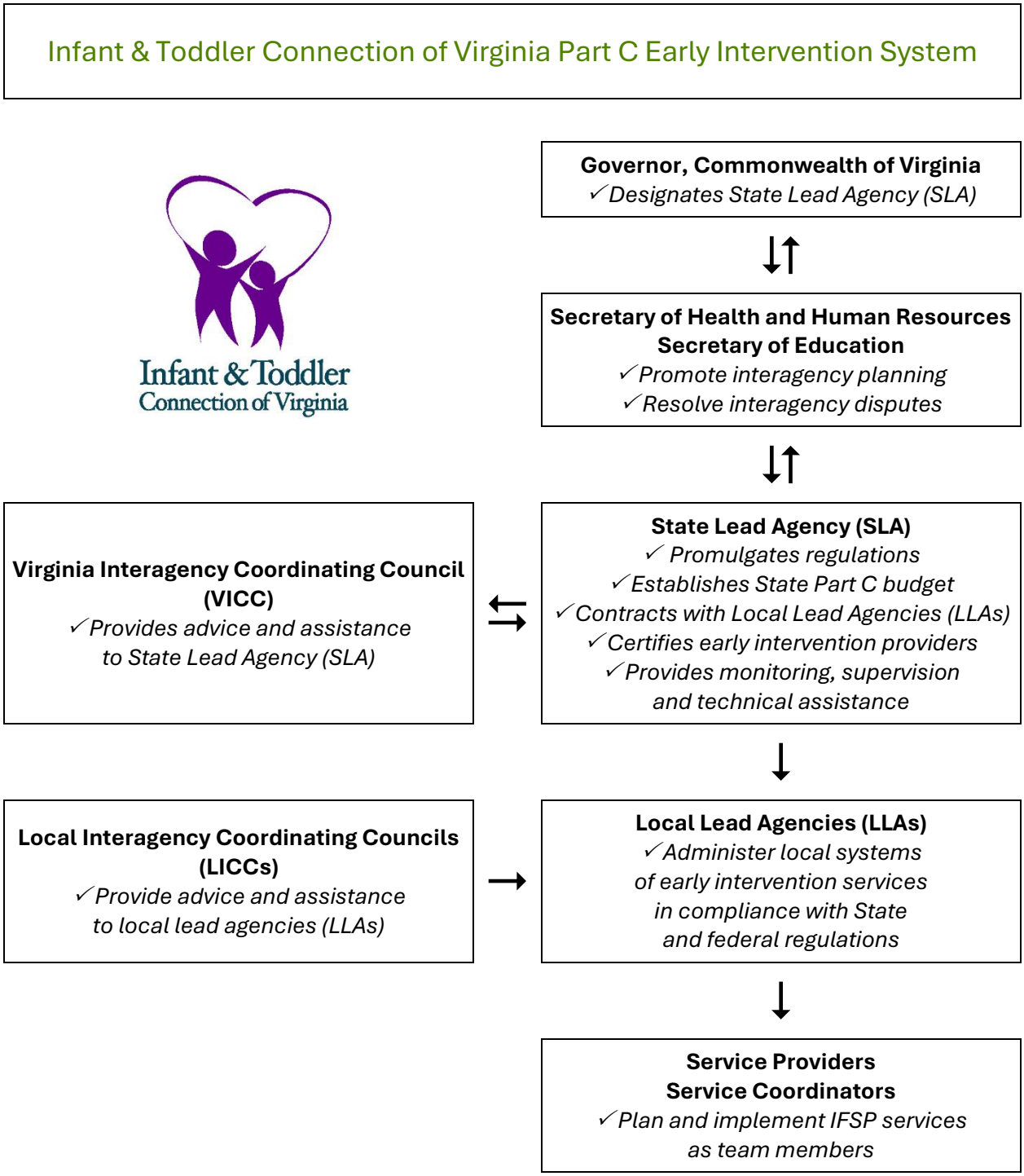
Chapter 2: State Infrastructure



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Chapter 3: Referral

An effective referral process ensures early identification of eligible children, timely supports and services for eligible children and families, and a strong base of referral sources who understand what is available through the Infant & Toddler Connection system and can rely on early intervention providers to partner with them in supporting the child and family they have referred. Referral is the first point of contact between the Infant & Toddler Connection system and the family. It is also a critical point of contact between the Infant & Toddler Connection system and the primary referral source. All referrals must receive a timely, professional and family-centered response.

Public Awareness and Child Find

Local Lead Agency Responsibilities

1. Use statewide materials and ensure that any local public awareness materials that are developed to use in addition to the statewide materials are consistent with the statewide public awareness materials and reflect the diversity of the local community.

2. Coordinate local activities with planned statewide public awareness activities (e.g., airing of public service announcements, dissemination of materials).

3. Provide notice throughout the community before any major child find activity takes place.

4. Disseminate to all primary referral sources (especially hospitals and physicians) information to be given to parents of infants and toddlers, especially parents with premature infants or infants with other physical risk factors associated with learning or developmental complications and assist the primary referral sources in disseminating that information. Primary referral sources include:

    a. Hospitals, including prenatal and postnatal care facilities;
    b. Physicians;
    c. Parents, including parents of infants and toddlers;
    d. Childcare programs and early learning programs;
    e. Local school divisions;

f. Public health facilities;
g. Other public health or social service agencies;
h. Other clinics and health care providers;
i. Public agencies and staff in the child welfare system, including protective service and foster care;
j. Homeless family shelters; and
k. Domestic violence shelters and agencies.

5. Disseminate public awareness materials to local agencies and places of business. The following agencies/businesses may be targeted for dissemination of information:

    a. Pediatricians'/general practitioners' offices;
    b. Hospitals, including NICUs and NICU follow-up and other outpatient clinics;
    c. WIC clinics;
    d. Well-baby/immunizations clinics and mobile vans;
    e. Community and migrant health centers;
    f. Head Start and Early Head Start programs;
    g. Family support programs;
    h. Child day care centers and family day care homes;
    i. Visiting public health nurse programs;
    j. Local social service departments;
    k. Programs that serve families affected by substance abuse;
    l. Mental health clinics;
    m. Civic groups;
    n. Ethnic/community centers;
    o. Homeless family shelters;
    p. Family planning organizations;
    q. Businesses (e.g., banks, utility companies, grocery stores, laundromats, beauty parlors, etc.);
    r. Places of worship;
    s. Professional associations;
    t. Advocacy associations;
    u. Private providers;
    v. Public schools;
    w. Adoption agencies;
    x. Parent support groups; and
    y. Other local points of contact with families and young children.

6. Develop and implement local public awareness and child find procedures that include the following:

    a. The methods to be used for planning and distributing public awareness information.

    b. The roles of agencies and individuals in the community involved in public awareness activities, including, but not limited to:

        i. Public agencies (e.g., local school systems, Head Start and Early Head Start, health agencies, social service departments);

        ii. Private entities (e.g., pediatricians);

        iii. Lay groups (e.g., Chambers of Commerce, service organizations, neighborhood associations, faith-based organizations, major employers, advocacy groups); and

        iv. Agencies and individuals who represent underserved groups, including minority, low-income, homeless and rural families and children, and children with disabilities who are wards of the State.

7. Involve primary referral sources, especially hospitals and physicians, in the child find system.

8. Inform primary referral sources, especially hospitals and physicians, about procedures to assist families in accessing the local Infant & Toddler Connection system. Emphasize that, although, under Part C, parent consent is not needed to make a referral to the local Infant & Toddler Connection system it is strongly recommended that the referral source inform the family prior to making the referral, explaining the reasons for the referral and the benefits of early intervention.

9. Work with physicians and other local agencies/providers to use a variety of mechanisms that may include, but are not limited to, mass general screenings, well baby checks, individual child screens, medical records/chart review, documentation of needs by primary referral sources, and parent observation and report to identify infants and toddlers potentially eligible for Part C early intervention services. Emphasize their responsibility to refer potentially eligible children to the local Infant & Toddler Connection system as soon as possible and within 7 days of identifying the child as potentially eligible for early intervention services.

10. Determine the required single point of entry for the local Infant & Toddler Connection system.

11. Collect and enter data into TRAC-IT for every age-eligible child referred to the local Infant & Toddler Connection system in accordance with the most current terms of the *Contract for Participation in Part C Early Intervention for Infants and Toddlers with Disabilities and Their Families*.

12. Use available data, including TRAC-IT data, regarding which children are receiving supports and services to evaluate the effectiveness of local public awareness and child find efforts on an ongoing basis and to determine the need to revise interagency agreements and other efforts related to child find and public awareness.

Provider Responsibilities

Refer to the single point of entry as soon as possible and within seven (7) days any child potentially eligible for early intervention who becomes known to the provider through a source other than the Infant & Toddler Connection system and who is potentially eligible for early intervention.

Receiving and Processing a Referral

General

1. Each local Infant & Toddler Connection system must designate a single point of entry for receiving all referrals to the local system.

2. Referrals may be made online via TRAC-IT or by phone, fax, in writing or in person to the local single point of entry. Referrals of children diagnosed with hearing loss may be received through the Virginia Infant Screening and Infant Tracking System (VISITS). Additional information about receiving and processing referrals received through VISITS is available at the end of this chapter.

3. It is not necessary to have parent consent to make a referral to the local Infant & Toddler Connection system, and the local system must still accept a referral even if the referral source has not informed the family.

4. The referral source must provide at least the child's or family member's name and one method of contact for the communication to be considered a referral. Additional referral information is necessary to use the online referral option through TRAC-IT.

5. The date of referral to the local Infant & Toddler Connection system is day one of the 45-day timeline for development of the initial IFSP.

    a. If a referral is received when the office is closed (e.g., for the weekend or on a State or federal holiday), then the referral is processed on the next business day. That next business day is considered the date of the referral. The local system must ensure timely processing of referrals through sufficient staffing of the single point of entry with back-up available when an individual is ill or on vacation. If the single point of entry office is closed for an extended period, such as during a week-long spring break or winter holiday break, then there must be a mechanism for processing referrals during that period.

    b. If a family or referral source calls the single point of entry just to ask a question about child development or to get other general information, then this is not considered a referral.

    c. The date of referral for a child referred from another local early intervention system (from either in or out of state) is the date the child is available (i.e., has moved into the area served by the local system) or the date of referral, whichever comes last.

    d. If a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or more when he/she is again referred to the local system, then the local system must conduct a new eligibility determination and assessment for service planning, establish new entry ratings on the child outcomes (if the child is still 30 months old or younger), and establish a new IFSP within 45 days of the new referral and before resuming services.

6. Children referred from another local early intervention system in Virginia and those who have been previously enrolled in the current or another local early intervention system in Virginia and who have been out of early intervention services for less than 6 months may not require all the steps (e.g., eligibility determination, assessment for service planning, IFSP development) that other new referrals require.

a. The steps necessary for a child that is transferring from another local system will depend on where that child was in the early intervention process with the sending local system. For instance, if eligibility determination had been completed by the sending local system, then the receiving local system can pick up with assessment for service planning. If a child with a current IFSP moves within Virginia, communication and coordination should occur between the sending local system and the receiving local system in advance of the move, whenever possible, to enable supports and services to be in place in the receiving local system based on the current IFSP. The family's new service coordinator may schedule an IFSP review soon after the family moves for the new IFSP team to review the existing IFSP and make any necessary modifications. However, an IFSP review is not necessary to begin services in the new local system.

b. If a child has been out of services in Virginia for less than 6 months, then it is only necessary to conduct a new eligibility determination if there is an indication that a significant change has occurred in the child's developmental status since the child left the system. Similarly, if an IFSP had already been developed for this child and family, then the local system may resume services in accordance with that IFSP if it was signed by the family and if the family does not indicate significant changes that would suggest the need for an IFSP review. Once services resume, an IFSP review may be held if either the providers or family identify a need to discuss changes in outcomes or services.

7. Information received by the local Infant & Toddler Connection system in a referral is considered confidential under the Family Educational Rights and Privacy Act (FERPA).

    a. If the local Infant & Toddler Connection system is unable to contact the family (e.g., depending on the contact information provided by the referral source, this may mean attempting to contact the family by phone, by letter and/or by stopping by the address), the single point of entry should contact the referral source to inform them that the family has not been contacted and to request additional contact information.

    b. Once the family has been contacted, information about the referral (beyond acknowledging receipt of the referral) may not be given to the referral source without a signed consent for release of information. If the referral source wants to know the outcome of its referral, the referral source should seek

consent from the family and provide a copy of a signed consent for release of information to the single point of entry at the time of referral. Information about referrals may also be given to the referral source if the parent provides consent using a local Infant & Toddler Connection system release form or the referral source later obtains parent consent and provides a copy of that signed release form to the local lead agency.

8. If the single point of entry is unable to contact a family after requesting additional contact information from the referral source or the family repeatedly fails to respond, then the dates of attempted contact must be documented in the child's record. Attempts to contact the family may be made by phone, mail, visiting the address provided by the referral source, and/or other means based on the contact information available. It is recommended that no more than 15 – 20 calendar days pass during this process of attempting to contact the family. Prior to closing the referral, a letter should be sent to the family stating that the child's referral record will be closed if contact is not made within a given number of calendar days from the date on the letter. The letter sent to the family must include information about how the family can re-establish contact with the local Infant & Toddler Connection system if they wish to and must include a copy of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. If the single point of entry is never able to contact the family, the single point of entry should inform the referral source that the family could not be contacted. Discharge the child in TRAC-IT, with the discharge reason "unable to contact."

Single Point of Entry Responsibilities

1. Provide general information to families and/or other interested persons who have questions regarding child development and accessing early intervention supports and services and/or other available resources.

2. Verify that the child is age eligible for early intervention and lives in the area served by the local Infant & Toddler Connection system.

    a. If it is clear at the time of referral that the child is past his third birthday or lives outside the area served by the local system, then inform the referral source and provide information about where and how to make an appropriate referral.

    b. If it is determined after contact with the family that the child is three or older or lives outside the area served by the local system, then facilitate a referral

to the appropriate program or services. Parental consent is required if the referral is to a program/service other than a local Infant & Toddler Connection system in Virginia.

3. Collect the following information from the referral source, if available:

    a. Child's full name;
    b. Parent(s) name(s);
    c. Address;
    d. Phone number(s);
    e. Date of birth;
    f. City/County of Residence;
    g. Gender;
    h. Reason(s) for referral;
    i. Whether developmental screening and/or assessment have occurred; and
    j. Name and contact number(s) for referral source.

    If screening and/or assessment information is available, request a copy.

4. Follow the steps outlined in the Virginia Department of Health attachment at the end of this chapter to access available referral information and process referrals received through the Virginia Infant Screening and Infant Tracking System (VISITS) of children diagnosed with hearing loss.

5. Inform referred families whose children are close to the age of eligibility for early childhood special education services through the local school division (under Part B) that they have the option to be referred to Part B instead of or simultaneously with referral to early intervention. If a child is referred to the Infant & Toddler Connection of Virginia fewer than 45 days before the child's third birthday, then the child may be referred directly to the local school division for early childhood special education services under Part B.

6. Begin the child's Part C early intervention record (see Chapter 9).

7. Acknowledge receipt of the referral by sending the *Acknowledgement Letter to Referral Source* to the referral source. This is an optional step in the process but is strongly encouraged since it conveys a professional response that promotes further referrals from this referral source. This correspondence is ***only*** for the purpose of acknowledging receipt of the referral and is intended for use with professional referral sources (e.g., physicians, social workers, school system, etc.) rather than

families or neighbors. Referrals submitted online through TRAC-IT receive an automated response indicating the referral was submitted successfully.

8. Assign a service coordinator.

9. Determine, in conjunction with the service coordinator, the need for a surrogate parent to protect the rights of a child when:

    a. No parent* can be identified;
    b. The parent cannot be located after reasonable efforts; or
    c. The child is a ward of Virginia.

    The *Surrogate Parent Identification of Need* form is an optional form that may be used in determining and/or documenting the need for a surrogate parent. If a surrogate parent is needed, then:

    a. Make reasonable efforts to appoint a surrogate parent within 30 days after determining the need for a surrogate parent in accordance with local procedures and, if the child is a ward of Virginia or in foster care, in consultation with the public agency that has been assigned care of the child;

    b. Ensure that the surrogate parent:

        i. Is not an employee of the local lead agency or any other public agency or provider that provides early intervention services, education, care or other services to the child or any family member of the child (A person is not an employee of an agency solely because he or she is paid by the agency to serve as a surrogate parent);

        ii. Has no personal or professional interest that conflicts with the interest of the child he or she represents; and

        iii. Has knowledge and skills that ensure adequate representation of the child; and

    c. Notify (1) the surrogate parent-appointee using the *Surrogate Parent Appointment Letter*; and (2) the person charged with responsibility for the child or the public agency and/or other participating agency/provider charged with responsibility for the child when the child is a ward of Virginia.

The *Surrogate Parent Identification of Need* form also may be used in determining and/or documenting when a surrogate parent is no longer needed. When the surrogate parent's role ends, he/she is notified using the *Surrogate Parent Termination Letter*.

Please see "Identifying the Parent" at the end of this chapter for further information on identifying who has the rights of a parent when the child is in foster care.

Parental Rights with Same-Sex Couples
This is a custody matter. Which adult has the legal relationship with the child? If a partner has no parental rights in Virginia, they cannot sign any of the early intervention paperwork because the parent is available. This would be like a stepparent not being able to sign paperwork unless the stepparent had legally adopted the child. The issue is not about the legal relationship of the adults to each other but of the legal relationship of the child to the adult. If, however, the parent was away for an extended period (e.g., deployment, extended business trip, etc.), the partner could "be acting in the place of" the parent and sign the necessary paperwork.

10. Ensure phone contact with the family to share basic information about the Infant & Toddler Connection system and to schedule an intake appointment with the service coordinator. This contact may be made by the single point of entry or by the service coordinator or there may be phone contact by both. The amount of information covered will depend on the family, including how much time they have available during the initial phone call and how much information they want and can receive at one time. It is expected that the information outlined in the "Early Conversations with Families" box on the next page will be discussed with families early in their experience with the local Infant & Toddler Connection system. This information may be shared during a single phone call with the family, through more than one phone conversation, or through a combination of an initial phone call(s) and the intake visit.

11. Ensure entry of referral data into TRAC-IT.

12. If, upon initial contact, the family declines an intake visit or any further service, provide an explanation of and then mail the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family.

a. Make reasonable efforts to ensure the family understands the eligibility determination services that are available, that these services are provided at no cost to the family, and that these services cannot be provided without parental consent.

b. Document your explanation to the family and their decision in a service coordination contact note (marked non-billable) or a communication log.

c. Offer to make referrals to other appropriate resources/services based on child and family needs and preferences, with parent consent.

d. Optional additional step: Using the bottom half of the *Declining Early Intervention Services* form, mark the first line (that they understand that eligibility determination may be conducted and that they do not choose to have their child receive an eligibility determination). Upload the completed form as a document to TRAC-IT.

e. Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

f. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.

g. Attempt to obtain parent consent to communicate with the primary care physician and the primary referral source, if not already provided. It is also acceptable to give the family the option to notify their physician themselves.

Talking with the Family About Notifying the Physician
Consider using the following language in seeking parent permission to notify the physician: "It's important to let your physician know that your child will not be receiving early intervention services so he/she can continue to keep an eye on your child's development. We can do that if you'll give us written consent (which we can do by mail). If not, we would ask that you let your physician know yourself."

h. Ensure that copies and explanations of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

i. Within 10 business days of the family declining to proceed, enter the discharge date (the date the family declined to proceed) and discharge reason (declined eligibility determination) in TRAC-IT. The user can select the Discharge-Declined to Schedule button on the Schedule Appointments and Assign Service Coordinator task.

Early Conversations with Families

This list is intended to guide conversations and should not be read to families.

- Be sure to introduce yourself and let the family know your role in the local system (e.g., service coordinator or staff at the single point of entry)
- Let the family know how you got their name and their child's name.
- Find out whether they knew their child was going to be referred.
- Confirm the information you received from the referral source, e.g., child's name, date of birth, address, phone number.
- Ask whether the family has heard of the early intervention program before and, if so, what they have heard. This may allow you to skip some of the basic information you would typically share with a newly referred family or give you the opportunity to address any misperceptions.
- Use concepts from the principles in Chapter 1 as the basis for sharing basic information about early intervention – early intervention is individualized, families and providers work in partnership at each step of the process, the focus is on increasing the child's participation in family and community activities and supporting the family in helping their child develop and learn.
- Introduce the child and family outcomes that drive early intervention: supporting children in developing positive social relationships, acquiring new skills, and assisting children in learning how to get their needs met in the routines and activities that are important to the child and family; assisting

families in helping their child develop and learn, communicating their children's needs, and knowing their rights in the early intervention system.

- Remember to spend some of the conversation listening to the family. Ask the family about their child, how he/she is doing, etc. to get to know the family and begin gathering information about how the child is doing in relation to the three child outcomes.

- Briefly explain the state definition of eligibility.

- Discuss the process of eligibility determination, explaining that information already available from the child's physician or other providers will be used to help determine eligibility, along with your observations, any developmental screening information, and information from the family. Share with the family that if existing information is not enough to determine eligibility, then additional assessment will be conducted with their consent.

- Explain what will happen during the first face-to-face visit with the family.

- Ask if the family has any medical or developmental records that they are willing to share about their child, and if so, to please have those available at the intake visit. Otherwise, explain that you will be asking at that visit for their permission to request those records.

- Inform the family that the eligibility determination and development of an Individualized Family Service Plan will occur within 45 calendar days unless the family prefers to extend that timeline.

- Introduce the rights and safeguards the family has and the need for parental consent to proceed with early intervention activities, including eligibility determination. If you will be sending notice and consent forms prior to the intake visit, then fully explain the family's rights and safeguards associated with eligibility determination as detailed in Chapter 4.

- Explain that some services are available at no cost to families (eligibility determination, assessment for service planning, IFSP development, service coordination). Let the family know that they may meet the cost of remaining services through use of Medicaid/FAMIS, TRICARE or private insurance and/or by monthly payment of a fee that is determined based on their family size and income. Emphasize that no family will be denied services because of an inability to pay.

Local Monitoring and Supervision Associated with Referral

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.

2. Consistent and accurate information is provided to the family and referral source at the point of referral.

3. Consistent and accurate information is provided to the family during the phone call(s) to share basic information about the Infant & Toddler Connection system.

4. Service coordinators are assigned in a timely manner to allow intake, eligibility determination, assessment for service planning and IFSP development to occur within the 45-day timeline.

5. TRAC-IT data entry is timely, complete and accurate.

Identifying the Parent When a Child is in Foster Care

Parent means:

- A biological or adoptive parent of a child;
- A foster parent, unless contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
- A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);
- An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or
- A surrogate parent.

If a judicial decree or order identifies a specific person or persons listed above to act as the "parent" of a child or to make educational or early intervention service decisions on behalf of a child, then such person or persons shall be determined to be the "parent" for Part C early intervention purposes. Otherwise, the biological or adoptive parent, when attempting to act as the parent and when more than one party is qualified under the definition of "parent," must be presumed to be the parent unless the biological or adoptive parent does not have legal authority to make educational or early intervention service decisions for the child. The term "parent" does not include any local or state agency, or their agents, including the Department of Social Services and their local departments, if the child is in the custody of said agency.

The Office of Special Education Programs has indicated that the definition based on IDEA 2004 is not intended to be substantively different from the 1997 definition. Rather, the new definition provides clarification related to the situation in which more than one person is qualified to act as parent under the definition.

The *Code of Virginia* at § 22.1-213 adds to the IDEA definition of parent a provision addressing the situation of a child in foster care. The provision requires local school divisions to provide written notice to the child's biological or adoptive parents at their last known address that a foster parent is acting as the parent and that the local school division is entitled to rely upon the actions of the foster parent until such time as the biological or adoptive parent attempts to act as the parent. Notice is not required if the biological or adoptive parent's rights have been terminated. This new *Code of Virginia* requirement **is intended to prevent a delay in the provision of educational services for a child in foster care**.

Although the *Code of Virginia* language specifies the written notice requirement for local school divisions, the definition of parent under the IDEA 2004 statute applies to both Part B and to Part C early intervention and will be implemented consistently in Virginia across both programs. Therefore, the local Infant & Toddler Connection system must provide the biological or adoptive parents of a child in foster care with written notice informing the biological or adoptive parent that it will deal with, and rely upon the decisions of, the foster parent for early intervention decisions until the biological or adoptive parents "attempt to act as the parent."

The following guidance is provided in implementing this new provision and is consistent with and based on the *Guidance Document for Implementing New Special Education Requirements for the Definition of Parent* developed by the Department of Education in May 2009.

- **Timing of Notice** — The required notice must be sent as soon as the system becomes aware of the foster care placement (either at referral or later during the child's enrollment in Part C early intervention if foster care placement occurs after referral). The notice is then sent again prior to each annual IFSP. In addition, the local Infant & Toddler Connection system should send any *Parental Prior Notice* form that goes to the foster parent to the biological/adoptive parent as well. Providing parallel notice may provide protection to the Infant & Toddler Connection system against parental allegations of a denial of rights particular to a specific event and against claims by the biological/adoptive parent that he or she has not received the written notice.

- **Content of Notice** — The *Notice to Biological/Adoptive Parents of a Child in Foster Care* letter must be used to provide the required notice.

- **Delivery Method** — The written notice may be delivered by any reasonable means including first class mail, hand-delivery or email (although email may be problematic since it could be overlooked, forwarded to spam folders, accidentally deleted, etc.). The *Code of Virginia* language does not specify that "address" is necessarily a residence address; therefore, an employer's address may, in some instances, qualify as a "known address." The "last known address" requirement does not impose on the local system a duty to investigate the current whereabouts of the biological/adoptive parent if the notice directed to the last known address is returned or otherwise proves undeliverable.

- **Burden of Coming Forward** — Consistent with federal and state mandates, the local Infant & Toddler Connection system is not required to wait for a

biological/adoptive parent to respond to the notice provided prior to relying on the actions of the foster parent. The burden of coming forward is on the biological/adoptive parent, and the local system may proceed with the foster parent in the role of parent until the biological or adoptive parent comes forward.

- **Contacting DSS** — Local systems are encouraged to send a copy of the notice to the child's social worker since he or she is a constant link between the child and the biological/adoptive parents while the child is in foster care and may be the best source of information related to the whereabouts of the biological/adoptive parent.

- **Parent Assertion of Rights** — As soon as the biological/adoptive parent notifies the local Infant & Toddler Connection of his or her intention to assert the rights of parent under IDEA, the biological/adoptive parent must be presumed to be the parent for early intervention purposes.

Virginia Vital Events and Screening Tracking System (VISITS)

The Virginia Infant Screening Infant Tracking System (VISITS) is a secure, web-based environment used to capture necessary data for children born in the Commonwealth of Virginia. VISITS allows authorized users to review and report hearing screening, diagnostic evaluations and referrals and outcomes for children diagnosed with hearing loss. Early Intervention providers will obtain information regarding referrals for children who are deaf or hard of hearing or those with congenital Cytomegalovirus through VISITS.

VISITS Access

- In order to obtain access to VISITS, complete the:
  - **Early Intervention User Access Form**
    - Download the EI User Access Form in Microsoft Word
    - Access the Adobe PDF version of the EI User Access Form online
  - **Access and Confidentiality of Records Agreement**
    - Download the Agreement in Microsoft Word
    - Access the Adobe PDF version of the Agreement online

- Return completed forms:
  - By email to va_ehdi@vdh.virginia.gov
  - By fax to (804) 864-7771

  Once access is granted you will receive an email from the Virginia Department of Health with your username and password.

VISITS Technical Assistance

- Each time a new referral is sent to you, you will receive an email notification that you have a new referral and need to log into VISITS.

- For Information regarding VISITS utilization and obtaining referral information, review our training videos on the VA EHDI website.

- For assistance with using VISITS for referrals, contact VA EHDI:
  - By email to va_ehdi@vdh.virginia.gov
  - By telephone (804) 212-3020 — select option 2 for professionals and option 6 for technical assistance

- For assistance with account access (password reset, locked account) contact the VISITS IT Support team:
  - By email to at oim_webappshelp@vdh.virginia.gov
  - By telephone (804) 864-7200 — select option 2

Chapter 4: Intake

The intake process includes the initial face-to-face visit with the family and the start of information gathering for eligibility determination. This initial visit between the service coordinator and the family provides the opportunity to welcome and get to know the family, further describe the Infant & Toddler Connection system (which was introduced in the phone call with the family to schedule the visit) and discuss the options and opportunities available to them through the system. At the point of intake, the local Infant & Toddler Connection system is already beginning to provide supports and services to the family by sharing tips and information on child development and/or parenting and by providing referrals to other resources, as appropriate and with parent consent.

The Intake Visit (The Initial Face-to-Face Visit)

Service Coordinator Responsibilities

1. Meet with the family to share information about the Infant & Toddler Connection system. All families receive consistent information about the Infant & Toddler Connection system using the outline of topics in the following box.

Topics to Discuss with Families During the Intake Visit
This list is intended to guide conversations and should not be read to families. • Introduce yourself and explain that you, as their service coordinator, will assist the family during the intake and eligibility process. Let the family know that if their child is found eligible, they will always have a service coordinator who will help them obtain the services and assistance they need. • Explain the purpose of your visit. For example, you might say, “I am here today to talk with you about the Infant & Toddler Connection of _____, to answer any questions you might have, and to learn about your child and his/her development, your family, your activities, and to discuss what information may be needed to proceed with determining your child’s eligibility for services.” • Explain or briefly review (if introduced in a previous conversation or through written materials) the state definition of eligibility.

- Explain that if medical or other records show the child is eligible, then the other steps in eligibility determination can be skipped.
- Explain that, otherwise, the eligibility team will be using medical record information, a developmental screening tool (if needed), and the information the family shares about their child's activities, what is going well or not going well, to determine whether their child is eligible.
- Share with the family that if the existing information is not enough to determine eligibility, then additional assessment will be conducted to determine eligibility.
- If the family asks you if you think their child is eligible, reflect on the information you have gathered and how that relates to Virginia's definition of eligibility. Unless you can establish eligibility based on records alone, explain that you cannot make a definitive statement at this time. (For example: "The information I have gathered today indicates that your child appears to be at age level with his development. Let me review with you the next step in our process. With your written consent, I will be taking this information to our early intervention team for eligibility determination. Once they have reached a decision, we will know for sure if your child is eligible or not.").
- Explain that if their child is eligible and they wish to receive early intervention services, an Individualized Family Service Plan, which is called an IFSP for short, will be developed. Let the family know that the IFSP will list the supports and services necessary to support the family in enhancing their child's development through everyday activities.
- Incorporate concepts from the principles in Chapter 1 as you talk about early intervention supports and services for eligible children and their families, emphasizing that the purpose of early intervention is to support children in developing positive social relationships, acquiring new skills, and assisting children in learning how to get their needs met in the routines and activities that are important to the child and family.

- Remind the family that the eligibility determination and development of an Individualized Family Service Plan, including an assessment to help with service planning, will occur within 45 calendar days of the day they were referred unless the family prefers to extend that timeline.

- Explain that parents and/or other caregivers are involved in each step of the process and, if their child is eligible, in each early intervention session.

- Explain that some services are available at no cost to families (eligibility determination, assessment for service planning, IFSP development, service coordination). Let the family know that they may meet the cost of remaining

services through use of Medicaid/FAMIS, TRICARE or private insurance and/or by monthly payment of a fee that is determined based on their family size and income. Emphasize that no family will be denied services because of an inability to pay.

- Let the family know that all information they share with you about their child and family is kept confidential. Specifically share that any information that has been received from the referral source and the information that you are gathering today is protected by confidentiality requirements.

- Give the family the opportunity to ask questions and to share with you information that they feel is important.

2. Fully inform the family about their rights, responsibilities and procedural safeguards under Part C and complete necessary paperwork (if not already addressed during phone or other contact prior to the intake visit). When explaining procedural safeguards, check with the family to see if they have any questions about their rights or why things need to be done a certain way. Emphasize the rights and safeguards applicable to the eligibility determination step in the early intervention process.

    a. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

    b. Provide a copy and explanation of *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* and *Strengthening Partnerships: A Guide to Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.

    c. Point out where information related to storage, disclosure, accessing and correcting of personally identifiable information is included in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

    d. Obtain and document informed, written parental consent to proceed to eligibility determination using the *Notice and Consent to Determine Eligibility* form in TRAC-IT. In some situations (e.g., when eligibility can be established by records or when the family wishes to combine eligibility determination with assessment for service planning), it also will be appropriate to obtain

informed written consent to proceed to assessment for service planning using the *Notice and Consent for Assessment for Service Planning* form in TRAC-IT (asking for consent for both the child and family assessments).

e. Since the financial intake must be completed prior to IFSP development, if the family wishes to combine eligibility determination with the assessment for service planning (and potentially the IFSP meeting) or will be proceeding directly to assessment for service planning combined with an IFSP meeting, and the *Family Cost Share Agreement* form has not already been completed, then talk with the family about completing the financial intake prior to the combined activities to ensure the financial information can be discussed privately.

f. Obtain parent signature on release of information forms (by using the Add Contact activity in TRAC-IT or using a local form) to obtain existing screening, medical, or other information to assist in determination of eligibility. If the family does not consent to this release of information, explain to the family the impact of their decision to refuse consent for the release of information, including why consent is needed, how the information will be used, and how the absence of that information may affect eligibility determination.

g. Obtain parent consent (by using the Add Contact activity in TRAC-IT or using a local form) to contact the referring agency/provider and the child's primary medical care provider to inform them of the child's status in the Infant & Toddler Connection system if consent was not already obtained by the referral source and/or primary medical care provider.

h. If the child has Medicaid/FAMIS:

    i. Ensure completion of the *Family Cost Share Agreement* form at intake (See instructions in Chapter 11). This step is necessary to begin billing for Early Intervention Targeted Case Management (EI TCM) at intake and to ensure Medicaid reimbursement for all reimbursable services, including assessment for service planning if the child is eligible.

    ii. Obtain the child's Medicaid/FAMIS number and enter it into TRAC-IT within 10 business days of the intake visit.

        (1) Children on a Medicaid Spenddown or children with Emergency Medicaid (which includes emergency dialysis) also

are not eligible for the Medicaid Early Intervention Services Program. These Medicaid types do not provide ongoing, full Medicaid coverage and do not include coverage for Medicaid-EI services. These children cannot be enrolled in the Medicaid-EI benefit and cannot have their early intervention services paid by Medicaid.

(2) DMAS offers the MES Public Portal to access information regarding Medicaid or FAMIS eligibility. From this page, click on the blue login button, use your secure credentials to sign in, select PRSS Portal, and then access the Eligibility tab. This web portal can be helpful in verifying the accuracy of the Medicaid/FAMIS number. New providers can enroll for DMAS web portal access or check their enrollment status online.

iii. Explain, complete and obtain parent and service coordinator signatures on the Initial Early Intervention Service Coordination Plan as part of the intake visit task in TRAC-IT or using the Consent for Initial EI Service Plan ad hoc task (if needed, after the intake visit task is completed). This form is required for children with Medicaid/FAMIS and is strongly recommended for children who are potentially eligible for Medicaid/FAMIS (since Medicaid can be billed retroactively for service coordination if the child receives Medicaid/FAMIS that is retroactive). Local systems have the option to use the Initial Early Intervention Service Coordination Plan with other families as well. The Initial Early Intervention Service Coordination Plan ends when the child is found ineligible for early intervention, the IFSP is signed, or 90 calendar days from the date of intake, whichever comes first, with billing not to exceed three calendar months.

iv. Document in the contact note for the intake visit the family's preferred method of contact (face to face, phone, email, or text) for the service coordination family contacts that are required every three months. The following requirements must be met to offer and use texting as the preferred method of contact:

(1) The service coordinator may only offer texting as an option if the service coordinator has the capability to receive and send texts.

(2) Texting may only be used if the family selects texting as their preferred method of contact and signs the Permission for Texting form, which notifies the family that there may be some level of risk that the information in the text may be read by a third party. The Permission for Texting form must be kept in the child's Early Intervention Record.

(3) The communication that occurs via texting must constitute service coordination. Sending a text to the family to ask how things are going and getting a reply of "Fine" is not service coordination. That is true for contacts via email, phone, or in person as well. The job of service coordination does not change based on the preferred method of contact. For that reason, contact notes must substantiate that the communication between the service coordinator and the family is substantive and does constitute actual service coordination.

(4) The service coordinator must either print out and store a copy of the texts in the child's early intervention record or include in the contact note a thorough summary of the communication.

(5) If, at any point, it becomes clear that texting is not a viable method of communication with a particular family, then the service coordinator needs to work with the family to identify a different method of contact.

Note: Service coordination for children with Medicaid/FAMIS is reimbursed through the EI TCM Program. While the regulatory terminology for this service is "case management," it is referred to as "service coordination" in the Infant & Toddler Connection of Virginia.

i. Ask the family about the child's race/ethnicity: American Indian or Alaska Native; Asian; Black or African American; Hispanic/Latino; Native Hawaiian or Other Pacific Islander; or White. Document the family's response in TRAC-IT.

    i. If the family states that they do not belong to one of the given racial groups and states their race as something other than one of the given categories, then record in the contact note or on an intake form the

race stated by the family. Based on the race stated by the family, enter the appropriate race category into TRAC-IT.

ii. If the family states more than one race for their child, then select "2 or more races" in TRAC-IT.

3. Begin a conversation with the family that lets you get to know the child and his family, their activities and the family's concerns, to be used for the purpose of eligibility determination. If the child is found eligible, this information will also be helpful in completing the family assessment and for IFSP development. Conversation starters may include, but are not limited to, the following:

    a. Tell me about your family - who is in your family.
    b. Who are the other caregivers for Johnny, e.g., extended family, childcare providers, etc.
    c. Tell me about the places your child and family spend time.
    d. What is a typical day like for your child and family?
    e. Tell me about your routines/activities. Which routines/activities are going well, and which are not?
    f. What other activities would you like your child and family to participate in?
    g. What activities really interest your child, and which ones interest you to do with your child?

    This list of suggested conversation starters is not presented in any order, and there is no requirement that they be worded as written.

4. Review the available medical and other records to determine whether those records potentially establish eligibility by documenting, without the need for any additional information, a diagnosed physical or mental condition with a high probability of resulting in developmental delay, developmental delay or atypical development that meets Virginia's eligibility criteria.

    a. If the records document a diagnosed condition (other than an endocrine disorder or a hemoglobinopathy), then complete the Eligibility Determination task in TRAC-IT, indicating that eligibility was established by records. For a child to be determined eligible based on a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, there must be documentation that the condition has been diagnosed by a professional qualified to make the diagnosis. Not all disorders within the categories of endocrine disorders and hemoglobinopathy have a high

probability of resulting in developmental delay for all children. Therefore, with these diagnoses the documentation from the physician would need to specifically indicate that this condition has a high probability of resulting in delay for this child for the service coordinator to establish eligibility based on the records. Otherwise, the eligibility determination practices described in Chapter 5 must be used to evaluate the child's eligibility.

b. If the records potentially document a developmental delay or atypical development, then coordinate with one individual who is certified as an Early Intervention Professional to review the record and determine whether it establishes eligibility. This individual may be from the same discipline as the individual who wrote the report/record being reviewed or from a different discipline. If the records are found to establish eligibility, then ensure the Eligibility Determination task is completed in TRAC-IT, indicating on the form that eligibility was established by records and including the individual who made the eligibility determination as an attendee.

c. When completing the Eligibility Determination task in TRAC-IT for a child whose eligibility is established by records:

    i. Enter the Date of Eligibility Determination. When recording the date of eligibility determination, use the date that eligibility was determined, even if that occurred on the same date as the assessment for service planning (Medicaid will still reimburse for the assessment for service planning in this situation since the child is eligible).

    ii. Check the box indicating that eligibility was established by records and list the record(s) used.

    iii. If this is not an initial eligibility determination, mark whether this is an annual, or interim eligibility determination.

    iv. Mark that the child was determined eligible.

    v. Check off all criteria on which that eligibility was based (e.g., developmental delay and/or atypical development and/or diagnosed condition), indicating the specific area(s) of delay, area(s) of atypical development and/or specific diagnosed condition(s) as appropriate.

    vi. Select the individual who determined eligibility as an attendee.

vii. Provide the family with a copy of the completed *Eligibility Determination Form* (at no cost to the family).

d. When eligibility is established by records, the eligibility determination process described below in #5 is not necessary and the family moves directly to the assessment for service planning, with parent consent.

i. During the intake visit, begin gathering functional information about the child's participation in everyday activity settings, within routines and across settings, keeping in mind the 3 child outcomes (positive social-emotional skills and social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) that will be the basis of the assessment for service planning.

ii. Ask engaging questions and make observations to encourage the family to share their perspective about their child's behavior, skills, engagement, and functional participation across settings and situations.

While records may be used, as described above, to establish that a child is eligible for early intervention, records may not be used to establish that a child is ineligible for early intervention without conducting the full eligibility process described below in #5 and in Chapter 5.

5. Unless eligibility is established by records (as described in #3 above), gather information about the child's development and health history. Some of this information may have been gathered during the referral call or during the call to schedule the intake visit. In that case, use the intake visit to document any additional information needed for eligibility determination.

a. Ensure the following eligibility determination activities have been or are conducted. When conducted after referral to the Infant & Toddler Connection System, these activities may be conducted by any certified Early Intervention Professional, Early Intervention Specialist or Early Intervention Case Manager trained to conduct the activity.

i. Hearing and vision screening, with the *Virginia Part C Hearing Screening* and *Virginia Part C Vision Screening* forms completed.

ii. An evaluation of the child's development in all areas using a screening tool ***unless the child has already received a developmental assessment or screening prior to referral***.

(1) The developmental screening tool may be completed by practitioners certified as early intervention professionals and by those certified as early intervention specialists or early intervention case managers who have been trained to use the screening tool.

(2) The provider using the tool must see the child to complete the tool.

(3) The following comprehensive developmental screening tools are strongly recommended for use in the Infant & Toddler Connection of Virginia: Parents' Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaire (ASQ), and Bayley Infant Neurodevelopmental Screen (BINS). These recommendations are based on the review of research and resulting recommendations presented in "Pediatric Developmental Screening: Understanding and Selecting Screening Instruments" (2008).

(4) Use of the ASQ-SE or another social-emotional-specific screening tool is strongly recommended for all children, in addition to the comprehensive screening tool, as part of the initial eligibility determination process. It is strongly recommended that no child be found ineligible for early intervention without completing the ASQ-SE or another social-emotional-specific screening tool. The social-emotional screening tool may be completed by practitioners certified as early intervention professionals and by those certified as early intervention specialists or early intervention case managers who have been trained to use the screening tool.

(5) While the primary focus is on gathering the information needed for eligibility determination, also begin noting functional information about the child's participation in everyday activity settings, within routines and across settings, keeping in mind the 3 child outcomes (positive social-emotional skills and

social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) that will be the basis of the assessment for service planning if the child is eligible.

Eligibility Determination Tools for Very Young Infants
Question: What instrument do we use for a child who is less than 1 month old since the ASQ does not address birth to 1 month? **Answer:** Information from a variety of resources can be used to compare the child's development to what is expected for a child who is less than one month old, including online developmental websites, print resources, and relevant sections of developmental assessment tools. The method(s) used should include identification of potential atypical development such as issues with tone and posture, sleep, feeding and self-regulation.

b. Document, in the TRAC-IT Intake Visit task or through other written means, the information shared by the family and gathered using a tool and observation so this information can be shared with other team members during eligibility determination, assessment for service planning and IFSP development. This promotes timely and accurate communication and minimizes the number of times the family needs to share the same information. Since this information will be used by the Eligibility Determination team, the documentation needs to clearly communicate to individuals who were not present at the intake visit what the service coordinator and/or other provider observed about the child's development and learned using a tool and/or parent report.

6. Let the family know when their child's eligibility determination will be made and how the information provided by the family will be used in that determination.

    a. Local systems have the option to invite the family to participate further in the eligibility determination process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.

    b. If the family will not participate in the eligibility discussion, then explain that you will call them following the determination to inform them of the decision.

7. If the family declines to proceed to eligibility determination:

    a. Provide a copy and explanation of the *Notice and Consent to Determine Eligibility* and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

        i. Make reasonable efforts to ensure the family understands the eligibility determination services that are available, that these services are provided at no cost to the family, and that these services cannot be provided without parental consent.

        ii. Using the *Notice and Consent to Determine Eligibility*, the family is asked to mark the second option (that they decline to allow the eligibility determination) and sign. – OR – Indicate in the IFSP task in TRAC-IT that the family is declining EI services and mark the first option (declining eligibility determination).

        iii. If unable to obtain the parent's signature on the *Notice and Consent to Determine Eligibility* indicating they declined eligibility determination, document that in a service coordination contact note and indicate the reason for discharge was declined eligibility determination.

        iv. In explaining the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

        v. Explain how to access early intervention services in the future.

        vi. If the child is close to being age-eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.

vii. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

viii. Obtain parent consent to communicate with the primary care physician and the primary referral source, if not already provided.

ix. Document in TRAC-IT within 10 business days of the family declining to proceed that eligibility determination was not completed for the child and that the reason was the family declined eligibility determination.

8. Once the Intake Visit Task is completed in TRAC-IT, send a parent portal request/invitation to the parent(s) unless the family has declined to proceed to eligibility determination, declines to provide or does not have an email address, or the parent will have equivalent access to documents through the local lead agency's electronic health record (EHR).

    a. Provide the resources for parents available through TRAC-IT to assist parents in accessing the portal.

    b. Explain what documents will be available for review and signature through the parent portal.

    c. Explain that the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* and *Strengthening Partnerships* documents also are available in the parent portal. Note: This does not negate the requirement to provide written copies of those documents initially and to offer new copies at subsequent procedural safeguard steps, as specified throughout the Practice Manual.

Other Intake Activities Following the Intake Visit

Service Coordinator Responsibilities

1. Request existing screening, medical and other information to assist in eligibility determination, if not already requested.

    a. Medical information requested should be specific to eligibility determination and service planning (e.g., diagnostic information and developmental

screening and assessment results). A full medical record is generally not necessary or appropriate.

b. Service coordinators are expected to make every effort to obtain physician and other appropriate records prior to eligibility determination, following up on initial requests with actions such as phone calls to request a fax of the needed records, going to the physician's office to pick up copies, or collecting the information via a telephone call with a hard copy received later for inclusion in the child's record.

    i. How quickly the service coordinator follows up after an initial request for medical or other records may depend on the extent to which those records are needed to determine eligibility.

    ii. Eligibility determination should not be delayed waiting for medical records unless other information gathered through intake or through intake plus assessment for eligibility is insufficient to determine and document the child's eligibility.

    iii. Remember that in some situations medical information will be very important in ensuring the eligibility determination team has complete information to consider since informed clinical opinion can be used to determine a child eligible even when screening or assessment instruments or other information does not establish that eligibility.

    iv. Also keep in mind that these records may be helpful to the team that is conducting the assessment for service planning and to the IFSP team even if they are not needed for eligibility determination.

2. If the referral was not from the child's primary medical care provider, then request the name of that provider from the family. If the child does not have a primary medical care provider, then offer help to the family in obtaining a primary care provider for their child. For example, assistance can be provided by giving the family a listing of area physicians and their phone numbers. The family cannot be required to obtain a primary care doctor to access early intervention services.

3. Arrange to assist the family in completion of a Medicaid/FAMIS application or applications for other programs and supports, as needed and as desired by the family. The family cannot be required to apply for Medicaid/FAMIS to access early intervention services.

Initial Data Entry for Enrollment in Medicaid EI Benefit

For providers to receive Medicaid reimbursement for Part C early intervention services, the following must be completed promptly and accurately in TRAC-IT:

- Medicaid/FAMIS must be selected as the coverage type in the child's insurance record;
- An accurate 12-digit Medicaid number must be entered. The 12-digit number is used by the State Lead Agency to locate the child's record in the Department of Medical Assistance Services (DMAS) database, VaMMIS;
- The insurance confirmation task must be completed in TRAC-IT; and
- The Intake Visit task must be completed in TRAC-IT, including the date of the intake visit.

Child has Medicaid/FAMIS when child is referred to Part C

- TRAC-IT data entry must be completed (Medicaid/FAMIS selected, 12-digit Medicaid number entered, insurance confirmation task completed, and Intake Visit task completed) within 10 business days of the Intake Visit Date to bill DMAS for Initial Early Intervention Service Coordination. (An Initial Early Intervention Service Coordination Plan also must be in place to bill for this service.)

- If any of the required information is entered in TRAC-IT more than 10 business days after the Intake Visit Date, then the date the required information is entered in TRAC-IT will be the start date for the Medicaid Early Intervention benefit.

Child enrolled in Medicaid/FAMIS after the child is referred to Part C

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in TRAC-IT within 60 calendar days of the Medicaid Disposition Date (the date the decision was made that the child was eligible for Medicaid or FAMIS) and the child has an Initial Early Intervention Service Coordination Plan in place, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Intake Visit Date. If the Medicaid/FAMIS start date precedes the Intake Visit Date, then the Intake Visit Date will be the start date for the Medicaid EI benefit.

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 60 calendar days after the Medicaid Disposition Date, then the date

the required information was entered in TRAC-IT will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the period that is not covered.

NOTE: Targeted Case Management (service coordination) is the only service reimbursable by Medicaid prior to confirming that a child is eligible for early intervention.

Local Monitoring and Supervision Associated with Intake

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. Consistent and accurate information is provided to the family during the intake visit.
3. There are timely requests and follow-up to receive medical and other records for eligibility determination.
4. Qualified personnel and approved tools are used in conducting hearing and vision screening and gathering developmental information for use in eligibility determination.
5. The intake visit occurs quickly enough after referral to allow time for eligibility determination, assessment for service planning and IFSP development to occur within the 45-day timeline.
6. Eligibility is determined based on medical or other records when appropriate and by the appropriate personnel.
7. TRAC-IT data entry is timely and accurate.

Chapter 5: Eligibility Determination

Eligibility determination is the process by which a multidisciplinary team reviews medical reports, results from a developmental screening tool, parent report, observation summaries, and assessment reports, if available, to determine whether a child meets the Infant & Toddler Connection of Virginia eligibility criteria. Assessments are conducted as part of the eligibility determination process only if a child's eligibility is uncertain based on existing information, and those assessments then become part of the information used by the multidisciplinary team to determine eligibility.

Infant & Toddler Connection of Virginia Eligibility Criteria

Infants and toddlers, birth to three years old, and their families are eligible for early intervention supports and services through the Infant & Toddler Connection of Virginia if the multidisciplinary team determines, based on medical or other records (using the practices described in Chapter 4) or through the practices described in this chapter, that the child meets one or more of the following criteria:

1. Developmental Delay – Children who are functioning at least 25% below their chronological or adjusted age in one or more of the following areas:

    a. Cognitive development;
    b. Physical development, including fine motor and gross motor;
    c. Communication development;
    d. Social or emotional development; or
    e. Adaptive development.

    For children born prematurely (gestation < 37 weeks), the child's adjusted age is used to determine developmental status. Chronological age is used once the child is 18 months old.

2. Atypical development – Children who manifest atypical development or behavior, which is demonstrated by one or more of the following criteria (even in the absence of a 25% developmental delay):

    a. Atypical or questionable sensory-motor responses, such as:

i. Abnormal muscle tone;
ii. Limitations in joint range of motion;
iii. Abnormal reflex or postural reactions;
iv. Poor quality of movement patterns or quality of skill performance;
v. Oral-motor skills dysfunction, including feeding difficulties.

b. Atypical or questionable social-emotional development, such as:

i. Delay or abnormality in achieving expected emotional milestones;
ii. Persistent failure to initiate or respond to most social interactions;
iii. Fearfulness or other distress that does not respond to comforting by caregivers.

c. Atypical or questionable behaviors that interfere with the acquisition of developmental skills.

d. Impairment in social interaction and communication skills along with restricted and repetitive behaviors.

3. Children with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. These conditions include, but are not limited to, the following:

a. Seizures with significant encephalopathy;
b. Significant central nervous system anomaly;
c. Severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage;
d. Symptomatic congenital infection;
e. Effects of toxic exposure including fetal alcohol syndrome, drug withdrawal and exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants;
f. Meningomyelocele;
g. Congenital or acquired hearing loss;
h. Visual disabilities;
i. Chromosomal abnormalities, including Down syndrome;
j. Brain or spinal cord trauma, with abnormal neurologic exam at discharge;
k. Inborn errors of metabolism;
l. Microcephaly;
m. Severe attachment disorders;
n. Failure to thrive;

o. Autism spectrum disorder;
p. Endocrine disorders with a high probability of resulting in developmental delay;
q. Hemoglobinopathies with a high probability of resulting in developmental delay;
r. Cleft lip or palate;
s. Periventricular leukomalacia;
t. Neonatal factors that make developmental delay highly probable:
    i. Gestational age ≤ 28 weeks; or
    ii. NICU stay ≥ 28 days ("NICU stay" is defined as the total number of days that an infant spends in a nursery other than the routine well baby nursery. This includes NICU, step-down, and other areas designed for more intensive care than a routine well baby nursery); or
u. Other physical or mental conditions at the multidisciplinary team members' discretion.

An additional explanation of the eligibility categories is provided at the end of this chapter.

Children may not receive services on or after their third birthday.

Planning and Preparation for Eligibility Determination

Service Coordinator Responsibilities

1. Use the procedures described in Chapter 4 if eligibility can be established by medical or other records. Otherwise, follow the procedures described below to determine eligibility. Remember, records may not be used to establish that a child is ineligible for early intervention without conducting the full eligibility process described below.

2. Assemble documentation that will be used in eligibility determination, including results from a developmental screening tool, medical information, parent report, formal/informal observation, and written assessment reports if available.

3. Facilitate identification of the multidisciplinary team that will determine eligibility and coordinate scheduling of the eligibility determination meeting, if needed.

    a. The multidisciplinary team must be comprised of the service coordinator and one or more professionals representing at least 2 different disciplines

(other than service coordination). There is no requirement that the disciplines on the team match the areas of concern for the child. When considering the use of one professional who is qualified in more than one discipline (other than service coordination) to serve as the multidisciplinary "team" for eligibility determination, consider the following:

i. The individual's experience and skills in evaluating a child's level of functioning across all developmental domains, including his or her ability to identify atypical development in all developmental areas;

ii. The amount of existing information available to use in eligibility determination and whether eligibility seems to be clear or more borderline; and

iii. Whether it is an initial determination of eligibility or an annual confirmation of the child's continuing eligibility and whether this impacts the individual's level of confidence in a making an eligibility determination decision without input from an additional team member(s).

b. The service coordinator may only serve as one of the disciplines if he or she is also a qualified practitioner in a discipline other than service coordinator (e.g., the service coordinator is also a speech-language pathologist who is certified as an Early Intervention Professional). In that situation, the service coordinator may participate on the multidisciplinary team in the dual function as one discipline and as the service coordinator.

c. Eligibility determination team members may communicate through a face-to-face meeting, phone call, email, fax, video conference, or other electronic means. Face-to-face meetings may take place in office settings, in a family's home or in other locations as determined by the team. Although eligibility determination does not require a face-to-face meeting, it must be planned to allow team members adequate opportunity to review available information.

d. All families participate in the eligibility determination process by sharing information during intake that is reviewed by the multidisciplinary team and used in determining eligibility. The family may be invited to participate further in the process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.

Determining Eligibility

General

1. Eligibility determination must include determining the child's level of functioning in each area of development. This does not mean that a specific age level must be identified in each area.

2. A child referred from another local Infant & Toddler Connection system within Virginia who has already been determined eligible does not need to be found eligible again and may move directly to assessment for service planning, IFSP development or IFSP implementation (with an IFSP review) depending on how far into the early intervention process the family was with the sending local system.

3. If a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or longer or is currently enrolled but has been lost to contact for 6 months or more, then the local system must conduct a new eligibility determination and assessment for service planning, establish new entry ratings on the child outcomes (if the child is still 30 months old or younger), and establish a new IFSP before resuming services. If a child has been out of services for less than 6 months, then it is only necessary to conduct a new eligibility determination if there is an indication of a significant change in the child's developmental status.

4. For children referred with an eligibility determination and/or an IFSP from another state, eligibility must be established in Virginia prior to proceeding to IFSP development and implementation. Existing information, such as medical records, developmental screening results, parent report, observation, and available assessment results, will be used for eligibility determination. If there is insufficient medical and developmental information from within the past 6 months to determine eligibility, then a developmental screening tool may be used to collect developmental information. The results from that tool, along with medical records, parent report and observation may then be used for eligibility determination. The service coordinator will ask the family for consent to request the early intervention records from the sending state.

5. The annual IFSP meeting includes confirmation of ongoing eligibility. The process for conducting the annual eligibility determination varies, as follows:

a. If the child was initially found eligible based on a diagnosed condition, then at the annual IFSP the service coordinator will complete the Eligibility Determination form indicating that eligibility was established by records.

b. If contact notes are enough to establish the child's ongoing eligibility, then one individual who is certified as an Early Intervention Professional may review those notes and complete the Eligibility Determination form indicating that eligibility was established by records. The individual determining eligibility based on the contact notes may be the same individual who wrote the contact notes if that person is an Early Intervention Professional.

c. If neither of the above conditions is met, then the determination of ongoing eligibility is made by two disciplines (either two individuals from different disciplines or one individual qualified in two different disciplines) and is based on the progress reports of team members and/or review of contact notes and other records. Formal testing is neither required nor recommended. The progress report may be written or may be a verbal report based on contact notes. The child's eligibility status is then documented in the TRAC-IT Eligibility Determination task.

Further information on the annual determination of eligibility, including procedural safeguards requirements associated with this step, is provided in the "Annual IFSP" section of Chapter 8.

6. If, prior to the annual IFSP meeting, the family or another IFSP team member(s) believes the child has reached age level in all areas of development and shows no sign of atypical development (and does not have a diagnosed condition), then an IFSP review is held to determine the child's eligibility status. Remember, records alone may not be used to establish that a child is ineligible for early intervention. Therefore, when the reason for determining the child's eligibility status is because one or more team members believe the child is no longer eligible, the service coordinator and one or more individuals representing two disciplines other than service coordinator must participate in the eligibility determination process. Details on determining eligibility in this situation are provided in the "IFSP Reviews" section of Chapter 8.

Multidisciplinary Team Responsibilities

1. Focus solely on whether the child meets Virginia's eligibility criteria. The assessment for service planning team will gather the information necessary to determine what supports and services an eligible child needs.

2. If the child has an endocrine disorder or hemoglobinopathy and eligibility was not established by records, review available documentation to determine whether that diagnosis has a high probability of resulting in developmental delay ***for this specific child*** since not all disorders within these categories have a high probability of resulting in developmental delay for all children.

3. Determine whether the child is eligible based on a developmental delay or atypical development as defined earlier in this chapter.

    a. Review pertinent records less than six (6) months old from the primary care physician and other sources related to the child's current health status, physical development (including vision and hearing), and medical history, or arrange for participation by the primary health care provider(s). Other records pertinent to eligibility determination, such as birth records, newborn screening results and early medical history, also should be reviewed by the team (with parent consent), even if those records are more than six (6) months old. Document in the child's early intervention record if the parent(s) chose not to consent to a review of records or if requested records were not received in time for review for eligibility determination, despite a timely request and follow-up.

        i. Eligibility determination should not be delayed waiting for medical records unless other information gathered through intake or through intake plus assessment for eligibility is insufficient to determine and document the child's eligibility.

    b. Consider the results from a developmental screening tool, parent report, formal/informal observation, and any available written assessment reports.

    c. Use informed clinical opinion – Informed clinical opinion is the result of synthesizing medical and developmental information (based on a tool, observation, parent report, medical records, etc.) with professional expertise and experience to decide a child's developmental status and/or eligibility. Informed clinical opinion may be the basis upon which the eligibility

determination is made. This does not violate the requirement (below) that no single procedure be the sole criterion for determining a child's eligibility since the informed clinical opinion would be based on multiple procedures and sources of information. **Informed clinical opinion may be used to establish a child's eligibility even when screening or assessment instruments or other information does not establish that eligibility.** However, informed clinical opinion cannot be used to negate eligibility established using appropriate assessment instruments or procedures.

d. Ensure that no single procedure is used as the sole criterion for determining a child's eligibility – By looking at the multiple sources of information available for eligibility determination (e.g., medical records, results from a developmental screening tool, information from formal/informal observation, parent report, etc.) the multidisciplinary team ensures that the eligibility determination is based on more than one procedure.

4. If existing information is insufficient to determine the child's eligibility for early intervention services, then determine the appropriate provider(s) to carry out any assessment activities necessary for eligibility determination.

    a. In this situation, it is recommended that any assessment needed to determine eligibility be combined with assessment for service planning, with parent consent. It is not necessary for the multidisciplinary team to meet again, as a separate activity, to determine eligibility before proceeding to assessment for service planning.

    b. In combining the assessment for eligibility determination and assessment for service planning, the multidisciplinary team is expected to consider how the assessment can proceed in such a way that, if it becomes clear that the child does not meet eligibility criteria, then a full assessment for service planning is not completed.

5. Complete the Eligibility Determination task in TRAC-IT. If eligibility was established by records, follow the instructions in Chapter 4 for completing the Eligibility Determination task. Otherwise, complete the task as follows:

    a. Enter the Date of Eligibility Determination. When recording the date of eligibility determination, use the date that eligibility was determined, even if that occurred on the same date as the assessment for service planning

(Medicaid will still reimburse for the assessment for service planning in this situation unless the child is found ineligible).

b. If this is not an initial eligibility determination, mark whether this is an annual or interim eligibility determination.

c. Mark whether the child was determined eligible or not eligible.

d. If the child is eligible, check off all criteria on which that eligibility was based (e.g., developmental delay and/or atypical development and/or diagnosed condition), indicating the specific area(s) of delay, area(s) of atypical development and/or specific diagnosed condition(s).

e. Use the Methods and Documents section of the task to check off all the methods and documents that were used and reviewed in making the eligibility determination. If a comprehensive developmental screening tool was used, identify the tool used and the person who completed it.

f. (Optional) Complete the Eligibility Narrative. Provide any additional information to support the decision to find the child eligible or ineligible. Any information entered here will be auto-populated into the IFSP task in TRAC-IT.

g. Enter the members of the eligibility determination team as attendees.

h. Although age levels or ranges are not required to determine eligibility, these may be recorded in the Eligibility Narrative sections of the Eligibility Determination task, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record if age levels or ranges were identified for some or all areas of development.

Service Coordinator Responsibilities

1. Participate in the determination of eligibility by sharing information from the family and from any screening tool used and/or observation completed by the service coordinator. This information may be shared through TRAC-IT, in writing or verbally. This may occur face-to-face with other team members, by phone or other electronic means, or in writing.

2. Share results of the eligibility determination process with the family, including a copy of the completed Eligibility Determination Form (at no cost to the family). This information may be shared with the family in person or by phone (with the form sent through the TRAC-IT Parent Portal, faxed, mailed, or handed to the family at the next contact). Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions about the eligibility finding and if desired by the family.

3. If the child is eligible, then schedule a visit or phone contact(s) with the family, as needed, to discuss and plan for assessment for service planning and the IFSP meeting. Remind the family that the eligibility determination team's job was to determine whether there was any delay, atypical development or diagnosed condition that would make their child eligible. Explain that the assessment for service planning will help to identify whether there are any other areas of concern beyond those identified during eligibility determination, as well as highlighting their child's areas of strength and interest and their child's functioning in the areas of positive social-emotional skills and social relationships, acquiring and using new knowledge and skills, and use of appropriate behaviors to meet needs.

4. If the child is eligible but the parents decline to proceed, then:

    a. Provide a copy and explanation of the *Notice and Consent for Assessment for Service Planning* or *Parental Prior Notice* (eligible/IFSP meeting needed), depending on what forms have already been completed, and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

        i. Using the *Notice and Consent for Assessment for Service Planning* form, the family is asked to mark the second line (that they do not give consent for the assessment for service planning).
        – OR –
        Indicate in the IFSP task in TRAC-IT that the family is declining early intervention services.

        ii. If unable to obtain the parent's signature on either the *Notice and Consent for Assessment for Service Planning* or *Declining early intervention services*, document that in a service coordination contact note.

iii. Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

iv. In explaining the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

b. Explain how to access early childhood special education services through the local school division (under Part B) if the child is close to being age eligible for Part B services.

c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

d. Attempt to obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided. It is also acceptable to give the family the option to notify their physician themselves.

Talking with the Family About Notifying the Physician
Consider using the following language in seeking parent permission to notify the physician: "It's important to let your physician know that your child will not be receiving early intervention services so he/she can continue to keep an eye on your child's development. We can do that if you'll give us written consent (which we can do by mail). If not, we would ask that you let your physician know yourself."

e. Document in TRAC-IT, within 10 business days of the family declining services, that eligibility determination was completed and that either the child was eligible/declined assessment for service planning or eligible/declined services. Enter the discharge date (the date the family declined to proceed).

5. If the child is ineligible:

    a. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating "Your child is not eligible for Infant & Toddler Connection of Virginia") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

    b. For Medicaid/FAMIS recipients only: Complete and provide the family with the Early Intervention Services – Notice of Action letter (available as an ad hoc task in TRAC-IT) and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is not eligible for early intervention services. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

    c. Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family.

    d. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

    e. Document in TRAC-IT, within 10 business days of completing eligibility determination, that eligibility determination was completed and that the child is not eligible. Enter the discharge date (the date the child was found ineligible).

6. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

7. Document in the child's early intervention record all circumstances that result in a delay in eligibility determination.

Interim IFSP

General

1. An interim IFSP may be developed and implemented for an ***eligible*** child in those exceptional circumstances where there is an obvious and immediate need for services to begin before the team has completed the assessment for service planning and developed the IFSP. These situations should be the exception rather than the rule. When an interim IFSP is needed, its purpose is to document those services that are needed immediately, as well as the parent's consent for those services to begin.

2. The use of an interim IFSP does not negate the requirement to develop an initial IFSP within 45 calendar days of referral. Rather, the interim IFSP allows essential services to begin while the team completes the remaining steps for developing the initial IFSP.

3. If there are exceptional circumstances that make it impossible to complete assessment for service planning and IFSP development within the 45-day timeline, then these circumstances must be documented in the child's record. An interim IFSP may be used for an eligible child in this situation, as appropriate to address immediate needs. One situation in which an interim IFSP may be appropriate would involve an eligible child who is medically fragile or experiencing a medical crisis who is currently unable to undergo necessary assessment or whose family is unable to participate in an IFSP meeting but for whom there is an immediate need for early intervention services. The use of an interim IFSP in this situation allows for needed services to begin while also allowing the child and family to wait until a more appropriate time to complete the assessment for service planning and IFSP development.

Service Coordinator Responsibilities

1. Ensure that either the child is found eligible based on medical or other records, or the eligibility determination process is completed and the child found eligible prior to development of an interim IFSP.

2. Develop the interim IFSP jointly with the family and with input from the multidisciplinary team. Input from the multidisciplinary team members may be provided in person, by phone or other electronic means or in writing. The interim IFSP must include:

    a. The name of the service coordinator who is responsible for implementation of the interim IFSP and coordination with other agencies and persons;

    b. The early intervention supports and services that are needed immediately by the child and the child's family. Specify the frequency, length, intensity (individual or group), location, method, and potential payment source(s) for each service; and

    c. Signatures of both the service coordinator and the parent(s).

    There is no requirement to use pages or sections from the statewide IFSP form in developing an interim IFSP. TRAC-IT does not include an interim IFSP task. The interim IFSP developed by the local team can be uploaded to the Documents section of TRAC-IT.

3. Facilitate the timely start of services identified on the interim IFSP. Although the services must begin within 30 calendar days of the date the family signs the interim IFSP, because services on an interim IFSP have been identified based on an immediate need these services should begin right away and certainly in much fewer than 30 days.

4. Ensure that assessment for service planning and development of the initial IFSP still occur within 45-calendar days of referral and that any circumstances resulting in a delay in development of the IFSP are fully documented in the child's record.

Local Monitoring and Supervision Associated with Eligibility Determination

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. There is a timely request for and follow-up to receive existing records for use in eligibility determination.

2. Assessment is carried out for eligibility determination only if the multidisciplinary team finds that existing information is insufficient to determine eligibility.

3. Determination of eligibility occurs quickly enough after referral to allow time for assessment for service planning and IFSP development to occur within the 45-day timeline.

4. Eligibility determination is completed by a multidisciplinary team representing at least 2 different disciplines and the service coordinator.

5. Providers participating in eligibility determination have a complete and accurate understanding of Virginia's eligibility criteria.

6. The Eligibility Determination task is accurately completed and reflects the necessary information to support the decision of the individuals determining eligibility (i.e., all sections of the form are completed and someone who was not a member of the team could read the form and understand why the child was found eligible/not eligible).

7. There is a timely and accurate entry of TRAC-IT data.

Interpretation of Eligibility Criteria for the Infant & Toddler Connection of Virginia

The following information is designed to provide interpretation of the criteria used in determining eligibility for the Infant & Toddler Connection of Virginia.

Developmental Delay

≥ 25% deficit based on adjusted age: adjusted age is determined by subtracting actual gestational age (weeks) at birth as determined by expected date of confinement (EDC, i.e., due date) or Dubowitz (or Ballard, a modification of the Dubowitz exam) from 40 weeks (normal term gestation). This value is then added to the actual birth date to determine the adjusted birth date. For example, an infant born at 36 weeks is 4 weeks early. If the birth date is 1/12/96, the adjusted birth date would be 4 weeks from the date, or February 8, 1996.

- **Cognitive development** refers to intellectual development.
- **Fine motor** refers to use of the hands, and hand-eye coordination.

- **Gross motor** refers to locomotion, and the ability to move and support oneself (sit, roll, walk).
- **Speech and language** refer to the development of both expressive and receptive speech.
- **Social-emotional** includes behavioral responses, interpersonal skills.
- **Adaptive** includes the ability to care for oneself.

Atypical Development

Refers to patterns of development that are clearly abnormal but do not necessarily result in a developmental deficit of 25%.

- **Atypical or questionable sensory-motor responses**, such as abnormal muscle tone; limitations in joint range of motion; abnormal reflex or postural reactions; poor quality of movement patterns or quality of skill performance; atypical articulation*; or oral-motor skills dysfunction, including feeding difficulties.

- **Atypical or questionable social-emotional development**, such as delay or abnormality in achieving expected emotional milestones; persistent failure to initiate or respond to most social interactions; or fearfulness or other distress that does not respond to comforting by caregivers.

- **Atypical or questionable behaviors** that interfere with the acquisition of developmental skills.

- **Impairment in social interaction and communication skills along with restricted and repetitive behaviors.**

A Note About Articulation Issues
A review of research indicates that infants and toddlers under the age of three should not be diagnosed with an articulation disorder. Developmentally, toddlers are not expected to produce all sounds accurately before age 3, and the diagnosis of an articulation disorder requires a delay of 6-12 months from the expected age for producing the sound accurately. Therefore, children would not be eligible for Part C early intervention services based solely on articulation issues (though articulation may impact a child's functioning in one or more of the child outcomes areas and, thus, indirectly impact a child's eligibility under Part C). For more information on articulation, please see:

- 2015 Talks on Tuesday webinar entitled "It's Almost Never Apraxia: Understanding Appropriate Diagnoses of Speech in Early Intervention" by Dr. Corey H. Cassidy

- Articulation and Phonological Development Chart

Diagnosed Conditions with High Probability of Resulting in Delay

- **Seizures with significant encephalopathy**: Seizures must be accompanied by evidence of alterations in brain function that impair normal mentation and responses to stimulation such as coma, hallucinations.

- **Significant CNS anomaly**: This refers to an anatomical abnormality that is known to be associated with future developmental abnormalities such as agenesis of the corpus callosum, hydrocephalus, encephalocele.

- **Grade III IVH with hydrocephalus**: Grade III intraventricular hemorrhage is defined as blood in the ventricles with evidence of ventriculomegaly. Hydrocephalus refers to enlargement of the ventricles that develops as a complication of the bleed and is felt to be due to abnormal reabsorption of cerebrospinal fluid. The hydrocephalus may be static or may increase requiring intervention.

- **Grade IV IVH**: A grade IV bleed is defined as both a bleed into the ventricles and a bleed into the parenchyma of the brain itself. These may or may not be associated with hydrocephalus. The area of intraparenchymal bleed normally results in necrosis of brain cells and will ultimately be a porencephalic cyst or empty space.

- **Congenital infection, symptomatic**: This refers to an infection that developed in utero and may manifest at birth, in infancy, or in childhood. The most common diseases in the category are the TORCHS infections; toxoplasmosis, rubella, CMV, herpes, and syphilis. The word symptomatic means that there are stigmata of the infections on exam which may include, but are not limited to, growth retardation, abnormal blood studies and/or organ involvement.

- **Toxic exposure, in utero to include fetal alcohol syndrome, drug withdrawal, and others (anticonvulsants, anticoagulants):** In these cases, there must be medical documentation that the baby was affected by prenatal toxic exposure. This category includes, but is not limited to, Fetal Alcohol Spectrum Disorders; Neonatal Abstinence Syndrome; symptoms of withdrawal; and evidence of "effects" of toxic exposure such as irritability, difficulties with self-soothing, and/or rigid or flaccid muscle tone.

- **Meningomyelocele**: This term is synonymous with spina bifida.

- **Hearing loss:** Any degree of hearing loss (unilateral, bilateral, mild, moderate, severe) makes the child eligible. Hearing loss must be diagnosed by a licensed audiologist.

- **Visual disabilities**: The diagnosis of visual impairment must be made by an ophthalmologist.

- **Chromosomal abnormality**: This includes any diagnosed abnormality of chromosome number or length.

- **Brain/spinal cord trauma with abnormal exam at discharge**: Trauma to these areas could include such diagnoses as hemorrhage, swelling. In this instance there must be continued evidence of neurologic dysfunction at the time of discharge to qualify.

- **Inborn error of metabolism**: These diseases are rare and are diagnosed with special tests, including those conducted through the Virginia Newborn Screening Services program. These include:

    - Argininosuccinic acidemia (ASA);
    - Beta-Ketothiolase deficiency (ßKT);
    - Biotinidase deficiency (BIOT);
    - Carnitine uptake defect (CUD);
    - Citrullinemia (CIT);
    - Congenital adrenal hyperplasia (CAH);
    - Congenital hypothyroidism (CH);
    - Cystic fibrosis (CF);
    - Galactosemia (GALT);
    - Glutaric acidemia type I (GA I);
    - Hemoglobin Sickle/Beta-thalassemia (Hb S/ßTh);
    - Hemoglobin Sickle/C disease (Hb S/C);
    - Homocystinuria (HCY);
    - Isovaleric acidemia (IVA);
    - Long chain hydroxyacyl-CoA dehydrogenase deficiency (LCHAD);
    - Maple syrup urine disease (MSUD);
    - Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
    - Methylmalonic acidemia (mutase deficiency) (MUT);
    - Methylmalonic acidemia (Cbl A,B);
    - Multiple carboxylase deficiency (MCD);
    - Phenylketonuria (PKU);
    - Propionic acidemia (PROP);

- Tyrosinemia type I (TYR I);
- Trifunctional protein deficiency (TFP);
- Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);
- 3-hydroxy 3-methyl glutaric aciduria (HMG); and
- 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC).

Other diagnostic tests may include the urine for metabolic screen and/or the urine for organic acids.

- **Microcephaly**: This is defined as a head circumference that is less than the 10th percentile for gestational age.

- **Severe attachment disorder**: This refers to a mental and emotional condition occurring in the first two years of life that causes a child not to bond or to trust his primary caretaker.

- **Failure to thrive**: This is defined as a failure to achieve expected growth for age. The causes are multiple with the most common being psycho-social.

- **Autism Spectrum Disorder:** This refers to impairment in social interaction, impairment in communication skills, and a restricted and repetitive repertoire of activities and interests. Includes the diagnosis of Autism, Pervasive Developmental Disorder (PDD), Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS), Asperger's Disorder, Rett's Syndrome, and Childhood Disintegrative Disorder

- **Hemoglobinopathies:** Sickle cell anemia (Hb SS disease) (Hb SS).

- **Periventricular Leukomalacia**

- **Gestational Age ≤ 28 weeks**

- **NICU Stay ≥ 28 days**

- **Cleft lip or palate**

Other Diagnosed Conditions with a High Probability of Resulting in Developmental Delay

The category of eligibility called “diagnosed physical or mental conditions with a high probability of resulting in developmental delay” is a limited one with some specific parameters. While IFSP teams are given discretion to identify “other” conditions under this category of eligibility, these “other” conditions must still meet the criteria that the

condition has a high probability of resulting in developmental delay. Many chronic conditions and genetic disorders are more appropriately considered risk factors rather than diagnosed conditions that meet Virginia's definition of eligibility. Some children with these risk factors will be eligible for early intervention services because of a developmental delay or atypical development.

"Other" conditions are discussed below under several headings which describe how they should fit in the determination of eligibility for early intervention services. However, please note that with any situation in which discretion is left to the IFSP team and only limited information is available to analyze, it is very difficult to state absolutes (e.g. this condition always goes here or never goes there). What follows is a summary related to where each of the listed "other" conditions would **usually** or **probably** fall:

<table>
<tr><th colspan="2">Other Diagnosed Conditions</th></tr>
<tr><td colspan="2">1. Conditions that are often listed as "Other" but belong in one of the conditions already listed in Virginia's definition of eligibility.</td></tr>
<tr><td>

Significant Central Nervous System Anomaly

Agenesis of the Corpus Callosum
CMV (if symptomatic)
Dandy-Walker Syndrome
Delayed myelinization
Fetal Stroke
Hydrocephaly
Left Arachnoid Cyst
Lissencephaly
Mobius Syndrome
Significant Central Nervous System Anomaly
Sturge-Weber Syndrome
Symptomatic Congenital Infection
Toxoplasmosis (if symptomatic)

Inborn Error of Metabolism

Krabbe's Disease

Seizures/Significant Encephalopathy

Infantile Spasms
Leucoencephalomalcia

</td><td>

Chromosomal Abnormalities

18P Syndrome
2-P Syndrome
Apert's Syndrome
Chondrodysplasia
Crouzon's Syndrome
Ehlers-Danlos Syndrome
Marden Walker Syndrome
Osteogenesis Imperfecta
Otopalatodigital Syndrome, Type II
Prader Willi Syndrome
Saethre-Chotzen Syndrome
Trisomy 2 with Mosaics
Tuberous Sclerosis
Turners Syndrome
Williams Syndrome
Wolf-Hirschorn Syndrome

Brain or Spinal Cord Trauma

Erb's Palsy/Brachial Plexus Injury
Left parietal infarct with small subdural hygroma

</td></tr>
</table>

• Visual Disabilities ○ Albinism	
2. **Conditions reported as "other" that are most likely listed correctly and qualify the child as eligible for early intervention services.**	
• Amniotic Band syndrome • Arthrogryposis • Caudal Regression Syndrome • Congenital amputee • Congenital muscle fiber disproportion type	• Congenital myotonic dystrophy • Muscular dystrophy • Poland Syndactyly • Spinal muscular atrophy/ Werdnig-Hoffman
3. **"Other" conditions which fit under developmental delay or atypical development categories.**	
• Hypotonia — atypical development	• Vocal Cord Paralysis — speech/language development; atypical development
4. **"Other" conditions which are considered risk factors rather than diagnosed conditions with a high probability of resulting in developmental delay.** The following would be listed under risk factors on the child data form and would not, by themselves, make a child automatically eligible for early intervention services in the absence of developmental delay or atypical development. Please note that some of the following may be symptoms of a qualifying diagnosed condition.	
• Bronchopulmonary dysplasia (BPD) • Burns • Chronic eczemoid rash • Chronic Lung Disease • Congenital Diaphragmatic Hernia • Congenital Hip Dysplasia • Diabetes Insipidus • DiGeorge Syndrome • Dwarfism/achondroplasia • Eating difficulties • Esophageal atresia • Heart Defect/Cardiac Condition • Hirshprung's Disease • Hyperthyroidism • Hypoplastic Lungs • Hypoxia	• Most tumors — (e.g. cystic hygroma, lymphangioma, nephroblastoma, non-Hodgkins lymphoma) • Oculoaricular Vertebral Syndrome (may be eligible under congenital or acquired hearing loss if that is present) • One Lung • Pseudo Obstruction Syndrome • Reflux Disorder/Gastroesophageal reflux • Renal Disease, end stage • Scoliosis • Shaken Baby Syndrome (could be a diagnosed disabling condition if it has resulted in a visual disability or brain or

• Infantile botulism • IUGR (intrauterine growth retardation) • Laryngomalacia • Leukemia/Acute Lymphocytic Leukemia • Liver Failure • Macrocephaly • Meconium Aspiration • Meningitis	spinal cord trauma with abnormal neurologic exam at discharge) • Short Gut Syndrome • Subglottic Stenosis • Torticollis • Total anomalous pulmonary venous return • Tracheo-esophageal fistula • VACETRL Association (Vertebral, Anal, Cardiac, Tracheoesophageal fistula, Renal/Radical, Limb Association)
5. **"Other" conditions where it just depends…**	
• Bihemispheric hematomas — Could be a diagnosed disabling condition under Brain or Spinal Cord Trauma if there is abnormal neurologic exam at discharge ***or*** could be a risk factor under Brain/Spinal Cord Trauma if there is normal exam at discharge. • Cranial Calcification — this is generally a symptom of some other disease or trauma. Depending upon the cause, this could be listed as a diagnosed condition under brain/spinal cord trauma, symptomatic congenital infection, or other. • Midline cerebellar epidural hematoma — same as above • Right Arm AVM (Arterial Veinous Malformation) with hypertrophy — depends on the degree of hypertrophy	
An excellent reference book regarding diagnoses, symptoms and outcomes (which may assist local teams in determining whether and how a medical condition fits within the diagnosed condition category) is available from W.B. Saunders Publishing: Smith's Recognizable Patterns of Human Malformation (5th edition, edited by Kenneth Jones, ISBN #0-7216-6115-7, the cost is about $100).	

Newborn Screen & Development: Facts about Genetic Diseases

(*Developed in 2006 by Alexandra Iwashyna, Medical Intern*)

Effective March 2006, the Virginia Newborn Screening Services program, through the Virginia Department of Health, was expanded to include testing for 28 heritable disorders and genetic diseases. Infants under 6 months of age who are born in Virginia will be screened for the following disorders and diseases, which are identified through newborn dried blood-spot screening tests. Any infant whose parent or guardian objects on the grounds that the tests conflict with his religious practices or tenets will not be required to receive the newborn dried blood-spot screening tests. All these disorders and conditions are considered diagnosed conditions with a high probability of resulting in developmental delay. Therefore, these infants will be eligible for early intervention services in Virginia.

1. **Argininosuccinic acidemia (ASA)**
    - Incidence: ~1 in 70,000
    - Deficiency in an enzyme of the urea cycle leading to hyperammonemia
    - May appear normal at birth
    - Without treatment: symptoms of lethargy, vomiting, poor appetite, seizures, hypotonia and muscle weakness, breathing problems, coma and death
    - Treatment: low protein diet and a special medical formula
    - With early treatment (before symptoms occur): may develop normally; however, more often children have some intellectual disability despite treatment
    - Autosomal recessive

2. **Beta-Ketothiolase deficiency (ßKT)**
    - Unknown incidence
    - Deficiency mitochondrial acetoacetyl-CoA thiolase leading to build up in isoleucine
    - May appear normal at birth (symptoms occur 6-24 months)
    - Without treatment: vomiting, dehydration, trouble breathing, extreme tiredness, occasionally convulsions, and can sometimes lead to coma or intellectual disability
    - NOTE: some with BKT never have symptoms
    - Treatment: L-Caritine & possibly low protein diet
    - With early treatment (before symptoms): probable normal growth and intelligence, however, even with treatment, some children still have symptoms (metabolic crises) which can cause brain damage leading to learning disabilities, intellectual disability or other problems (although after age 10 symptoms/crises are rare)
    - Autosomal recessive

3. **Carnitine uptake defect (CUD)**
    - Unknown incidence
    - Deficiency of carnitine uptake leads to in the tissues impaired ability to use fats to produce energy and ketone bodies.
    - Without treatment: cardiomyopathy, muscle weakness, hypotonia and with repeat episodes brain damage leading to learning disabilities and intellectual disability, heart failure, death.
    - NOTE: some children never have symptoms
    - Treatment: supplementation with carnitine & frequent feedings
    - Treatment before symptoms or early: typical growth and development
    - Treatment with continuing symptoms: repeat metabolic episodes can cause neurological damage over time leading to learning disabilities and intellectual disability
    - Autosomal recessive

4. **Citrullinemia (CIT)**
    - Incidence: ~1 in 57,000
    - Deficiency in an enzyme of the urea cycle leading to hyperammonemia
    - Without treatment: symptoms of lethargy, vomiting, poor appetite, seizures, hypotonia and muscle weakness, breathing problems, cerebral edema, coma and death
    - Treatment: Dietary restriction of protein & oral dosage of sodium phenylbutyrate and arginine
    - With early treatment (before symptoms occur): may develop normally, however, some children may have some neurological impairment despite treatment
    - Possibility of brain damage leading to learning disabilities and intellectual disability correlates to severity of initial presentation and amount of recurrent episodes
    - Recurrent episodes often occur with illnesses (e.g., common cold)
    - Autosomal recessive

5. **Glutaric acidemia type I (GA I)**
    - Incidence: ~1 in 30,000/40,000
    - Deficiency in Glutaryl-coenzyme A dehydrogenase leading to excessive levels of amino acids and their intermediate breakdown products
    - Without treatment: brain damage (particularly the basal ganglia which are helps control movement) leading to hypotonia, spasticity, involuntary movement disorder, delays in motor skills, speech problems and intellectual disability
    - Treatment: Prompt treatment of catabolic events and prevention of fasting during illnesses; diet modifications
    - With treatment (even early treatment): up to 35% will have neurological insult and disability
    - Autosomal recessive

6. **Isovaleric Acidemia**
    - Incidence: ~1 in 100,000 live births
    - Enzyme deficiency in isovaleryl-CoA dehydrogenase, involved in catabolism of Leu
    - Without treatment: vomiting, lethargy, severe metabolic ketoacidosis progressing to coma and death (50% with the acute neonatal form will die during their first episode); some may have neurological damage though several make complete recoveries. The majority of patients are developmentally normal.
    - Treatment: protein-restricted diet, special formula and carnitine supplementation
    - With treatment: Most will have normal development (especially with early treatment)
    - Autosomal recessive

7. **Long chain hydroxyacyl-CoA dehydrogenase deficiency (LCHAD)**
    - Incidence: ~1 in 75,000 births
    - Enzyme defect that prevents the body from breaking down fatty acids into an energy source
    - Without treatment: lethargy, hypoglycemia, hypotonia, liver dysfunction, cardiomyopathy. Acute symptoms may be difficult to manage and resistant to therapeutic attempts (with high mortality) because the presentations may involve a lethal acute liver failure, a rapidly evolving cardiomyopathy, or hypoketotic hypoglycemic encephalopathy
    - Treatment: avoid fasting, high carbohydrate and low fat diet supplemented with MCT oil
    - With treatment: Normal development and learning abilities (if no damage from crises). Peripheral neuropathy, if present, may not improve and prevention of ophthalmological changes (pigmentary retinopathy*) may not occur with treatment.
    - Autosomal recessive

8. **Methylmalonic acidemia (mutase deficiency) (MUT)**
    - Incidence: ~1 in 50,000-100,000
    - Deficiency of the adenosylcobalamin-dependent enzyme methylmalonyl-CoA mutase leading to an inability to process certain proteins and fats properly
    - Without treatment: lethargy, failure to thrive, recurrent vomiting, profound metabolic acidosis, respiratory distress, hypotonia, and later on renal failure. Complications of these episodes can include metabolic stroke, extrapyramidal signs, dystonia and brain damage leading to neurological damage.
    - NOTE: Disease varies from fatal neonatal disease to asymptomatic & age of onset of symptoms can help prognosticate – those with later onset tend to have a more benign course.
    - Treatment: Protein-restricted diet and special formula diet, OH-Cbl injections, carnitine supplementation, may need other medications
    - With treatment: most serious of the methylmalonic acidemias up to 60% of patients die within the first year of life and of those that survive, 40% are developmentally impaired.
    - Autosomal recessive

9. **Methylmalonic acidemia (Cbl A,B)**
    - Incidence: ~1 in 50,000-100,000
    - Defect in intracellular cobalamin metabolism leading to an inability to process certain proteins and fats properly
    - Without treatment: Episodic ketoacidosis with vomiting, lethargy and coma which can lead to death. Survivors can have developmental delays, growth

* Loss of night vision and peripheral vision in varying degrees

retardation, spastic quadriparesis, dystonia and seizures, neutropenia, thrombocytopenia and osteoporosis
- Treatment: Protein-restricted diet, OH-Cbl injections, Vitamin B12
- With treatment: Children who respond to vitamin B12 treatment tend to do very well as long as treatment is continued. Cb1A has a far better prognosis than Cb1B. Cb1B has ~33% of patients with neurologic impairment.
- Autosomal recessive

10. **Multiple carboxylase deficiency (MCD)**
    - Incidence: ~1 in 87,000
    - Defect in cellular biotin transport or metabolism leading to impaired activity of three enzymes that are dependent on the vitamin biotin: propionyl CoA carboxylase, beta-methylcrotonyl CoA carboxylase, and pyruvate carboxylase
    - Mimics biotinidase deficiency

11. **Propionic acidemia (PROP)**
    - Incidence: ~1 in 100,000
    - Deficiency of propionyl CoA carboxylase leading to acidosis and hyperammonia
    - Without treatment: tachypnea, vomiting, lethargy, irritability, shock, coma, and death. Death is very likely if symptomatic in infancy. Repeated episodes leading to intellectual disability
    - Treatment: Diet modifications with special formulas without specific amino acids that make propionyl CoA
    - With treatment: If had symptoms before treatment (or difficulty maintaining treatment), high probability of brain damage leading to developmental delay. Also optic nerve atrophy may occur.
    - Autosomal recessive

12. **Tyrosinemia type I (TYR I)**
    - Incidence: ~1 in 100,000
    - Deficient enzyme in catabolism of tyrosine
    - Without treatment: Symptom onset as early as 2-6 weeks with FTT, chronic liver disease (liver disease can start prenatally)
    - Treatment: special formula restricted in specific amino acids, the medication Orfadin, and typically liver transplant
    - With treatment: Risks with liver transplant including infections or rejection
    - Autosomal recessive

13. **Trifunctional protein deficiency (TFP)**
    - Unknown incidence
    - See LCHAD (mimics disease)
    - Autosomal recessive

14. **Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD)**
    - Unknown incidence
    - Defect in very long-chain acyl-CoA dehydrogenase leading to problems breaking down fats to energy
    - Without treatment: variable, from recurrent episodes of hypoglycemia to cardiomyopathy and liver problems and can progress to coma, cardiac arrest, brain damage, or even death (especially in children who are not eating well)
    - Treatment: eating frequently and avoiding fasting, and sometimes medication (carnitine)
    - With treatment: not much data but it looks like resolution of cardiomyopathy and normal development and learning abilities especially for later-onset disease
    - Autosomal recessive

15. **3-hydroxy 3-methyl glutaric aciduria (HMG)**
    - Unknown incidence
    - A defect in HMG lyase leading to problems breaking down an amino acid (leucine)
    - Without treatment: vomiting, dehydration, extreme tiredness, seizures, hypoglycemia, metabolic acidosis, and coma
    - Treatment: a special diet (low leucine), including medical foods and formula, possible medications (carnitine)
    - With treatment: good chance to have typical growth and development. However, even with treatment, some children still have repeated bouts of hypoglycemia or metabolic crises which may cause brain damage leading to learning problems or intellectual disability
    - Autosomal recessive

16. **3-Methylcrotonyl-CoA carboxylase deficiency (3MCC)**
    - Rare
    - A deficiency in 3-methylcrotonyl CoA carboxylase (3MCC) is leading to problems breaking down an amino acid (leucine)
    - Without treatment: vomiting, dehydration, extreme tiredness, seizures, hypoglycemia, metabolic acidosis, and coma
    - Treatment: a special diet (low leucine), including medical foods and formula, possible medications (carnitine)
    - With treatment: good chance to have typical growth and development. However, even with treatment, some children still have repeated bouts of metabolic crisis which may cause brain damage leading to learning problems or intellectual disability
    - Autosomal recessive

17. **Severe combined immunodeficiency (SCID)**[1]
    - Incidence: ~ 1 in 50,000
    - Primary immunodeficiency disease that renders the body unable to fight off infections. Became known as "Bubble Boy Disease" after the highly publicized case of David Vetter, a Texas boy born in 1971 with a form of SCID who lived for 12 years in a plastic, sterile bubble before passing away.
    - Treatment: often requires a bone marrow transplant from a healthy donor; success of the transplantation decreases with delayed diagnosis.
    - Undiagnosed cases are fatal, usually within the first two years of life

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[1] *Added June 2015. Information from Governor McAuliffe's announcement adding SCID to Virginia's newborn screening program.

Chapter 6: Assessment for Service Planning (ASP)

Assessment for service planning includes several steps in the early intervention process. The required activities will occur through a combination of phone contact and/or a visit(s) with the family. The number of visits and phone calls needed to accomplish these activities will be individualized to meet each family's need for information, time to consider options and other family scheduling preferences. This step in the early intervention process includes the identification of the resources, priorities and concerns of the family through a family-directed family assessment. A multidisciplinary team reviews existing medical and developmental information and conducts observation and assessment of the eligible child to determine the child's strengths and needs in all areas of development, to determine the child's functional status on the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs), and to assist the IFSP team in identifying the early intervention supports and services necessary to address the child's unique needs. An assessment tool (s) will be used at this point as an objective anchor for the comprehensive assessment of the child's functional skills in comparison to same age peers for determination of the child's entry status on the three child outcomes. Planning and preparation for the IFSP meeting begin and family cost share paperwork is completed.

Completing the Assessment for Service Planning

General

1. Assessment can occur in a variety of ways and at several points in the early intervention process. This chapter describes the practices associated with the assessment for service planning that occurs after the child's initial eligibility is determined and before the meeting to develop the initial IFSP. The following is a list of all the different types and purposes of assessment that occur throughout the early intervention process:

    a. Assessment for eligibility — Targeted assessment designed to provide the eligibility determination team with further information about a specific area(s) of development when existing information is not sufficient to determine eligibility. The eligibility determination team identifies the area(s)

of development that need to be assessed, and the purpose of this assessment is to determine whether the child meets the Infant & Toddler Connection of Virginia eligibility criteria. An assessment tool is not required.

b. Assessment for service planning — Comprehensive assessment designed to:

    i. Determine the child's strengths and needs in all areas of development, including the child's functional status on the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs);

    ii. Identify the family's priorities, resources and concerns;

    iii. Assist the IFSP team in identifying the early intervention supports and services necessary to address the child's unique needs; and

    iv. Determine entry summary statements for the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) based on the assessment of the child's functional skills in comparison to same-age peers.

    Use of a comprehensive assessment tool is required.

c. Discipline-specific assessment — Assessment that occurs during a provider's first session with the child and family when the provider did not participate in the initial assessment for service planning or when a new service is added. The purpose of this assessment is to determine the best approach to addressing the IFSP outcomes and short-term goals identified during the IFSP meeting, with a continued focus on the child's functional skills and the three child outcome areas. The provider determines whether an assessment tool will be used. It is not necessary to revise the Team Assessment section of the IFSP following a discipline-specific assessment. Any new information from this assessment can be noted during the next periodic or annual IFSP.

d. Ongoing assessment — Assessment that occurs as a routine part of service delivery based on observation of the child's functioning and skills across all

developmental domains and child outcome areas. The purpose of ongoing assessment is to give the provider and the IFSP team, including the family, information on the child's progress on the IFSP outcomes and short-term goals being addressed by the current activities and to assist in identify any emerging concerns in other areas of development. No assessment tool is required; but, when needed, the service provider may use an assessment tool as a reference point, especially for areas of development outside his/her area of expertise.

e. Exit assessment — An assessment of the child's functional skills compared to same-age peers using information from parent report, an assessment instrument, observation, and other sources to determine the child's status (summary statement) for each of the three child outcomes. A formal assessment is not required, though documentation of the child's abilities using an assessment tool (such as the HELP, ELAP, etc.) as an objective anchor for the assessment is required.

Service Coordinator Responsibilities

1. When notifying the family that their child is eligible, share information about the process for child and family assessment and IFSP planning. Explain the family's role in these steps of the early intervention process, the other people who will be involved, and the service coordinator's role in coordinating the activities and supporting the family's active participation. Discuss the notice and consent requirements related to assessment for service planning and determine with the family whether they would like to proceed to assessment or would prefer more time to consider their options. This may be accomplished by phone contact(s) or a virtual or in-person visit with the family, depending on the needs and preferences of the family.

2. Provide a copy and explanation of the procedural safeguards forms associated with assessment for service planning:

    a. Provide a copy and explanation of the *Notice and Consent for Assessment for Service Planning* form (checking the Initial Assessment box on that form and asking for consent for both the child and family assessments) and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* prior to conducting any assessment activities. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has

previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. The form and rights document may be mailed to the family after discussion by phone or may be handled during a visit with the family depending on family preferences. Depending on the child and family circumstances, this paperwork may have been completed during intake.

i. Individual families and participating family members must be informed before any formal or informal process to identify family resources, priorities and concerns begins, that participation in such family assessment activities is strictly voluntary on the part of the family, that the process shall be family directed, and that a family's decision not to participate in the assessment of the family's resources, priorities and concerns will not affect the child's eligibility for early intervention supports and services.

ii. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

b. Obtain informed written consent to proceed to assessment for service planning using the *Notice and Consent for Assessment for Service Planning* form in TRAC-IT (asking for consent for both the child and family assessments).

c. Ensure the following occur if the family declines to proceed to assessment for service planning:

i. Provide a copy and explanation of the *Notice and Consent for Assessment for Service Planning* form and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost*.

(1) Using the *Notice and Consent for Assessment for Service Planning*, the family is asked to mark the second option (that they do not give consent for child assessment and do not give consent for family assessment) and sign – OR – Indicate in the IFSP task in TRAC-IT that the family is declining EI services and mark the third option (eligible but declining services).

(2) If unable to obtain the parent's signature on the *Notice and Consent for Assessment for Service Planning*, document that in a service coordination contact note and indicate the reason for discharge was "eligible, declined assessment for service planning."

(3) In explaining the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

(4) Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

ii. If the child is close to being age-eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.

iii. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

iv. Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.

v. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

vi. Document in TRAC-IT, within 10 business days of the family declining to proceed, that the child was evaluated to determine eligibility and that the child was eligible/declined assessment for service planning. Enter the discharge date (the date the family declined to proceed).

3. Support the family in assessing their resources, priorities and concerns. This includes identifying natural environments and gathering other family input for IFSP development. Discuss how information gathered from the family is used in planning the assessment and in developing IFSP outcomes, strategies and services since the focus of supports and services is on increasing the child's participation in family and community activities that are important to the family. Explain that the family assessment information helps the team identify the child's strengths and needs, understand the family's priorities in relation to the three child outcomes, and identify opportunities for incorporating intervention strategies into the child's and family's life.

    a. The family-directed assessment must be based on information obtained through Virginia's family assessment tool questions and an interview (conversation) with those family members who choose to participate. The following questions constitute the family assessment tool:

        i. Tell me about your family - who is in your family.
        ii. Who are the other caregivers for Johnny, e.g., extended family, childcare providers, etc.
        iii. Tell me about the places your child and family spend time.
        iv. What is a typical day like for your child and family?
        v. Tell me about your routines/activities. Which routines/activities are going well, and which are not for your child? What are the most challenging aspects of your daily routine for you as the parent?
        vi. What other activities would you like your child and family to participate in?
        vii. What activities really interest your child, and which ones interest you to do with your child?
        viii. Strongly recommended: Describe your relationship with your child. What are some of the strengths and challenges you encounter, or times you feel particularly stressed or overwhelmed as a parent?
        ix. Strongly recommended: Please share any aspects of your culture, faith, spiritual or parenting practices you want us to be mindful of when working with your child and family.

    It is not necessary to have a separate form that lists these questions. Each local Infant & Toddler Connection system can incorporate use of these questions into their own local processes. A family's responses to the questions must be documented and in the child's record, but where they are

documented (e.g., on an intake form, in a contact note, etc.) is determined by the local system.

b. Follow-up questions should be used, as needed, to understand how the family's concerns, resources and priorities relate to the child and family's routines and activities and impact the child and family.

c. Each family should be offered multiple and continuing opportunities to identify their own resources, priorities and concerns in those areas of family life that the family feels are relevant to their ability to enhance the child's development.

d. The information gathered from the family during intake to assist in determining eligibility may be re-visited or expanded upon as part of the family assessment.

4. Coordinate the multidisciplinary assessment of the child for service planning. The assessment for service planning includes reviewing available pertinent records that relate to the child's current health status and medical history and conducting personal observation and assessment of the child to identify the child's unique strengths and needs including the child's functional status on the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) compared to same-age peers. The determination of entry summary statements on the three child outcomes usually occurs at the assessment for service planning. However, if assessment for service planning and the IFSP meeting occur on different days and the team will not meet until the IFSP meeting, then the determination of the actual child outcome summary statements may occur at the IFSP meeting.

    a. (Optional) Use the *Confirmation of Scheduled Meetings/Activities* form to provide the family with a written reminder of the date, time, place and participants for the assessment for service planning.

    b. Obtain physician referral/authorization, if needed, for assessment.

        i. Physician referral is needed for a physical therapy assessment regardless of the reimbursement source, except as allowed under PT regulations [see Virginia Department of Health Professions Board of Physical Therapy (Laws and Regulations) and *Code of Virginia* § 54.1-

3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.]

c. Complete the required hearing and vision screenings, using the *Virginia Part C Hearing Screening* and *Virginia Part C Vision Screening* forms, if the child's eligibility was established by records and these screenings were not completed at intake.

d. Strongly recommended: Complete an ASQ-SE or another SE-specific screening tool, if the child's eligibility was established by records and this screening was not completed at intake.

e. Ensure that a comprehensive assessment tool is used as the foundation of the child assessment. The reason for using a foundation tool is not to generate age levels but to serve as an anchor for the assessment and to provide a standard measure to be used in combination with other assessment sources for determining the child's functional status on the three child outcomes in relation to same-age peers. Discipline-specific assessment tools may be used in addition to the comprehensive assessment, if needed for an individual child.

f. Strongly recommended: If the ASQ-SE was completed during eligibility determination and results were in the monitoring zone or above the cutoff, the assessment for service planning should include the use of a social-emotional-specific assessment tool. If the ASQ-SE is completed at the assessment for service planning and the results were in the monitoring zone or above the cutoff, then the assessment for service planning should also include the use of a social-emotional-specific assessment tool or the IFSP team should recommend to the family that a social-emotional assessment be included as an IFSP service.

    i. It is strongly recommended that the assessment for service planning team includes a practitioner with infant mental health expertise (social worker, counselor, psychologist) or a practitioner with Infant Mental Health endorsement at the Family Specialist Level or higher for those children with ASQ-SE results in the monitoring zone or above the cutoff or when other risk factors are present.

    ii. The following tools are recommended for assessment of social-emotional development — Devereux Early Childhood Assessment

(DECA) Infant and Toddler, Infant & Toddler Social Emotional Assessment (ITSEA), Social Emotional Assessment/Evaluation Measure (SEAM). Please reference Virginia's *Social-Emotional Assessment Toolkit* and *Social-Emotional Related Factors Screening & Assessment Toolkit* for information about these and other tools. Virginia's *SE Related Factors Guiding Questions* may be helpful in identifying appropriate screening and assessment tools that consider child, parent and family factors that may impact the child's social-emotional development.

g. Facilitate identification of the multidisciplinary team that will complete the assessment for service planning.

    i. The multidisciplinary team must include one or more professionals representing at least two different disciplines (other than service coordination). When considering the use of one professional who is qualified in more than one discipline (other than service coordination) to serve as the multidisciplinary "team" for assessment for service planning, consider the following:

        (1) The individual's experience and skills in assessing a child across all developmental domains, including his or her ability to identify the child's strengths and needs and the services necessary to meet those needs in all areas of development; and
        (2) The individual's knowledge of typical development in all domains and ability to determine the child's functional status on the three child outcomes compared to same-age peers.

    ii. It is possible that one or more disciplines were involved in assessment activities prior to or since referral that may be used for service planning. These assessors count towards the requirement for 2 disciplines to participate if there is a written report from that discipline.

        (1) Information gathered by a qualified provider as part of the intake (such as completion of a screening tool and observation performed by an Occupational Therapist) can be used to meet the requirement for one of the disciplines.

(2) Developmental information provided by a physician or a provider who is from a discipline listed in Table A at the end of Chapter 12 but who practices outside the local Infant & Toddler Connection system can be used to meet the requirement for one of the disciplines if the physician or outside provider includes ***information that can be used for service planning***. This information may include, but is not limited to, results from an assessment tool, observations of child development, and information about current or projected impact of the child's health on his/her development. The local system determines whether the information provided by the physician or outside provider can be used for service planning (e.g., whether it is helpful in identifying IFSP outcomes, short-term goals, necessary supports and services, and/or treatment modalities).

h. Participate in any assessment activities that occur after referral, supporting the family as an active participant in the assessment. Scripts are available in *Virginia's Child Outcomes Booklet* to assist in explaining the assessment and child outcome summary process to families.

i. Facilitate the summary of assessment results in terms of the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) and determination and documentation of entry summary statements for the three child outcomes for all eligible children. *Virginia's Child Outcomes Booklet* provides questions and prompts that can be used to guide team conversation about the child's functioning in the three child outcome areas.

i. Assessment information is derived from multiple sources:

(1) Results from developmental instruments and observation;
(2) The family, including information about the child's performance in relation to the three child outcomes across situations and settings and with different people;
(3) Any other source (e.g., childcare provider, medical records, etc.)

ii. Using the Decision Tree and considering the information above and functional skills of same-aged peers, the team determines the

appropriate summary statement for each of the three child outcomes.

(1) A printed or electronic copy of the Decision Tree must be used by the team, which includes the family, at the assessment for service planning or the IFSP meeting to determine the summary statement for each of the three child outcomes. The Decision Tree is available online at VEIPD.

(2) Families are fully involved as team members in using the Decision Tree. The service coordinator and service provider team members support family engagement in this process by: (1) explaining basic information about why we focus on the three child outcome areas, how the Decision Tree is used and how the summary statement information is used; (2) encouraging families to share information about their child's functioning in each of the outcome areas; and (3) encouraging family participation in the team discussion at each question and related decision point in the Decision Tree.

iii. The assessment process and documentation of assessment results and child outcome summary statements are the same for all children. This includes children who have received early intervention from other states, but who are new to early intervention in Virginia.

iv. The entry summary statements recorded in TRAC-IT follow the child. A child who moves within Virginia from one early intervention system to another will already have entry assessment data, and the new local system does not need to do a new entry-level assessment. If a child is discharged from the Infant & Toddler Connection system and returns within 6 months of leaving the system, then the initial child outcome summary statements continue to be used as the entry summary statements. If the child is out of the system for more than six months but returns to the system, then new entry child outcome summary statements are completed as part of the new initial IFSP.

5. If additional reasons for eligibility were identified during the assessment for service planning than were identified at the time of eligibility determination, then add them to the Eligibility Determination form if that task has been previously saved but not completed in TRAC-IT or complete a new Eligibility Determination task in TRAC-IT.

6. Complete the following steps in those rare instances where the child was found eligible by the multidisciplinary team based on a review of available documentation (including results of any screening tools used, medical information, parent report, formal/informal observation and written assessment reports if available) but the child has made progress since the eligibility determination and is no longer eligible based on the information gathered during the assessment for service planning.

    a. Congratulate the family on the good news that their child's development now appears to be closer to or at age level or more typical than it first appeared.

    b. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating "Your child is not eligible for Infant & Toddler Connection of Virginia") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

    c. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is not eligible for early intervention services. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

    d. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

7. Document all circumstances that result in required assessments not being completed within the required timelines.

Responsibilities of Other Early Intervention Service Providers

Focus on gathering information through the assessment that is important for the IFSP team to use in service planning (i.e., focus on function, rather than discreet skills or domain-based skills since discrete behaviors may or may not be important to the child's functioning in everyday routines and activities). ***The providers conducting the assessment are not recommending specific services***, only providing information (e.g., functional skills the child has, areas of concern, skills not observed, etc.) for the IFSP team to use in identifying desired IFSP outcomes and the necessary supports and services.

1. Review any assessment information less than six (6) months old to determine if it is appropriate for consideration in service planning to prevent children and families from undergoing unnecessary assessment and duplication of existing assessment information. However, given the rapid changes in growth and development in infancy, it is important that all information used in service planning accurately reflects a child's status.

2. Check in with the family during the assessment to determine whether the skills and behaviors observed are representative of what the family sees at other times and in other places or situations. Ask engaging questions that invite the family to share their perspective and use prompts and observations to encourage the family to describe their child's behavior, skills, engagement, and functional participation across settings and situations.

3. Document the assessment results in terms of the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs), ensuring adequate information to support the child outcome summary statement for each of these three child outcomes. Individuals participating in the assessment for service planning may document their findings directly in in the assessment sections of the IFSP or in a separate written report that the team then reviews and integrates into the assessment sections of the IFSP during the IFSP meeting.

4. Provide assessment results to the service coordinator prior to the IFSP meeting, unless clearly not feasible to do so, so that this information is available to all IFSP team members.

5. Participate in the team determination of the child's outcome summary statement on the three child outcomes.

6. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

Planning for the IFSP Meeting

Service Coordinator Responsibilities

1. Review family cost share practices with the family (unless the child has Medicaid/FAMIS and the *Family Cost Share Agreement* was completed at Intake), referencing the information in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. These practices should have been introduced during referral and intake. The service coordinator is also responsible for ensuring the *Family Cost Share Agreement* form is completed in accordance with the procedures specified in Chapter 11 (taking the steps detailed in Chapter 11 if the family does not sign the agreement form promptly). Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.

    a. If eligibility can be determined based on medical or other records and the family will be combining the assessment for service planning and the IFSP meeting, then financial intake can be conducted prior to the combined activities.

    b. Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.

2. Identify an ongoing service coordinator. If there is more than one agency that provides service coordination in the local system, then the family must be offered a choice between the provider agencies.

3. Work with the family to identify the composition of the multidisciplinary IFSP team, which must include the parent, the service coordinator and at least one more individual from another discipline. More specifically, required team members include the following:

    a. The parent(s) of the child;
    b. Other family members, as requested by the parent, if feasible;
    c. An advocate or person outside the family if requested by the parent;
    d. The service coordinator who has been working with the family since referral and/or the ongoing service coordinator;
    e. A person or persons involved in eligibility determination and/or assessments; and
    f. As appropriate, individuals who may be providing supports and services to the child and family.

4. Determine with the family whether a foreign language or sign language interpreter will be needed for the IFSP meeting. If so, identify an interpreter in accordance with the following:

    a. A professional foreign language interpreter is not required. An IFSP team member may be able to interpret or there may be an extended family member, neighbor, clergyman, or other family friend who would be willing and able to interpret (if the family agreed). The local Infant & Toddler Connection system may wish to collaborate with the local school system(s) in finding foreign language interpreters since Part B has the same requirements related to native language. A neighboring local system also may be able to assist if the service coordinator is having difficulty locating a foreign language interpreter. Document in a contact note all efforts to locate an interpreter.

    b. When sign language interpreters are needed during IFSP meetings to meet the requirement related to family's mode of communication, these interpreters must meet professional licensure requirements. To locate qualified sign language interpreters, contact the Virginia Department for the Deaf and Hard of Hearing (1-800-552-7917) or access their website, www.vddhh.org, for a directory of qualified interpreters. If a licensed sign

language interpreter is not available in the area served by the local system, then document efforts to locate a licensed sign language interpreter and use a family member, family friend or other informal resource to provide the needed interpreting.

5. Plan and schedule the IFSP meeting.

    a. Provide the family with a copy and explanation of the *Parental Prior Notice* form (with check marks by "Your child is eligible for Infant & Toddler Connection of Virginia" and "A meeting to develop the initial IFSP is needed"); *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form or *Confirmation of Scheduled Meetings/Activities* form; and *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Emphasize those safeguards applicable to IFSP development. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

    b. Schedule the IFSP meeting at a time convenient for team members with preference being given to times that are best for the family. While development of the IFSP is a separate step in the process, the IFSP meeting may occur on the same day as the assessment for service planning if that is the family's preference. Talk with families about this when planning and scheduling the assessment for service planning.

        Families may need time to review and consider the assessment information, do research, or ask questions in understanding and preparing for the IFSP development process. Parents may want to talk with other family members or individuals who offer guidance and support to them before participating in the IFSP meeting. A decision to combine the assessment and IFSP meeting activities on the same date must be made by a fully informed family and cannot be required by the local system.

Talking with Families About Conducting the Assessment for Service Planning and the IFSP Meeting on the Same Day
Consider using the following language in explaining the advantages and disadvantages of completing the assessment for service planning and the IFSP meeting on the same day: "Some families prefer to move straight from the assessment for service planning into the IFSP meeting. This can mean fewer visits/meetings, getting started sooner on services and has the advantage that the assessment information is fresh in your mind. On the other hand, some families prefer to wait and hold the IFSP meeting on a different date. Combining it all on one day can be a lot … it can take a couple of hours. Families may find it helpful to wait because they want time to review and consider the assessment information, do research, or ask questions in understanding and preparing for the IFSP development process. You may want to talk with other family members or individuals who offer guidance and support to you before participating in the IFSP meeting. You should feel free to decide based on what you think is best for your family."

c. Arrange IFSP meetings in the setting and language that facilitates a family's ability to participate.

d. Notify all participants in writing of the date, time and location for the IFSP meeting.

    i. Parents must be notified using the *Confirmation of Individualized Family Service Plan (IFSP) Schedule* form or *Confirmation of Scheduled Meetings/Activities* (either form may be used; it is not necessary to send both).

    ii. Other team members may be notified using that same form or through other written means (e.g., email).

    iii. Documentation must be maintained in the child's early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.

    If the family thinks they want to do the assessment for service planning and IFSP meeting at the same time, then notification of the IFSP meeting is sent out ahead of the assessment for service planning to ensure all participants are aware of the plans. Even though the family may have planned to do the

IFSP on the same day as the assessment for service planning, the family may change their mind after the assessment is completed and decide that they prefer to delay the IFSP meeting until another day.

e. Ensure that IFSP team members who are not able to meet at times convenient for the family are given other options for IFSP participation, such as telephone consultations or providing written information.

f. Assist the family in preparing for the IFSP meeting by reviewing a blank copy of the statewide IFSP form with the family, explaining the different sections and discussing the kind of information included and the role the family can play in providing that information. Offer to leave a blank form or select pages of the blank form with the family, suggesting that they might want to make notes of their input and questions in each section of the blank form and bring that to the IFSP meeting as a reminder for the family during the meeting. The level of support that each family will want and need in preparing for the IFSP meeting will vary and preparation should be individualized for each family.

g. Ensure the following occur if the family declines to proceed to IFSP development:

    i. Indicate in the IFSP task in TRAC-IT that the family is declining EI services and mark the third option (eligible but declining services). Ensure that the family receives further explanation of sections of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* related to declining services.

        (1) Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

        (2) In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

ii. If the child is close to being age-eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.

iii. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

iv. Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.

v. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

vi. Document in TRAC-IT, within 10 business days of the family declining to proceed, that eligibility determination was completed, and the child was eligible/declined services. Enter the discharge date (the date the family declined to proceed).

Local Monitoring and Supervision Associated with Assessment for Service Planning

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.

2. Assessment for service planning occurs in a timely manner so that the initial IFSP meeting can be held within the 45-day timeline. Any circumstances that result in a delay in the assessment for service planning are fully documented in the child's record.

3. A comprehensive assessment tool is used as an objective anchor for the comprehensive child assessment.

4. Assessment documentation is focused on the child's functional status in relation to the three child outcomes and is sufficient to support child outcome summary statement decisions.

5. Child outcome summary statements appear to be appropriate based on the documentation of child functioning.

6. Efforts to secure foreign language and sign language interpreters to assist the family's active participation in the assessment for service planning are documented.

Chapter 7: IFSP Development

The Individualized Family Service Plan (IFSP) is developed through a family-centered team planning process in which the family is supported to participate as an equal team member. The child's family helps the IFSP team and service providers understand the child's and family's daily routines and activities. The providers then assist the family in recognizing and utilizing existing learning opportunities and creating new ones that will help the child reach the desired IFSP outcomes. The resulting IFSP reflects the family's priorities, resources, and concerns; the child's functional strengths and needs; the IFSP outcomes the family would like to see for their child and family; and the supports and services necessary to achieve those IFSP outcomes.

The Initial IFSP Meeting

Service Coordinator Responsibilities

1. Conduct, in person or virtually (with parent consent), the initial IFSP meeting within the 45-calendar day timeline. If more than one meeting is needed to complete the IFSP, the first meeting must be within the 45-day timeline.

   Refer to Chapter 7 of the Early Intervention Services Provider Manual located on the DMAS Medicaid Enterprise System (MES) Public Portal for specific requirements regarding parent consent for telehealth.

2. Ensure that the IFSP meeting includes determination of entry summary statements for the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs), unless this was completed during the assessment for service planning. Details about the determination of entry summary statements are provided in the "Completing the Assessment for Service Planning" section of Chapter 6.

3. Ensure that the meeting is conducted in the family's native language or other mode of communication unless clearly not feasible to do so.

4. Ensure that the IFSP team uses both information from the family regarding their priorities and results of the child assessment, including a review of pertinent records less than six (6) months old from the primary care physician and other

sources related to the child's current health status, physical development, medical history, and other information regarding the child's development in determining which IFSP services and informal/formal supports and resources are needed.

5. Inform the family that inclusion in the IFSP of information from a family-directed family assessment related to enhancing the development of the child is voluntary and refusal to include information from such an assessment in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP.

6. Encourage and support the family to be a full and equal partner on the IFSP team. The service coordinator may support the family's participation in the IFSP meeting in a variety of ways, including, but not limited to, the following: by ensuring the family is able to lead discussions within the meeting (e.g., family resources, priorities and concerns) as desired by the family, raising issues the family has identified as important, ensuring the family is getting the chance to speak and share opinions, explaining any jargon, etc.

7. Establish and support a team approach to service planning that recognizes and respects the expertise of all team members, including the family.

8. Build team consensus on IFSP outcomes and the supports and services necessary to achieve the IFSP outcomes.

9. Begin a discussion with the family about transition. Depending on the child's age at the initial IFSP as well as family priorities and preferences, transition planning at the initial IFSP meeting will range from sharing basic and general information about what transition means and when it may occur to development of a Transition Plan with specific transition steps and services.

Responsibilities of Other Early Intervention Service Providers

1. Participate in the IFSP meeting. This applies to service providers who were part of the eligibility determination team and/or conducted assessment for service planning. Providers who may be providing supports and services also participate in the initial IFSP meeting, as appropriate. Service providers who are not able to participate in the meeting in person or virtually may participate through other options, such as telephone consultations or providing written information. When participating by providing written information, service providers include assessment information related to service planning as well as recommendations related to

intervention strategies for the rest of the IFSP team to consider when developing IFSP outcomes, strategies and necessary supports and services.

2. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

3. Assist the family in developing desired IFSP outcomes by starting with the activity settings in which the family participates and identifies as important and/or activity settings the family would like to pursue.

4. When developing strategies to address the IFSP outcomes, focus on interest-based learning opportunities that occur throughout the child's and family's daily routines and activities.

5. Consider multiple factors when working as a team, with the family, to identify the supports and services necessary to meet the IFSP outcomes. These factors include the expertise needed to support the family in addressing the IFSP outcomes, the abilities and interests of the child and family, needs expressed by the family, and family and community resources. IFSP team members assist the family in examining the expertise and experience of individual providers across disciplines to determine which service can best meet the IFSP outcome(s).

6. Consider whether one primary provider can address all the IFSP outcomes, with support from other team members. This is often the case since there is significant overlap in training and scope of practice across disciplines. Identify on the IFSP not only the primary service provider(s) but also the role of other team members in supporting the family and other service providers. These other team members may participate in joint early intervention visits with the primary provider(s) to the child and family and/or provide consultation to the primary provider(s) by suggesting strategies and techniques to enhance progress toward IFSP outcomes.

7. Consider the following kinds of questions in determining the frequency and length of supports and services needed to meet the IFSP outcomes:

    a. Is the relationship between the child/family/caregiver and the provider new (e.g., because they have just begun this service or because there has been a change in providers) or well-established?

    b. Will the strategies used to address the IFSP outcomes need to be modified frequently or will the same strategies be used for a long period of time?

c. Is attainment of an IFSP outcome(s) especially urgent and able to be resolved quickly with intensive intervention (e.g., new referral of a child with non-organic failure-to-thrive, which needs quick resolution; or a child's behavior is preventing the family from finding a childcare provider who will accept the child)?

d. Are there a large number and/or wide variety of strategies involved in addressing the IFSP outcomes or are there relatively few or more similar strategies?

e. Is the child progressing at the expected rate in meeting identified IFSP outcomes?

f. What are the family's/caregiver's learning needs in relation to the child's developmental needs and the IFSP outcomes?

g. Do the IFSP outcomes require a high level of specialized skill to address or are they more easily implemented with minimal guidance and instruction?

h. Are the IFSP outcomes or strategies new for the child and family?

i. Will the service provider (s) be working with only the family or with other caregivers as well in addressing IFSP outcomes?

j. Is the parent's understanding of and/or his or her ability to assist with implementing suggested activities affected by his or her own cognitive or emotional issues?

k. Does the child need intensive, one-on-one support to participate in his/her environment? (In this case, there also may be a need for an increase in support to the family in addressing the IFSP outcomes.)

8. Consider whether the IFSP service(s) can be delivered and the IFSP outcomes can be addressed effectively with this child and family using telehealth and offer this option, if it is appropriate. The IFSP team also must consider the provider's and family's comfort with and access to necessary technology and internet connectivity when determining with the family whether telehealth is an appropriate service delivery option.

a. Center-based services may not be delivered via telehealth.

b. If some or all IFSP services will be delivered via telehealth, parent consent for telehealth must be obtained. When seeking consent, the IFSP team helps the family understand what telehealth service delivery looks like and what to expect.

c. For information on billing telehealth services, see Chapter 11.

9. Consider the information in the box on the next page when discussing a child's need for an assistive technology device.

10. Participate in the identification of a location (s) for supports and services that is based on the activities that are being addressed (as identified in the IFSP outcomes).

When Considering the Purchase of an Assistive Technology Device

- Determine whether the assistive technology device is a medical device or a developmental device. If a physician must deliver the device, then it is considered a medical device and is not the responsibility of the Infant & Toddler Connection of Virginia. If providers other than a physician (e.g., nurse, physical therapist, occupational therapist, audiologist, speech-language pathologist, etc.) can deliver the device then it is considered developmental and can be considered an early intervention service under Part C. Medical devices include, but are not limited to, suction machines, glucose monitors, feeding pumps, apnea monitors, enteral and parental solutions and supplies, nebulizers, ventilators, and surgically implanted devices (including a cochlear implant).

- Teams should consider a full range of assistive technology options, including no-tech, low-tech, mid-tech, and high-tech. Decisions should be based on an individualized, feature-matching assessment of the child's strengths, needs, environments, and family priorities. There is not a requirement to begin with no-tech or low-tech options and progress through set steps before considering high-tech assistive technology when a more robust system/device is necessary to address the child's IFSP outcomes.

- Whenever possible, use loaner equipment for higher-tech devices[2] before purchasing a specific device for an individual child. This allows the family and provider to determine how well the device meets the needs of this individual child and his/her family before spending money on the purchase of the device.

- Assist the family in understanding the implications of the funding source for an assistive technology device:

    - If purchased with the family's health insurance (public or private), the assistive technology device belongs to the family, and they may keep it when they leave the Infant & Toddler Connection of Virginia.

    - If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at $5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:

        - The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or trial basis.

        - If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it if the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.

        - If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.

[2] * The Virginia Hearing Aid Loan Bank is open to children under age 18 years of age whose hearing loss is confirmed by an audiologist. The bank loans hearing aids and FM systems for up to six months. The initial loan period can be extended for an additional 6 months in certain circumstances. To qualify, families must be residents of Virginia and be in the process of securing permanent hearing aids through insurance or other means. Parents can apply for hearing aids and FM systems by completing an application form. For more information about this program, call (434) 924-0222 or visit MAKING CONNECTIONS- Resources - Early Hearing Detection (virginia.gov).

- Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.

- Ensure Part C funds are used as the payor of last resort in purchasing an assistive technology device and document efforts to access other funding sources, including, but not limited to, the following:

  - Equipment loan organizations, if appropriate
  - Equipment donation facilities
  - Local civic and community organizations
  - Public or private health insurance
  - Family fees

Efforts to access other funding sources prior to the use of Part C funds must be documented in contact notes or on a payor source checklist or similar form.

Completing the IFSP Form

Service Coordinator Responsibilities

1. Ensure the development of an IFSP for each eligible child, with parent consent. The IFSP is developed in or uploaded to TRAC-IT in accordance with the instructions detailed at the end of this chapter and in the TRAC-IT User Manual.

2. Explain the contents of the IFSP to the parent (s) and obtain written consent from the parent(s) by signature on the IFSP form prior to the provision of early intervention supports and services described in the IFSP. Ensure the IFSP is translated orally or in writing into the family's native language or other mode of communication unless clearly not feasible to do so. The IFSP must be complete (except for the Addendum page) before asking the family to sign.

3. Provide a copy to the family (at no cost to the family) and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.

4. Send a copy of the IFSP to the child's primary care physician, with parent consent (by using the Add Contact activity in TRAC-IT or using a local form). Consent to send a copy of the IFSP to the physician is not covered by the consent statement on the IFSP and requires a separate release of information form.

5. Obtain physician (or physician assistant or nurse practitioner) signature on one of the following to document medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan.

    a. The IFSP; or
    b. A separate letter referencing the IFSP that is sent with the IFSP, like the *Physician Certification Letter*; or
    c. The IFSP Summary Letter.

    This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Physician certification is not needed if there is no third-party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed to receive Medicaid reimbursement for assessments. The box on the next page provides additional information about the requirement for physician signature on the IFSP.

Specific Requirements Related to Physician Signature for Medical Necessity

- The physician signature is required for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). For example, physician signature is:
    - Required when adding assistive technology if it can be reimbursed by family's insurance;
    - Required when increasing or decreasing frequency of services;
    - Not required when the service location changes from one natural environment to another;
    - Not required when ending a service; and
    - Not required when adding an assessment for children covered by Medicaid.
- The physician signature must be dated by the physician.
- The physician certification of the IFSP is considered a part of the IFSP and must be attached to the IFSP. Medical necessity is established by the IFSP combined with physician certification.
- The IFSP must be certified as a whole (i.e., it is not acceptable to have more than one individual or agency obtain certification for individual services on the IFSP). The local system/service coordinator is responsible for assuring that the physician certifies the IFSP and that the physician certification is a part of the IFSP document. The local

system may delegate this process, but only to one individual/agency so that physicians receive only one request for review and certification of the IFSP. If this responsibility is delegated to an individual/agency, that individual/agency must send the signed document to the local system to be filed with the IFSP in the child's EI record.

- Service coordinators are expected to make every effort to obtain physician certification quickly enough to ensure the timely start of services. Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization or physician certification, except by parent request. If there is difficulty in getting timely physician signature from the child's primary care physician, service coordinators may seek a signature from another physician on the child's medical team or IFSP team or may be able to get the signature of a physician assistant or nurse practitioner associated with the physician.

- In those rare instances when the service coordinator is unable to obtain the physician signature in a timely manner, Part C funds must be used, as needed, to avoid a delay in the start of services. Remember that Medicaid allows the service to start without a physician signature and will still reimburse for the service if the physician (or physician assistant or nurse practitioner) signature is obtained no more than 30 days after the first IFSP services (other than service coordination) begin. However, if an IFSP is not signed by the physician, physician's assistant, or nurse practitioner within 30 days of the first IFSP service other than service coordination, then services provided prior to the date the IFSP is certified (by the physician, physician's assistant, or nurse practitioner) will not be reimbursed by Medicaid or Part C.

- Follow-up to ensure physician certification is in place is a shared responsibility between the service coordinator and the service provider(s). Providers must assure that certification by the child's physician, physician assistant or nurse practitioner is obtained by the 30th day from the first visit. Providers are responsible for contacting the local system manager to work out alternate payment arrangements in those rare instances when physician certification is not obtained in a timely manner despite collaboration between the provider, service coordinator and local system manager and multiple, ongoing efforts to obtain the certification. This discussion of alternate payment options must begin prior to the end of the 30-day period following the first service. Providers are responsible for paying back any Medicaid or FAMIS reimbursement retracted because the IFSP was not certified.

- Physical therapists must follow Virginia PT regulatory requirements governing physician referrals for services, even if Part C funds are available as payor of last resort.

6. For children with Medicaid or FAMIS, request completion of the health status indicator questions by the child's physician every six months using either the combined *Physician Certification Including Health Indicator Questions* letter, the *Health Indicator Questions* letter, or another form or mechanism developed by the local system. The health status indicator questions must be asked as written in the *Health Indicator Questions* letter unless the local system has an alternate mechanism (e.g., request and review of well-child records) that provides the information necessary to answer all the health status indicator questions. For purposes of completing the health indicator questions, "every 6 months" means making the request any time between 5 months and 7 months from the previous request to the physician about the health status indicator questions. Local systems are encouraged to follow-up with physicians to receive this information but are not responsible for ensuring the information is provided by the physician. While requesting completion of these questions is required only for children with Medicaid or FAMIS, local systems are encouraged to consider requesting this information for all children to support routine well-child care and positive health outcomes.

7. Ensure that if at an initial IFSP, annual IFSP or IFSP review, the rest of the IFSP team believes the child needs a particular service, but the family does not agree and does not wish to receive that service), then the following steps occur:

    a. That service does not need to be listed on the IFSP since the full team, including the family, has not agreed on that service.

    b. Capture the rest of the team's recommendation and the family's decision not to receive that service in a service coordination contact note.

    c. Optional additional step: Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service(s) the family is declining. Both the service coordinator and family must sign and date the form. Upload the completed form to TRAC-IT as a document.

    d. Explain that the services that are not declined will be provided at the frequency, length, intensity (individual/group) and duration listed on the IFSP.

    e. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to

leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

f. Explain how the family may, later, through the IFSP review process, accept a service previously declined.

8. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:

   a. Indicate in the IFSP task in TRAC-IT that the family is declining EI services and then mark the third checkbox (eligible but declining services) and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

      i. Optional additional step: Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system).

      ii. Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

      iii. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

   b. If the child is close to being age-eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.

   c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

   d. Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.

e. Document in TRAC-IT, within 10 business days of the family declining all services, that eligibility determination was completed, and the child was eligible/declined services. Enter the discharge date (the date the family declined to proceed).

9. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, length, intensity (individual/group), location or method of delivering services that the rest of the team does not agree is necessary to achieve the outcomes identified on the IFSP, then the following steps occur:

    a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). Parent signature is obtained to acknowledge receipt of the form.

    b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures.

    c. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

    Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.

10. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

Selecting Service Providers

1. Early intervention supports and services will be provided only by qualified early intervention practitioners who are affiliated with the local system. Practitioners who provide service coordination or other early intervention services, except audiology, nutrition services and medical services, must be certified by the Department of Behavioral Health and Developmental Services as an Early Intervention Professional, Early Intervention Specialist or Early Intervention Case Manager. See Chapter 12 – Personnel for more information about practitioner qualifications, certification, and affiliation with a local system.

2. The service coordinator assists the family to select a provider(s). The service coordinator:

    a. Explains that the family can select from among the provider agencies (including independent practitioners) affiliated with the local system who are qualified to provide the service identified on the IFSP ***and*** who are in the family's payor network ***and*** who practice in the area where the child/family lives.

        i. The family must be offered a choice of service coordination provider if there is more than one agency that provides service coordination in the local system. In accordance with federal guidelines, a family moving from one local system to another may request to keep their current service coordinator. However, it may be determined that this is not feasible because of distance, the service coordinator's incomplete knowledge about resources in the new local system, or other reasons.

        ii. If no practitioner who can support and assist the family in accomplishing the IFSP outcomes is available within the family's Medicaid or private insurance network, then the family may choose a practitioner from outside their third-party payor network.

        iii. If the family would like to receive services from a practitioner who is not affiliated with the local system but who meets the Early Intervention Certification requirements and who is within the family's payor network, the local lead agency should arrange with that practitioner to become affiliated with the local system.

iv. The family may request a specific provider from within the selected provider agency.

v. If there is only one provider agency, then the family must be offered a choice of providers from within that one agency for services other than service coordination. If the family has a concern about receiving services from that agency, then the local system must work to identify an additional provider.

The family must be offered the opportunity to select a provider agency any time a new service is added or when a change in provider agency is needed.

b. Contacts the selected provider agency and arranges for a service provider(s). If the selected provider agency is unable to provide the service due to full provider caseloads or the requested service provider within that agency is unavailable, then the service coordinator explains to the family their option to begin services right away with an available qualified provider or to wait for their chosen provider to become available.

c. Ensures the process of selecting a service provider does not result in a delay in the timely start of early intervention services. Although the IDEA Part C program is not required to offer parents the choice of a specific provider, in the Infant & Toddler Connection of Virginia, the parent may choose a specific early intervention service provider agency or service provider. The IDEA Part C program will make available the IFSP service that is needed by the child in a timely manner even if it is not with the provider of the parent's first choice. If the parent wishes to select a specific provider, then the parent's consent to the IFSP service will begin once the parent's specific provider is available and services will be provided in a timely manner. The service coordinator will document the parent's decision to choose a provider, monitor the availability of the provider, and inform the parent if the parent’s choice of provider will not be available within a reasonable period of time (within 30 days of when the parent notified them of their choice).

d. Informs the family that they may request to change their service provider at any time by contacting the service coordinator.

It is possible that some families may not prefer a specific practitioner or provider agency. In those situations, the local system should have a mechanism in place for assignment of providers. There still must be documentation by parent signature on

the IFSP addendum page that the parent was offered the opportunity to choose a provider. If the family's choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.

3. The choice of service provider (s) is documented on the IFSP Addendum page, which may be completed after the IFSP itself is signed. In TRAC-IT, the Addendum page is created using the Assign IFSP Services task. The Addendum page documents not only the service provider selected but also the family's signature acknowledging that they were offered the opportunity to choose a provider. No services, other than service coordination, can be delivered until the addendum page is signed (though it is acceptable for the provider to have the family sign the addendum page at his/her first visit if it has not already been signed).

Local Monitoring and Supervision Associated with IFSP Development

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. The 45-day timeline for conducting the initial IFSP meeting is met.
3. Mitigating circumstances are documented when the 45-day timeline is exceeded.
4. Development of IFSPs is in accordance with the IFSP Instructions provided at the end of this chapter.
5. TRAC-IT data entry is timely and accurate.
6. IFSP outcomes reflect family priorities and routines and the child's functional abilities and needs.
7. Planned supports and services are appropriate to meet the IFSP outcomes.
8. Efforts to secure foreign language and sign language interpreters to assist the family's active participation in the IFSP meeting are documented.

Instructions for Completing the Virginia IFSP Form

General Information

1. Virginia's statewide IFSP has been designed to meet the IFSP requirements of Part C of IDEA and Medicaid plan of care requirements under the Medicaid Early Intervention Services Program.

2. The IFSP must be completed in TRAC-IT either through direct data entry or an electronic health record (EHR) upload.

3. Each section of the IFSP should be filled in (except that "Date Met" and "Date Outcome Added" do not need to be completed in the outcomes of the initial or annual IFSP and items on the transition page should be filled in over time, as appropriate. If an item is non-applicable, place "N/A" in that space. If a space seems to ask for unnecessary or redundant information, review the instructions to ensure you have correctly interpreted the intent of the item.

4. If a child with a current IFSP moves within Virginia, communication and coordination should occur between the sending local system and the receiving local system in advance of the move, whenever possible, to enable supports and services to be in place in the receiving local system based on the current IFSP. The sending local system should ***not*** record an end date for services in the Services Needed to Achieve Early Intervention Outcomes section of the IFSP simply because the child is moving to another local system in Virginia. The family's new service coordinator may schedule an IFSP review soon after the family moves for the new IFSP team to review the existing IFSP and make any necessary modifications.

Child and Family Information

The information in this section is primarily for the purposes of the Infant & Toddler Connection system. Other demographic information required by third-party payors (e.g., Social Security number, insurance policy number/s, diagnosis codes) and possibly by individual local Infant & Toddler Connection systems (e.g., program ID numbers) is highly specific, confidential, and irrelevant to many of the recipients of an IFSP (e.g., local school systems, childcare providers). Therefore, it should be provided, as required by individual circumstances, on a separate page as an attachment.

When the IFSP is created in TRAC-IT, all of the Child and Family Information fields listed below are pre-populated on the IFSP print template.

1. **Child's Name** — Fill in child's name

2. **Date of Birth** — Fill in child's date of birth

3. **Gender** — Check M or F to indicate whether the child is male or female

4. **Child's County or City of Residence** — Fill in child's city or county of residence. This is important for local systems that have more than one city or county in their catchment area. This may by pre-printed on the form for local systems who only serve one city or county. Other local systems may permanently add the list of counties and cities served to the extent that they fit in the available space (the applicable county or city can then be circled when the IFSP is completed).

5. **IFSP Date** — Enter the date the parent signs the IFSP. If the IFSP cannot be completed in one meeting, then the contact notes must reflect the dates of all meetings held to develop the IFSP. (The date of the first IFSP meeting will be auto-populated by TRAC-IT in the Initial field in the IFSP print template.)

6. **Initial/Annual** — Check the appropriate box to indicate if this is the child's initial IFSP or if it is an annual IFSP and write in which annual IFSP it is (e.g., #1, #2. The annual IFSP done one year after the initial IFSP is annual #1).

Using the Form as an Interim IFSP
If the IFSP form is used for an interim IFSP, then "Interim IFSP" should be hand-written on the cover page. When the initial IFSP is developed, the team starts with a new IFSP form.

7. **Date Six-Month Review Due** — Fill in the date by which the six-month IFSP review must be completed. This date will be 6 months from the IFSP Date entered above.

8. **Date(s) Review(s) Completed** — When the 6-month or other IFSP review is conducted, write in the date of the review. It is not necessary to rewrite the IFSP at every six-month review or when a review is held at a time other than 6 months, if the IFSP is updated to reflect the child's current needs and plans. However, a new IFSP form must be initiated at each annual IFSP meeting.

9. **Family's Primary Language and/or Mode of Communication** — Fill in the family's primary language or mode of communication (e.g., English, Spanish, American sign language, augmentative communication system). Indicate whether a translator was used.

10. **Child's** — Fill in the child's primary language or mode of communication.

11. **Medicaid Number (Optional)** — If the child has Medicaid/FAMIS, the team may choose to enter the number here. This should be the child's permanent 12-digit Medicaid number (as opposed to a MCO number, for instance).

12. **Family's Name, Address, Phone, And Other Contacts** — Fill in all contact information for the family. The amount of space in this section allows for the wide range of potential *contacts* required, (e.g., surrogate parents, foster parents, social services or natural parents, childcare provider), the variety of *methods* of contact possible for each contact listed (e.g., home phone, work phone, cell phone, pager, e-mail, personal fax), and allows room for updates as information changes. Some local systems may also wish to include the physician's name and contact information in this section. [When completing the IFSP electronically, this section is formatted into 2 columns. The section will allow you to continue entering information in column one until you click into column 2. You will need to click into column 2 when the last information on page 1 is at the bottom of the page (i.e., before it scrolls onto a new page).]

13. **Service Coordinator's Name, Agency, Address, Phone and Email** — Fill in all contact information for the family's service coordinator, as assigned at the IFSP meeting, including if appropriate, cell phone, e-mail, etc.

Families Acting as Service Coordinators
Some families may prefer to handle most or all of their own service coordination duties; it is still a requirement of Part C, however, that they have an official service coordinator assigned.

Team Assessment

Begin Gathering Information Early
The service coordinator is expected to gather information for this section prior to the IFSP meeting, through conversations with the family beginning at the ***initial*** visit with family. This practice will assist families and providers in preparing for the development of IFSP outcomes during the IFSP meeting.

1. **Referral Information, Medical History, Health Status** — Record the referral source and reason for referral, any medical diagnoses (especially those related to the reason for referral), and pertinent health information (including pertinent medical history, clinical signs and symptoms, and current health status). The reason for the child's eligibility for early intervention may also be included here. This information is pre-populated in the TRAC-IT IFSP task if it was entered in the intake task, and it can be edited during IFSP development.

2. **Daily Activities and Routines** — Fill in information regarding the family's everyday activities and routines, including what is going well for the family, what challenges they have with specific routines, what the child and family normally enjoy, and what changes they would like to see in their routines and activities. This information is pre-populated in the TRAC-IT IFSP task if it has been previously entered in TRAC-IT (during intake, for instance) and can be edited during IFSP development.

   Following the narrative summary of daily activities and routines, identify the easiest or most enjoyable times (including the routine, what makes the routine go well and who is involved) and the hardest or most challenging times (including the routine, what makes the routine so challenging and who is involved). If the narrative summary includes this level of detail, "see narrative" can be entered in the easiest and hardest fields.

   This information and level of detail is essential in developing functional, relevant, routines-based IFSP outcomes and will guide development of strategies for achieving those IFSP outcomes within the context of the child's and family's interests and naturally occurring activities, routines, and community supports.

3. **Family Concerns, Priorities and Resources** — Record information shared by the family about their concerns, priorities and resources, related to enhancing their child's development. The service coordinator is responsible for informing the family that inclusion in the IFSP of information from a family-directed assessment related

to enhancing the development of the child is voluntary and declining to include such a statement in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP. If the family declines to provide this information or provides this information but does not want it to be included on the IFSP, they are to initial the appropriate statement in the box in this section of the IFSP form.

This information is pre-populated in the TRAC-IT IFSP task if it has been previously entered in TRAC-IT (during intake, for instance) and can be edited during IFSP development. It must be deleted if the family declines to include this information on the IFSP.

Since the purpose for collecting information about the family's concerns, priorities and resources is to guide identification of functional, relevant IFSP outcomes, it is crucial that this section describe how the concerns, priorities and resources relate to the family's routines and activities (rather than just presenting a list of concerns, priorities and resources). The IFSP team needs to understand how the concerns, priorities and resources impact the child and family.

a. My Family's Concerns — Describe the family's concerns (if any) about their child's health and development and any information, resources and/or supports that the family identifies that they want.

b. My Family's Priorities — Describe what the family identifies as most important to them.

c. My Family's Resources — Describe the resources the family has for support, including people, activities, and programs/organizations. Include other caregivers in the child's life who the family indicates may be able to assist in addressing the IFSP outcomes. The extent to which other caregivers (such as child care providers, extended family members, respite care providers, etc.) are involved in addressing IFSP outcomes depends on a number of factors including, but not limited to, the following: the extent to which the family would like to have these other caregivers involved, how much time the child spends with these caregivers, and the willingness of these caregivers to learn and apply strategies for increasing the child's learning opportunities and ability to participate in everyday activities.

4. **Summary of Your Child's Development** — This section is organized by the three federally required child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs), which serve as the foundation for the IFSP. For each child outcome:

    a. Provide a description of the child's functional developmental status, integrating information across all developmental areas covered by the child outcome (see Virginia's *Child Outcomes Booklet*), across all settings, and from all assessment sources (e.g., parent report, assessment tool, observation, informed clinical opinion, medical and other reports). This information is pre-populated in the TRAC-IT IFSP task if it has been previously entered in TRAC-IT (during intake, for instance) and can be edited during IFSP development.

        i. Skills should be discussed in the context of the child and family's routines. It is not simply a matter of whether children can produce behaviors, but how the child uses behaviors to interact with and affect people, objects, and symbols in the different contexts of the child's life. For example, it is not as helpful to say Johnny can crawl or that he did a nice job crawling as it is to describe how he uses this skill to get to his toys and other things that he wants. Or the narrative might state that while Abby is able to say several words, she only uses them when looking at her books and does not use them spontaneously to communicate what she wants or needs.

        ii. While narratives need not include a list of things the child cannot do, it is important for the narrative to support the summary statements for the child outcomes. Include a description of the expected skills that were not yet demonstrated or mastered so the reader understands why the child received the child outcome statement chosen. Including information about what the child is not yet doing provides documentation needed by payor sources to understand why intervention is necessary and provides a balanced picture for the child's parents about the child's development in relation to other children the same age.

        iii. It is sufficient to document in the summary what the parent reported without adding that it was not observed during the assessment unless what was observed by the assessor was different from what was

reported. (i.e., did the assessor not observe rolling or did the assessor observe the child to roll without arching).

iv. Include information about how the child is functioning in different settings, in different situations and with different people.

v. Avoid using statements about age levels in developmental domains in this section. These will be documented in the Age and Developmental Levels section of the IFSP.

b. Document the child's development in relation to other children the same age by using one of the following child outcome summary statements. Remember that child outcome summary statements are based upon the child's **chronological age and there is no adjustment for prematurity**.

i. Child has all the skills that we would expect in this area.
ii. Child has the expected skills in this area, but there are some concerns.
iii. Child shows **many age expected** skills.
iv. Child shows **occasional use of some** age expected skills.
v. Child uses **important** skills necessary for development of advanced skills.
vi. Child is beginning to show some of the early skills.
vii. Child has the **very early** skills in this area.

c. Select the child outcome summary statement from the dropdown menu in TRAC-IT or, if completing the IFSP in a local electronic health record (EHR) for TRAC-IT upload, use the child outcome summary statements **as written** when completing the *Child's Development in Relation to Other Children* section. Do not add to or modify these statements to reflect the skills that justify the rating. Information about the skills that justify the rating should be reflected in the narrative section for each child outcome.

d. Select all sources of assessment information used to arrive at the information reported in the Team Assessment section of the IFSP. Please note that the Virginia Part C Vision and Hearing Screening tools must be completed as part of each child's **initial** assessment.

Avoid Duplication of Assessments
To avoid duplication of assessments, the IFSP team may use assessment reports written by providers outside of the Infant & Toddler Connection of Virginia for development of the IFSP and service planning. When using outside assessment reports, relevant information must be transferred from that assessment report and integrated with information from other assessment sources to complete the Team Assessment section of the IFSP, so that it is clear that all required assessment components have been completed. If a provider from outside the Infant & Toddler Connection of Virginia assessed only some, but not all, of the developmental areas required by Part C, the remaining areas of development must be assessed during the assessment for service planning. Assessments must have occurred no more than 6 months prior to being used for service planning. Any outside assessment reports used must be included in the child's record and may be attached to the IFSP.

Age and Developmental Levels

1. **Age and Developmental Levels Table** — The child's age and adjusted age, if applicable, will be pre-populated by TRAC-IT on the IFSP print template.

    a. Fill in a developmental age equivalent or range for each area of development in the table based on the synthesis of information from all assessment sources marked in the section below this table. If the team finds the child's development to be atypical in one or more areas, it is acceptable to write an age level or range and note "atypical' in parentheses after that information, but it is not sufficient to write "atypical" without an age level or range. Any atypical development or behavior and its impact on the child's functioning in any of the three child outcome areas must also be described in the Summary of Your Child's Development section of the IFSP.

    b. For vision and hearing, the results of the Virginia Part C Vision and Hearing screening tools will be pre-populated if completed in TRAC-IT. In addition, provide information about the child's current vision and hearing status, including eye-specific and ear-specific information whenever possible. This information is pre-populated in the TRAC-IT IFSP task if it was entered in the hearing and vision screening tasks in TRAC-IT and can be edited during IFSP development.

2. **The following people participated in the assessment for service planning** — Individuals who completed assessments are selected in or uploaded to TRAC-IT, including their name and discipline, as appropriate.

3. **Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning** — The name, credentials and organization of any assessor who is not part of the Infant & Toddler Connection of Virginia system must be entered here.

Outcomes of Early Intervention

IFSP outcomes are identified based on information gathered through the assessment for service planning process, including conversations with the family to identify current daily routines, activities and settings; potential child learning opportunities; and areas where the family would like assistance. Asking families questions like "What activities that your family participates in are most important to you?" and "What new activities would you like to pursue?" can assist families and the IFSP team in identifying the desired IFSP outcomes, and IFSP outcomes written with family routines and activities in mind become personal and important to the family.

1. **Service Coordination Outcome** — One IFSP outcome documents the IFSP outcome and short-term goals for service coordination and must be completed for every child who has an IFSP, even if the family wishes to have only minimal service coordination from the local system and wants the service coordinator only to coordinate IFSP meetings. Parts of the page are partially completed to assure inclusion of required activities. For children receiving Early Intervention Targeted Case Management (EI TCM), the Initial Early Intervention Service Coordination Plan ends with the family's signature on the IFSP, and the IFSP and this IFSP outcome page become the plan for continued provision of EI TCM.

2. **Short Term Goals** — The short-term goals provide the Part C-required ***criteria*** for determining the degree to which progress is being made toward achieving the IFSP outcome. The short-term goals should be written from the perspective of what the service coordinator will do for the child and family and must include a target date. The short-term goals should be specific and based on family priorities and needs at the time the IFSP is developed. Please note that the third pre-printed short-term goal (providing information and support for accessing routine medical care)

includes requesting physician completion of the health status indicator questions every 6 months. These questions are:

a. Is this child up to date (per CDC/ACIP guidelines for this year) on immunizations?
b. What is the date of this child's most recent visit with you?
c. What is the date of the most recent well child visit?
d. What month/year should this child see you for the next well-child visit?
e. Are there immunizations needed at time of next visit?
f. Does the child's record have any lead testing (either capillary or venous) results? If yes, date services provided and results.

The questions may be posed using either the combined *Physician Certification Including Health Indicator Questions* letter, the *Health Indicator Questions* letter, or another form or mechanism developed by the local system. The health status indicator questions must be asked as written in the *Health Indicator Questions* letter unless the local system has an alternate mechanism (e.g., request and review of well-child records) that provides the information necessary to answer all the health status indicator questions.

A Note About Pre-Printed Service Coordination Goals
If the family only wants to address the three pre-printed short-term goals, then the fourth pre-printed goal (provide supports identified by your family to include resources for…) may be marked not applicable (N/A). In TRAC-IT, click on that goal, click Edit and add N/A at the end of the printed goal statement.

For purposes of completing the health indicator questions, "every 6 months" means making the request any time between 5 months and 7 months from the previous request to the physician about the health status indicator questions. Local systems are encouraged to follow-up with physicians to receive this information but are not responsible for ensuring the information is provided.

3. **Target Date *(for short term goals)*** — Provide target dates (month/day/year) for when each short-term goal is expected to be achieved. For the three pre-printed short-term goals, TRAC-IT assigns a Target Date of one year from the IFSP meeting date. The user can edit this date if needed.

4. **Date Met *(for short term goals)*** — Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.

Click "Create" in the TRAC-IT IFSP Outcome section to add other outcomes.

1. **Date Outcome Added –** Enter the date of the initial IFSP or IFSP review during which the IFSP outcome was added (this is the start date for the new IFSP outcome).

2. **Outcome** (Long-term functional goal) - This statement is what the family would like to see happen because of their participation in early intervention. It may be a major developmental goal related to the child's participation in home and community activities, or it may be an outcome related to the family's ability to assist appropriately in their child's development. It must be functionally stated, reflect the family's priorities (i.e., the IFSP outcome focuses on the child's participation in activities that are important to the family), and be consistent with information gathered from the team assessment of the child's functional strengths and needs in relation to the three child outcomes and with information from the family-directed family assessment (if completed). IFSP outcomes can be stated in the family's words, or they can be restated with help from the early intervention providers either in addition to the family's statement or instead of it if the family prefers. IFSP outcomes related to the ***child*** must be measurable and functional and represent what the ***child*** is expected to be able to do, e.g., "Jane will feed herself the entire supper meal each day." The prompts provided on the IFSP outcome page of the print template remind the IFSP team that a well-written IFSP outcome addresses acquisition (describes the skill or behavior the child or family is to acquire or achieve), the context or setting within everyday activities and routines in which the desired behavior is expected, and the criteria for achievement (including the frequency/duration/rate for the new skill or behavior and over what specific period of time).

3. **Target Date** – Enter the date (month/day/year) by which the IFSP outcome could reasonably be expected to be achieved. Since an IFSP Review must be held anytime changes are made to the IFSP outcome (and/or short-term goals), it is helpful to choose a target date that corresponds to a required review date.

4. **Date Met, Changed Or Ended** – Enter date (month/day/year) at any point at which the IFSP outcome was met, changed or discontinued. The change this date represents must be documented in contact notes in the child's record. An IFSP review must be held to change an IFSP outcome.

5. **Learning opportunities and activities that build on child's and family's interests and abilities** – List here activities that the child finds (or might find) enjoyable (based on child's interests and ability) and that could be incorporated into the child's and/or family's existing or desired routines and activities. This should not be an exhaustive listing of all the activities possible, but rather an overview of the possible activities that will be explored in ongoing intervention (specific activities will be recorded in ongoing contact notes/lesson plans). All intervention should, however, be planned in the context of the family's daily routines, activities, and resources available in the community, consistent with the information recorded in Daily Routines and Assessment sections of the IFSP.

6. **Interventions (Treatment procedures and/or modalities)** – Enter the specific interventions (treatment procedures and/or modalities) that will be used to address the IFSP outcome. Specific interventions may include, but are not limited to, the following:

    a. Balance/coordination
    b. Positioning
    c. Therapeutic exercise
    d. Gait training
    e. Community living skills
    f. Functional activities/mobility
    g. Assistive technology devices
    h. Equipment/device training
    i. Weight-bearing
    j. Range of motion
    k. Caregiver/parent training
    l. Fine motor training
    m. Developmental handling
    n. Expressive language skills training
    o. Visual perceptual skills training
    p. Receptive language skills training
    q. Feeding
    r. Oral motor skills development
    s. Swallowing
    t. Pre-verbal skills
    u. Cognitive skills development
    v. Sign language
    w. Behavior modification

x. Hearing aid tolerance/use
y. Sensory integration
z. Functional visual skills
aa. Self-feeding skills
bb. Articulation therapy/phonological awareness
cc. Cognitive linguistic therapy

7. **Short Term Goals** – The short-term goals provide the Part C-required ***criteria*** for determining the degree to which progress is being made toward achieving the IFSP outcome. The short-term goals should be written from the perspective of what the child will be able to accomplish, should represent a result rather than a process, should be **functional and measurable**, and must include a target date. Ensure inclusion of measurable, functional criteria that ***any*** team member could use to review progress toward achieving IFSP outcomes. The short-term goals can be thought of as the building blocks leading up to achievement of the IFSP outcome, e.g., ***"****Child will pull to stand while holding on to the sofa in the family room several times each evening without physical assistance****."*** To enter short-term goals in TRAC-IT, click on the outcome, click Edit, the click Create under the Goals.

8. **Target Date *(for short term goals)* –** Provide target dates (month/day/year) for when each short-term goal is expected to be achieved.

9. **Date Met *(for short term goals)*** - Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.

Services Needed to Achieve Early Intervention Outcomes

Determine the specific early intervention services that are necessary to help the child and family achieve the IFSP outcomes. The IFSP team considers multiple factors when identifying appropriate supports and services to address IFSP outcomes, including the expertise needed to support the family, abilities and interests of the child and family, and family and community resources.

Complete the table as follows:

1. **Entitled Service –** Service coordination must be provided to every eligible child and family and must be added in TRAC-IT. Enter each additional early intervention service that was determined through the IFSP process to be necessary for the child/family to achieve the IFSP outcomes. The following list of early intervention

services is not exhaustive and does not preclude the IFSP team from identifying another type of service as an early intervention service as long as that service meets the criteria of an early intervention service under Part C (i.e., services that are provided under public supervision, by qualified personnel, in accordance with the State's system of payments, selected in collaboration with the family, and designed to meet the developmental needs of the child or the needs of the family to assist appropriately in the child's development):

a. Assistive technology devices and services
b. Audiology
c. Developmental services
d. Counseling services
e. Health services
f. Medical evaluations
g. Nursing services
h. Nutrition services
i. Occupational therapy
j. Physical therapy
k. Psychological services
l. Service coordination
m. Sign language, cued language and listening and spoken language services
n. Social work services
o. Speech-language pathology
p. Transportation and related costs
q. Vision services
r. Other services, as identified by the IFSP team

See the TRAC-IT Data Dictionary or Entitled Services field dropdown menu in TRAC-IT for how these services are listed on the IFSP.

Important information About Assistive Technology
• When listing assistive technology on the IFSP, please specify whether it is an assistive technology device or assistive technology service. • When listing Assistive Technology Device, the length should be listed as 0, intensity as individual, and location should be the location where the device is expected to be delivered. The projected end date and actual end date should reflect the anticipated and actual date of delivery of the device to the child, respectively.

- It is not necessary to list Assistive Technology Device on the IFSP when the provider is trying out potential equipment with a child to determine whether it is appropriate to meet the child's and family's needs and the IFSP outcomes. Once an appropriate assistive technology device has been identified and will be acquired for this child (through loan or purchase), an IFSP review is held to add this device(s) to the entitled services listed on the IFSP.

- Assistive technology services should be listed according to the provider of that service (e.g., if the assistive technology service is being provided by the physical therapist, then list the service as Physical Therapy/Assistive Technology Services). The frequency, length, method, etc. should reflect both the physical therapy service and assistive technology service, combined.

- Assistive technology services are services that directly assist the child with a disability in the selection, acquisition or use of an assistive technology device and include the following: evaluation of the needs of the child with a disability, including functional evaluation of the child in the child's customary environment; purchasing, leasing or otherwise providing for the acquisition of assistive technology devices; selecting, designing, fabricating, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with education and rehabilitation plans and programs; training or technical assistance for the child, family, other caregivers or service providers; and collaboration with the family and other early intervention service providers. If a provider is delivering any of the services included in the definition of assistive technology services, then the IFSP should reflect both the service that provider generally provides (e.g., physical therapy if the provider is a physical therapist) and assistive technology service as indicated above.

Developmental Services Provided by Nurses

- List "developmental services" as the service on the IFSP even when that service is provided by a nurse.

- When billing for developmental services provided by a nurse, the provider will use billing codes G0154/G0154 U1 for services in natural environments and T1026/T1026 U1 for center-based services. Similarly, when a nurse is providing assessment, participating in IFSP meetings, team treatment activities, etc., the appropriate billing codes are T1023 U1 and T1024 U1. Billing code descriptions are provided in Chapter 11.

Sign Language, Cued Speech and Listening and Spoken Language Services

- These are three separate services. The IFSP should list only the one(s) of these services that will be provided to this child.
- These services should be listed according to the provider of that service (e.g., if the sign language services will be provided by a Teacher of the Deaf, then list the service as Developmental Services/Sign Language Services). The frequency, length, method, etc. should reflect both the Developmental Services and Sign Language Services, combined.

Entitled Service Versus Intervention/Treatment Modality

Applied Behavior Analysis (ABA) or other such approaches to service delivery are not entitled early intervention services; but rather interventions/treatment modalities. The IFSP must list the entitled early intervention services based on the provider type who will implement the intervention/treatment modality.

2. **Frequency and Period -** Enter the number of visits per week/month/etc. each service is to be provided (e.g., 1x/wk.). ***It is not acceptable to list a range (such as 1-2x/week) for frequency.*** If a service will be provided only once, then record the frequency as 1 and the period as "only."

   The frequency for a service may be planned over a period of up to 6 months (e.g., 1x/week, 4x/month, 10x/6 months). Given that service frequency is based on a family's need for support in implementing strategies to meet the IFSP outcomes, scheduling service frequency over a longer period is one strategy for addressing a known/expected family need for flexibility or fluctuation in that level of support. The following may be indicators that considering frequency over a period greater than one month is appropriate:

   a. The team determines there is a need for front-loading of services followed by a tapering of service frequency, and it is unclear exactly when it will be appropriate to taper.

b. The team identifies a likely need for a burst of services along the way (e.g., child is scheduled to receive orthotics and a greater frequency of services will be needed for a short period after the child is fitted).

c. There is a primary provider seeing the child at a more "traditional" frequency, and the team would like flexibility in the frequency with which the primary provider and family call on another team member to provide support.

This level of flexibility will not be necessary or appropriate for all families and must not be used to meet a local system's or service provider's need for flexibility.

Documenting Service Frequency Over Period Longer than 1 Month

If the planned frequency is for multiple visits over greater than a one-month period, contact notes must include:

- Justification for the frequency chosen and the need for flexibility for this specific child and family;
- For each visit, discussion with the family about when the provider will come next and why;
- Documentation of discussions with the family and other providers to ensure frequency remains appropriate based on child and family priorities and concerns; and
- Justification if the maximum number of services planned over the period were not delivered.

Someone reviewing the child's record should be able to clearly understand how and why decisions were made about service delivery within the parameters of the frequency listed on the IFSP.

For service coordination, record the projected **minimum** frequency of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc. For children receiving EI TCM, there must be at least one direct contact between the service coordinator and family every three (3) calendar months. Such contacts shall be person-centered with the choice of contact method determined by the family (face-to-face, phone, email, or text). The family's preferred method of contact (face to face, phone, email, or text) for the family contacts that are required every three months can be documented in the contact note for the intake visit.

3. **Length –** Enter, in 15-minute increments, the length of time the service is to be provided during each visit (e.g., 60 min/visit). ***It is not acceptable to list a range (such as 30-45min/visit) for length*.**

   For service coordination, record the projected minimum length of direct contact time between the service coordinator and the family, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc.

Frequency and Length of Service Coordination
The Infant & Toddler Connection of Virginia Office recognizes that the frequency and length of service coordination provided will fluctuate since service coordination is an active, ongoing process that is responsive to individual family needs and circumstances. When the frequency and length of service coordination delivered vary from that planned on isolated occasions, the service coordinator's contact notes must reflect the reason for increase/decrease in frequency/length. If the frequency and/or length of service coordination delivered vary greatly from that planned on a consistent basis, then it is time for an IFSP review. During State monitoring of service delivery, local systems will NOT be cited as out of compliance if there is not an exact match between the planned and delivered frequency and/or length for service coordination if there is documentation that service coordination was active and ongoing and based on meeting the family's needs and IFSP outcomes. Similarly, for children receiving EI TCM, a provider will not be cited as out of compliance with the requirement for direct contact with the family every three months as long as there have been repeated and documented attempts to make that contact within the required 3-calendar-month period.

4. **Group/Individual** – Specify whether the service is to be provided on an individual or group basis. Although early intervention services are most often provided on an individual basis, an example of when group might be listed as the intensity would be when one service provider is working with twins, who are both eligible for early intervention, in the home, together on a shared IFSP outcome or when a provider is seeing two children who are both working on feeding at lunchtime at daycare.

5. **Methods** – Using a, b, c, or d, specify whether the service is to be provided through coaching, including hands-on as appropriate; consultation; provision of an assistive technology device; or assessment.

a. Coaching, including hands-on as appropriate – Record this method any time the provider will provide a service (other than assessment, see below) to the child and/or family and/or other caregiver.

b. Consultation – This method refers to consulting between service providers (i.e., the child and family are not involved in the consultation session). The IFSP will list the service (discipline) that is providing the consultation.

    i. If the consultation between providers is planned at the time of the IFSP, then it should be documented as an entitled service on the IFSP. If a concern comes up later and the primary provider is just making a call to another provider, say the OT, to ask a question, then there is no need to have an IFSP review to record that call as consultation. However, depending on the outcome of that call, an IFSP review may be needed to add assessment or further consultation by the OT.

    ii. Consultation between team members who are both providing ongoing services to the child using the method "coaching, including hands on as needed" is not listed on the IFSP as consultation between the two providers (without the child and family). Instead, this is considered teaming, an expected part of service delivery that is included in the EI rate paid for the service they are already providing.

c. Provision of an assistive technology device – Record this method only when the service listed is Assistive Technology Device.

d. Assessment – This method refers to assessment completed after the initial assessment for service planning and does not include ongoing assessment conducted at each session by the service provider. The need for follow-up or annual assessments (other than ongoing assessment) and parent consent for that assessment may be documented either on the IFSP or on the Notice and Consent for Assessment for Service Planning form, whichever is easier in each situation. For instance, if the need for additional assessment comes up during an IFSP review, it will be easier to document that additional assessment on the IFSP Review page rather than using the consent form. On the other hand, if it is close to time to develop the annual IFSP and there is not enough information available through ongoing assessment, then the service coordinator may find it easier to use the Notice and Consent for Assessment for Service Planning form (marking Annual Assessment in the

Action Proposed section) rather than going through the process of holding an IFSP review in order to add the needed assessment(s) to the IFSP.

6. **Natural Environment/Location** - Select the natural environment/location where the service will take place. The choice of location is based on the activities that are being addressed (as identified in the IFSP outcomes). The choices are Home/Child Care/Community Setting or Other Setting. If the services will be provided in one or more natural environments, select Home/Child Care/Community Setting.

   If the location is not a natural environment, select Other Setting and provide justification for why the IFSP outcomes cannot be met in a natural environment.

About Service Coordination IFSP Location
For service coordination, if the family wants contact to be by phone and e-mail, the service coordinator will see the family face-to-face at least for the annual IFSP. In this situation, the location listed on the IFSP would be the location where the service coordinator will be with the family for the annual IFSP meeting.

7. **Payment** – The IFSP print template notes that "Payment arrangements for services are specified on the Family Cost Share Agreement form."

8. **Projected Start Date** - Enter the **projected** date (month/day/year) on which the service will begin. The projected start date should reflect the local system's best estimate of when services can start. The exact date of the first appointment is not required. The date should be within 30 calendar days of the date the parent signs the IFSP unless the IFSP team decides on and documents the reasons for a later start date to meet the individual needs of the child and family. It is not permitted to delay services while waiting for insurance authorization, except by parent request. The projected start date for a one-time service (e.g., an audiology evaluation) should reflect the anticipated date for delivery of that service. The IFSP is not valid or in effect until the parent signs the IFSP. The IFSP date would be listed as the projected start date only if (1) the family signs the IFSP on that date and (2) the service is anticipated to be delivered that same day.

   Please note that the 30-day timeline does ***not*** apply to delivery of an assistive technology device. The projected start date listed on the IFSP for an assistive technology device should reflect the anticipated date for delivery of that device.

9. **Projected End Date** – Enter date (month, day, and year) when the service can reasonably be expected to have met all IFSP outcomes, or a future IFSP review date. The projected end date for a one-time service would be the same as the projected start date.

10. **Actual End Date** – During an IFSP Review or Annual IFSP, enter the date the service ended. In TRAC-IT, this is done by clicking on Service Plan, selecting the service, clicking Edit and adding the actual end date. Do ***not*** enter an actual end date if the service is continuing but the frequency, length, intensity, method or location is changing. In this situation, just use the edit button to reflect those changes within the service.

    An end date should not be recorded by the sending local system for services on the IFSP simply because the child is moving to another local system in Virginia.

11. **Primary Service Setting** – The IFSP task in TRAC-IT requires entry of the primary service setting. This is not included on the printed IFSP. Select the setting where the majority of the IFSP services will occur for the child and family.

12. **Justification of why early intervention outcomes cannot be achieved satisfactorily in natural settings and a plan with timelines and supports necessary to return early intervention services to natural settings –** If any service will be provided outside of a natural setting, explain here why IFSP outcomes cannot be achieved by receiving services in a natural setting within the context of the daily activities and routines of the child and family. The justification must document the IFSP team's decision that the child's IFSP outcome(s) could not be met in a natural setting ***even with supplementary support*** (e.g., adaptations or modifications to activities or environments; use of assistive technology). The justification must include ways that services provided in specialized settings will be generalized into the child's daily activities and routines and a plan with steps, timelines and supports necessary to return early intervention services to natural settings within the child's and family's daily activities and routines. The need for services to continue outside of natural settings must be monitored carefully, and IFSP reviews should be held more frequently to determine whether the child's IFSP outcomes can now be met within natural settings. Provider or parent preferences are not acceptable justifications. (If services are not provided in natural settings within the context of the daily activities and routines of the child and family because of family preference, then the services are not Part C early intervention services and cannot be paid for with any federal, state or local early intervention funds).

13. **Reason for later projected start date (if services are planned to start more than 30 calendar days after the family signs the IFSP)** — For each service that is planned to start more than 30 calendar days after the family signs the IFSP, list here the service and indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs, or other. If the reason is that the team planned a later start date to meet child and family needs, then explain here or in a contact note how the delay in the start of services meets child and family needs. If the reason is "other," then this other reason must be fully documented/explained in the contact notes.

    a. IFSP services may start more than 30 calendar days after the family signs the IFSP and still be considered "timely" if the IFSP team decides on and documents the reasons for a later start date to meet the individual needs of the child and family. It is also acceptable to plan a later start date due to family scheduling preference.

    b. Provider unavailability is not a reason for planning a later start date, since it is not known for certain at the time of IFSP development that there will be no provider available. There are circumstances when the IFSP team anticipates a delay in the start of services due to a provider issue. For instance, if audiology is listed as an entitled service and the team knows it usually takes 6 weeks to get an appointment, then the projected start date should be realistic and reflect that fact. The reason for the later projected start date would be "other," and the local system will work to get an earlier appointment either through a cancellation or by seeking the services of another audiologist, if possible. The contact notes will document the attempts to get an earlier appointment. Similarly, if the team anticipates a delay in the start of physical therapy because of a provider shortage, then the projected start date will reflect that fact, the reason given will be "other," and contact notes will detail the circumstances as well as efforts to start the service as soon as possible.

    c. Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization, except by parent request. In order for this to be considered an acceptable reason for the delay in starting a service(s), there must be documentation that contact has been ongoing with the insurance company and that the local early intervention system has been working with the company to determine if there will be coverage for early intervention services ***AND*** that the parent chose not to begin services

until insurance issues were resolved. Otherwise, Part C funds must be used to avoid a delay in the start of services.

Documenting Start Date Delay(s)
If a service has a projected start date on the IFSP that is within the 30-day time frame, but the actual start date is delayed beyond the 30 days, then the reasons for that delay are documented in the contact notes rather than on the IFSP. The contact notes also provide documentation of the actual start date of each service. Compliance with the requirement for timely start of services is based on the actual start date in relation to the date the family signed the IFSP.

14. **Other Services *(services needed, but not entitled under Part C –include medical services such as well baby checks, follow up with specialists for medical purposes, etc.*)** — List all medical and any other ongoing services a child and/or family may need but are neither required nor covered under Part C, e.g., follow-up by a medical specialist for a chronic health condition, orthopedic visits, etc. For each service, list the name of the provider of the service and the location at which the service is typically rendered. If those services are not yet being provided, describe the steps the service coordinator or family may take to assist the child and family in securing those services.

Entitled vs. Other
• Any medical services for diagnostic or assessment purposes that the IFSP team identifies as necessary to determine the child's developmental status are considered entitled services and should be listed in the entitled services section. • Services parents secure on their own outside of the Infant & Toddler Connection system (because they want more frequent services or a specific location, for example) should be listed as Other Services.

Transition Planning

The activities in this section are intended to help service coordinators plan individual child/family transitions in compliance with Part C requirements. Chapter 8 of the Practice Manual provides additional information about transition requirements.

Generally, the information at the top of the Transition task in TRAC-IT (the top box on the IFSP print template) will be shared with families during the initial IFSP meeting.

1. **The following information about transition is discussed beginning at the initial IFSP** – This box provides an outline of the general information about transition that must be shared with families beginning at the initial IFSP meeting. The date this information was shared with the family will be populated on the IFSP print template based on the signed date of the first IFSP for which "Transition was Discussed" is selected in the IFSP task.

2. **Important Dates for Transition Planning** – This information assists the service coordinator and family in knowing some of the important dates for transition planning with this specific child and family.

    a. **Two-year target date for transition** – This is the target date for notification and referral to determine eligibility for early childhood special education services. This date must always be at least 90 days before the anticipated date of transition. Generally, local systems will enter April 1 of the year that the child will be 2 by September 30th. This date provides the target date for notification and referral to the local school division for the child to begin receiving early childhood special education services on the first day of school. Some local systems may work with local school divisions that allow admission of 2-year-olds throughout the school year (rolling admissions) or have other agreed upon timelines for referral. In that case, enter the target date here accordingly.

    b. **Date of child's third birthday** –This date will be pre-populated by TRAC-IT. Discuss with the family the eligibility and age requirements for early intervention so they understand their child will not be eligible for Part C early intervention services on or after the child's third birthday.

3. **Transition Plan –** Please see the Transition section of Chapter 8 for information about the transition plan and how to complete the remainder of the Transition task in TRAC-IT, which then populates the transition section of the IFSP.

IFSP Agreement

1. **Parental Consent for Provision of Early Intervention Services** — This is a statement of agreement with and informed consent for the services as specified in the IFSP. The *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* must be given to the parent (s) and the rights and payment policies explained prior to asking them to sign the IFSP. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

   If the parent expresses disagreement with any portion of this statement, the service coordinator should determine the source of the disagreement and attempt to resolve it with the parent(s). If the parent(s) decide to opt out of one or more services or to opt out of early intervention, then follow the procedures described earlier in this chapter.

2. **Parent (s)/Legal Guardian Signature and Date** — Parents sign to affirm their agreement with the consent statement above. Check the appropriate box to indicate whether the signer is the child's Parent, Legal Guardian, or Surrogate Parent. The date must be entered with the parent signature since the date of parent signature is the date the parent has consented to services listed on the IFSP and begins the 30-day timeline for the timely start of services. In TRAC-IT, click the box in the IFSP task to indicate IFSP Updates are Complete. This will generate the agreement/consent form.

3. **IFSP Attendees, Other IFSP Participants and Individuals who Participated electronically or in writing** — When scheduling the IFSP meeting in TRAC-IT, record the practitioners who will participate in the IFSP meeting, and they will populate here in this section of the print template. Their discipline and method of participation (if not present) will be selected in the IFSP task.

4. **Translator/Interpreter (if used)** — In TRAC-IT click the checkbox to indicate a translator was used and list the name of any individual(s) who either interpreted any portion of the IFSP development process for the family/child, or who was responsible for translating the IFSP into the family's native language, as an attendee on the agreement page.

5. **Related documents** — List any related documents that were used to develop the IFSP (for example, medical specialist's evaluation of an aspect of the child's health that is relevant to his developmental progress). These documents, while not part of the IFSP itself, must be included in the child's early intervention record.

6. **Transition** — Indicate, using the checkbox in TRAC-IT, if transition was discussed.

7. **Physician certification** — This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically-necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, and date of signature may be obtained on a separate letter referencing the IFSP that is sent with the

   IFSP or on the *IFSP Summary Letter* instead of on the IFSP. Physician certification is not needed if there is no third-party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed to receive Medicaid reimbursement for assessments. Please see the text box in the "Completing the IFSP Form" section of this chapter for specific requirements associated with the physician signature.

IFSP Review Record

This page is intended to provide documentation for the IFSP reviews that must be conducted every six months or more frequently as requested by the parent or other team members. The services and the transition plan often require updating during a review. The IFSP Review Record documents the parent's consent for any changes to the IFSP made at the time of review.

Review Required...?	
Yes	• An IFSP Review must occur whenever a change to the IFSP outcomes, short-term goals or service provision (frequency, length, intensity (group/individual), method, natural environments/location) specified in the IFSP is being considered.
Yes	• An IFSP Review must occur to develop the Transition Plan and for the Transition Planning Conference unless that plan is developed or the conference is held during the initial or an annual IFSP meeting.

No	• An IFSP Review is not required to add or change learning opportunities and activities or modalities or to add/document specific transition activities after the Transition Plan has been developed. Changes to contact information for the family and/or change in the service coordinator do not require an IFSP review.
No	• An IFSP Review is not required if a short-term goal is ***not*** met by the target date. However, it may be appropriate to hold an IFSP review to discuss progress and whether there is a need to change the short-term goal. Otherwise, if the short-term goal is continuing, the team will revise the target date at the next IFSP review. An IFSP review is not needed when a short-term goal ***is*** met unless that progress means there is a need to add a new short-term goal(s) or IFSP outcome or change a service.
No	• A review is not required to change the service provider for an entitled early intervention service. If the change is to another provider within the same provider agency selected by the family, then a contact note must document that the family was informed of the change and of their options for informing the service coordinator if a change from the new provider is desired. The new service provider should be assigned using the Reassign IFSP Services task in TRAC-IT. This will add the new provider to the Addendum, but a parent signature is not needed. If a change in provider is necessary or requested by the family and no other provider from the same provider agency is available, then documentation of parent choice of a new provider agency is required on the Addendum (i.e., the new provider must be added, and parent signature is required).
No	• The IFSP Review Record does not need to be completed to "Close out" an IFSP prior to developing the annual IFSP.

Other Requirements Associated with IFSP Reviews
• *Parental Prior Notice* and *Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to an IFSP review. These forms may be mailed ahead of the meeting if necessary (e.g., if the meeting will not be face-to-face and the service coordinator will not see the family before the meeting).

- At a minimum, the review must include the parent (s) and any other friend or family member(s) requested by the parent, the service coordinator, and any direct service provider (s) as appropriate.

- This does not have to be a face-to-face meeting. Any means of reviewing the IFSP that is acceptable to the parents and other participants is permissible, if all participants have the opportunity to provide input.

- If the IFSP review is held by means other than a face-to-face meeting, then the contact note must document the date of the IFSP review. Even though the parent's signature may not be obtained on that date, it is the date the review is held that must be within 6 months of the date the initial or annual IFSP was developed. Contact notes then document efforts to obtain the parent's signature, which is required before any changes to the IFSP may be implemented.

- Any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs.

1. **Purpose of Review** – Select whether the review is being held as the required 6-month review of the IFSP or has been specifically requested by the parent or another member of the team (other).

Mark As a 6-Month Review…?

Question: If a service coordinator does a review at 3 months after the IFSP is signed and then again 6 months later (at the 9-month point following the IFSP), does the service coordinator select the purpose as "6-month review" at the 3-month review or -the 9 month review – or both – or never and just checks the "other" box for both reviews?

Answer: If the IFSP review is being held because it has been about 6 months since the IFSP was developed or reviewed, then "6-month review" should be selected. If the review is being held because it was requested by the family or another team member and it is not near the 6-month mark, then check the "other" option. In the example given in the question, the review held at 3 months would be "other" and the review held at 9 months would be "6-month review."

2. **Review Date** — Date of the IFSP review ***meeting***. If the IFSP review occurs by phone, then the date of the phone call to review the IFSP is the review date.

3. **Summary** — Provide an overview of what was discussed and decided at the review. This should include:

    a. Information from the family regarding their priorities and preferences; and

    b. Information from ongoing assessment, including progress toward IFSP outcomes and goals and the child's current functioning and progress (since the initial IFSP) in the areas of positive social relationships, acquiring new knowledge and skills and use of appropriate behaviors to meet needs.

    Include the way the review was conducted and any other new information that might affect the IFSP. If there are changes made to the existing IFSP outcomes and/or services because of this review, include the rationale for the change(s) here.

4. **Changes** — Enter any changes that were made to the IFSP because of the meeting. This should consist of the current provision and what is changing about it, e.g., Physical Therapy is being changed from 1x/wk. to 1x/mo. If no change is recommended, write "none." Update the service plan and/or outcomes to reflect these changes (in the lower section of the IFSP Review task in TRAC-IT).

5. **Projected Start Date for Change** — Record the date the change is projected to begin. If the change is a change in a service, then the projected start date for the change is the projected start date for the new service.

6. **If Transition Discussed** — Indicate, using the checkbox in TRAC-IT, if transition was discussed.

7. **Parental Consent** — The parent signs and dates to indicate his/her involvement in the decisions and his/her informed consent for the changes. Parent signature and date of parent signature are required even if no changes were made. In TRAC-IT, click the box in the IFSP Review task to indicate IFSP Updates are Complete. This will generate the agreement/consent form. A written copy of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* must be offered and explained to the parent(s).

8. **If services increased on this IFSP review and my child is covered by private insurance** — If the child is covered by private insurance ***and*** the parent has consented to use of that insurance to pay for early intervention services ***and*** services have increased (in frequency, length or duration, or gone from group to

individual) on this IFSP, then the family must indicate here whether their private insurance can continue to be billed for covered services. The family must check one of the two boxes, then sign and date where indicated.

a. If the family checks the second box, indicating that they no longer consent to use their private insurance to pay for covered services, then a new *Family Cost Share Agreement* form must be completed and signed by the family showing that the family has declined use of their private insurance. If a new agreement form cannot be completed during the IFSP Review, then the checkbox and parent signature in on the IFSP Review Record can be used for up to 30 days to allow the local system to update their billing information for this family and to stop billing the family's private insurance while the new *Family Cost Share Agreement* form is being completed and signed. If the family declines to continue using their private insurance to pay for early intervention services ***and*** the family has Medicaid/FAMIS, then complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance*.

b. If the family is not ready to decide about continued use of their private insurance to pay for early intervention services but signs the Parental Consent box of the IFSP Review Record, then all services will continue/begin as planned at the IFSP Review. However, billing of private insurance must stop until the parent provides the required consent to continue billing their private insurance. Please see Chapter 11 for details.

9. **Other IFSP Participants** — When scheduling the IFSP Review meeting in TRAC-IT, record the practitioners who will participate in meeting, and they will populate in this section of the print template. Their discipline and method of participation (if not present) will be selected in the IFSP Review task.

10. **Physician certification** — This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, and date of signature may be obtained on a separate letter referencing the IFSP that is sent with the IFSP or on the *IFSP Summary Letter* instead of in the IFSP Review Record. Physician certification is not needed if there is no third-party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed to receive

Medicaid reimbursement for assessments. Please see the text box in the "Completing the IFSP Form" section of this chapter for other specific requirements associated with the physician signature.

Physician Signature Needed at IFSP Review...	
• If the projected end date has been reached and the service will continue?	Yes
• If a new service (other than assessment, for children with Medicaid), is added?	Yes
• If there is a change (increase or decrease) in frequency or length of an existing service?	Yes
• If a service ends?	No
• If the child is discharged from early intervention?	No
• If services stay the same but an IFSP outcome(s) and/or short-term goal(s) changes?	No
• If the only entitled early intervention service listed on the IFSP is service coordination?	No

Addendum

The addendum is used to document the provider for each entitled IFSP service and is populated using Assign IFSP Services task in TRAC-IT. Generally, the providers are not known at the time of the IFSP meeting so this task may be completed after the IFSP is signed.

1. **Entitled Service** — Lists the entitled services from the Service Plan section of the IFSP

2. **Service Provider** — Lists the service provider's name (e.g., Jane Doe), agency, address and phone number The provider for an assistive technology device may be left blank.

3. **Current?** — If creating an Addendum outside of TRAC-IT and there is a change in service provider, check the N in this column next to the exiting service provider indicating that this provider is not a current provider.

    a. An IFSP review is not required to change the service provider if the service, as listed in the Service Plan section of the IFSP, remains the same.

    b. Changing from one provider to another within the same provider agency does not require a new signature on the addendum. However, if a change in provider is needed and no provider is available from within the agency already selected by the family or if the family is requesting a change in provider agency, then the family must be offered a choice of provider agency and must sign the addendum form.

    c. If there will be a change of provider for a planned segment of time (e.g., summer, maternity leave), then this must be noted in the addendum. The family would need to sign to indicate that they have been provided a choice only if there will be a change in provider ***agency*** for this planned segment of time. If different therapists will fill in for individual sessions (e.g., therapist sick, make up sessions, etc.), then that substitution should just be noted in the contact notes and no change is needed on the addendum page.

4. **Parent Signature** – The parent signs and dates the Addendum to indicate that he/she was given the opportunity to choose from among available provider agencies that work in their local system area and who are in their payor network. All parents must be given this opportunity. More information about parent choice of provider is available in the “Selecting Service Providers” section of this chapter.

Annual IFSP

The annual IFSP must be completed within 365 days.

Requirements Associated with Annual IFSPs
• *Parental Prior Notice* and *Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to the annual IFSP meeting. • Prior to developing the annual IFSP, the child's continuing eligibility must be confirmed. This may occur prior to or during the IFSP meeting. The requirements for confirmation of the child's eligibility are specified in the "Annual IFSP" section of Chapter 8. • At a minimum, the annual IFSP meeting must include the parent(s) and any other friend or family member(s) requested by the parent, the service coordinator, anyone involved in new or ongoing assessment, and any direct service provider (s) as appropriate. • This must be a face-to-face meeting. • Any new services added at the annual IFSP must begin within 30 days of the date the family signs the IFSP unless the team planned a later start date to meet child and family needs.

The Annual IFSP is completed in the same manner as the initial IFSP, with the following considerations:

1. **Team Assessment**

    a. Include any updated medical and health status information in the Referral Information and Medical History section. While it may be helpful to succinctly re-state the reason for referral, the Referral section of the annual IFSP should not repeat all of the information that was on the initial IFSP (e.g., no need to repeat the birth history).

    b. Otherwise, complete the Team Assessment in the same way as for the initial IFSP. The means of gathering the information may be different since much of it may be gathered through ongoing assessment and conversations during intervention sessions and service coordinator visits or calls. The providers

who are serving the child are expected to be able to describe the child's functioning in each of the child outcome areas since ongoing assessment is a routine part of intervention. Re-assessment to determine the child's functioning in the child outcome areas at the time of the annual IFSP would only be completed if specifically needed because of individual circumstances such as the child has recently had major surgery that significantly impacted his/her developmental status, or the child receives services infrequently and no provider has had the opportunity for ongoing assessment for a long period of time.

c. In addition to describing the child's current functioning in the areas of positive social relationships, acquiring new knowledge and skills and use of appropriate behaviors to meet needs, include information for each child outcome area about the child's progress since the initial IFSP. This progress information is important in supporting the yes/no response to the progress question (Has the child shown any new skills since the entry assessment?) that must be recorded in TRAC-IT and gives the family a picture of progress over time.

2. **Age and Developmental Levels**

a. Use of the Virginia Part C Vision and Hearing Screening tools are ***not*** required for the annual IFSP. Providers should be alert to any signs that the child may be having trouble with hearing or vision, as such issues can arise at any age. In such cases, administration of the Hearing or Vision Screening tool would be appropriate. If the child had no problems with vision or hearing when initially screened and does not show any indication of problems at the time of the annual IFSP, it is acceptable to record the status as "no problems noted." The status may also include examples of hearing and vision behaviors noted or updated eye or ear-specific status, if available.

b. Providers who completed ongoing assessment must be listed as ASP Attendees in the Annual IFSP task in TRAC-IT.

c. If an assessment tool was completed as an age anchor for the child outcomes based on ongoing assessment and the provider does not feel comfortable marking the instrument as an assessment tool because it was not implemented according to its protocol, then mark "Other" and specify "used ___ {tool name} as age anchor."

d. The providers who are serving the child are expected to be able to make a statement concerning the child's present level of development in each of the developmental areas since ongoing assessment is a routine part of intervention. Re-assessment to determine the child's level of development at the time of the annual IFSP would only be completed if specifically needed to complete the annual determination of eligibility.

3. **Outcomes of Early Intervention** — In TRAC-IT, current outcomes and short-term goals (those without an actual end date) are pre-populated in the Annual IFSP task. Edit existing outcomes and short-term goals and add new ones, as appropriate.

4. **Services Needed to Achieve Early Intervention Outcomes** — In TRAC-IT, current services (those without an actual end date) are pre-populated in the Annual IFSP task. Edit existing services and add new ones, as appropriate.

5. **Transition Planning** — Use the Update Transition Plan task to add new plans and activities, as appropriate. See the Transition section of Chapter 8 for more information about transition requirements and documentation.

6. **Addendum** — Use the Assign IFSP Services task in TRAC-IT to document the provider for any new entitled IFSP service(s) added at the Annual IFSP. as you did for the initial IFSP.

Chapter 8: IFSP Implementation and Review

As children develop and grow and family priorities and concerns change over time, the IFSP changes to reflect new IFSP outcomes, supports and services. The service coordinator coordinates and monitors the delivery of IFSP supports and services. The IFSP is reviewed at least every 6 months or whenever a team member, including the family, identifies the possible need for a change. A new IFSP is written annually during the child's enrollment in the Infant & Toddler Connection system. Transition planning and support also occur during this phase of the early intervention process.

Service Delivery

General

1. The early intervention supports and services listed on the IFSP must begin in a timely manner, within 30 calendar days of the date the parent (s) signs the IFSP. Early intervention supports and services may begin more than 30 calendar days after the parent(s) signs the IFSP if the IFSP team decides on and documents the reasons for a later start date to meet the individual needs of the child and family. It is also acceptable to plan a later start date due to family scheduling preference.

    a. The 30-day timeline applies to new services (i.e., those listed on the initial IFSP and any new services added at an IFSP review or annual IFSP). The 30-day timeline and the practices listed below also apply to assessments that are needed after the initial assessment for service planning and documented on the *Notice and Consent for Assessment for Service Planning* form rather than the IFSP. Those assessments must be completed within 30 days of the parent's signature on the consent form.

    b. The date of parent signature on the IFSP is day 0 of the 30 calendar days.

    c. The 30-day timeline begins on the date the parent signs the IFSP regardless of the projected start date listed on the IFSP. In addition, ***the timely start of services is not related to the frequency with which the service will be provided*** (e.g., even if the planned frequency of the service is once every two months, that service must begin within 30 days of the date the parent signs

the IFSP, unless the team has agreed to a later start date to meet child and family needs or the family prefers to schedule the first visit after 30 days).

d. A contact note is required to document the date a service begins.

e. The service coordinator's signature on the IFSP is adequate to document that the date of parent signature on the IFSP was the start date for service coordination. Other entitled supports and services would begin on the date the parent signs the IFSP only if the service provider delivers an entitled service on that day that is separate from ***and after*** the IFSP meeting.

f. The 30-day timeline does ***not*** apply to delivery of an assistive technology device. The child's early intervention record must include documentation of the steps taken from the date of the signed IFSP to secure the device as quickly as possible.

g. Early intervention supports and services must be provided only by qualified practitioners. Practitioners, except audiologists, registered dietitians and physicians, who provide early intervention services must be certified by the Department of Behavioral Health and Developmental Services as an Early Intervention Professional, Early Intervention Specialist or Early Intervention Case Manager. See Chapter 12 – Personnel for more information about practitioner qualifications and certification.

2. Families are active participants in each early intervention session. Missed appointments and limited caregiver participation in early intervention sessions are cues that discussion is needed with the family to determine if/why the IFSP outcomes or supports and services are not meeting their needs and/or what barriers exist to keeping scheduled appointments or engaging in sessions. An IFSP review should be conducted to better align supports and services with family priorities and/or daily activities and routines in order that the early intervention system can be involved in their lives in a way that is helpful to them and that facilitates the parent-provider partnership.

3. To establish/maintain rapport and partnership with the family and to determine whether existing supports, services and strategies are working, the service coordinator and other service providers use the following kinds of questions/ideas to begin conversations with families and to guide their listening during visits and other contact with the family:

a. How have things been going?
b. Tell me about how things are going with breakfast, getting your family out of the house in the morning, etc.
c. Tell me about what you and your child did over the weekend.
d. Did you have any appointments for your child? Any coming up?
e. Tell me about any time of day that's not going well for you with your child.
f. In the past week, what time of day has been going well (with or without your child)?
g. Have you been able to implement the strategies you practiced at our last session?
h. Do you have enough activities to do with your child? Too much?
i. How did your child respond to the activities you did with him/her? What worked well? What did not work well?
j. Is there anything else I can help you with?

4. Consider what information may be helpful to leave with the family to support them in implementing the activities practiced during the session. Leaving a copy of the contact note or providing pictures or video of strategies or positions are potential methods for providing this kind of information to families. Joint planning for implementation of strategies during daily routines between visits must be documented in the session contact note.

Service Coordinator Responsibilities

1. Coordinate and monitor the delivery of those IFSP supports and services for which the family has given consent.

2. Explain to families who are receiving early intervention supports and services that they may receive an annual survey from the State requesting their input on the supports and services they are receiving. Explain that family responses to the survey are confidential and help to improve service delivery in the local area and across the state. Encourage the family to complete the survey when they receive it.

3. Ensure that the language or other mode of communication normally used by the child in the home or learning environment is used in all direct contact with the child, when appropriate and if feasible to do so. Instances in which it is not necessary to provide services in the native language include a multilingual home or learning environment, when the family requests that English be used with the child, or when the child's receptive or expressive language has not yet developed to indicate a clear spoken language preference. If it is appropriate to provide the service in the

native language but the service provider is not able to use the native language and the parent is not able to interpret for the child, then:

a. A foreign language interpreter must be present. A professional foreign language interpreter is not required. Another IFSP team member may be able to interpret or there may be an extended family member, neighbor, clergyman, or other family friend who would be willing and able to interpret (if the family agreed). The local Infant & Toddler Connection system may wish to collaborate with the local school system(s) or neighboring early intervention systems in finding foreign language interpreters.

b. When sign language interpreters are needed, these interpreters must meet professional licensure requirements. To locate qualified sign language interpreters, contact the Virginia Department for the Deaf and Hard of Hearing (1-800-552-7917) or access their website, www.vddhh.org, for a directory of qualified interpreters. If a licensed sign language interpreter is not available in the area served by the local system, then document efforts to locate a licensed sign language interpreter and use a family member, family friend or other informal resource to provide the needed interpreting.

4. If the child has Medicaid/FAMIS:

    a. Make at least one direct contact with the family every three (3) calendar months. Such contacts shall be person-centered with the choice of contact method determined by the family (face-to-face, phone, email, or text). The following requirements must be met to offer and use texting as the preferred method of contact:

        i. The service coordinator may only offer texting as an option if she has the capability to receive and send texts.

        ii. Texting may only be used if the family selects texting as their preferred method of contact and signs the *Permission for Texting* form, which notifies the family that there may be some level of risk that the information in the text may be read by a third party. The *Permission for Texting* form must be kept in the child's Early Intervention Record.

        iii. The communication that occurs via texting must constitute service coordination. Sending a text to the family to ask how things are

going and getting a reply of “Fine” is not service coordination. That is true for contacts via email, phone, or in person as well. The job of service coordination does not change based on the preferred method of contact. For that reason, contact notes must substantiate that the communication between the service coordinator and the family is substantive and does constitute actual service coordination.

iv. The service coordinator must either print out and attach a copy of the texts to the contact note or include in the note a thorough summary of the communication.

v. If, at any point, it becomes clear that texting is not a viable method of communication with a particular family, then the service coordinator needs to work with the family to identify a different method of contact.

b. Provide at least one of the allowable activities listed in the “EI TCM Allowable Activities” text box in Chapter 11 with the child, the family, service providers, or other organizations on behalf of the child/family in each month for which EI TCM billing occurs. The contact must be relevant to the child/family needs and IFSP. If the family’s preferred method of contact (face to face, phone, or email or text) for the family contacts that are required every three months changes, document the family’s new preference in a contact note. If the family’s new choice is texting, then obtain family signature on the Permission for Texting form.

c. Request completion of the health status indicator questions by the child’s physician every six months using the combined *Physician Certification Including Health Indicator Questions* letter, the *Health Indicator Questions* letter, or another form or mechanism developed by the local system. The health status indicator questions must be asked as written in the *Health Indicator Questions* letter unless the local system has an alternate mechanism (e.g., request and review of well-child records) that provides the information necessary to answer all the health status indicator questions. For purposes of completing the health indicator questions, “every 6 months” means making the request any time between 5 months and 7 months from the previous request to the physician about the health status indicator questions. Local systems are encouraged to follow-up with physicians to receive this information but are not responsible for ensuring the information

is provided by the physician. While requesting completion of these questions is required only for children with Medicaid/FAMIS, local systems are encouraged to consider requesting this information for all children in order to support routine well-child care and positive health outcomes.

5. Document all contacts made and all activities completed with or on behalf of the child and family in accordance with the requirements specified in Chapter 9.

6. Consider ongoing use of the ASQ-SE or another social-emotional-specific screening tool. This is recommended every 6 months and strongly recommended annually for all children unless the child is receiving IFSP services from a social worker, counselor or psychologist or the child is receiving mental health treatment outside the early intervention system.

    a. Service coordinators and service providers are encouraged to use the *SE Related Factors Guiding Questions* over time and as needed to assist in understanding factors that may impact a child's development and a family's parenting beliefs and practices. Information from the guiding questions will assist the team in identifying other ongoing or one-time screening or assessment tools that may be helpful in supporting the family to help their child develop and learn.

    b. Neither the ASQ-SE nor a social-emotional-specific assessment tool are necessary to access services to support social-emotional development or infant mental health if concerns arise at any point after initial eligibility/initial IFSP. Encouraging ongoing use of the ASQ-SE or another social-emotional screening tool at a designated interval is a fail-safe to make sure no child falls through the cracks; but, if a social-emotional concern arises, there is no requirement to use a social-emotional-specific screening or assessment tool for the IFSP team to add outcomes and/or services to the IFSP immediately.

7. Complete contact notes and enter/upload notes to TRAC-IT in a timely manner, no more than 7 business days from the time of the contact

8. Ensure that no shows (sessions missed by the family without advanced notice) for services listed on the IFSP are handled in accordance with the procedures given in the flow chart that follows. There are four critical points that local system managers and service providers, including service coordinators, must be aware of when dealing with a no-show situation:

a. A no-show situation must be addressed promptly. This protects the child and family in their entitlement to receive supports and services in accordance with the IFSP. It also protects the local system and its available funding;

b. The service coordinator plays a very important role in addressing a no-show situation;

c. All steps in addressing the situation must be thoroughly documented; and

d. A child may only be discharged from the Infant & Toddler Connection system after all the flow chart steps have been taken ***and*** there has been no contact from the family.

While implementation of the four points above is required, the timelines provided in the no-show flow chart may be viewed as guidelines. Any monitoring activities associated with the no-show policy will focus on ensuring that the child and family were discharged only under the circumstances listed in the fourth point above and will not focus on whether the exact timelines in the flow chart were met.

Flow Chart for "No Shows" for Service Visits

Provider Arrives for Scheduled Visit

Service Provider Responsibilities

Service Provider (SP) informs Service Coordinator (SC) of each missed appointment ***within 2 business days*** after the missed appointment (even if SP was able to speak with family within the 2 business days and reschedule appointment)

↓ Meanwhile

1. SPs who do not have standing appointments **do not go back out for visits** until the SC or SP is able to contact family.
2. SPs who do have standing appointments must go out for visits as designated on the IFSP

GIVENS

Documentation of attempts to contact and schedule appointment is critical:

1. SP's notes reflect contact with SC
2. SC's notes reflect specific attempts to contact family & schedule appointment AND contact(s) with SP

AND

Any *communication back from the family* ***re-starts the timelines established within this document.***

Definitions

Contact may include, but is not limited to any of the following:

- Telephone call, Home Visit, Fax, E-Mail, Text, Letter, Visit to Place of Employment, etc.

Then

Service Coordinator Responsibilities

SC makes initial attempt to contact family within ***2 business days of notification by service provider*** (if SP was unable to contact family)**.**

Purpose of Contact

1. Find out reasons for missed appointments
2. Determine need for IFSP review, and
3. Coordinate scheduling next visit for other service providers

↓ Then

SC has ***3 additional business*** days to make an ***additional two attempts*** to contact the family. If 2 attempts are by phone & no voice message is left, the third attempt **MUST** be either by regular US mail or home visit.

↓ Then

If there has been no response from family within ***7 calendar days of the third attempt*** to contact, then on the next business day the SC sends ***a letter*** and ***Parental Prior Notice*** *(certified letter recommended but not required)****.*** *Include* ***Notice of Action*** *if child has Medicaid/FAMIS.*

Content of letter

1. Information letting the family know about missed appointment(s)
2. Attempts to contact
3. Services are still available
4. Can do IFSP review
5. Child will be discharged if no contact

Parental Prior Notice is sent to family with a copy in child's record.

Top Section:

- Check "Other" (Your child will be discharged on {date} unless you contact us)

"Reason" Section:

- **MUST** summarize all attempts to contact family.

If there has been no contact initiated by the family ***within 10 calendar days of sending letter***, SC notifies SP, in writing, that status of the case is closed. If family re-establishes contact after child has been discharged, then the enrollment is re-opened and services resume (see Chapter 3 of Practice Manual).

7. Complete the following steps if a child and family are lost to contact (without a no-show):

    a. Contact the referral source, physician or other contacts to request additional or updated contact information;

    b. If still unable to contact a family after requesting additional contact information or the family repeatedly fails to respond, document the dates of attempted contact in the child's record. Attempts to contact the family may be made by phone, mail, visiting the address provided, and/or other means based on the contact information available. It is recommended that no more than 15 – 20 calendar days pass during this process of attempting to contact the family;

    c. Send a letter to the family notifying them of the attempts to contact them, the services that are still available to them, the opportunity for an IFSP review if an IFSP has been developed, the need for them to contact their service coordinator if they wish to continue receiving services and that, otherwise, their child will be discharged from early intervention. Include with the letter a *Parental Prior Notice* form completed as follows:

        i. In the top section, check "Other" and specify that "Your child will be discharged on {date – 10 calendar days from the date the letter and form are being sent} unless you contact us prior to that date." Allowing 10 calendar days before discharge considers the time it takes for mailing and the 5 days required for prior notice; and

        ii. In the "Reason" section, indicate that you have been unable to contact the family since {date} and summarize all attempts to contact the family.

        If the child is covered by Medicaid/FAMIS, the *Early Intervention Services – Notice of Action* letter also must be included.

    d. If no contact has been made by the family within 10 calendar days of sending the letter, then discharge the child.

    The child may only be discharged from the Infant & Toddler Connection system after all the above steps have been taken ***and*** there has been no contact from the family. If the family re-establishes contact with the local early intervention system after

their child has been discharged, then the enrollment will be re-opened and services resume if an IFSP was in place (see Chapter 3).

8. Offer to hold an IFSP review if a family indicates they wish to decline all services after having started services. Explain to the family that the purpose of the IFSP review meeting would be to:

    a. Discuss the IFSP outcomes, supports and services and whether the family would like changes in the current supports and services instead of ending all services; and/or

    b. Determine child progress on the three child outcomes if the child has been receiving services for at least 6 months. If the family wants to end services immediately, ongoing assessment and progress information that has been gathered and documented through service delivery and previous IFSPs and IFSP reviews may be sufficient for to use in determining the child's exit status on the child outcomes. If, in this situation, existing information is insufficient, then that fact must be documented in a contact note. See the "Discharge and Determination of Child Progress at Exit" section later in this chapter for additional information on determining child outcome ratings at exit.

9. Follow-up on any child who no longer has Medicaid/FAMIS coverage by checking with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements.

    a. If the family is in the process of re-applying, then the service coordinator should:

        i. Connect with the local Department of Social Services office so the child's eligibility worker can assist the family with completion of the steps necessary to restore the benefit;

        ii. Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and

        iii. Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.

b. If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form with the family, and the Medicaid insurance record in TRAC-IT must be ended. A new insurance record must be created if the child is now uninsured. If Medicaid/FAMIS coverage is later restored, a new insurance record must be created in TRAC-IT with the 12-digit number re-entered and the uninsured record must be ended.

Responsibilities of Other Early Intervention Service Providers

1. Schedule the initial service session within 30 days of the date the family signs the IFSP and assessments within 30 days of the date the family signs the *Notice and Consent for Assessment for Service Planning* (if that form is used instead of the IFSP) unless the team has planned a later start date to meet child and family needs. Document in contact notes all attempts to schedule and deliver services, being especially careful to specify all circumstances resulting in a delay in holding the first visit with the child and family.

2. For children covered by Medicaid, follow-up with the service coordinator to ensure certification of the IFSP by the child's physician, physician assistant or nurse practitioner is obtained by the 30th day from the first visit. Providers are responsible for contacting the local system manager to work out alternate payment arrangements in those rare instances when physician certification is not obtained in a timely manner despite collaboration between the provider, service coordinator and local system manager and multiple, ongoing efforts to obtain the certification. This discussion of alternate payment options must begin prior to the end of the 30-day period following the first service. Providers are responsible for paying back any Medicaid or FAMIS reimbursement retracted because the IFSP was not certified.

3. Deliver services in accordance with the IFSP. If the frequency, length, intensity or location of a service provided differs from what is listed on the signed IFSP due to a specific circumstance, then the purpose for that difference must be clearly documented in the contact note. When a provider cancels a visit, that visit must be rescheduled as soon as possible to ensure that the service is delivered at the frequency and length listed on the IFSP.

    a. It is not necessary to make up sessions missed because the family cancels.

b. Sessions cancelled by the provider (including those cancelled due to severe weather) and sessions that fall on holidays must be made up, unless the family states that they do not wish to make up the missed session (contact notes must document the offer to reschedule and the fact that the family declined this offer).

c. If the provider is unable to make up the session her/himself, every attempt should be made to schedule a make-up session with a therapist from the same agency, so the service is still authorized and provided by a practitioner within the child/family's insurance network. If there is not a provider in that agency, the substitute provider should be selected from among those participating in the child/family's insurance network if possible; and, if necessary, pre-authorization must be obtained.

d. Missed sessions may be made up by scheduling a new, full session or by adding time to other sessions (e.g., if a 45-minute session is missed, a new 45-minute session may be added, or 15 minutes could be added to each of the next 3 sessions). The determination of how best to make up the time missed in a previous or upcoming session must be based on what is best for and meets the needs of the child and family. Time can be made up ahead of a missed session only when there is a known reason (e.g., vacation, surgery) for the provider to miss a specific upcoming session and not in anticipation of possible missed sessions (e.g., scheduling extra sessions in November and December to make up for possible snow days in January and February).

e. Contact notes must document efforts to reschedule missed sessions and must clearly document when a session is a make-up from a missed visit or when it is extended to make up for a missed visit.

An IFSP Review must occur whenever an ongoing change to the frequency, length, intensity or location of services specified in the IFSP is being considered.

4. Conduct ongoing functional assessment as part of service delivery. Service providers observe the child's functioning and skills across all developmental domains and in relation to the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) as a routine part of service delivery. When needed, the service provider may use an assessment tool as a reference point especially for areas of development outside his/her area of expertise. This still occurs as a part of the provider's interactions with the child during service delivery and is not a separate activity.

Ongoing assessment gives the provider information not only on the child's progress on the IFSP outcomes and short-term goals being addressed by the current activities but also helps the provider identify any emerging concerns in other areas of development.

5. Encourage the family to observe and assess the child's skills, behaviors, and interests as a partner in ongoing functional assessment.

6. Work as a team member to support the child and family in achieving the IFSP outcomes. Team members consult and team with each other and with the family to ensure that services are coordinated and consistent with one another and support functional development of the whole child. This is true whether multiple providers are visiting the family or there is a primary provider. If the IFSP team determines that one primary provider will work with the family, then other team members support the primary provider and the child and family by providing consultation to the primary provider, participating in joint visits with the primary provider to the child and family, and/or suggesting strategies and techniques to enhance progress toward IFSP outcomes.

7. Schedule visits during the family's everyday routines and activities.

8. Use items already present in the child's environment when providing early intervention supports and services. This assists the family/caregiver to identify what they have in their own environment that can be used during daily routines and activities to accomplish the IFSP outcomes.

9. Focus interaction with the child and family on expanding the family's confidence and competence to help the child learn and develop during everyday activities by:

    a. Modeling strategies during the routine for the family;

    b. Coaching the family as they try out the strategies for themselves. Coaching is critical since it is through the process of practicing the strategy themselves and receiving feedback from the provider that families become confident and competent with implementing the strategies; and

    c. Checking with the family before the visit ends to ensure the family understands the strategies and can implement them during their routines.

10. Continually consider what support the family or other caregiver needs to implement strategies within their child's and family's daily routines and activities.

11. Monitor on an ongoing basis, in partnership with the family, the effectiveness of strategies used and the appropriateness of service frequency and length. These issues should be considered at every intervention session.

12. Contact the service coordinator to request an IFSP review when there is a need to discuss potential changes to IFSP outcomes or services or if the child may now be at age level and demonstrating typical development. Specific recommendations to the family about potential changes to IFSP outcomes and/or services should be discussed during the IFSP review.

13. Contact the service coordinator when there are missed appointments or when limited caregiver participation in early intervention sessions suggests the need for discussion to determine if/why the IFSP outcomes or supports and services are not meeting their needs and/or what barriers exist to keeping scheduled appointments or becoming involved in sessions.

14. Routinely (at least once a month) confirm with families whether their insurance has changed. Notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage. For children with Medicaid/FAMIS, the following specific procedures apply. The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid/FAMIS eligibility prior to every visit, changes in Medicaid/FAMIS eligibility tend to occur at the beginning or end of the month. The provider must:

    a. Contact the Infant & Toddler Connection of Virginia Office if the Medicaid EI benefit is not added within a week; and

    b. Retain documentation of all contacts with the Local System Manager and with the Infant & Toddler Connection of Virginia Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

Options for verifying a child's Medicaid/FAMIS coverage are discussed in the "Family Cost Share Practices" section of Chapter 11 (see the text box titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification").

15. Document all contacts made and all activities completed with or on behalf of the child and family in accordance with the requirements specified in Chapter 9.

16. Complete contact notes and enter/upload notes to TRAC-IT in a timely manner, no more than 7 business days from the time of the contact.

IFSP Reviews

General

1. The purpose of the periodic IFSP review is to determine the degree to which progress toward achieving the IFSP outcomes is being made and whether modification or revision of the IFSP outcomes or supports and services, including frequency and length, is necessary.

2. An IFSP Review must occur whenever a change to the IFSP outcomes, short-term goals or service provision (frequency, length, intensity - group/individual, method, natural environments/location) specified in the IFSP is being considered. More information about when an IFSP review is required is available in the IFSP Instructions at the end of Chapter 7 (see instructions for completing the IFSP Review Record).

3. If a follow-up (discipline-specific) or annual assessment is needed, the need for that assessment may be documented on the IFSP by holding an IFSP Review and adding the assessment(s) as a service ***or*** the *Notice and Consent for Assessment for Service Planning* form may be used.

    a. If the consent form is used, a new form must be completed each time an assessment is needed (i.e., a consent form is needed for the initial assessment for service planning and a new consent form must be filled out if a follow-up or annual assessment is needed – multiple boxes cannot be checked on the same consent form). Generally, only the consent for child assessment will be needed when using the form for follow-up or annual assessment since family assessment information is gathered through ongoing contact with the family.

b. Parents must be offered a choice of provider for assessments that occur after the initial assessment for service planning. Parent choice is documented on the Addendum page if the IFSP is used. On the consent form, the choice of provider is documented in the parent consent section (if the parent states that he and she has no preference or wishes to have the first available provider, then that may be noted on the line).

c. Physician certification is not needed for assessments to receive Medicaid reimbursement for that assessment.

d. Follow-up and annual assessments must be completed within 30 days of the date the parent signs the IFSP or the consent form unless the IFSP team planned a later start date or there is a family reason for the delay.

4. If the family or another IFSP team member(s) believes the child has reached age level in all areas of development and shows no sign of atypical development, then an IFSP review is held to determine the child's eligibility status. Remember, records may not be used to establish that a child is ineligible for early intervention. Therefore, when the reason for determining the child's eligibility status is because one or more team members believe the child is no longer eligible, the service coordinator and one or more individuals representing 2 disciplines must participate in the eligibility determination process.

    a. Ongoing assessment should document the child's functional status across settings and situations before a provider considers that the child's development is typical and at age level compared to same-age peers.

    b. If at any time ***the family*** feels their child is demonstrating age-appropriate skills and is no longer in need of services, the service coordinator must offer to coordinate an eligibility determination to confirm the child's status. If the family accepts the offer to complete eligibility determination, the service coordinator provides the family with a copy of the completed *Eligibility Determination Form* at no cost to the family. However, if the family declines this offer, then the service coordinator must document both the offer and the family's decision in a contact note and the eligibility determination is not held. When reporting in TRAC-IT the reason for discharge in this scenario:

i. Use “Completion of IFSP prior to reaching age 3” if the rest of the team agrees that the child no longer has a 25% delay or atypical development and the child does not have a diagnosed condition

ii. Use “Parent withdrew” if the child is eligible based on a diagnosed condition or the rest of the team believes, based on ongoing assessment, that the child continues to be eligible because of a developmental delay or atypical development.

c. The information gathered for determining eligibility may also assist the team in completing the exit ratings on the three child outcomes for those children found to be no longer eligible and who have been in the Infant & Toddler Connection of Virginia system for at least 6 months since their initial IFSP. See the “Discharge and Determination of Child Progress at Exit” section of this chapter for additional information on exit assessment.

d. It is only necessary to determine the child’s eligibility prior to discharge if ***the local system*** is proposing to end services prior to the child’s third birthday. Eligibility determination is not necessary prior to discharge if the child is leaving the local system for any of the following reasons: the child is turning three, the child is transitioning to Part B, the family is moving out of the area served by the local system, the child and family are lost to contact, or the parent declines continued services.

5. Families and other IFSP team members can request an IFSP review at any time by contacting the service coordinator.

6. The IFSP review may be carried out by a meeting or by another means that is acceptable to the parents and other participants if all IFSP team members have the opportunity to provide input about all contents of the IFSP.

7. Any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs.

A Question About Adding New Services

Question: Prior to adding a new service is it necessary to have an assessment completed by that discipline (e.g., if the team wants to add occupational therapy, is an OT assessment required before adding that service)?

Answer: Neither the Infant & Toddler Connection of Virginia Office nor DMAS requires an assessment when services by new disciplines are added to the child's IFSP. However, providers must be aware of their discipline's licensure requirements. For example, physical therapists must evaluate (assess, in Part C terms) a client prior to providing services. When a new service is added to the IFSP, the provider will need to use his/her discipline-specific expertise to determine what strategies are needed to address the IFSP outcomes determined by the team. This type of assessment will occur during the first session(s) with the child and family. This session(s) should be documented in a contact note, just as ongoing assessments are documented. The provider may or may not determine that additional IFSP outcomes or short-term goals are needed (in which case an IFSP review will be needed).

Service Coordinator Responsibilities

1. Facilitate the periodic review of the IFSP at least every six months or more frequently if conditions warrant or the family requests a review.

    a. If a review is conducted before 6 months, then the 6-month review timeline may be re-started at that point. For example, if the initial IFSP is developed on 6/30/09 and an IFSP review is conducted on 10/15/09 because the family requests consideration of a change in service frequency, then the next IFSP review must be conducted by 4/15/10. Local systems are not required to use a moving 6-month review date as illustrated in the example. It is acceptable to keep the 6-month review date fixed at 6 months from the date of the initial IFSP regardless of whether interim reviews are held.

    b. The due date for the annual IFSP does not change regardless of when IFSP reviews are held. The annual IFSP must be held within 365 days of the date of the initial or previous annual IFSP.

2. Ensure the family receives a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to revise or review the IFSP is needed"),

Confirmation of the Individualized Family Service Plan (IFSP) Schedule form and *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Review the purpose of the IFSP review, the family's role in the review process, the safeguards applicable to this step in the early intervention process, and the family's rights and choices related to use of private insurance if services increase because of the IFSP review. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

3. Assist the family in preparing for the IFSP review. Share any written information from providers about the child's progress with the family prior to the IFSP review, if available. Encourage families to make notes of their input and questions prior to the IFSP review. The level of support that each family will want and need in preparing for the IFSP review will vary and should be individualized for each family.

4. Work with the family to identify the composition of the IFSP review team, which must include:

    a. The parent (s) of the child;
    b. Other family members, as requested by the parent, if feasible;
    c. An advocate or person outside the family if requested by the parent;
    d. The service coordinator who has been working with the family; and
    e. A person or persons involved in ongoing or new assessments and individuals who are providing supports and services to the child and family participate if conditions warrant.

5. Work with the family and other participants to determine a process for reviewing and revising the IFSP that is acceptable to all parties and allows for all participants to provide input. A face-to-face meeting is not required for an IFSP review. The method used to conduct the IFSP review should ensure the following:

    a. The family has the information and support they need to make informed decisions for their child and family;
    b. The family's current priorities and concerns are reviewed; and
    c. All participants have a current and complete picture of the degree to which progress toward meeting the IFSP outcomes is being made.

6. Ensure that the meeting is conducted in the family's native language or other mode of communication unless clearly not feasible to do so.

7. Complete the appropriate sections of the statewide IFSP form (see IFSP instructions at the end of Chapter 7).

8. Ensure the family's signature is obtained on the IFSP Review Record to document their consent for the changes, if any. Even if there are no changes, the family still signs the IFSP Review Record. If new services are being added at the IFSP review, the family must be offered the opportunity to select a service provider and must sign the addendum page indicating they were given this opportunity.

9. If services are increasing as a result of the IFSP review, the child is covered by private insurance and the parent has consented to use of their private insurance to pay for early intervention services up until now, ensure the family completes and signs the box on the IFSP Review page that documents whether they consent or decline to continue using their private insurance to pay for covered early intervention services. Services are increasing if there is an increase in frequency, length or duration, or if the intensity has changed from group to individual.

    a. Prior to an IFSP review, review the family's current *Family Cost Share Agreement* terms to know whether the family is currently using their private insurance to pay for their child's early intervention services and to be prepared to answer questions the family may have about continuing to use their private insurance if services increase because of the IFSP review. It may be helpful to have a copy of the family's current *Agreement* form at the meeting in case the family wishes to review the current terms of their Agreement prior to deciding about continued consent. If, at the IFSP Review, the family provides consent to continue services/begin new services but wants more time to consider whether to continue using their private insurance to pay for early intervention services, then services may be provided but the family's private insurance may not be billed until the family provides consent for continued use of that private insurance. Discussing this issue with families ahead of the IFSP Review meeting (especially if the purpose of the meeting is to discuss potentially increasing services) and taking the steps identified here will improve the chances that the family is prepared to decide at the IFSP Review about consent for continued use of their private insurance.

b. If the family is currently using their private insurance to pay for early intervention services, be prepared to update the Family Cost Share Agreement form in TRAC-IT (or bring a blank *Family Cost Share Agreement* form to the IFSP Review if a meeting will be held and a paper form will be completed) in case the family declines to continue using their insurance and a new agreement form is needed.

10. Retain a signed copy of the IFSP Review Record and provide a copy to the family (at no cost to the family) and to all service providers who participated in assessment or the IFSP review or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP Review Record gives consent for the IFSP to be shared with these providers.

11. If a new service is being added or the frequency of an existing service is changing (increasing or decreasing), obtain physician (or physician assistant or nurse practitioner) signature to document medical necessity for services the child will receive that can be reimbursed under public (e.g., Medicaid/FAMIS, TRICARE) or private insurance. The physician's signature may be obtained on one of the following:

    a. The IFSP; or
    b. A separate letter referencing the IFSP that is sent along with the IFSP, like the *Physician Certification Letter*; or
    c. The *IFSP Review Summary Letter*.

    This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Physician certification is not needed if there is no third-party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed to receive Medicaid reimbursement for assessments. Please see the text box in the "Completing the IFSP Form" section of Chapter 7 for specific requirements associated with the physician signature.

12. Ensure that if the rest of the IFSP team believes the child needs a particular service, but the family does not agree and does not wish to receive that service, then the following steps occur:

    a. That service does not need to be listed on the IFSP since the full team, including the family, has not agreed on that service.

b. Capture the rest of the team's recommendation and the family's decision not to receive that service in a service coordination contact note.

c. Optional additional step: Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service (s) the family is declining. Both the service coordinator and family must sign and date the form. Upload the completed form to TRAC-IT as a document.

d. Explain that the services that are not declined will be provided at the frequency, length and duration listed on the IFSP.

e. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

f. Explain how the family may, later, through the IFSP review process, accept a service previously declined.

13. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:

    a. Indicate in the IFSP Review task in TRAC-IT that the family is declining EI services and mark the third checkbox (eligible but declining services) and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

        i. Optional additional step: Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system). Upload the completed form to TRAC-IT as a document.

ii. Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

iii. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

b. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.

c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

d. Communicate the child's exit from early intervention services to the primary care physician and primary referral source (if appropriate), with parent consent.

e. Enter the date of closure in TRAC-IT within 10 business days of the family declining all services and indicate that the parent withdrew.

14. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, length, intensity (individual or group), location or method of delivering services that the rest of the team does not agree is necessary to meet the needs of the child or family, then the following steps occur:

    a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based

practice, etc.). Parent signature is obtained to acknowledge receipt of the form.

b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

c. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* (available as an ad hoc task in TRAC-IT) letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP or if the local system is proposing to decrease or end a service. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.

15. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

Responsibilities of Other Early Intervention Service Providers

1. Provide information to the family and other team members on the child's current functioning and progress in the three child outcome areas based on ongoing assessment.

2. Participate in the IFSP review through the methods determined by the team, which may include a face-to-face meeting or sharing information by phone or in writing.

3. Consider the family's current priorities and concerns when making recommendations or participating in team decisions about changes to IFSP outcomes and/or supports and services.

4. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

Annual IFSP

Service Coordinator Responsibilities

1. Conduct, in person, an annual IFSP meeting within 365 days of the date of the initial or previous annual IFSP meeting to review the child's progress and to write a new IFSP if the child continues to be eligible. If a child moves from one local early intervention system within Virginia to another, the child's annual IFSP date is based on the child's initial IFSP date (or previous annual IFSP date) regardless of the child's location for the previous IFSP (e.g., if child had an initial IFSP developed on 10/12/08 in one local system, then moved to a new local system on 4/1/09, then the annual IFSP still must be developed by 10/12/09).

2. Ensure the family receives a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to develop the annual IFSP and confirm eligibility is needed"), *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, and *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

3. Notify other team members in writing of the date, time and location of the annual IFSP meeting. Other team members may be notified using the same form used to notify the family, the *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, or through other written means (e.g., email). Documentation must be maintained in the child's early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.

4. Explain that the annual IFSP meeting will include a confirmation of ongoing eligibility and that if the child no longer meets the Infant & Toddler Connection of Virginia eligibility criteria then he/she will be discharged.

    a. Use of the Virginia Part C Vision and Hearing Screening tools are not required for the annual confirmation of eligibility. Providers should be alert to any signs that the child may be having trouble with hearing or vision, as such issues can arise at any age. In such cases, administration of the Hearing or Vision Screening tool would be appropriate.

    b. The confirmation of ongoing eligibility may occur prior to or during the annual IFSP meeting.

    c. The process for determination of ongoing eligibility varies, as follows:

        i. If the child was initially found eligible based on a diagnosed condition, then the service coordinator will complete the Eligibility Determination form indicating that eligibility was established by records.

        ii. If contact notes are enough to establish the child's ongoing eligibility, then one individual who is certified as an Early Intervention Professional may review those notes and complete the Eligibility Determination form indicating that eligibility was established by records. The individual determining eligibility based on the contact notes may be the same individual who wrote the contact notes if that person is an Early Intervention Professional.

        iii. If neither of the above conditions is met, then the determination of ongoing eligibility is made by 2 disciplines (either 2 individuals from different disciplines or one individual qualified in 2 different disciplines) and is based on the progress reports (written or verbal) of team members and/or additional information. Therefore, if, for example, the child is receiving only service coordination and occupational therapy or the child is only receiving service coordination, then it will be necessary to pull in a second discipline to participate with the occupational therapist and the service coordinator or to pull in 2 disciplines to participate with the service coordinator in the determination of ongoing eligibility. If a child is receiving only service coordination, then the same types of

information that are gathered for initial eligibility determination would be gathered for this annual confirmation of eligibility (e.g., current results from a developmental screening tool, observation, parent report, current information from the physician, etc.). The service coordinator, if properly trained, can use the developmental screening tool, conduct observation, and gather information from the parent. The determination of ongoing eligibility considers all areas of development and is documented in the Start Eligibility Determination ad-hoc task in TRAC-IT (see the "Determining Eligibility" section of Chapter 5 for instructions.

iv. The service coordinator provides the family with a copy of the completed *Eligibility Determination Form* at no cost to the family.

d. If, at the time of the annual IFSP, the family feels their child is demonstrating age-appropriate skills and is no longer in need of services and the family does not want to have an eligibility determination to confirm the child's status, then the service coordinator must document both the offer and the family's decision in a contact note. When reporting in TRAC-IT the reason for discharge in this scenario:

i. Use "Completion of IFSP prior to reaching age 3" if the rest of the team agrees that the child no longer has a 25% delay or atypical development and does not have a diagnosed condition; or

ii. Use "Parent withdrew" if the child is eligible based on a diagnosed condition or the rest of the team believes, based on ongoing assessment, that the child continues to be eligible because of a developmental delay or atypical development.

Annual Eligibility Determination Scenarios

- **A child is receiving service coordination only and was initially found eligible based on a diagnosed disabling condition.**
  The service coordinator will complete the *Eligibility Determination Form* (using the Start Eligibility Determination ad-hoc task in TRAC-IT), indicating that eligibility is established by records.

- **A child is receiving service coordination only and it is unknown whether the child continues to meet eligibility criteria based on developmental delay or atypical development.**
  The service coordinator (if trained) or another provider will complete a developmental screening tool. The service coordinator will then compile up-to-date health and developmental information (including results from the screening tool, parent report, and information from observation) for the multidisciplinary eligibility determination team to review. As with the initial determination of eligibility, if the available health and developmental information is insufficient to confirm the child's eligibility, then the team may request targeted assessment to gather the additional information needed.

- **A child is receiving service coordination and occupational therapy, but continued eligibility is unknown due to child progress.**
  The OT and one other discipline review existing information based on ongoing assessment (progress reports, contact notes) and determine the child's eligibility. In the rare situation when the team needs more information, targeted assessment is done to gather the additional information needed to determine continued eligibility.

- **A child is receiving service coordination and developmental services, and his continued eligibility can be determined using progress notes and informal assessment by the current service provider.**
  The educator, who is providing the developmental services, will review existing information based on ongoing assessment (progress reports, contact notes) and complete and sign the *Eligibility Determination Form* (using the Start Eligibility Determination ad-hoc task in TRAC-IT), indicating that eligibility is established by records. In this scenario, it is not necessary to involve a second discipline to confirm ongoing eligibility.

- **A child will be turning 3 within 6 months and an exit assessment (formal or informal) by an Early Intervention Professional is needed to determine the child's progress on the three child outcomes.**
  The information gathered for the exit assessment can also be used to confirm the child's continued eligibility. It would make sense for the provider that is completing a tool (based on ongoing assessment) for the exit assessment to participate in the eligibility determination along with one other discipline. Or, if there is enough information in the contact notes to establish eligibility then that provider can complete and sign the *Eligibility Determination Form* (using the Start Eligibility Determination ad-hoc task in TRAC-IT), indicating that eligibility was established by records, without involving a second discipline.

5. **If the child is ineligible:**

    a. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating "Your child is not eligible for Infant & Toddler Connection of Virginia") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the Notice of Child and Family Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

    b. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is no longer eligible for early intervention services. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

    c. Provide the family with a copy of the completed *Eligibility Determination Form*.

    d. Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family.

    e. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

6. **If the child continues to be eligible, proceed with the steps below**.

    a. Assist the family in planning and preparing for the annual IFSP meeting. Encourage families to make notes of their input and questions in each section of their current IFSP or a blank IFSP form and to bring that to the IFSP meeting as a reminder for the family during the meeting. The level of support

that each family will want and need in preparing for the annual IFSP meeting will vary and should be individualized for each family.

b. Work with the family to identify the composition of the multidisciplinary IFSP team, which must include the parent, the service coordinator and at least one more individual from another discipline. More specifically, required team members include the following:

    i. The parent(s) of the child;
    ii. Other family members, as requested by the parent, if feasible;
    iii. An advocate or person outside the family if requested by the parent;
    iv. The service coordinator who has been working with the family;
    v. A person or persons involved in ongoing or new assessments; and
    vi. As appropriate, individuals who are providing supports and services to the child and family.

c. Arrange IFSP meetings in the setting and language that facilitate a family's ability to participate.

d. Notify all participants in writing of the date, time and location for the IFSP meeting:

    i. Parents must be notified using the *Confirmation of Individualized Family Service Plan (IFSP) Schedule* form.
    ii. Other team members may be notified using that same form or through other written means (e.g., email).
    iii. Documentation must be maintained in the child's early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.

e. Ensure that IFSP team members who are not able to meet at times convenient for the family are given other options for IFSP participation, such as telephone consultations or providing written information.

f. Review the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* and obtain their signature on a new *Family Cost Share Agreement* form. Please see the "Family Cost Share Practices" section of Chapter 11 for steps to take if the family does not sign the new agreement form promptly.

g. Facilitate the summary of the child's functional status in terms of the three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) and determination and documentation of child outcome ratings and progress using the procedures described in the Discharge section of this chapter.

    i. Generally, there will be enough information from ongoing assessment to complete the summary of the child's functional status on the three child outcomes and unique strengths and needs when the annual IFSP is developed. Re-assessment at the time of the annual IFSP would only be necessary in a few circumstances, like if the child is receiving service coordination only, if there had not been an opportunity for ongoing assessment for an extended period, or maybe if there had been a major event (like surgery) that had recently had a significant impact on the child's development. When a re-assessment (annual assessment) is needed, the assessment must be conducted by a multidisciplinary team.

    ii. If an annual assessment is needed, the need and parent consent for that assessment may be documented on the IFSP by holding an IFSP Review and adding the assessment(s) as a service ***or*** the *Notice and Consent for Assessment for Service Planning* form may be used.

        (1) If the consent form is used, a new form must be completed each time an assessment is needed (i.e., a consent form is needed for the initial assessment for service planning and a new consent form must be filled out for the annual assessment - multiple boxes cannot be checked on the same consent form). Generally, only the consent for child assessment will be needed when using the form for annual assessment since family assessment information is gathered through ongoing contact with the family.

        (2) Parents must be offered a choice of provider for assessments that occur after the initial assessment for service planning. Parent choice is documented on the Addendum page if the IFSP is used. On the consent form, the choice of provider is documented in the parent consent section (if the parent states

that he or she has no preference or wishes to have the first available provider, then that may be noted on the line).

(3) Physician certification is not needed for assessments to receive Medicaid reimbursement for that assessment.

(4) Annual assessments must be completed within 30 days of the date the parent signs the IFSP or the consent form unless the IFSP team planned a later start date or there is a family reason for the delay.

Annual IFSP – Assessment Scenarios

- **Service coordination is the only service listed on the IFSP. The service coordinator also is qualified as an EI Certified Professional.**
  There will need to be two disciplines (other than service coordination) involved in the assessment for service planning. It makes sense that the individual who has been providing service coordination and is also qualified as an EI Professional will be one of the disciplines. Remember that developmental information provided by a physician or a provider who is from a discipline listed in Table A at the end of Chapter 12 of the Practice Manual but who practices outside the local Part C system can be used to meet the requirement for the other discipline if the physician or outside provider supplies information that can be used for service planning. Also, note that information gathered by a qualified provider as part of the eligibility determination (such as completion of a screening tool and observation performed by the service coordinator who is also qualified as an EI Professional) can be used to meet the requirement for one of the disciplines for the assessment for service planning.

- **Child has been receiving OT and service coordination. Based on ongoing assessment, the OT can provide information on the child's functional status in all areas except language development.**
  A second discipline will need to complete an assessment to provide information on language development since this information will be needed to complete the assessment summary on the annual IFSP and to identify IFSP outcomes, supports and services.

h. Ensure the annual IFSP is developed in or uploaded to TRAC-IT in accordance with the instructions detailed at the end of Chapter 7 and in the TRAC-IT User Manual.

i. Ensure the family's signature is obtained on the IFSP to document their consent for the services.

j. Retain a signed copy of the IFSP and provide copies to the family (at no cost to the family) and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.

k. Send a copy of the IFSP to the child's primary care physician, with parent consent. Consent to send a copy of the IFSP to the physician is not covered by the consent statement on the IFSP and requires a separate release of information form.

l. Obtain physician (or physician assistant or nurse practitioner) signature to document medical necessity for services if the child will receive services that can be reimbursed under public (e.g., Medicaid/FAMIS or TRICARE) or private insurance. The physician's signature may be obtained on one of the following:

    i. The IFSP; or
    ii. A separate letter referencing the IFSP that is sent along with the IFSP, like the *Physician Certification Letter*; or
    iii. The *IFSP Summary Letter*.

    This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Physician certification is not needed if there is no third-party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed to receive Medicaid reimbursement for assessments. Please see the text box in the "Completing the IFSP Form" section of Chapter 7 for specific requirements associated with the physician signature.

m. Ensure that if the rest of the IFSP team believes the child needs a particular service, but the family does not agree and does not wish to receive that services, then the following steps occur:

    i. That service does not need to be listed on the IFSP since the full team, including the family, has not agreed on that service.

ii. Capture the rest of the team's recommendation and the family's decision not to receive that service in a service coordination contact note.

iii. Optional additional step: Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service (s) the family is declining. Both the service coordinator and family must sign and date the form. Upload the completed form to TRAC-IT as a document.

iv. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

v. Explain how the family may, later, through the IFSP review process, accept a service previously declined.

n. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:

i. Indicate in the Annual IFSP task in TRAC-IT that the family is declining EI services and then mark the third checkbox (eligible but declining services) and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

(1) Optional additional step: Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do

not choose to have their child receive services through the Infant & Toddler Connection system).

(2) Explain to the family how they can contact the local Infant & Toddler Connection system in the future if they have concerns about their child's development.

(3) In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

ii. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.

iii. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

iv. Communicate the child's exit from early intervention services to the primary care physician and primary referral source (if appropriate), with parent consent.

v. Enter the date of closure in TRAC-IT within 10 business days of the family declining all services and indicate that the parent withdrew.

o. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, length, intensity (individual or group), location or method of delivering services that the rest of the team does not agree is appropriate to meet the needs of the child or family, then the following steps occur:

i. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). Parent signature is obtained to acknowledge receipt of the form.

ii. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

iii. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP or if the local system is proposing to decrease or end a service. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.

p. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

Responsibilities of Other Early Intervention Service Providers

1. Provide information to the family and other team members on the child's progress based on ongoing assessment for use in determining the child's ongoing eligibility and, if the child remains eligible, for use in completing Team Assessment and Age and Developmental Levels sections of the IFSP, including the child's functional status in the three child outcome areas and the child outcome summary statement.

2. Participate in the annual IFSP meeting. This applies to service providers who were part of new or ongoing assessment and, as appropriate, providers who are providing supports and services to the child and family. Service providers who are not able to participate in the meeting in person may participate through other options, such as telephone consultations or providing written information.

3. Consider the family's current priorities, resources and concerns when making recommendations or participating in team decisions about IFSP outcomes and/or supports and services. Additional considerations are detailed in Chapter 7 under "Responsibilities of Other Early Intervention Service Providers."

4. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

Transition

Service Coordinator Responsibilities

1. Ensure that each child and family are offered individualized transition supports and services, keeping in mind the following:

    a. Children in Virginia are age eligible for Part B services at the start of the school year in which the child is 2 by September 30.

    b. Children in early intervention are considered "potentially eligible" for Part B unless there is a clear expectation that they will no longer require services by the time they reach age 3. The determination of whether a particular child in early intervention is potentially eligible for Part B is made by that toddler's IFSP team as part of the transition process.

2. At least 90 days and up to 9 months before the child becomes age eligible for Part B services at age 2, determine with the IFSP team whether the child is potentially eligible for Part B services.

    a. If the child is not potentially eligible, then re-visit the transition discussion as the child approaches his or her third birthday (see #3 below).

    b. If the child is potentially eligible, then ask the family if they are interested in considering transition to preschool special education services through the local school division at age 2.

        i. If the family is not interested, then re-visit the transition discussion as the child approaches his or her third birthday (see #3 below).

        ii. If the family is interested, proceed with the transition activities outlined below in #5 below.

3. For those children who did not transition at age 2, at least 90 days and up to 9 months before the child turns 3 years old, determine with the IFSP team whether the child is potentially eligible for Part B services.

    a. If the child is not potentially eligible, proceed with the transition activities outlined below in #4 below.

    b. If the child is potentially eligible, proceed with the transition activities outlined below in #5 below.

4. **For children who are not potentially eligible for Part B, complete the following**:

    a. Ensure development of the transition plan in the IFSP to identify the steps for the child and family to exit from the early intervention system and any transition services that the IFSP team determines are needed by the child and family.

        i. **Timeline** — The transition plan must be developed at least 90 days and, at the discretion of all parties, up to 9 months before the child's anticipated date of transition. Service coordinators are encouraged to hold the meeting to develop the transition plan well in advance of transition, closer to the 9 months than the 90 days. This allows the family time to consider their options and plan for any

steps necessary to ensure any needed services are in place for a smooth transition at age 3.

ii. **Procedural Safeguards** — Provide a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to develop a transition plan is necessary.") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

iii. **Meeting** — The meeting to develop the transition plan must meet the requirements of an IFSP meeting and may be combined with the transition conference described in #4b below. If the transition plan is not developed in conjunction with the initial or an annual IFSP, then an IFSP review must be held to develop the transition plan (both the IFSP Review and Transition tasks must be completed in TRAC-IT). Once the transition plan has been developed, an IFSP review is ***not*** needed to make changes. The family and service coordinator may update or make changes to the transition plan and then share the updated information with other team members at the time of the next IFSP review or annual IFSP.

iv. **Documentation** — The transition plan is documented in the Transition Planning section of the IFSP using the transition plan task in TRAC-IT. The transition steps and activities that will be completed for an individual child and family will depend on that family's specific transition plans and preferences. The steps and activities may be completed in whatever order is most appropriate for each child and family.

(1) If the child will receive no further services upon leaving early intervention, then non-applicable activities (e.g., sending child-specific information to the next setting) should be marked "N/A." If the family chooses not to complete an

activity (e.g., Arrange visits to programs as desired by the family), then note that in the blank.

(2) *Community Options* – This step may be applicable for any child and family and includes documentation of any transition conference held for children who are not potentially eligible for Part B. Please see #4b below for more information about this type of transition conference.

(3) *Notification and Referral* – This step does not apply to children who are not potentially eligible for Part B. Leave it blank.

(4) *Support to Enroll in Other Programs* – This step is applicable to any child whose parents are interested in enrolling their child in a community program other than the local school system. Complete the information in Steps a – c as appropriate.

(5) *Transition Planning Conference* - This step does not apply to children who are not potentially eligible for Part B. Leave it blank.

(6) *Transition Services* – This step may be applicable to any child and family and should reflect what the local Infant & Toddler Connection system will do to assist the child and family prepare for the transition. This may include steps to help the child become more familiar with the new program/setting and/or learn new skills needed to adjust to the new program/setting (e.g., working on specific IFSP outcomes that will help the child adjust to the new setting like climbing stairs, communicating wants and needs, or social skills). For a child who spends most of his/her time at home, the IFSP team may need to consider expanding the location of services to assist the child in adjusting to a group setting, riding the bus, etc. This may also include steps to assist the family in determining and completing other activities that are needed before the child can move into the new program/setting (e.g., enrollment forms, immunizations, transportation issues, etc.). For children who are not entering a new program/setting, transition services may include providing the family with information and resources to continue monitoring and

supporting their child's development, providing links to community resources they may find helpful in the future, or other supports and services.

v. **Target Date** — Enter the date (month/day/year) by which the step is expected to be completed.

vi. **Date Completed** — Enter the date (month/day/year) the corresponding step was completed.

vii. **Initials Person Completing** — Enter the initials of the person who completed the step.

Note: The transition pages also are appropriate for use when a child is moving out of the local Infant & Toddler Connection system's jurisdiction, either to another local system in Virginia or out of state. If much of the transition page has already been completed based on an expected transition other than the move, then the service coordinator and family will add information to relevant steps of the plan to reflect the new transition destination and the steps and activities associated with the move.

b. Inform the family that the local Infant & Toddler Connection system will, with parent approval, make reasonable efforts to convene a transition conference among the local Infant & Toddler Connection system providers, the family and community programs of interest to the family (e.g., head start, preschool/childcare programs) to discuss appropriate services the child may receive.

i. The offer to hold a transition conference, the family's decision to approve or not approve such a conference and the completion of the conference if the family approved must be documented in the Community Options step of the Transition Plan task in TRAC-IT. A *Parental Prior Notice* form (with a check mark by "The required transition conference is necessary.") is **not** needed if the child is not potentially eligible for Part B.

ii. Any transition conference held for a child who is not potentially eligible for Part B must meet the requirements for an IFSP meeting. If the transition conference is not held in conjunction with the initial or an annual IFSP, then the transition conference would be

considered an IFSP review (and the IFSP Review Record must be completed along with updating information in the Transition Plan task in TRAC-IT as appropriate). A *Parental Prior Notice* form is needed for the IFSP meeting. The transition conference and the meeting to develop the transition plan may be combined into one meeting. While a face-to-face meeting among all participants is preferable, participation by teleconference and/or videoconferencing are options as well.

iii. There is no timeline requirement associated with a transition conference for a child who is not potentially eligible for Part B.

5. **For children who are potentially eligible for Part B, complete the following**:

   a. Ensure development of the transition plan in section of the IFSP by completing the Transition Plan task in TRAC-IT to identify the steps for the child and family to exit from the early intervention system and any transition services that the IFSP team determines are needed by the child and family.

      i. **Timeline** — The transition plan must be developed at least 90 days and, at the discretion of all parties, up to 9 months before the child's anticipated date of transition. Service coordinators are encouraged to hold the meeting to develop the transition plan well in advance of transition, closer to the 9 months than the 90 days. This allows the family time to consider their options and plan for notification and referrals or other steps necessary to ensure services are in place for a smooth transition at age 2 or age 3.

      ii. **Procedural Safeguards** — Provide a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to develop a transition plan is necessary.") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

iii. **Meeting** — The meeting to develop the transition plan must meet the requirements of an IFSP meeting and may be combined with the transition conference described in #5c below. If the transition plan is not developed in conjunction with the initial or an annual IFSP, then an IFSP review must be held to develop the transition plan (both the IFSP Review and Transition Plan tasks must be completed in TRAC-IT). Once the transition plan has been developed, an IFSP review is ***not*** needed to make changes. The family and service coordinator may update or make changes to the transition plan and then share the updated information with other team members at the time of the next IFSP review or annual IFSP.

iv. **Documentation** — The transition plan is documented in the Transition Planning section of the IFSP using the transition plan task in TRAC-IT. The transition steps and activities that will be completed for an individual child and family will depend on that family's specific transition plans and preferences. The steps and activities may be completed in whatever order is most appropriate for each child and family. Follow the instructions in the *Documentation* section of #4a above for completing Steps 1, 2, 5 and 6 of the transition plan. Complete the documentation for Steps 2 and 4, which must be completed for all children who are potentially eligible for Part B, as specified in the *Documentation* sections of #5b and #5c below.

b. Ensure notification, which constitutes a referral, to the local school division and the Virginia Department of Education. For children who are potentially eligible for Part B, the local early intervention system is ***required*** to send the child's name, date of birth, and parent contact information to the local school division and the Virginia Department of Education at least 90 days before the anticipated date of transition, ***unless*** the parent opts out. The point at which the special education director (or designee) receives this information is considered the date of referral.

i. **Timeline** — Notification and referral must occur at least 90 days before the child's anticipated date of transition. However, unless otherwise agreed to with the local school division, notification and referral must be made no later than April 1 in a given year or at least 6 months prior to the child's third birthday, in order to ensure the child can begin services at the beginning of the school year in which

he/she turns two by September 30 or on his/her third birthday. Local Infant & Toddler Connection systems and local school divisions have the option to work out other timelines for notification and referral (if it is at least 90 days before the anticipated date of transition) and are expected to document any alternate timelines in a local interagency agreement.

(1) All families are informed about the general timeline for notification and referral when the initial IFSP is developed. The dates for notifying parents of the details regarding notification and referral to the local school division and their option and deadline to opt out are individualized for each child based the family's transition plans and timing. However, to ensure families have sufficient notice and information, the parent must be notified in writing on the IFSP transition plan about the notification and referral at least 100 days before the anticipated date of transition (10 days before the 90-day timeline) and given at least 5 days to opt out of the notification before it is sent.

(2) Document any circumstances that result in these timelines not being met.

ii. **Meeting** — There are no meeting requirements associated with notification and referral.

iii. **Procedural Safeguards** — Using the Notification and Referral step of the Transition Plan, the service coordinator notifies parents of all children who are potentially eligible for Part B of the local Infant & Toddler Connection system's intent to share the child's name, birth date, and parent contact information (name, address, and telephone number), with the appropriate local school division and the Virginia Department of Education as well as the earliest date on which this notification will occur. Parents may opt out of this notification and referral by initialing in the Notification and Referral step of the transition plan indicating they do not want this information transmitted.

(1) Even if the parent has referred or plans to refer their own child to the local school system, the service coordinator must

complete the information in Notification and Referral step of the Transition Plan (see *Documentation* section below) and must send the notification and referral to the local school division and the Virginia Department of Education unless the parent opts out by initialing in the Notification and Referral step of the transition plan.

(2) The information sent to the local school division as part of the notification may also include the service coordinator's name and contact information and the language(s) spoken by the child and family to further assist the local school division in meeting its child find responsibilities and responding to the referral.

(3) Local agencies that require written consent beyond the federal requirement of providing notice (via the transition plan section of the IFSP in Virginia) can follow their agency requirements to obtain consent for release of the child's name, date of birth and parent contact information (name, address, phone number).

(4) If the family initials the line indicating they do not want this information sent to the local school division and Virginia Department of Education but later changes their mind, then the service coordinator can either: (1) have the parent initial and date the opt in line in the Notification and Referral step of the transition plan task indicating "I have changed my mind and agree to have this information sent to the local school division and VDOE."; or (2) the service coordinator documents the family's decision in a contact note and enters the initials and date in the opt in line in the Notification and Referral step of the transition plan task; or (3) The family signs a release of information to send child-specific transition information to the local school division (e.g., copies of the most recent IFSP, assessment reports, etc.) and enters the initials and date in the opt in line in the Notification and Referral step of the transition plan task. Signing such a release indicates the family has agreed to notification and referral.

(a) If either the second or third option is used, then discuss this during the next IFSP review meeting, note in the IFSP Review Record that the family has decided to allow transmission of this information to the local school division and Virginia Department of Education.

(b) If the family initially leaves the space blank (indicating that they agree to have the information sent), then later they decide (prior to it being sent) they do not want their information sent, they must initial and date the opt out sentence indicating that they do not want the information sent.

iv. **Documentation** — Notification and referral are documented in the Notification and Referral step of the Transition Plan as follows:

(1) Step a - Enter the earliest date by which the child's name, date of birth and parent contact information (parents' name, address and phone number) will be sent to the local school division and the Virginia Department of Education and enter the name of the local school division.

(a) If the family is interested in transition at age 2, then the date entered in the notification step of the Transition Plan must be no later than the April 1 prior to the start of the school year in which the child turns 2 by September 30 (unless there is an alternate timeline documented in the local interagency agreement).

(b) If the family is not interested in transition at age 2, this decision may be documented in one of the following ways: (1) Enter in the Notification and Referral step of the Transition Plan a date no later than the April 1 prior to the start of the school year in which the child turns 2 by September 30 and have the parent indicate they are opting out of notification at that time. They may use the opt in line to allow notification later, as their child approaches age 3; or (2) Document in a contact note or in the IFSP Review Record the family's decision to continue in early intervention until age 3. As the child

approaches age 3, enter in the Notification and Referral step of the Transition Plan a date at least 6 months prior to the child's third birthday (unless there is an alternate timeline documented in the local interagency agreement).

(c) If the initial IFSP is being developed after April 1 of the year the child would be age-eligible to start Part B services in September and the family is interested in transition at age 2 or if the initial IFSP is being developed less than 6 months before the child's third birthday, the "no earlier than date" recorded should reflect that the notification and referral will occur immediately. The date may be a week or two in the future (from when the IFSP form is being completed) to allow time for the family to review and sign the IFSP and for the local system to send the notification and referral.

(2) Step b - When/if the notification and referral are sent to the local school division, enter the dates here. Notification to the Virginia Department of Education (VDOE) happens automatically when required data is entered into TRAC-IT. If the "potentially eligible for special education" box has been checked and there is no date in the opt-out field (***or*** if there is a date in the opt-out field, there is also a date in the opt-in field), then notification is sent to VDOE when the "no earlier than" date is reached. The VDOE Notification and Referral Date then will be automatically populated by TRAC-IT. If the family has opted out of notification and referral, no information is entered in Step b.

(3) Step c – If the parent consents to release child-specific information needed by the local school division to ensure continuity of services (i.e., most recent IFSP, assessment reports, eligibility determination information), then enter the date consent was obtained and the date the information was sent to the local school division. If the family has opted out of notification and referral, no information is entered in Step c.

c. Ensure the transition conference is scheduled within the required timelines and all required parties (the service coordinator, family and a representative from the local school division) are invited to discuss any services the child may receive under Part B.

    i. **Timeline** — The required transition conference for children who are potentially eligible for Part B must be held at least 90 days, or up to 9 months, prior to the child's anticipated date of transition to early childhood special education services under Part B.

        (1) If the family would like the child to transition to early childhood special education services under Part B at the start of the school year in which the child turns 2 by September 30, then the transition conference must be held at least 90 days and up to 9 months before the start of the school year.

        (2) Some local school divisions allow eligible children to begin early childhood special education services throughout the year, as they turn 2. In this case, the transition conference must be held at least 90 days and up to 9 months before the child turns 2.

        (3) If the family chooses to delay transition to early childhood special education services under Part B until the child's third birthday (or to delay transition until some point before the child's third birthday), then the transition conference must be held at least 90 days and up to 9 months before the child's third birthday.

        (4) The transition conference may occur before or after notification and referral.

    ii. **Meeting** — The transition conference must meet the requirements for an IFSP meeting. If the transition conference is not held in conjunction with the initial or an annual IFSP, then the transition conference would be considered an IFSP review (and the IFSP Review Record must be completed along with updating information in the transition plan task as appropriate). The transition conference and the meeting to develop the transition plan may be combined into one meeting.

(1) While a face-to-face meeting among all participants is preferable, participation by teleconference and/or videoconferencing are acceptable methods as well.

(2) In that rare instance when the local school division representative cannot participate in any of these ways, the local Infant & Toddler Connection system must provide parents at the conference with information about early childhood special education services through the local school system, including a description of the Part B special education eligibility definitions, timelines and process for consenting to an evaluation and conducting eligibility determinations under Part B, and the availability of special education and related services. Discuss the difference in scope between the two programs (Part B and Part C), including how Part C services and supports are child and family centered while Part B services are student-specific with parent involvement. The local school division must provide the family with a contact name and phone number where the family can call with questions about school services.

(3) If the local school division does not respond or fails to attend the transition conference, the service coordinator must document:

    (a) The method (phone call, email, text, etc.) used to coordinate with the local school division;
    (b) The number of attempts to schedule the transition conference;
    (c) The date(s) the invitation to the transition conference was sent to the local school division; and
    (d) The lack of response.

(4) The local school division representative to the transition conference must be an individual who is knowledgeable about the services available in the local school system. The local school division representative does not need to be the special education director or any other specific position. The key is that the local school division representative can provide

information and answer questions regarding the continuum of supports and services available through the school system, as well as participate in developing the transition plan with the family. This may be the ECSE (early childhood special education) teacher, a speech therapist or other related service provider who sees children in the early childhood special education program, or child find person for the school division.

(5) Determine whether the family is interested in transition options in addition to early childhood special education services through the local school system. If so, service coordinators must make reasonable efforts to include representatives from other community programs of interest to the family (e.g., head start, preschool/childcare programs) in the transition conference. These representatives can explain the services available through their programs including timelines and requirements for enrollment.

iii. **Procedural Safeguards** — Provide a copy and explanation of the *Parental Prior Notice* form (with a check mark by "The required transition conference is necessary.") and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Ensure that the family understands the purpose of the conference. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

(1) Since the purpose of the conference is to help families understand the services available through the local school division, all families whose children are potentially eligible for Part B must be offered a conference and given the *Parental Prior Notice* form (to document this offer) regardless of their interest in notification and referral. This notice should be provided close to the time that a transition conference would be scheduled, when the family has a better idea about the kinds of transition options that might be appropriate for their

child and can make an informed decision about whether to proceed with a transition conference.

(2) Document parent approval for the Transition Planning Conference step of the Transition Plan task in TRAC-IT and in a contact note. Verbal approval by the family is sufficient and no approval form or signature is required. If the parent declines the conference, that decision is documented in a contact note, the TPC Approved box is left blank in the Transition Planning Conference step of the Transition Plan task in TRAC-IT and the No TPC box is checked in the Schedule TPC task in TRAC-IT. Provide the family with a contact person at the school division to answer any questions they have about school services if the family declines to participate in a transition conference.

iv. **Documentation** — Transition conference information for all children who are potentially eligible for Part B and whose parents approve the conference must be documented in the Transition Planning Conference step of the Transition Plan task in TRAC-IT as follows:

(1) Indicate whether the parent approves holding the transition conference. Verbal approval from the family for the transition conference is sufficient. Document the family's approval in a contact note and by checking the TPC Approved box.

(a) Note: If the parent declines a transition conference with the local school division but wants to hold a conference with representatives of other community programs, do ***not*** check the TPC Approved box in the Transition Planning Conference step of the Transition Plan task in TRAC-IT. The service coordinator then makes a reasonable effort to convene a conference with representatives of other community programs. The offer to hold a transition conference with other community programs, the family's decision to approve or not approve that conference and the completion of the conference if the family approved must be documented in the narrative field in the Community Options step of the Transition Plan task in TRAC-IT.

(2) Record the date that the transition conference for Part B transition occurs and record participants. Use the checkbox to indicate if a representative from the local school division participated in the conference. If the family is interested in transition options in addition to early childhood special education services through the local school system and representatives from other community programs can participate in the transition conference, note their participation here. If the parent declines a transition conference with the local school division (i.e., the TPC Approved box is not checked), then N/A should be written in the Transition Planning Participants field in TRAC-IT.

Contact Notes Related to Transition

Question: Given the level of detail in the IFSP, what needs to go in contact notes related to transition?

Answer: Contact notes should be used to document the following:

- The fact that discussion with the family about transition occurred and that information is documented in the IFSP and the Transition Plan task in TRAC-IT;
- The fact that the service coordinator worked on a transition activity on behalf of the family;
- Communication and planning related to the transition conference (including cancelled meetings with reasons); and
- Any additional information related to transition that is not documented in the IFSP and the Transition Plan task or Schedule TPC task in TRAC-IT.

6. Transmit, with parent permission, child-specific information (e.g., current IFSP, recent assessment findings, and other pertinent records) to the appropriate school division in which the child resides as soon as possible after the notification and referral to the local school division to ensure continuity of services.

7. Make every effort to participate in the initial Individualized Education Plan (IEP) meeting for children transitioning to early childhood special education services if invited by the local school division at the request of the parent.

8. Complete a new transition task in TRAC-IT for children who transfer from another local Infant & Toddler Connection system since their previous transition plan does

not transfer. The previous transition plan will be visible to the new local system but not editable. If development of the transition plan or completion of other required transition steps and activities occur outside of timelines because the child transferred within 90 days of their third birthday, then this is a family reason for delay.

9. Ensure that families whose children are referred to the local Infant & Toddler Connection system close to the child's third birthday or after April 1 when the child will reach the age of eligibility for special education at the beginning of the upcoming school year are informed of services available through the public schools and that, with parental permission, child-specific information is shared with the local school division as soon as possible following referral to the local Infant & Toddler Connection system.

    a. If a child is referred to the Infant & Toddler Connection of Virginia fewer than 45 days before the child's third birthday, then the child may be referred directly to the local school division for early childhood special education services under Part B.

    b. For children who are close to the age where they will transition, but for whom the early intervention process can be completed, the single point of entry must inform parents of their options for services through the local school division (under Part B) and/or the local Infant & Toddler Connection system (under Part C).

        i. The family can choose to refer themselves to the local school division for early childhood special education services under Part B at the same time they make the referral to the Infant & Toddler Connection system. They should make both systems aware of the dual referral. If the family has not already referred themselves to the local school division, the service coordinator can assist the family by making this referral, with parent consent. The local Infant & Toddler Connection system and the local school division should work together during the eligibility determination process and assessment for service planning to avoid duplication of assessments.

Requirements Associated with Late Referrals

- If the local system is able to complete the IFSP process before the child turns 3 for a child who is referred to the local Infant & Toddler Connection system fewer than 45 days before the child's third birthday and the family opts to proceed with the early intervention referral, then the local Infant & Toddler Connection system may, but is not required to, develop a transition plan as part of the IFSP and provide notification and referral for this child.

- If a child is referred less than 90 days before the child's third birthday, then the local Infant & Toddler Connection system may, but is not required to, hold a transition conference.

- If a child is referred to the local Infant & Toddler Connection system at least 45 days before the child's third birthday and the child is found eligible and is receiving services under Part C, then the local Infant & Toddler Connection system must develop a transition plan (generally this would be part of the initial IFSP) and provide notification and referral to the local school system and Virginia Department of Education as soon as possible after determining the child eligible.

These same requirements and timelines apply to a child referred close to the time he/she would be eligible to start school at 2 years old if the family wishes to transition to Part B at the beginning of the school year in which the child turns 2 by September 30.

Discharge and Determination of Child Progress at Exit

Children and their families exit the local Infant & Toddler Connection system for a variety of reasons, which include but are not limited to the following: they move out of the area served by the local Infant & Toddler Connection system, either to another state or to another local Infant & Toddler Connection system within Virginia; the family decides to withdraw from the system; the child and family are lost to contact; the child no longer has a developmental delay, atypical development or a diagnosed condition; the child transitions to early childhood special education services through the local school division or to other community services; or the child reaches his/her third birthday.

Service Coordinator Responsibilities

1. Ensure exit summary statements for all three child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs) are completed and entered in TRAC-IT prior to exit for all children who had an entry summary statement **AND** who have been in the system for 6 months or longer since their initial IFSP (i.e., there have been 6 months between the initial IFSP and the exit assessment. The rating must be done no more than 6 months prior to exit from early intervention.

    a. To complete the exit summary statements:

        i. Using the Decision Tree and information from parent report, an assessment instrument, observation and other sources, determine the child's status (summary statement) for each of the three child outcomes. A formal assessment is not required. Instead, the provider (s) determines the child's functional status on the three child outcomes through ongoing assessment (which can occur over multiple sessions). The provider must document the child's abilities by filling in an assessment instrument (such as the HELP, ELAP, etc.). The reason for documenting what has been observed through ongoing assessment on an assessment tool is not to generate age levels but to serve as an anchor for the assessment and to provide a standard measure to be used in combination with other assessment sources for determining the child's functional status on the three child outcomes in relation to same-age peers. Completing the ASQ does not meet the requirement for using an assessment tool. It is not necessary to use the same instrument that was used for the entry assessment.

            -OR-

            Obtain entry summary statements from the local school division to use as the exit summary statements for the Infant & Toddler Connection system. If Part B entry assessment data is being used for the early intervention exit assessment data, then that Part B assessment information must be available prior to the child's discharge from early intervention.

        ii. The IFSP team considers information from the sources listed above in conjunction with the Decision Tree to determine the child's status in relation to same-age peers for all three child outcomes.

Document the child's functional status on the three child outcomes (including the child outcome rating statement) in the designated fields in the Discharge task in TRAC-IT. Use a contact note to document the sources of information used in the assessment process. When documenting whether the child has made progress for each child outcome (to respond to the yes/no progress question in TRAC-IT), remember that the answer to that question must always be based on the child's progress since the initial assessment, even if there have been one or more interim assessments. Information to support the yes/no answer to whether the child has made progress may be documented on an IFSP Review page, an annual IFSP or in a contact note(s).

iii. Although exit summary statements are not always determined during a formal meeting of the full IFSP team, those determining the ratings must refer to a paper or electronic copy of the Decision Tree and must engage families in the process of using the Decision Tree whenever possible.

b. Local systems are strongly encouraged to enter exit summary statements for all children exiting the local system, even those expected to transfer to another local system in Virginia and those who have been in the system for less than 6 months. This practice ensures exit ratings are available in case the child who is expected to transfer becomes lost to contact and never re-enters the Infant & Toddler Connection of Virginia and ensures consistent ongoing assessment and discharge practices that maximize the percentage of children exiting early intervention with complete child outcome data.

c. There may be situations where it is not possible to complete the exit summary statements because there is insufficient ongoing assessment information available (e.g., the child has not been seen for an extended period and the family leaves the system without notice). Keep in mind that, in most situations where the child leaves early intervention unexpectedly, it will still be possible to determine the child's exit status on the three child outcomes based on ongoing assessment information from contact notes. If it is not possible to complete the exit summary statements, this must be documented in a contact note and the reason must be entered in TRAC-IT.

d. The local Infant & Toddler Connection system's exit summary statements may serve as the local school division's entry summary statements under

Part B, and the local school division's entry summary statements may be used for the local Infant & Toddler Connection system's exit summary statements under Part C (if the Part B assessment information is available prior to the child's discharge from early intervention). Local systems are strongly encouraged to collaborate with their local school division representatives to establish mechanisms to accomplish this sharing of data and non-duplication of assessment.

e. Since the exit summary statements reflect the child's status at the time of the assessment, it is important to time the exit assessment/summary statements as close to exit as possible to capture results for the full time the child was receiving early intervention services. This may mean using ongoing assessment information to update the summary statements just before exit, even if there was an annual IFSP developed within the last 6 months.

f. When entering information in TRAC-IT, the date of the exit assessment is one of the following:

    i. The last date on which assessment information was collected (e.g., date of the last visit during which ongoing assessment information was documented);

    ii. If completed within the 6 months prior to the child's discharge ***and*** it reflects the most up-to-date assessment information available, then the date of the most recent IFSP in which the child outcome summary statements were documented; or

    iii. If completed within the 6 months prior to the child's discharge ***and*** they reflect the most up-to-date assessment information available ***and*** they are available to the local early intervention system by the date of the child's discharge, the date that child outcome entry summary statements were determined by the local school division.

2. Provide a copy and explanation of the *Parental Prior Notice* form (with "Your child is not eligible for Infant & Toddler Connection of Virginia" marked) and the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Parental prior notice must be provided to the family at least 5 days before early intervention services will be terminated.

a. If the child is no longer eligible (but is within the age range for early intervention services), the reason listed on the *Parental Prior Notice* form will explain that ongoing assessment results indicate that the child no longer meets the eligibility criteria for early intervention. In explaining the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

b. If the child is "aging out" of early intervention, the reason listed on the *Parental Prior Notice* form will be that "Your child will be turning three years old on _____. Effective on that date, your child is no longer eligible for early intervention services through the Infant & Toddler Connection of Virginia."

c. If the child is transitioning to early childhood special education services under Part B, the reason listed on the *Parental Prior Notice* form will be that "Your child will soon be receiving early childhood special education services through your local school division. On the date Part B services begin, your child is no longer eligible for early intervention services through the Infant & Toddler Connection of Virginia."

It is not necessary to provide parental prior notice if the family is moving out of the area served by the local Infant & Toddler Connection system, the family has stated that they wish to withdraw from services, or if the child dies (since, in these situations, the system is not proposing to end services).

a. If the child is moving out of the area served by the local Infant & Toddler Connection system, then any referrals made must be documented in the service coordinator's contact notes.

b. If the parent decides to withdraw from services, then the service coordinator documents the parent's decision in a contact note.

3. For Medicaid/FAMIS recipients only: If the family is receiving prior notice that their child is no longer eligible (but is within the age range for early intervention services)

or that their child is being discharged after being lost to contact, complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is no longer eligible for early intervention services. Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. ***Note***: The Notice of Action letter is ***not*** needed if the child is transitioning to Part B, even if the child is still age-eligible for early intervention.

4. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

5. **Ensure that no IFSP services are delivered on or after the child's third birthday**.

6. Enter discharge information into TRAC-IT as children exit the local Infant & Toddler Connection system, within 10 business days of discharge.

Local Monitoring and Supervision Associated with IFSP Implementation and Review

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.

2. Services begin in a timely manner and are delivered in accordance with the IFSP.

3. Mitigating circumstances are documented when services begin more than 30 days after the family signs the IFSP.

4. Efforts to secure foreign language and sign language interpreters to communicate with the child during service delivery and to assist the family's active participation in periodic reviews and annual IFSP meetings are documented.

5. IFSP reviews and annual IFSP meetings are held in accordance with required time frames.

6. All IFSPs include transition planning, as appropriate, and a transition plan is included in the IFSP within the required time frame.

7. Notification to the local school division and Virginia Department of Education occurs within required timelines for all potentially eligible children (if the family does not disagree) and is documented.

8. The transition conference occurs within required time frames and with required participants.

9. Mitigating circumstances are documented when the transition conference does not occur within required timelines.

10. Child outcome exit summary statements are appropriate based on the documentation of child functioning.

11. TRAC-IT data entry is timely and accurate.

12. Medicaid/FAMIS and other insurance eligibility and the status of the Medicaid EI benefit are checked at least monthly for all children receiving services through the Local Lead Agency. If insurance eligibility has changed, update the Family Cost Share Agreement form and the insurance record in TRAC-IT, as needed. If the child has Medicaid/FAMIS but the Medicaid EI benefit is not showing in the verification system, uncheck the Medicaid EI benefit box in TRAC-IT immediately, but no later than 60 calendars days from the date the Medicaid EI benefit dropped. Options for verifying a child's Medicaid/FAMIS coverage are discussed in the "Family Cost Share Practices" section of Chapter 11 (see the text box titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification").

Chapter 9: The Early Intervention Record

The Early Intervention Record

Local Lead Agency Responsibilities

1. Ensure maintenance of each child's early intervention record at the local lead agency, at the local agency that houses the system's service coordinators, or in TRAC-IT.

2. Make children's early intervention records available to the State Lead Agency, the Department of Behavioral Health and Developmental Services, upon request and at the location designated by the State Lead Agency.

3. Ensure that each child's ***one*** early intervention record includes the following:

    a. Accurate demographic and referral information
    b. Signed releases and consents
    c. Other completed procedural safeguards forms
    d. Completed and signed Initial Early Intervention Service Coordination Plan, if child is new to the Infant & Toddler Connection of Virginia and has Medicaid/FAMIS
    e. Screening and assessment reports
    f. Medical reports
    g. All other documentation collected during eligibility determination and IFSP development including reports from previous outside screenings, assessments, etc.
    h. Completed Eligibility Determination form
    i. All IFSPs developed – current and past, including documentation of periodic reviews
    j. Contact notes and communication logs submitted by providers, including service coordinators
    k. Copies of all correspondence to and from the local Infant & Toddler Connection system or its providers with or on behalf of the family
    l. Court orders related to service provision, custody issues, and/or parental rights

m. Signed *Family Cost Share Agreement* form, unless it is kept in a separate financial file. If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.
n. Record Access log

Contact Notes and Communication Logs

The term "contact note" will be used in discussing below how Part C early intervention service provision, including service coordination, is to be documented. The term "contact note" is intended to be interchangeable with other commonly used terms such as "progress note," "case note," or "service coordination note." Local Infant & Toddler Connection systems and early intervention providers are not required to call their service delivery documentation contact notes.

Communication logs are entities within TRAC-IT that can document non-billable activities with the family and others in the child's record. These activities can include appointment cancelations or attempts to communicate with the family when scheduling appointments. Communication logs are also created when a TRAC-IT user completes any task as Left Message, No Answer, No Show or Family or Clinician Canceled.

Effective and complete contact notes and communication logs are critical to address the following purposes of such documentation. Part C contact notes and communication logs are:

1. A chronological record of the child's and family's participation in the Infant & Toddler Connection system (including the supports and services provided to the child and family), the course of intervention, and the child's developmental progress. Therefore, thorough contact notes:

    a. Provide an objective basis to determine the appropriateness, effectiveness and necessity of intervention, and

    b. Assist the IFSP team in assessment and service planning at IFSP reviews and annual IFSPs.

2. A means for communication among service providers and with the family.

a. Not only do thorough contact notes facilitate communication among current service providers, but they also provide critical information to substitute providers who fill in when the usual provider is ill or on vacation and to new providers who begin services after an IFSP review or annual IFSP or when the former provider is no longer providing services to that child and family.

b. Under Part C, parents have the right to review their child's record.

3. Billing documents.

    a. Contact notes are used for billing purposes and must provide the information required by DMAS and other third-party payors.

4. Monitoring documents.

    a. Contact notes and communication logs are reviewed by local system managers, program managers, State Infant & Toddler Connection of Virginia personnel, and DMAS personnel to monitor compliance with federal and State requirements and to facilitate quality assurance and improvement. Contact notes and communication logs that are complete and accurate will assist local systems in documenting compliance and improvements.

5. Legal documents.

    a. Contact notes and communication logs are legal documents and may be used in the investigation of an administrative complaint or in a due process hearing under Part C, or in a court case such as a custody dispute. Thorough contact notes and communication logs are essential in documenting compliance with Part C requirements, provision of supports and services in accordance with the IFSP, reasons for missed appointments, and other contacts and activities completed on behalf of the family.

General Rules for Documentation

1. Document all contacts made, and all activities completed with or on behalf of the child and family. This includes, but is not limited to, phone calls (including "no answer" or a "voice message left"), face – to – face contacts, consultations between providers related to the child and family but not with the child and family, and written correspondence. If someone is looking at a child's record and a contact

or activity is not written down, then the reviewer must assume that the contact or activity did not occur.

a. If two or more providers participate in the same treatment session, then they must each write a separate note documenting their time and activities.

b. If one provider is performing two roles during a single visit (e.g., one provider is delivering service coordination and developmental services), then that provider must write two notes specifying the amount of time spent and activities completed in each role.

c. If one provider participated in two different activities on the same day (e.g., assessment for service planning and the IFSP meeting), then that provider may write one note specifying the amount of time spent and his/her role in each activity/service (assessment and IFSP meeting). Upon completion of the task, TRAC-IT will create two separate contact notes, one for each service provided (i.e. one for IFSP Meeting and one for ASP with the service details indicated by the provider, respectively). It is acceptable to refer in the note to the IFSP for the specifics about assessment information and IFSP decisions made rather than repeating that information in the note.

d. If there is communication related to a child who has been discharged from the local system, then such communication would require a non-billable contact note or communication log in TRAC-IT.

e. If someone other than the service coordinator or other service provider (e.g., a program supervisor or the central point of entry) gets a call from the family, then that contact must be documented in a communication log, which is then filed in the child's early intervention record.

Do I Need to Write a Contact Note?	
• To document my participation in an assessment or an IFSP or IFSP review meeting, time spent (in minutes), and method of participation?	Yes
• To document provision of procedural safeguards?	Yes
• To document what services are planned?	No*
*The IFSP is sufficient documentation of planned services. *Not sure if you need to write a note or communication log…? It's better to go ahead and write one!*	

2. Use contact notes to provide essential information that is not contained in meeting record forms such as the IFSP.

    a. The service coordinator must complete a contact note following the IFSP meeting to document the following:

        i. The length of the IFSP or IFSP review meeting in minutes. Since providers are billing for these services, the time spent must be clearly documented.

        ii. Any supports and services recommended by the team but not accepted by the family.

        iii. Instances where the family opted for a frequency, length, intensity (individual/group), or method of service that was different than what was proposed by other team members.

        iv. Justification for any frequency with multiple visits planned over more than a one-month period (10x/6 months), including why the frequency was chosen and the need for flexibility for this specific child and family.

        v. Any other areas of disagreement among team members, including the resolution reached or, if the issue was not resolved, the plan for addressing the area of disagreement; and the rationale for planning a later start date for services, when applicable.

3. Document the reasons for cancellation (whether cancelled by the provider or the family) any time a contact was scheduled and did not occur. The more specificity provided, the more helpful the documentation is for individuals monitoring billing. In TRAC-IT, a nonbillable contact note or communication log must be used to document cancellations.

4. Document the reason for any difference in the frequency, length, intensity or location of a service provided compared to what is listed on the signed IFSP.

5. When the frequency planned on the IFSP is for multiple visits over a period of more than one month (e.g., 10x/6 months):

    a. Document justification if the maximum number of services planned over that period were not delivered;

    b. For each visit, document discussion with the family about when the provider will come next and why; and

    c. Document discussions with the family and other providers to ensure the planned frequency remains appropriate based on child and family priorities and concerns.

6. Document that native language requirements have been met if the native language is other than English.

7. Write legibly.

8. Use the provider agency's rules regarding ink color for contact notes. Generally, black ink is preferred since it works best for faxing and copying.

9. Provide complete and accurate information about the contact or activity, ensuring that a third party could read the contact note and understand what occurred.

10. Record events and observations in a factual, non-judgmental way and avoid subjective comments.

11. Use positive statements.

12. Use language understood by all team members, including the family. Avoid jargon and abbreviations or explain them in the note.

13. Complete contact notes and enter/upload notes to TRAC-IT in a timely manner, no more than 7 business days from the time of the contact. Day 1 of the 7-business-day timeline is the day the service was provided/contact was made. Ideally, the contact note should be done immediately following the contact to ensure optimal recall of what occurred and so that the note is available for other team members who may need the information for their service provision to the family.

14. Correct errors on handwritten contact notes by drawing a ***single line*** through the incorrect information, providing the date of the correction and the initials of the reviser, then adding the correct information. Correct errors in electronic documentation by following agency requirements or using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note. Follow the TRAC-IT User Manual to edit/correct contact notes in TRAC-IT.

Specific Content Requirements for Contact Notes

Fully completed contact notes in TRAC-IT will meet all requirements below.

1. **For all contact notes**:

    a. Child's first and last names

    b. Type of service provided (physical therapy, developmental services, service coordination, etc.)

    c. Method of contact (phone, face-to-face, telehealth, e-mail, etc.)

    d. Date of the note and date of service or contact if the note is not written on the same date.

    e. Provider signature (with at least first initial and last name), discipline and credentials of provider and the date the note is signed by the provider. The signature of the provider must be handwritten or electronic; no stamps allowed. Notes completed in TRAC-IT are automatically signed since they are completed by the logged in provider, and the typed signature of that provider

will show on the contact note print template. If a student participates in an assessment, meeting or services to a child (e.g., as part of a practicum or internship), then that student must be listed in the 'Participants' field of the Contact Note in TRAC-IT and the certified provider that was supervising the student must sign the note. If the student wrote the note, then a statement to the effect of, "This note was captured by Sam Student, Intern." can be included in one of the narrative sections of the note and the certified provider that was supervising the student must sign the note.

2. **For contact notes documenting a service session with the child and family, also include the following:**

    a. A ***narrative*** description of what occurred during the session including what the provider did, what the family/caregiver did, how the child responded during the session (including what the child was able to do in relation to IFSP outcomes, goals, etc.), and suggestions provided to the family/caregiver for strategies to incorporate in the child's daily routines and activities. A contact note formatted as a check-off list of general statements does not provide the level of information required to know what occurred during the session.

    b. Who was present (participants).

    c. Length of session (in minutes).

    d. Location/setting (e.g., home, day care, etc.) in which the service was provided.

    e. Information from the family/caregiver about what has happened since the last visit. [The contact note should make clear that the information is from the family by using phrases like "as reported by (family member)," or "(Caregiver) reports…."]

    f. Plan for next contact.

3. **For contact notes documenting contact or other activities completed by the service coordinator, also include the following:**

    a. The service coordination short-term goal that the contact activity is addressing and progress toward achieving the service coordination goal. Many of the supports that service coordinators provide to families are not

specifically listed as goals on the IFSP. These generally fall under the second service coordination goal in Section IV of the IFSP, "Provide support and assistance to your family in addressing issues or concerns that emerge over time."

b. Length of time (in minutes) for the contact or other activity completed by the service coordinator. This applies to all contacts made with or on behalf of the family and can be recorded as the total time spent or by recording the start time and end time for the activity.

A contact note checklist is provided at the end of this chapter.

Additional Documentation Requirements Associated with Early Intervention Targeted Case Management (EI TCM)

1. Document the family's preferred method of contact (face to face, phone, email or text) for the family contacts that are required every three months. This can be documented in the contact note for the intake visit.

2. If the family's preferred method of contact is email or text, then there are three options for documenting the email or text communication that occurs:

    a. Place a copy of the email or text communication in the child's record;

    b. Copy and paste the content of the email communication into the contact note; or

    c. Summarize the content of the email or text communication in a contact note (as you would for a phone contact).

Access to Records

The local lead agency may assume that the parent has the authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority under applicable Virginia law governing such matters as guardianship, separation, and divorce.

Local Lead Agency/Provider Responsibilities

1. Identify one individual to assume responsibility for ensuring the confidentiality of any personally identifiable information.

2. Provide training or information on Part C confidentiality requirements (in accordance with the Family Educational Rights and Privacy Act, FERPA) to all individuals collecting or using personally identifiable information.

3. Provide parents, upon request, a list of the types and locations of records collected, maintained, or used for Part C by the local lead agency/provider.

4. Establish a procedure for parents or a representative of the parent to inspect and review the child's record (s) collected, maintained or used for Part C without unnecessary delay, before any meeting regarding an IFSP or any due process hearing, and in no case more than 10 days after the request has been made.

5. Keep a record using the *Access to Record* form of person(s), except parents and authorized employees, obtaining access to records collected, maintained or used by the local lead agency/provider, including the name of the person(s), date of access and purpose of access.

6. Respond to a parent request to amend information considered to be inaccurate or misleading or which violates the privacy or other rights of the child or parent by:

    a. Amending the information in accordance with the request within a reasonable period of receipt of the request; or

    b. Informing the parent of the local lead agency's refusal to make the requested amendments and advising the parent of their right to a hearing, as described in the *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System*.

7. Make available to parents an initial copy of the child's record at no cost to the family. After making available one copy of the record, the local lead agency/provider may not charge a fee for copies of records if the fee would effectively prevent the parents from exercising their right to inspect and review those records.

8. Inform parents when personally identifiable information collected, maintained, or used is no longer needed to provide supports and services to the child and destroy

the information at the request of the parents. Permanent records of the child's name, date of birth, parent contact information (including address and phone number), name of service coordinator (s) and other early intervention service providers and exit date (including year and age upon exit and any programs entered into upon exiting) may be maintained.

9. Ensure the early intervention record is maintained for a minimum of 3 years following the child's discharge from the Infant & Toddler Connection system. Local lead agencies have the option to require records be maintained for a longer period. The 3-year period ensures access to the records in case dispute resolution or due process proceedings requesting reimbursement of any kind occur after the child's discharge.

Service Coordinator Responsibilities

During the intake visit, point out where information related to storing, accessing, and correcting records is included in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Remind parents of this information when reviewing the Notice of Child and Family Rights and Safeguards at other required points in the early intervention process.

Contact Note Checklist

CONTENTS

For all contact notes:

- ☐ Child's first and last name - on the note or the page
- ☐ Type of service provided (e.g., service coordination, physical therapy, etc.)
- ☐ Type of contact (e.g., phone, face-to-face, mail, telehealth, etc.)
- ☐ Date of contact note
- ☐ Length of the session/contact/activity in minutes
- ☐ Date of service/contact (if different than date of note)
- ☐ Location/setting in which the service was provided
- ☐ Signature of provider (at least first initial and last name; handwritten or electronic, no stamp)
- ☐ Title of provider (discipline and credentials)
- ☐ Date of provider signature (should be date the note was written)

For contact note on a service session with child and family, must also include:

- ☐ Who was present (including child)
- ☐ A narrative that includes the following:
  - ☐ Information from family/caregiver about what has happened since last session including progress on joint plan developed at previous session
  - ☐ Details of how the provider supported the family/caregiver in a routine or activity related to goals and outcomes; strategies practiced and child's response
    - ☐ Specific examples of how the family/caregiver participated in the session including strategies practiced with the child and the child's response
  - ☐ Ongoing Assessment: documentation of child's skills observed and/or reported by family/caregiver including:
    - ☐ Child's progress in relation to the IFSP outcomes/ short term goals
    - ☐ New functional skills (if any) in any of the three global outcome areas.
  - ☐ Documentation of joint planning for implementation of strategies and supports between visits during the family/caregiver daily routines and activities
  - ☐ Plan for next contact

For service coordination contact note, must also include:

- ☐ Short-term Service Coordination goal (s) that is being addressed; progress toward goal(s)

OTHER

- ☐ Handwriting is legible
- ☐ Language used can be understood by all team members, including the family
- ☐ Events and observations are recorded in a factual, non-judgmental way
- ☐ Information is presented in a positive manner
- ☐ Note is completed and entered in or uploaded to TRAC-IT within 7 business days of contact
- ☐ Errors on handwritten notes are corrected by a single line through incorrect information, citing date of the correction and initials of reviser then adding correct information. Errors in electronic documentation are corrected by following agency requirements or using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note.

Chapter 10: Dispute Resolution

General

1. Every effort should be made to resolve family-provider disagreements using informal decision making. If informal decision making is unsuccessful, parents may choose, by filing a written request to the State Lead Agency, the Department of Behavioral Health and Developmental Services (DBHDS), one of the following options:

    a. Administrative complaint;
    b. Mediation alone;
    c. Mediation and a due process hearing simultaneously; or
    d. A due process hearing alone.

2. In addition to the dispute resolution options available through the Infant & Toddler Connection of Virginia, Medicaid/FAMIS recipients have the right to file an appeal with the Department of Medical Assistance Services when they disagree with certain actions. Actions that may be appealed include disagreement about:

    a. The child's eligibility for early intervention services;
    b. The development of an Individualized Family Service Plan within 45-calendar days from the date of referral to the Part C early intervention system;
    c. The provision of early intervention services, including those listed on an Individualized Family Service Plan (IFSP); and
    d. The frequency and length of the IFSP services.

3. Therefore, regardless of whether the family expresses agreement or disagreement, the family must receive the *Early Intervention Services – Notice of Action* letter if:

    a. The child is found ineligible;
    b. The local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency/length desired by the family; or
    c. The IFSP team is proposing to decrease or end a service.

4. The Notice of Action letter ensures families know their right to appeal since not all families will express their disagreement and some families may initially agree with

the action but later change their mind. Appeals must be requested in writing and postmarked within 30 days of the date on the *Early Intervention Services – Notice of Action* letter. The family or their authorized representative may write a letter or complete an Appeal Request Form. Forms are available online at www.dmas.virginia.gov. The *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* provides additional information about the process of filing a Medicaid appeal.

FAQs: When *Notice of Action* Is Needed	
• When the local system is going to discharge a child who has been lost to contact (through repeated no-shows or other circumstances)? Yes	Yes
• If the child no longer meets eligibility requirements (but is still under 3)?	Yes
• When the family declines one or more or all services?	No
• When the family requests to decrease or end a service?	No
• When the child reaches age 3?	No
• When the child transitions to Part B (between ages 2 and 3)?	No
• When the child moves to another state or another local system in Virginia?	No

Service Coordinator Responsibilities

1. Ensure that when disagreement occurs on matters relating to identification, eligibility determination, or placement of the child or the provision of appropriate early intervention supports and services under Part C for the child and family, the parent of the child is informed, in writing and verbally, of the options for resolution. The *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* and *Strengthening Partnerships: A Guide to Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* provide written information about the options for dispute resolution. The Strengthening Partnerships document is an especially helpful tool for service coordinators to use in reviewing this information with families.

For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid any time there is an adverse action proposed by the Infant & Toddler Connection system (e.g., the child is found ineligible, the local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency/length desired by the family, the IFSP team is proposing to end a service). Point out where additional information about the appeal process is in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

2. Provide the family with a contact at DBHDS who can:

    a. Offer them technical assistance in framing their complaint, including language interpreters as requested and/or reducing oral complaints to writing; and

    b. Inform them of individuals and organizations who provide free or low cost legal or lay assistance to persons who wish to lodge a complaint (such as parent training and information centers, protection and advocacy programs, and legal aid organizations).

3. Ensure that during dispute resolution, unless the family and local lead agency agree otherwise, the child and family continue to receive the supports and services on the child's current IFSP.

4. Ensure that if the family-provider disagreement involves initial eligibility to receive supports and services under Part C, the child and family will not receive supports and services under Part C until the eligibility question is resolved.

5. Ensure that if a family chooses to appeal a decision using the Medicaid Right to Appeal procedures, the family also is informed of their options for dispute resolution under Part C.

6. Ensure that families understand their right to bring a civil action in Federal or State court if they are not satisfied by the hearing officer's decision in a due process hearing.

Procedures for Mediation

1. Either party (the family or local lead agency) may request or decline the mediation conference. If the local lead agency declines the mediation, the parents must be informed as soon as possible (within four days) of this decision and the right to pursue a hearing.

2. DBHDS appoints a trained mediator on a rotation basis within five (5) days of receiving the request for mediation.

3. The local lead agency appoints a representative to serve on their behalf during mediation.

4. The mediation, including a written mediation agreement reflecting agreements reached by the parties to the dispute, is completed within 15 calendar days of the receipt by the DBHDS of notice that both parties have agreed to mediation. The mediation agreement must be signed by both the parent and an authorized representative of the local lead agency. If resolution is not reached within 15 days, DBHDS informs the parents in writing that they may request a due process hearing. Extensions of the 15-day timeline may be granted for good cause. Examples of good cause include injury, illness, or natural disaster. If there is a simultaneous request for mediation and a due process hearing, the extension must not result in a violation of the 30-day timeline for completion of the due process hearing.

5. At any time during the mediation process, a request for a due process hearing may be initiated.

6. DBHDS bears the full cost of the mediation process.

7. A flow chart of the process for requesting and using mediation to resolve disagreements is provided at the end of this chapter.

Procedures for a Due Process Hearing

1. DBHDS arranges for the appointment of an impartial hearing officer within five days following receipt of the request for a hearing.

2. The due process hearing is carried out at a time and place that is reasonably convenient for the parents.

3. Any family involved in a due process hearing has the right to:

    a. Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention supports and services for children eligible under Part C;

    b. Present evidence and confront, cross-examine and compel the attendance of witnesses;

    c. Prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five days before the proceeding;

    d. Obtain a written or electronic verbatim transcription of the proceeding at no cost to the parent; and

    e. Obtain written findings of fact and decisions at no cost to the parent.

4. Costs for resolution of parent/provider disagreements by due process hearing are equally shared by the local lead agency and DBHDS. The costs shared include expenses of the hearing officer (i.e., time, travel, secretarial, postal and telephone expenses), expenses incurred by order of the hearing officer (i.e., independent educational evaluations, deposition or transcript), and expenses for making a record of a hearing (i.e., hearing tapes). DBHDS is not responsible for expenses incurred for witnesses (except where hearing officers subpoena witnesses on their own initiative) or for attorney's fees.

5. The hearing officer issues a written decision to all parties within 30 days of receipt by DBHDS of the request for a due process hearing unless the hearing officer grants an extension of the timeline at the request of either party.

6. A flow chart of the process for requesting and using a due process hearing to resolve disagreements is provided at the end of this chapter.

Procedures for an Administrative Complaint[3]

DBHDS will complete the following steps within 60 days of receiving a written complaint.

1. Send notification in writing to each complainant and the local lead agency against which the violation has been alleged, acknowledging receipt of a complaint with copies to other appropriate personnel and the family. The notification sent by DBHDS includes:

    a. A copy of the complaint;
    b. A summary of issues to be addressed in resolving the complaint;
    c. An offer of technical assistance in resolving the complaint; and
    d. A request for written response to the complaint within ten days of the date of the letter of notification. When possible, resolution is reached at the local level during this time.

    If a reply from the local lead agency is not filed with DBHDS within ten days, DBHDS sends a second notice to the local lead agency and telephones the local lead agency.

2. Review the complaint and the reply filed by the local lead agency.

    a. If no further investigation or action is necessary, DBHDS notifies both parties, in writing, stating the resolution.

    b. If the reply does not resolve the complaint, DBHDS reviews all documentation presented and conducts an independent onsite investigation, if necessary.

3. Resolve the complaint based upon the facts and applicable law and notify the parties, in writing, of the decision, including findings of fact and conclusions and the reasons for the final decision reached by DBHDS.

[3] If a written complaint is received that is also the subject of a due process hearing, or contains multiple issues, of which one or more are part of that hearing, DBHDS must set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action will be resolved within the 60-calendar-day timeline using the complaint procedures described above. If an issue is raised in a complaint that has previously been decided in a due process hearing involving the same parties, the hearing decision is binding; and DBHDS informs the complainant to that effect.

4. Address, if it finds a failure to provide appropriate supports and services, the following:

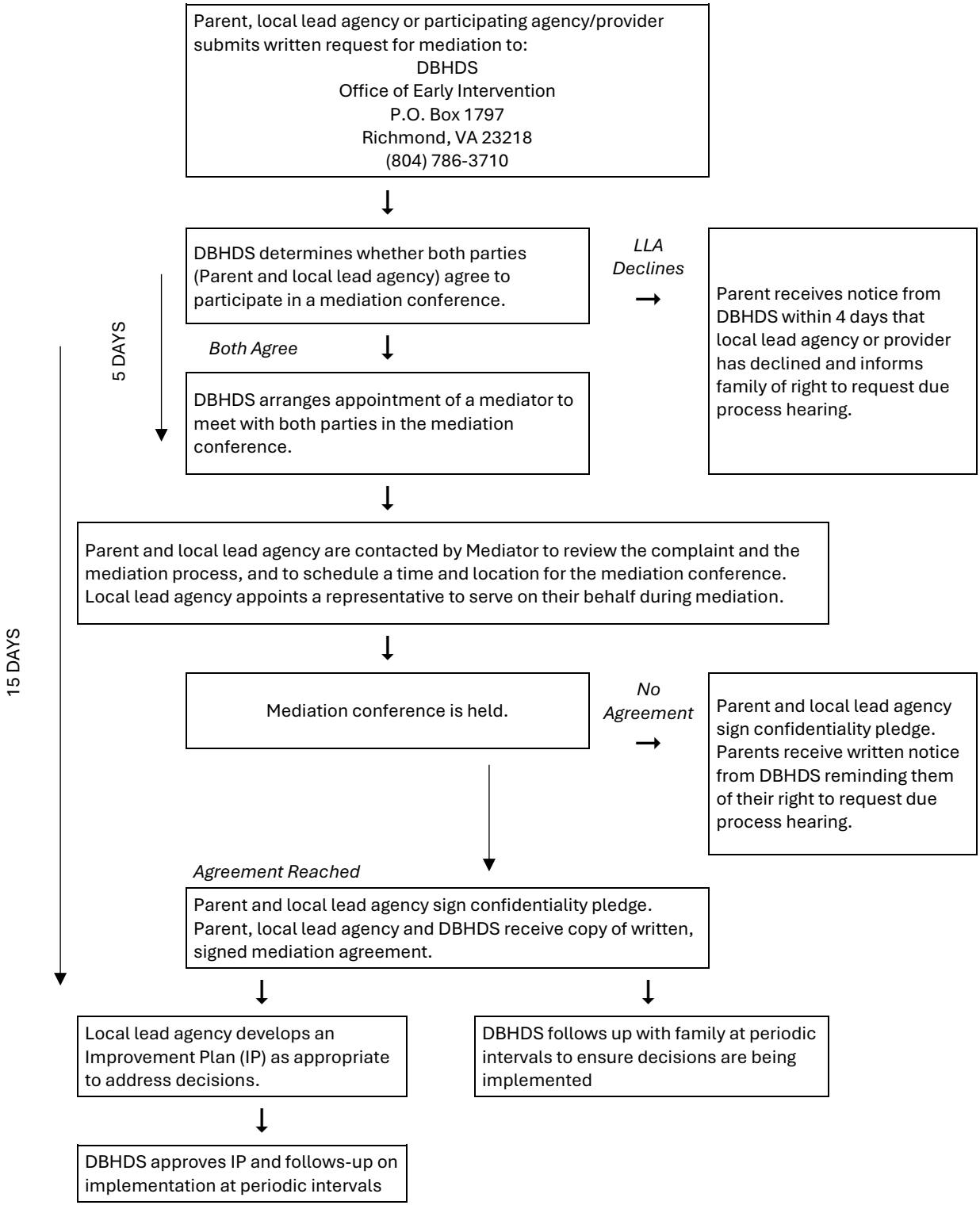
    a. How to remediate the denial of those supports and service, including, as appropriate, the awarding of compensatory services or monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family; and

    b. Appropriate future provision of supports and services for all infants and toddlers with disabilities and their families.

5. A flow chart for filing and resolving administrative complaints is provided at the end of this chapter.

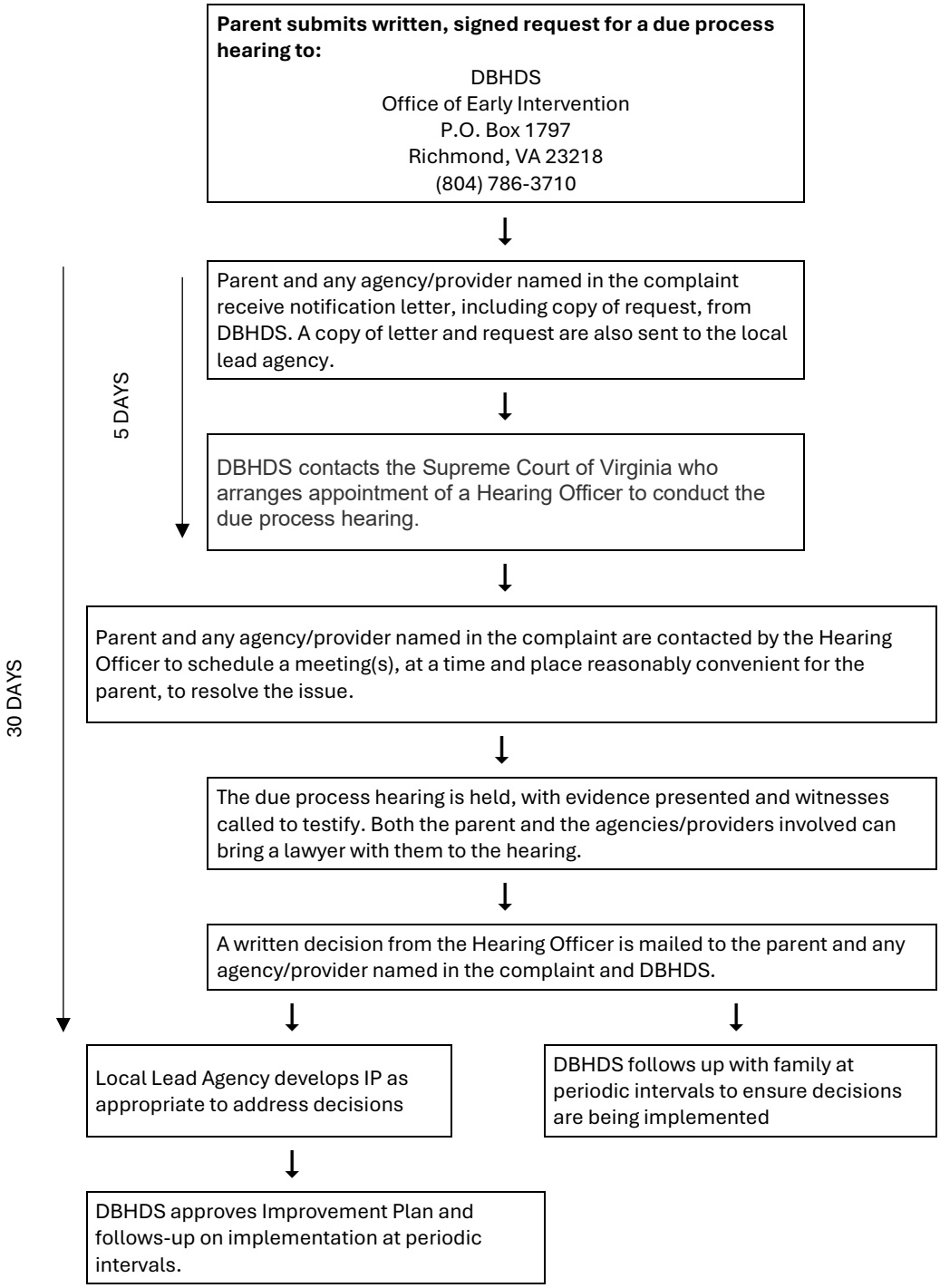
An extension of the 60-calendar day limit may occur if exceptional circumstances exist with respect to a particular complaint. Both parties to the complaint are notified in writing by DBHDS whenever exceptional circumstances (e.g., illness, death) exist and the extended time limit is specified.

Process for Requesting and Using Mediation to Resolve Disagreements[4]



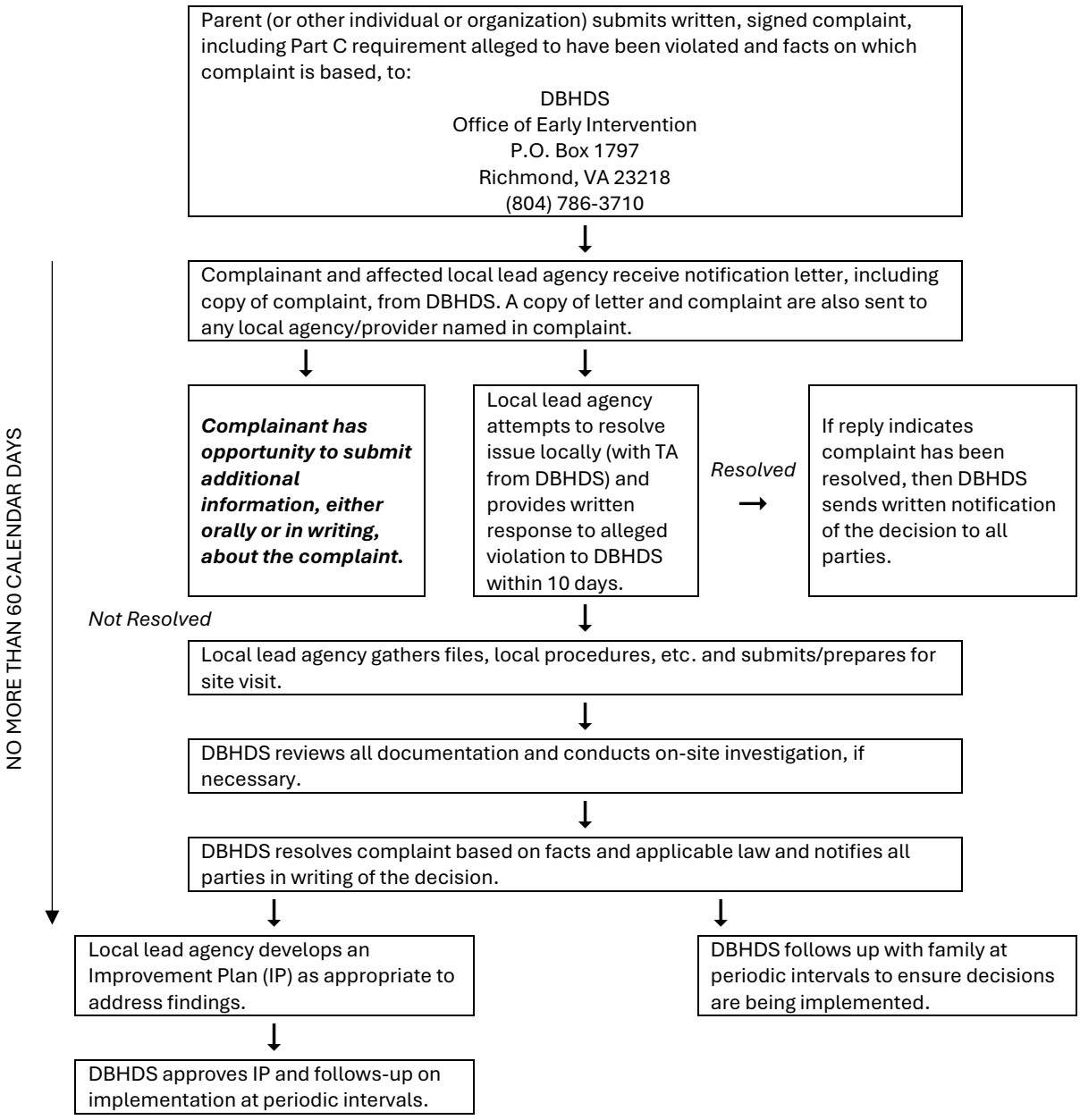
[4] At any time during the mediation process, the parent may request a due process hearing being initiated. Mediation may not be used to deny or delay a parent's rights to a due process hearing.

Process for Requesting and Using a Due Process Hearing to Resolve Individual Child Complaints[5]



[5] If the parent requests mediation and a due process hearing simultaneously, then the steps in the flow charts for both mediation and due process would take place at the same time and must all be completed within 30 calendar days of the receipt of the request (with mediation completed within the first 15 days).

Process for Filing and Resolving Administrative Complaints



Chapter 11: Finance and Billing

Finance and billing practices in the Infant & Toddler Connection of Virginia system support compliance with federal Part C requirements to ensure non-supplanting and use of Part C funds as payor of last resort as well as promoting equity and parity across local systems and enhancing access to early intervention supports and services.

Definitions

1. **Ability to pay** — Amount the family can contribute toward the full cost of early intervention services, based on family size, income and expenses and as documented on the *Family Cost Share Agreement* form and/or the *Fee Appeal Form*.

2. **Family fee** (or "fee") — Amount required as payment from families for IFSP services based on the accrued charges and co-payments incurred because of the services a family receives each month. The family fee may not exceed the monthly cap.

3. **Inability to pay** — Family's inability to pay any dollar amount at all toward the cost of early intervention services. An inability to pay is determined and documented through the policies (including the fee appeal process) described in this chapter and results in the family receiving all early intervention services at no cost to the family.

4. **Monthly cap** (or "cap") — The maximum amount, as determined by the Family Cost Share fee scale or fee appeal process, that a family will be required to pay per month for IFSP services regardless of the number, type, frequency or length of services a child and family receive.

General

Local Lead Agency Responsibilities

1. Ensure the following functions are carried out at no cost to families:

    a. Child find requirements;
    b. Eligibility determination;

c. Assessment (this does not include the ongoing assessment that is integrated into and occurs as a routine part of service delivery);
d. Service coordination;
e. Development, review and evaluation of IFSPs; and
f. Implementation of procedural safeguards.

2. Ensure that the charges for early intervention supports and services are consistent regardless of the anticipated payment source and that families with public or private insurance are not charged disproportionately more than families who do not have public or private insurance.

3. Make every effort during planning and implementation of the interagency system of early intervention supports and services to consider and access all available sources of funds prior to use of state and then federal Part C funds. Every effort must be made to access private insurance (including private HMOs) and public insurance through the Department of Medical Assistance Services (DMAS), Medicaid Managed Care Organizations (MCOs) and TRICARE for all early intervention supports and services covered by these payors. Other potential resources include, but are not limited to the following:

    a. Private foundations, civic organizations (i.e., Kiwanis, Lions Club, etc.), and faith organizations that have potential supports/resources for children and families in early intervention;

    b. Publicly and privately funded initiatives (i.e., Healthy Families, Comprehensive Health Investment Project of Virginia, Early Head Start, etc.) that may have overlapping services and supports for families;

    c. Public and private agencies/organizations including health/medical, social services, education and mental health agencies; and

    d. Parent organizations.

    Funding for the various steps in the early intervention process (such as intake, determination of eligibility, assessment for service planning, provision of supports and services) varies according to the step in the process and to what is "covered" by the funding source. The two *Reimbursement Sources* tables at the end of this chapter show the potential funding sources for each step in the early intervention process.

4. Ensure that, in accordance with the Education Department General Administrative Regulations (EDGAR, § 80.25) and 34 CFR 303.520(e), all income generated by the local Infant & Toddler Connection system is retained by the local Infant & Toddler Connection system. For the purposes of Part C, income includes income from family fees and fundraising. Under 34 CFR 303.520.(d)(1), reimbursement from public or private insurance is not treated as program income. However, under Virginia's early intervention practices, agencies with programs in addition to Part C early intervention are strongly encouraged to put public and private insurance revenue generated by the early intervention program back into the early intervention program.

5. Develop interagency agreements, contracts or memoranda of agreement with as many providers as possible to meet the needs of children with disabilities and their families. These agreements or contracts must specify the responsibilities of each party including the requirement to comply with Part C of the Individuals with Disabilities Education Act, as well as the supports and services that will be provided and how these supports and services will be financed. Local lead agencies must allow families to have access to any certified practitioner in the family's payor network who is working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to allow for exchange of Part C funds.

6. Implement the family cost share practices specified below to ensure documentation that payor of last resort requirements are met and that no child and family are denied supports and services due to an inability to pay. The family cost share practices also specify the process for documenting the family's choices related to use of public or private insurance and payment of family fees.

7. Implement procedures for the use of Part C funds to cover the cost of supports and services pending reimbursement from the agency or entity that has ultimate responsibility for the payment or pending designation of the responsible agency or entity to prevent a delay in the timely provision of supports and services.

    a. During a dispute between/among local counterparts of participating agencies regarding financial or other responsibilities, the local lead agency notifies the State Lead Agency of the dispute and uses Part C funds until the dispute is resolved to ensure that no supports and services that a child is entitled to receive are delayed or denied. Upon resolution of the dispute, the agency determined responsible reimburses the Infant & Toddler Connection system as follows:

i. If reimbursements are not made by a State participating agency (or its local counterpart) within 45 days of resolution of the dispute, the State Lead Agency contacts the staff involved at the State participating agency of the given program.

ii. If not resolved by the respective State agency within 14 days, the matter is referred to the Secretary of Health and Human Resources and/or the Secretary of Education.

b. Under extraordinary circumstances, Part C funds may be utilized to ensure the provision of services until a monthly cap is determined through the family cost share practices described later in this chapter.

Early Intervention Rates

Standard rates are in place for reimbursement of early intervention services regardless of reimbursement source (though not all reimbursement sources will reimburse for all services listed below – see tables at the end of this chapter). These rates reflect the full cost of providing a unit of early intervention services, including not only salary and benefit costs but also travel and administrative and support costs. In the case of assistant-level practitioners, the rate also accounts for supervision costs. The table below reflects the standard rate for each type of service.

Early Intervention Rates			
Service	**Location**	**Provider***	**Rate (per 15 minute unit)**
Eligibility Determination - Travel required to be with family	Any location	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
Eligibility Determination - No travel to be with family	Any location	RC 1 + Audiologists	$25.31/unit
		RC 2 + Dietitians	$18.55/unit
Initial Assessment for Service Planning	Natural environment or center	Reimbursement category 1 providers	$42.19/unit
		Reimbursement category 2 providers + Dietitians***	$30.94/unit
		Audiologists***	$168.76/assessment
		Physicians	Negotiated individually at local level
Initial or Annual IFSP Meeting	Natural environment or center	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
Team Treatment activities (more than one professional providing services during same session for an individual child/family)	Natural environment**	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
IFSP Review Meeting (family present)	Natural environment**	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit

Early Intervention Rates			
Service	**Location**	**Provider***	**Rate (per 15 minute unit)**
Assessments that are done ***after*** the initial Assessment for Service Planning	Natural environment**	RC 1	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
		Audiologists	$168.76/assessment
		Physicians	Negotiated individually at local level
Group (congregate) early intervention services	Natural environment**	RC 1 + Audiologists	$28.27/unit
		RC 2 + Dietitians	$20.73/unit
Individual early intervention services	Natural environment**	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
Center-based group (congregate) services	Center	RC 1 + Audiologists	$8.36/unit
		RC 2 + Dietitians	$6.12/unit
Center-based individual services	Center	RC 1 + Audiologists	$25.31/unit
		RC 2 + Dietitians	$18.55/unit
Consultation (child and family not present) - No travel involve	Any location but must be face-to-face	RC 1 + Audiologists	$25.31/unit
		RC 2 + Dietitians	$18.55/unit
Consultation (child and family not present) - Travel by provider required	Any location but must be face-to-face	RC 1 + Audiologists	$42.19/unit
		RC 2 + Dietitians	$30.94/unit
* Reimbursement category 1 providers are physical therapists, occupational therapists, speech-language pathologists, nurses (registered nurses or nurse practitioners; providing nursing services or developmental services), speech-language pathology assistants, physical therapist assistants and occupational therapy assistants. Reimbursement category 2 providers are			

Early Intervention Rates			
Service	**Location**	**Provider***	**Rate (per 15 minute unit)**
certified therapeutic recreation specialists, child life specialists, counselors, educators, family and consumer science professionals, family therapists, music therapists, orientation and mobility specialists, psychologists, social workers, early intervention assistants, certified nursing aides, licensed practical nurses, qualified mental health professionals or qualified mental health professional-trainees, residents in counseling, residents in psychology, and supervisees in social work. ** Includes center-based services with acceptable justifications AND for which travel by the provider is required. Such situations should be infrequent. Audiology and medical assessments are not required to occur in natural environments. *** The rates listed for services provided by audiologists, dietitians and physicians are only guidelines and actual rates may be negotiated on an individual basis. Medically necessary services from audiologists, dietitians, and physicians are reimbursed by Medicaid outside of the Medicaid Early Intervention Program. Providers are required to accept the Medicaid reimbursement as payment in full for these services.			

Application of Rates

1. Services are reimbursed for the time spent directly with the child/family. The family member or caregiver must physically be present and actively participate in the intervention session for the session to be reimbursed.

2. Providers may bill for their entire time spent in an IFSP meeting or assessment.

3. Services provided more than the frequency, length, or duration specified on the IFSP, without acceptable justification, will not be reimbursed.

4. Providers are required to accept Medicaid reimbursement for medically necessary early intervention services as payment in full.

5. When the child is covered by private health insurance or has no insurance, the rate for a delivered service may be paid through multiple payor sources (private insurance, family fees, Part C funds, etc.). These payor sources and billing procedures are discussed below.

6. The entity that bills receives the standard EI rate. If the Local Lead Agency bills for the service, the local lead agency receives the EI rate and pays the employee or contractor who provided the services. Since the standard rates represent the total cost of providing a unit of service, including not only salary and benefit costs but also administrative and support costs such as billing and supervision, as well as costs for personnel development and teaming, local lead agencies can negotiate with contracted providers regarding the portion or amount of the standard EI rate that will be "paid" to the local lead agency for the functions the local lead agency is doing. For example, the standard EI rate for PT is $168.76/hour. If ABC provider delivers 20 hours of PT services and is doing all their own billing and supervision, then ABC provider will receive the $168.76 rate multiplied by the number of PT hours provided. If, on the other hand, the local lead agency does all the billing for ABC provider, then the local lead agency would negotiate with ABC provider to determine how much ABC provider will pay the local lead agency to do their billing. While the rate remains $168.76/hour, the amount that the local lead agency will pay ABC provider for PT will be reduced by the amount the provider is paying the local lead agency for billing.

7. A provider will not be reimbursed for participation in consultations or IFSP meetings by phone.

8. For eligibility determination:

    a. While eligibility determination does not have to be a face-to-face meeting, it must be planned ahead of time.

    b. A provider may participate by phone, protected email, videoconference, etc. or a combination of those mechanisms to allow for review of available information and team interaction. Both the time spent for review/preparation and the time for team interaction are reimbursable.

    c. No separate reimbursement is needed or appropriate if the provider participating in eligibility determination is a salaried employee of the local lead agency or if the eligibility determination is combined with the assessment for service planning (and the child is found eligible).

9. An Individualized Education Plan (IEP) meeting is not a medically necessary treatment service and participation by service providers other than service coordinators is not covered by Medicaid/FAMIS. The State Lead Agency considers

participation in an IEP meeting to be a teaming activity that cannot be billed by the provider and will not be reimbursed by Part C.

Family Cost Share Practices

Local Lead Agency Responsibilities

1. Identify the individual(s) who will be responsible for explaining the family cost share practices to families and assisting the family to complete the *Family Cost Share Agreement* form.

2. Ensure that the individual(s) who are responsible for implementing the family cost share practices are trained to:

    a. Explain financial information, including use of Medicaid/FAMIS, Medicaid waivers, TRICARE and private insurance for early intervention services, availability of other resources to support early intervention service provision, family fees and monthly caps; and

    b. Collect and record the required financial information from families in a sensitive, confidential and accurate manner.

3. Ensure all families are advised that:

    a. Except for the functions that must be provided at no cost to families (listed in #1 in the "General" section above), all other early intervention services are subject to the family cost share practices detailed here.

    b. They must be charged the cost of care (i.e., full charge) to comply with federal Medicaid requirements that indicate all services must be charged in like manner; and

    c. A sliding fee scale is available to reduce charges based on family size and income.

    This and other critical aspects of the family cost share practices are explained in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, which outlines Virginia's family cost share policies. *Notice of Child and Family Rights and Safeguards*

Including Facts About Family Cost Share is given to all families at the same time they receive *Notice and Consent to Determine Eligibility*, when consent is sought for services on the initial and annual IFSP, at an IFSP review, and any time there is a change in the parent's choices regarding use of public or private insurance on the *Family Cost Share Agreement* form. The family must be offered a copy of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* at each of the points listed above. However, if the family has previously received a copy of the document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

4. Ensure billing for and collection of all family fees for the local Infant & Toddler Connection system. The local lead agency may: 1) do all billing and collection of family fees, 2) contract with a single entity to bill for and collect all family fees for the local Infant & Toddler Connection system, or 3) assign the billing and collection of the family fee to a specific agency/provider for each child.

5. Maintain and report semi-annually to the State Lead Agency data on the total amount of family fees collected. Data must be on file at or accessible to the local lead agency and made available to the State Lead Agency, upon request, to document charges billed, payments received, and the status and follow-up for those families who are required to pay but do not do so.

6. Assist the family in accessing the Part C administrative complaint process, mediation and/or a due process hearing if disagreements regarding family cost share cannot be resolved.

7. Require providers to routinely (at least once a month) confirm with families whether their insurance has changed. The provider must notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage.

8. For children with Medicaid/FAMIS, the following specific procedures apply:

    a. Confirm eligibility: The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid/FAMIS benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid/FAMIS eligibility prior to every visit, changes in Medicaid/FAMIS

eligibility tend to occur at the beginning or end of the month. The provider must:

i. Contact the Infant & Toddler Connection of Virginia Office if the Medicaid EI benefit is not added within a week; and

ii. Retain documentation of all contacts with the Local System Manager and with the Infant & Toddler Connection of Virginia Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

Options for verifying a child's Medicaid/FAMIS coverage are discussed in the text box that follows, titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification."

b. Ensure the following steps occur if notified by a provider that a child is not showing the Medicaid EI benefit:

i. The local system manager must:

(1) Check to be sure that all information is entered correctly in TRAC-IT;

(2) Notify the Infant & Toddler Connection of Virginia Office immediately but no later than 60 calendars days from the date the Medicaid EI benefit dropped, if applicable; and

(3) Retain documentation of contacts with providers and with the Infant & Toddler Connection of Virginia Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

ii. For a child who no longer has Medicaid/FAMIS coverage, the service coordinator must check with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements. If the family is in the process of re-applying, then the service coordinator should:

(1) Connect with the local Department of Social Services Office so the child's eligibility worker can assist the family with completion of the steps necessary to restore the benefit;

(2) Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and

(3) Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.

iii. If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form with the family, and the Medicaid insurance record in TRAC-IT must be ended. A new insurance record must be created if the child is now uninsured. If Medicaid/FAMIS coverage is later restored, a new insurance record must be created in TRAC-IT with the 12-digit number re-entered and the uninsured record must be ended.

9. Check for Medicaid/FAMIS eligibility, with parent consent, for all children in the local system using one of the eligibility mechanisms below to identify children whose families have forgotten to inform the service coordinator that they have Medicaid/FAMIS coverage, which can occur especially when Medicaid is secondary. This is important because DMAS cannot be billed retroactively if the timelines for adding the EI benefit are not met, and Part C funds cannot be used for children who have Medicaid or FAMIS coverage.

Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification
There are two options for providers to use to verify Medicaid FAMIS benefits, including the Medicaid Early Intervention benefit. • By Phone: Verify the member's eligibility by using the MediCall automated phone system at (800) 884-9730 or (804) 965-9732. • Online: Verify the member's eligibility through the DMAS Medicaid Enterprise System (MES) web portal. From this page, click on the blue login button, use your secure credentials to sign in, select PRSS Portal, and then access the Eligibility tab.

To enroll as a Medicaid provider, visit the DMAS Medicaid Enterprise System (MES) web portal and look for New Provider Enrollment.

Medicaid Medical Case Management Programs and Contacts

A list of the contacts for the various Medicaid Managed Care Organizations can be found online by visiting Provider & Health Plan Resources on the DMAS Medicaid Enterprise System (MES) web portal.

Responsibilities of the Individual(s) Designated to Implement Family Cost Share Practices for the Local Infant & Toddler Connection System:

1. **Conduct financial intake** following eligibility determination and prior to the initial IFSP meeting unless the child has Medicaid/FAMIS (in which case the *Family Cost Share Agreement* form must be completed at the intake visit to ensure timely entry of Medicaid/FAMIS data into TRAC-IT and, as a result, Medicaid reimbursement for all reimbursable services).

    a. Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.

        i. If eligibility can be determined based on medical or other records and the family will be combining the assessment for service planning and the IFSP meeting, then financial intake can be conducted prior to the combined activities.

        ii. Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place

where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.

b. Under extraordinary circumstances, Part C funds may be utilized to ensure the timely provision of services until a monthly cap is determined through the family cost share practices. Any extenuating circumstances that result in the financial intake not being conducted prior to initiation of IFSP services must be clearly documented. In the event of such circumstances:

    i. The family cost share process still must be fully explained to the family prior to IFSP development;

    ii. All family cost share forms must be shared with the family prior to IFSP development;

    iii. The family must sign the *Temporary Family Cost Share Agreement Form* (available as an ad hoc task in TRAC-IT), indicating in Section A whether they are opting to delay services until they can provide financial information or to begin services and decide within 30 days about providing financial information. The temporary agreement form explains the family's obligation to provide financial information within 30 days of the date they sign the IFSP and the options available to them at the end of those 30 days. It should also be made clear that the family will be obligated to pay, in accordance with the terms of the agreement form that is signed no later than 30 days after the IFSP, for any services (other than those that must be available at no cost) delivered prior to the agreement form being signed.

        (1) If the family opts to delay services, this would be a family reason for a delay in start of services.

        (2) Part C funds must be reimbursed once the monthly cap is established and payment is received.

        (3) If the family has private insurance or TRICARE and wants to use that insurance to pay for early intervention services, then

the family must complete a *Family Cost Share Agreement* form in addition to the *Temporary Family Cost Share Agreement* form. The Family Cost Share Agreement form will document the parent's consent to use their private insurance or TRICARE and the "Charges" section of that Agreement form must reference the fact that a *Temporary Family Cost Share Agreement* form is in effect.

iv. Section B of the temporary agreement form must be completed no later than 30 days from the date the parent signed the IFSP to document the family's decision about completing the *Family Cost Share Agreement* form and starting services. Section B gives the family three options:

(1) Complete the *Family Cost Share Agreement* form and begin services, in which case a completed *Family Cost Share Agreement* form may be used to document the family's choice rather than completing Section B of the temporary agreement form;

(2) Delay further services (other than those available at no cost) until they can provide income information; or

(3) Decline further services.

c. The financial intake must include providing families with the following:

i. A list of chargeable services as well as services for which there are no charges;
ii. Charges and/or fees for the services;
iii. Family Cost Share Agreement forms; and
iv. A copy of the family cost share fee scale.

d. Financial intake also includes explaining the following:

i. No child and family will be denied services because of an inability to pay. The family cost share practices determine a family's ability or inability to pay.

ii. Families will be charged a monthly fee towards the full charge of their IFSP services unless:

(1) The ***child*** has Medicaid (including FAMIS, FAMIS Plus, FAMIS Select). For children with FAMIS, Part C funds will be used to pay the family's co-pay for early intervention services listed on the child's IFSP;

(2) The family has an income that puts them at $0 on the fee scale; or

(3) The child and family receive no services other than those that must be provided at no cost to families.

iii. The family fee covers all IFSP services, including assistive technology devices, regardless of the number, type, frequency or length of services provided.

iv. The family fee may not exceed the total of any applicable co-payments, deductibles, and/or the full early intervention reimbursement rate (if the service is not covered by insurance) for delivered IFSP services in each month.

Background Information: Assistive Technology Devices and Family Fees

There is no separate fee to the family for assistive technology devices. The family's responsibility for payment toward the cost of such devices is covered by their use of insurance and/or the family fee just like all other IFSP services. (Note: Resources other than insurance also may be available to assist in the purchase of an assistive technology device. If available, these resources must be accessed prior to the use of Part C funds.)

An assistive technology device is considered a one-time cost that is incurred in the month of purchase. If the full charge for IFSP services other than the assistive technology device is less than the family's monthly cap, the family may pay a higher fee (up to the monthly cap) in the month the assistive technology device is purchased.

Example: Family's monthly cap is $207. The child is receiving PT weekly and their insurance co-pay for each PT visit is $25. Therefore, the family has been paying $100/month. This month, the assistive technology device listed on the child's IFSP was purchased at a cost of $500. Insurance did not reimburse any of that cost. This month the family will pay not only the $100 they've been paying for PT but also an additional $107 toward the cost of the assistive technology device since this brings them up to their monthly cap of $207.

v. Families who will be charged a fee can provide documentation of taxable income that will be used along with family size to determine a monthly cap, or maximum amount, for their family fee, based on the family cost share fee scale. Because it is based on taxable income, the family cost share fee scale automatically takes into consideration normal living expenses, including medical costs associated with the child's disability.

vi. The monthly cap established by the family cost share fee scale is the same regardless of the number of children the family has enrolled in the Infant & Toddler Connection system at the same time (e.g., if the family's monthly cap is $231 based on the fee scale, then that family pays no more than $231 per month, total, regardless of the number of children in their family who are enrolled).

In TRAC-IT, the monthly cap is set for each enrollment, not each family, so the local system/billing agency will need to manage that when a family has more than one child enrolled. The Monthly Cap report can be used and sorted by last name to help with identifying children/enrollments that may be part of the same family.

vii. If the family chooses not to provide income information, then the family has declined to access the family cost share fee scale.

(1) If the family has health insurance and agrees to have it billed for reimbursable IFSP services, then they are required to pay all applicable co-payments and deductibles for those services.

(2) If the family does not have health insurance, declines to have their insurance billed or the service is not covered by their health insurance, they must pay the full EI reimbursement rate for IFSP services.

viii. There are parent consent requirements, no-cost protections, and general categories of costs that parents must be aware of before the local system can use the child's or parent's Medicaid benefits to pay for early intervention services. Notification to parents of these requirements is included in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

(1) Families cannot be required to apply for or enroll in Medicaid/FAMIS to access Part C early intervention services.

(2) Parent consent is required to bill Medicaid/FAMIS if the child is not already enrolled in Medicaid/FAMIS. If the parent does not provide consent for use of Medicaid in this situation, then the local lead agency must still make available all IFSP services to the child and family in accordance with a signed *Family Cost Share Agreement* form.

(3) Parent consent is required for the local system to release a child's personally identifiable information to the Department of Medical Assistance Services for billing purposes. Parents may withdraw this consent at any time.

(4) In Virginia, families incur ***none*** of the following costs because of using Medicaid/FAMIS to pay for early intervention services:

(a) Decrease in available lifetime coverage or other insured benefit for the child or parent under the Medicaid/FAMIS program;
(b) Requirement to pay for services that would otherwise be covered by the public benefits or insurance program;
(c) Increase in premiums or discontinuation of public benefits or insurance for the child or the child's parents; or
(d) Risk of loss of eligibility for the child or the child's parents for home and community-based waivers based on aggregate health-related expenses.

(5) The only potential cost to parents from using their Medicaid/FAMIS for early intervention services would be the required use of their private insurance, if they have that and if they have consented to use of that private insurance, prior to billing Medicaid.

ix. Parent consent is required to bill private insurance or TRICARE for IFSP services. Consent is required to use private insurance or TRICARE to pay for the services listed on the child's initial IFSP and any time there is an increase (in frequency, length, duration or a change in intensity from group to individual) in the provision of services listed on the child's IFSP. When obtaining parent consent to bill private insurance or TRICARE, the parent must receive a copy of the family cost share policies, including the potential costs to the family of using their private insurance or TRICARE to pay for early intervention services. These policies are provided in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

x. If the necessary financial information is provided, the family cost share fee scale can be accessed by families who decline consent for use of their insurance. Lack of consent to use TRICARE or private insurance to pay for early intervention services cannot be used to delay or deny those services to families who have been determined unable to pay. The family cost share fee scale can also be accessed by families:

(1) With insurance that does not cover early intervention services; or
(2) Who do not have access to a provider in their insurer's network within the local Infant & Toddler Connection system.

xi. Families that use their insurance as well as accessing the family cost share fee scale are responsible for covering the cost of insurance co-pays and deductibles up to the monthly cap except that the family cost share fee scale may not be used to reduce co-pays and deductibles that are ***automatically*** paid to the family or the provider through the family's flexible spending account.

(1) If the family does not have a flexible spending account that automatically pays the provider or the family, Part C funds may be used to cover the remaining balance of the co-pays and deductibles above the family's monthly cap. Deductibles and co-pays are an obligation between the subscriber and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-pay from the family, and these cannot be waived. Therefore, the full deductible/co-pay (minus the amount the parent pays that month) is the responsibility of Part C.

(2) Families with flexible spending accounts that automatically pay the provider or the family must pay the full cost of any co-pays or deductibles until the funds in their flexible spending account have been exhausted.

Example: Family Cost Share When Family has Flexible Spending Account that Automatically Pays the Family or the Provider

- A family has private insurance and has $1,000 in their health care flexible spending account.
- Based on the family cost share fee scale, the family's monthly cap is $50.
- Their child is receiving Physical Therapy (PT) and Developmental Services.

This family is responsible for all co-pays and deductibles for the PT services until their flexible spending account is exhausted. In addition, the family will pay up to $50 per month toward the cost of Developmental Services. Once their flexible spending account is exhausted, the family will pay no more than $50 per month to cover all services

xii. If the family feels the monthly cap calculated on the family cost share fee scale is more than they can afford, they may request to reduce the monthly cap through completion of the Fee Appeal Form. The fee appeal process is detailed later in this section.

xiii. In cases where services are expected to extend over one year, the family is informed that an annual re-evaluation of their financial circumstances is required.

2. Prior to development of the initial and each annual IFSP, complete the following steps to **determine the family cost share**:

    a. Determine whether the child is covered by Medicaid/FAMIS, TRICARE and/or private health insurance.

        i. Request written parent consent on the *Family Cost Share Agreement* form to access Medicaid/FAMIS (if the child is not already enrolled in Medicaid/FAMIS), TRICARE and/or private insurance for reimbursable early intervention supports and services.

            (1) When there is an increase in service provision (in frequency, length, duration or intensity changes from group to individual) as a result of an IFSP Review, parent consent for continued use of their private insurance or TRICARE to pay for early intervention services is documented in the IFSP Review Record.

            (2) If the parent declines continued use of their private insurance or TRICARE as a result of an increase in service provision, then this is documented in the IFSP Review Record, and a new *Family Cost Share Agreement* form must be completed. If a new *Family Cost Share Agreement* form cannot be completed during the IFSP review, then the checkbox and parent signature in the IFSP Review Record can be used for up to 30 calendar days to stop billing to private insurance or TRICARE while a new *Family Cost Share Agreement* form is being completed and signed.

            (3) If, at the IFSP Review, the family provides consent to continue services/begin new services but wants more time to consider whether to continue using their private insurance to pay for early intervention services, then services may be provided but the family's private insurance may not be billed until the family provides consent for continued use of that private insurance.

        ii. Use the Information Release and Assignment of Benefits section of the *Family Cost Share Agreement* form or an agency release form to document the parent's consent for disclosing personally

identifiable information to the Department of Medical Assistance Services (DMAS) for children with Medicaid/FAMIS or to private insurance companies or TRICARE for billing and care coordination purposes. If a child is enrolled in a Medicaid Managed Care Organization (MCO), then “Medicaid and my child’s assigned Managed Care Organization” (rather than the specific name of the MCO) may be listed as the recipient/sender of the information from/to the local system on the release of information and assignment of benefits form that is signed by the parent.

b. Determine family size. All related or non-related persons who share income as an economic unit are considered part of a family unit. "Shared income" is income that is pooled or commingled to support the economic unit. "Shared expenses" is not the same as "shared income," and does not define an economic unit.

Examples: Determining Family Size

- A pregnant woman counts as 2 family members (or more in the case of multiple gestation). A woman’s statement that she is pregnant is sufficient, and medical confirmation is not required.
- A college student living away from home but receiving financial support from his family counts as part of the family unit.
- Multiple families who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family unit.
- A child and her mother live with the grandparents. The mother is employed and pays her own expenses. She pays rent to her parents. The child and her mother would be considered a family unit of 2, and only the mother’s income would be used to determine the family cost share because payment of rent to grandparents does not constitute pooling of income.
- A child lives with his unmarried father and his father’s companion. Both adults are employed. They are both signatories on their apartment lease and pay living expenses for food, utilities, etc. out of both incomes. The child, father and the companion would be considered an economic unit of 3 and both adults’ incomes would be used in determining the family’s cost share.

- A family member who is paying child support for the eligible child is not considered a part of the child's family unit.

- In cases where there is joint custody of the child, the parents must designate which of them is the head of the family (e.g., will the child be considered part of the mother's family unit or the father's family unit). If the head of the family unit is not designated, the parent presenting for services will be considered the head of the family.

- A husband and wife who are separated and are not living together are considered separate units. If a husband and wife are legally separated, but are living together and sharing their income, the two of them become a single economic unit despite their separated status.

When situations arise that do not match exactly with one of those listed above, local systems are encouraged to use the given examples to make their best effort in determining who constitutes the family unit in the specific situation being considered.

c. Determine the family's monthly cap using the family cost share fee scale. Request that the family provide proof of income by presenting (1) a copy or transcript of last year's federal 1040 tax returns; or (2) an estimated taxable income calculated by using the federal 1040 format (i.e., by completing a blank federal 1040 form, either the short form or the long form, from last tax year); or (3) if the family is unable to provide a copy of last year's tax return or estimated taxes in accordance with (1) or (2) above, proof of net monthly income in accordance with steps outlined in the fee appeal process.

    i. Taxable income must be taken from the most recent federal 1040 tax return. Taxable income found on the state return may not be used.

    ii. In situations where family conditions have materially changed since the most recently filed federal 1040 form, the family is required to notify their service coordinator. A revised taxable income will be determined by estimating taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form), or by providing proof of net monthly income in accordance with the steps outlined in the fee appeal process.

iii. In situations where families have not retained copies of their most recent tax return, families should take two steps: (1) request a transcript of the most recently completed federal 1040 from the IRS (see note below); and (2) estimate their taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form) for immediate use until the requested information is received. This will prevent a delay in the start of services. NOTE: Families are encouraged to request a transcript from the IRS and not a copy of their most recent tax return. There is a charge for copies of tax returns, and they can take several weeks to receive. Transcripts are sent at no cost within one to three weeks and can be requested by calling (800) 829-1040 or online http://www.irs.gov/.

iv. Completion of the federal 1040 form is the responsibility of the family and under no circumstances is it the responsibility of the individual designated by the local system to implement family cost share practices to assist the family in preparing estimated and/or annual income taxes.

v. If the family's income level is low enough to make the child eligible for Medicaid or FAMIS, there is no family ability to pay and the monthly cap for the family fee is automatically assessed at zero ($0). A family with income below the level that requires completion of federal income tax returns also has a monthly cap of zero ($0) under the family cost share practices.

3. **Complete the *Family Cost Share Agreement* form**. The *Family Cost Share Agreement* form is designed to clearly identify the specific responsibilities of the parent(s), document the choices parents have made regarding the manner in which they will pay for their services (i.e., use of insurance, full EI rate vs. monthly cap), identify the information used to determine the amount of the monthly cap, and obtain a written agreement from the parent(s) to pay for their early intervention services within their financial ability. If the family wishes to access the family cost share fee scale, then proof of income must be viewed by the individual designated by the local system to implement family cost share practices. Proof of income must be one of the following:

    a. A copy of the family's most recent federal 1040 form (only the page showing taxable income); or

b. If the federal 1040 form is grossly misrepresentative of the current financial status (e.g., due to birth of new baby, change in employment or marital status, etc.) or is non-existent, an estimate of their taxable income using a blank federal 1040 form with current financial information filled in; or

c. If no paystub or income documentation of any kind exists, then a written statement from the employer verifying the net income amount; or

d. If the family's income qualifies them for Medicaid/FAMIS, then documentation of Medicaid/FAMIS eligibility; or

e. If the family states they have no income and no Medicaid/FAMIS and no proof of this is available, then a signed statement by the parent certifying that they have no income.

Visual regard of the income documentation is adequate verification of income, and it is not necessary under federal and state Part C requirements to retain a copy of the document viewed. Signatures on the *Family Cost Share Agreement* form of the parent and the individual reviewing the income documentation confirm that the required income documentation was viewed. Local agency or local system requirements may be different from the state practice that allows visual regard of income and expense documentation. The individual designated to implement the family cost share practices for the local Infant & Toddler Connection system must be aware of and comply with any local requirement to receive and maintain a copy of income and expense documentation. The *Family Cost Share Agreement* form must be maintained in TRAC-IT, the child's early intervention record or in a separate financial file.

4. **Ensure that re-evaluation of the family's cost share occurs at least annually (at each annual IFSP)** and whenever the family's financial circumstances change. Make sure the family knows to inform their service coordinator of any significant changes in their financial status, including a change in their insurance coverage, income, or family size, throughout enrollment in services unless the family has chosen to pay all applicable co-pays, deductibles and/or the full EI reimbursement rate (if the service is not covered by insurance) for IFSP services.

    a. Once notified by the family of a change in the family's financial circumstances, the service coordinator facilitates completion of a revised *Family Cost Share Agreement* form that reflects the family's new financial

circumstances. The revised *Family Cost Share Agreement* form is signed by the family. If there is a new monthly cap, it becomes effective on the date of signature on the *Family Cost Share Agreement* form.

b. Any delay in signing the *Family Cost Share Agreement* form annually must be handled the same way as a delay in initially signing the form. Under extraordinary circumstances, Part C funds may be utilized to ensure the continued provision of services until the agreement form is signed. In the event of such extraordinary circumstances:

    i. The family must sign the *Temporary Family Cost Share Agreement Form*, indicating in Section A whether they are opting to delay services until they can provide financial information or to continue/begin services and decide within 30 days about providing financial information. The temporary agreement form explains the family's obligation to provide financial information within 30 days of the date they sign the IFSP and the options available to them at the end of those 30 days. It should also be made clear that the family will be obligated to pay, in accordance with the terms of the agreement form that is signed no later than 30 days after the IFSP, for any services (other than those that must be available at no cost) delivered prior to the agreement form being signed.

        (1) If the family opts to delay services and those services have not yet started, this would be a family reason for a delay in start of services.

        (2) Part C funds must be reimbursed once the monthly cap is established and payment is received.

        (3) If the family has private insurance or TRICARE and wants to use that insurance to pay for early intervention services, then the family must complete a *Family Cost Share Agreement* form in addition to the *Temporary Family Cost Share Agreement* form. The Family Cost Share Agreement form will document the parent's consent to use their private insurance or TRICARE and the "Charges" section of that Agreement form must reference the fact that a *Temporary Family Cost Share Agreement* form is in effect.

ii. Section B of the temporary agreement form must be completed no later than 30 days from the date the parent signed the annual IFSP to document the family's decision about completing the *Family Cost Share Agreement* form and continuing/starting services. Section B gives the family three options:

(1) Complete the *Family Cost Share Agreement* form and begin services, in which case **a completed *Family Cost Share Agreement* form may be used to document the family's choice rather than completing Section B of the temporary agreement form**;

(2) Delay further services (other than those available at no cost) until they can provide income information; or

(3) Decline further services.

Fee Appeal Process

1. The intent of the fee appeal process is to provide families with the opportunity for individual consideration of financial circumstances including documentation of extraordinary expenses, such as medical or other expenses related to the child's disability, and to appeal for additional reduction of the monthly cap. The fee appeal process is also used when the family is unable to provide a copy of last year's tax return or estimated taxes as described in the section on determining the family cost share.

2. There should be no duplication of processes between the family cost share fee scale and the fee appeal process. If a family expresses financial hardship after the monthly cap is established using the family cost share fee scale and accesses the fee appeal process, the monthly cap established through the fee appeal process is the final determination of the family's monthly cap.

3. The following steps are used consistently with all families who access the fee appeal process:

    a. Families are informed of all factors considered in the fee appeal process, including, but not limited to, the following:

i. The basis for the fee appeal is disposable income derived from taxable income or net monthly income less actual expenses;

ii. For items on the fee appeal form specifying a fixed average allowable amount (i.e., food, gasoline, clothing), no proof of expenses is needed unless the family's actual expenses exceed the average allowable amount. The average allowable amounts may be exceeded only if the family provides documentation. The family is required to provide documentation of expenses for all items on the fee appeal form where an average allowable amount is not specified. Visual regard of the expense documentation is adequate unless the local agency or local system does not allow this practice.

iii. The amount allowed for **recreation/entertainment** is limited to $25 per person per month and may not exceed that amount. This is an automatic deduction of $25 per person.

iv. **Credit card payments** may be deducted for families carrying a credit card balance. Use the current minimum monthly payment amount or the documented monthly payment negotiated with the creditor, through a debt counseling service or court ordered. This monthly amount does not need to be updated more than annually unless there is a significant change, which substantially impacts the family's ability to pay.

v. Child support payments should be included under **Other Debt Payment**. However, if taxable income is being used on the Fee Appeal form, be certain that child support has not already been deducted on the individual's tax form.

vi. **Educational expenses** include tuition, books, room and board and may be for any member of the family. Costs for programs like Gymboree classes or recreational programs may not be included as educational expenses.

vii. **Expenses to maintain the home in a livable condition** include expenses associated with adaptations necessary to make the home accessible and safe for a family member with a disability or to make repairs because of a natural disaster, fire or similar damage. Costs associated with a lawn service, weekly housecleaning service or

remodeling for a purpose other than maintaining the home in a livable condition (e.g., cosmetic improvements) are not allowed.

viii. The category of **job-related necessities** includes expenses incurred when the wage earner must purchase job necessities that the employer does not furnish or reimburse, such as tools, equipment, materials or uniforms.

ix. The following are not allowed as family monthly expenses on the fee appeal form: tithing; contributions to retirement or education savings accounts.

FAQs About Allowable Expenses for Fee Appeal

1. For the elder care deduction, do the parents need to be declared as a dependent on their income tax return to get this deduction?
   No

2. If families have second homes or vacation homes, are they an allowable deduction?
   Yes

3. For car repair bills under transportation deductions, are these outstanding bills or does this line-item account for past repairs?
   Outstanding bills

4. For medical expenses, do you take into account bills they've already paid and if so how far back or do you just allow routine monthly expense (i.e. doctor visits and prescriptions)?
   Take into account expenses from the past 12 months; divide that number by 12 to get a monthly amount to enter on appeal form.

5. The credit card payments category is only used if they carry a balance, right?
   A deduction can only be taken if the family carries a credit card balance and not if they pay their bill in full each month.

6. What if a family is doing unreimbursed medical/childcare pre-taxed?
   If the family has set aside pre-tax dollars in a flexible spending account for medical or childcare expenses, then expenses paid with these pre-tax dollars cannot be deducted on the fee appeal form since these dollars have already been deducted in determining the taxable income or net monthly income figure. For example, if the family put $1,000 into a

FAQs About Allowable Expenses for Fee Appeal
medical flexible spending account this year and had $1,000 in medical expenses (all of which were paid through the flexible spending account), then the amount the family can deduct for medical expenses on the Fee Appeal Form is $0.

b. The monthly cap is calculated by first subtracting expenses from taxable income (or net monthly income) and then taking 5% of that total. For example, if taxable income minus expenses equals $100, then the monthly cap is 5% of $100, which is $5. Five percent (5%) of the disposable income is the amount determined as the monthly cap.

c. The *Fee Appeal Form* (available as an ad hoc task in TRAC-IT) is completed and signed, and the family must provide documentation of their expenses as required by the *Fee Appeal Form*.

   i. If using taxable income, the family will have already provided documentation of their taxable income to complete the *Family Cost Share Agreement* form. No further documentation of income is required. Divide the family's taxable income by 12 and enter that amount on the "Monthly Family Income" line at the top of the *Fee Appeal Form*.

   ii. If using net monthly income, then enter this amount (based on pay stubs or written statement certifying income) on the "Monthly Family Income" line at the top of the *Fee Appeal Form*.

   iii. In situations where the family's taxable or net monthly income puts them at $0 on the family cost share fee scale, no documentation of expenses is required (because the family would already be at $0 and showing further expenses would have no effect on the monthly cap amount).

d. Information on the monthly cap resulting from the fee appeal process is transferred to the *Family Cost Share Agreement* form.

4. A family's inability to pay is different from a family's unwillingness to pay. If a family has been given access to the family cost share fee scale and fee appeal process but

is unwilling to pay for services that have been delivered, then providers may proceed with their own agency's process for collecting delinquent accounts.

5. If the family refuses to pay the fee determined through the fee appeal process, then the local system manager and service coordinator are notified. The service coordinator notifies all other service providers and provides a *Parental Prior Notice* form to the family indicating that all services, other than those that must be provided at no cost (e.g., service coordination, assessment, IFSP review) will not start or will end due to parent refusal to pay. The family must receive a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures.

6. Parents have the right to access the administrative complaint, mediation and/or due process procedures if they disagree with assigned fees or other decisions related to family cost share.

Billing Procedures

General

1. To be reimbursed, services must be provided in accordance with the IFSP. The frequency and length for a service cannot exceed that listed on the IFSP over a one-month period unless the provider is making up missed sessions from another month or there is documentation of other unusual circumstances that clearly justify the one-time variance.

2. Except for physicians, audiologists and registered dietitians, only certified early intervention providers and agencies who employ certified early intervention providers can bill for early intervention services.

3. Billing for early intervention services occurs at the local level. Each provider must have a mechanism to bill for services, either by:

a. Being employed by or contracted with an agency (including a local lead agency) that does the billing or contracts out the billing function; or

b. Doing their own billing.

4. Providers must have a National Provider Identifier, NPI, or Atypical Provider Identifier, API, for billing (group number if employed by an agency that is doing the billing, or an individual number if an independent practitioner). The National Provider Identifier is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, a unique identification number for covered health care providers. An Atypical Provider is an individual or business that bills DMAS for services rendered but does not meet the definition of a healthcare provider according to the NPI Final Rule 45CFR 160.103.

Medicaid/FAMIS; Medicaid Early Intervention Services Program

1. Under the Medicaid Early Intervention Services Program, providers bill DMAS (for children with Medicaid or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the codes listed in the Medicaid Early Intervention Services Program Reimbursement Information table at the end of this chapter.

    a. Children enrolled in FAMIS Select are not eligible for the Medicaid Early Intervention Services Program. These children have private insurance coverage and their co-pays and deductibles will be covered by Part C (since eligibility for FAMIS Select will put the family at $0 on the family cost share fee scale).

    b. Children on a Medicaid Spenddown or children with Emergency Medicaid (which includes emergency dialysis) also are not eligible for the Medicaid Early Intervention Services Program. These Medicaid types do not provide ongoing, full Medicaid coverage and do not include coverage for Medicaid-EI services. These children cannot be enrolled in the Medicaid-EI benefit and cannot have their early intervention services paid by Medicaid.

2. Medically necessary audiology, nutrition, medical services and assistive technology devices are reimbursed by Medicaid outside of the Medicaid Early Intervention Services Program and require different codes.

3. To be reimbursed by Medicaid for early intervention services:

    a. Providers must be EI Certified;

    b. Providers must enroll with the Department of Medical Assistance Services (DMAS) as an early intervention provider, even if already enrolled as a rehab provider. Follow the instructions on the DMAS Medicaid Enterprise System (MES) web portal to enroll as an early intervention provider;

    c. All Early Intervention service providers participating in the Virginia Medicaid Medical Assistance Services Program and Managed Care Organizations (MCOs) must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of early intervention services, as well as both Early Intervention Practice Manuals (DMAS and Infant & Toddler Connection of Virginia);

    d. Services must be provided to children who are determined eligible for early intervention and are receiving early intervention services, which may include an assessment for service planning, through the Infant & Toddler Connection system. Please see "Initial Data Entry for Enrollment in Medicaid EI Benefit" and "Maintaining Enrollment in Medicaid EI Benefit" text boxes on the next two pages for specific information on the TRAC-IT information required for children who are eligible for early intervention and who have Medicaid/FAMIS); and

    e. Services must be covered services identified on an IFSP signed by the parent and, except for assessments and IFSP meetings, approved by a physician, physician's assistant or nurse practitioner (for specific requirements associated with physician signature, please see the "Completing the IFSP Form" section of Chapter 7).

    For additional information about early intervention services through the Medicaid Early Intervention Services Program, visit the DMAS Web Portal (see link above), click on the link to provider manuals, and then select Medicaid Early Intervention Services.

4. No service that is ***planned*** solely for the parent is reimbursable by Medicaid. However, if the child falls asleep during an intervention session, it is okay to provide teaching/coaching to the caregiver and to bill for this service. This situation should be infrequent and well-documented; and the length of the session will generally be

shorter than planned since the provider and caregiver are not able to practice the strategies with the child. In addition, Medicaid reimbursement is available for providers participating in IFSP meetings even if the child is not present.

5. Rounding the minutes of service provided up or down is allowed in accordance with the 8-minute rule when billing DMAS for the service. This rule is used for rounding up when eight (8) minutes or more of service are rendered and rounding down when seven (7) minutes or less are rendered.

Chart: Units — Number of Minutes		
NUMBER Units	**≥ Minutes**	**Through Minutes**
ONE (1) unit	≥ 8 minutes	22 minutes
TWO (2) units	≥ 23 minutes	37 minutes
THREE (3) units	≥ 38 minutes	52 minutes
FOUR (4) units	≥ 53 minutes	67 minutes
FIVE (5) units	≥ 68 minutes	82 minutes
SIX (6) units	≥ 83 minutes	97 minutes

The ability to round minutes up or down for billing does not change the requirement to deliver services in accordance with the length listed on the IFSP.

6. Providers also may bill for a range of dates within a month.

7. Except for center-based services, early intervention services provided via telehealth may be billed to Medicaid. The provider must follow the requirements specified in the DMAS Provider Manual: Telehealth Services Supplement. These requirements are summarized here, but providers are responsible for reviewing and following the supplement directly:

    a. Providers must bill telehealth services using the GT modifier. Base the two-digit code indicating the setting of the telehealth service on the place where the service would have taken place had it been delivered in person. Providers should not use POS 02 on telehealth claims.

b. Before providing a telehealth service, the provider must inform the parent about the use of telehealth and document electronic or written parent consent for the use of telehealth. When obtaining consent, the provider must convey at least the following information:

    i. The parent's choice to receive telehealth is voluntary and the parent may change their mind at any time and that choice will not change their child's eligibility for the service, or any future services or health insurance benefits;

    ii. The use of telehealth will comply with all confidentiality laws;

    iii. The parent will be told about anyone in addition to the early intervention provider(s) who is present for the telehealth service and can exclude anyone they do not want to have present; and

    iv. The parent can refuse to have the session videotaped or recorded.

c. Audio only services are not permitted.

d. Certain early intervention services must be provided in person, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review or service delivery:

    i. The initial service visit for G billing codes (services provided by occupational therapists, speech therapists, physical therapists and nurses) must be in-person with a member of the clinical team physically present. The service coordinator is considered a member of the clinical team.

    ii. The initial assessment (billing code T1023) must be in person with each assessing member of the clinical team physically present with the child.

e. A family member/caregiver must be physically present with the child during the telehealth visit.

8. For children with Medicaid/FAMIS and commercial insurance coverage, providers must bill the commercial insurance first except in the following circumstances:

a. If a family has declined access to their private health/medical insurance for covered early intervention services, then the following steps may be taken to secure Medicaid reimbursement without billing the commercial insurance first:

    i. Check “yes” for box 11-D on the CMS 1500 form; and

    ii. Complete and sign a *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form and attach it to the claim form.

b. Edits (requirements to submit proof of billing commercial insurance if the client has Medicaid/FAMIS as secondary) have been removed for the following billing codes: T1023 and T1023 UI; T1024 and T1024 U1; T1027 and T1027 U1; T1015 and T1015 U1; and T2022. This means providers do not have to go through the additional paperwork step of providing an explanation for why commercial insurance is not being billed or is not paying for developmental services, assessments or early intervention targeted case management/service coordination.

Medicaid Early Intervention Targeted Case Management (EI TCM)

1. EI TCM providers bill DMAS (for children with Medicaid fee for service, MCO or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the billing code T2022.

2. To be reimbursed monthly by Medicaid for service coordination:

    a. The service coordinator must be certified as an Early Intervention Case Manager.

    b. The agency providing service coordination must be enrolled with the Department of Medical Assistance Services (DMAS) as an early intervention provider with specialty type 119. To enroll, follow the instructions on the DMAS Medicaid Enterprise Service (MES) web portal. The Local Lead Agency determines which agencies within the local system will provide and bill for early intervention service coordination.

c. Service coordination must be delivered in accordance with a signed Initial Early Intervention Service Coordination Plan or a signed Individualized Family Service Plan (IFSP).

    i. To bill Medicaid for service coordination starting at intake, an Initial Early Intervention Service Coordination Plan must be completed, signed and dated at Intake as part of the intake visit task in TRAC-IT.

    ii. The Initial Early Intervention Service Coordination Plan ends when the child is found ineligible for early intervention, the IFSP is signed, or 90 calendar days from the date of intake, whichever comes first, with billing not to exceed three calendar months.

    iii. The month in which a child is determined to be ineligible or no longer eligible is the last month that service coordination can be billed.

d. During the month being billed, at least one of the allowable activities listed in the text box on the next page must be provided by the service coordinator with the child, the family, service providers, or other organizations on behalf of the child/family. The contact must be relevant to the child/family needs and the Initial Early Intervention Service Coordination Plan or Individualized Family Service Plan (IFSP). The service may not duplicate any other Medicaid service. The documentation must include the length of time documented in minutes for conducting the allowable activity (either as the total time spent or by recording the start time and end time for the activity).

e. The contact or communication and the length of time in minutes for conducting the contact must be documented completely and correctly, as outlined in the contact note requirements in Chapter 9.

f. At a minimum, phone, email, text, or face-to-face contact with the family must occur every three calendar months, or there must be documented attempts of such contacts. Three calendar months does not mean every 90 days, nor does it mean quarterly. The contacts must begin no later than the next month after the month that the initial IFSP is signed, and the 3-calendar-month period restarts after each contact (i.e., if the service coordinator contacts the family on October 7 and November 10, then the next contact must be made no later than the last day of February).

i. The family's preferred method of contact must be documented. This can be documented in a contact note for the intake visit and any time the family's preference changes. (See Chapter 9 for more information about documentation requirements).

ii. The following requirements must be met to offer and use texting as the preferred method of contact:

(1) The service coordinator may only offer texting as an option if she has the capability to receive and send texts.

(2) Texting may only be used if the family selects texting as their preferred method of contact and signs the *Permission for Texting* form, which notifies the family that there may be some level of risk that the information in the text may be read by a third party. The *Permission for Texting* form must be kept in the child's Early Intervention Record.

(3) The communication that occurs via texting must constitute service coordination. Sending a text to the family to ask how things are going and getting a reply of "Fine" is not service coordination. That is true for contacts via email, phone, or in person as well. The job of service coordination does not change based on the preferred method of contact. For that reason, contact notes must substantiate that the communication between the service coordinator and the family is substantive and does constitute actual service coordination.

(4) The service coordinator must either print out and store a copy of the texts in the child's early intervention record or include in the contact note a thorough summary of the communication.

(5) If, at any point, it becomes clear that texting is not a viable method of communication with a particular family, then the service coordinator needs to work with the family to identify a different method of contact.

iii. The provider may not bill for a month in which the only activity was attempted contacts with the family, but these attempted contacts

within the three calendar month period will prevent the provider from losing all billing during the three calendar month period (e.g., they could bill for another month in that period during which an allowable activity was completed even though their attempts to make the required contact with the family by phone, email, text or face-to-face every three calendar months were unsuccessful).

g. There must be documented face-to-face interaction between the service coordinator and the family at the development of the initial IFSP and the annual IFSP along with documentation that the service coordinator observed the child during the calendar month that the IFSP meeting was held.

h. The health status indicator questions must be submitted to the child's physician every six months or an alternate local mechanism (e.g., request and review of well-child records) used to collect the answers to these questions.

i. EI TCM may not be billed for any month in which the child was hospitalized for the entire month. However, EI TCM can be billed if service coordination/case management activities occur when the child is not hospitalized for the entire month and the allowable service coordination/case management activities occur before or after the hospitalization.

3. When a child transitions from one local system to another and both systems provide service coordination during that month, only one of the local systems can bill for EI TCM. If the child is transferred on or before the 15th of the month the receiving local system would bill. If the child is transferred from the 16th of the month to the end of the month, the sending local system would bill.

4. Early Intervention (EI) enrollees must receive EI targeted case management. Since DMAS allows only one case management program to be billed during the same period, DMAS cannot be billed for DD or MH TCM for EI enrollees.

    a. DMAS does allow an exception for BabyCare case management to be billed simultaneously along with EI targeted case management during the same period.

    b. Because case management is built into the reimbursement for therapeutic foster care, EI and Therapeutic Foster Care (TFC) case management cannot

be billed to DMAS for the same service month. If an EI enrollee is receiving TFC, the EI case manager should review the child's needs and services with the TFC case manager to determine if the child's services are better monitored and coordinated by the EI case manager or the TFC case manager. The two case managers are responsible for making the determination of which TCM is better suited for the child's particular needs and services. If it is determined that Therapeutic Foster Care will be billed, then Part C funds may be used as payor of last resort to cover the costs of Part C service coordination.

EI TCM Allowable Activities for Billing Medicaid

Allowable activities include but are not limited to the following:

1. Coordinating the initial Intake and Assessment of the child and planning services and supports, to include history-taking, gathering information from other sources, and the development of an Individualized Family Service Plan, including initial IFSP, periodic IFSP reviews, and annual IFSPs. This does not include performing medical assessments, but may include referral for such assessment.

2. Coordinating services and supports planning with other agencies and providers.

3. Assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources.

4. Enhancing community integration through increasing the child and family's community access and involvement.

5. Making collateral contacts to promote implementation of the Individualized Family Service Plan and allow the child/family to participate in activities in the community. A collateral contact is defined as "Contact with the child's significant others to promote implementation of the service plan and community participation, including family, non-family, health care entities and others related to the implementation and coordination of services."

6. Monitoring implementation of the Individualized Family Service Plan through regular contacts with service providers, as well as periodic early intervention visits.

EI TCM Allowable Activities for Billing Medicaid

7. Providing instruction and counseling that guide the family in problem-solving and decision-making and developing a supportive relationship that promotes implementation of the Individualized Family Service Plan. Counseling in this context is defined as problem-solving activities designed to enhance a child's ability to participate in the everyday routines and activities of the family within natural environments where children live, learn, and play.

8. Submitting to the client's physician (semiannually) the health status indicator questions or using an alternate local mechanism to collect the information necessary to answer these questions. Based upon the results of the questionnaire from the physician, following up with the family/caregiver to inform and/or assist in obtaining needed medical services.

9. Coordinating the child/family's transition from Part C early intervention services.

10. Making contacts (face-to-face, phone, email, text) with the family (see #2f in the section directly above for minimum requirements).

For All Children with Medicaid/FAMIS

The local system manager (or designee) must provide oversight to ensure Medicaid/FAMIS information is correctly entered into TRAC-IT within the required timeframes to begin and maintain enrollment in the Medicaid EI benefit. The following text boxes and the one titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification" in the Family Cost Share section of this chapter provide further information.

Initial Data Entry for Enrollment in Medicaid EI Benefit

For providers to receive Medicaid reimbursement for Part C early intervention services the Insurance Record must be created promptly and accurately in TRAC-IT and the following data must be entered:

- Medicaid/FAMIS must be selected in the insurance coverage field;
- An accurate 12-digit Medicaid number must be entered in the Subscriber's Member ID/Child's Medicaid Number. The 12-digit number is used by the State Lead Agency to locate the child's record in the Department of Medical Assistance Services (DMAS) database, VaMMIS.

Initial Data Entry for Enrollment in Medicaid EI Benefit

- The Intake task must be completed in TRAC-IT.

Child has Medicaid/FAMIS when the Child is Referred to the Infant & Toddler Connection

- TRAC-IT data entry must be completed (Medicaid/FAMIS selected, 12-digit Medicaid number entered and Intake Visit Task completed) within 10 business days of the Intake Visit Date to bill for Initial Early Intervention Service Coordination. (An Initial Early Intervention Service Coordination Plan also must be in place to bill for this service).

- If any of the required information is entered in TRAC-IT more than 10 business days after the Intake Visit Date, then the date the required information is entered in TRAC-IT will be the start date for the Medicaid Early Intervention benefit.

Child Enrolled in Medicaid/FAMIS after the Child is referred to the Infant & Toddler Connection system

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in TRAC-IT within 60 calendar days of the Medicaid Disposition Date (the date the decision was made that the child was eligible for Medicaid or FAMIS) and if the child has an Initial Early Intervention Service Coordination Plan in place, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Intake Visit Date. If the Medicaid/FAMIS start date precedes the Intake Visit Date, then the Intake Visit Date will be the start date for the Medicaid EI benefit.

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 60 calendar days after the Medicaid Disposition Date, then the date the required information was entered in TRAC-IT will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the period that is not covered.

NOTE: Medicaid reimbursement is available only for service coordination (Early Intervention Targeted Case Management) until it is determined that the child is eligible for early intervention.

Maintaining Enrollment in Medicaid EI Benefit

Child's Medicaid Early Intervention Benefit is "Dropped" in the Medicaid VaMMIS System:

- Occasionally, a child's EI benefit in the Medicaid MMIS system may be dropped, which can occur when the child has changes in their Medicaid/FAMIS benefits. If this happens, the local system must uncheck the Enrolled/Re-Enrolled in EI Medicaid Benefit box on the child's insurance record within 60 calendar days of the date the Medicaid EI benefit dropped (the date the EI benefit was ended by the VaMMIS system) for the EI benefit to be added back to the Medicaid VaMMIS system starting the next day from when the benefit had ended. Unchecking the box populates the child to the state enrollment report to add back the benefit.

Child Loses Medicaid/FAMIS Coverage, Then Coverage is Restored:

- The local system must end date the Medicaid insurance record in the state data system when coverage is lost. When coverage is restored, the local system must create a new Medicaid insurance record in the state data system within 60 calendar days of the Disposition Date (date the decision was made to restore Medicaid/FAMIS). When the local system meets this timeline, the date the Medicaid/FAMIS is restored will be the start date for restoration of the Medicaid EI benefit. Creating a new Medicaid insurance record populates the child to the state enrollment report to add back the benefit.

- If the local system creates a new Medicaid insurance record in the state data system more than 60 calendar days after the Medicaid Disposition Date, then the date the new Medicaid insurance record was created will be the start date for the Medicaid EI benefit and reimbursement will not be available through Medicaid or Part C for the time period that is not covered.

Child is Transferred from One Local System to Another Local System in Virginia:

- The "sending" local system must complete the discharge task in TRAC-IT and refer the child to the new ("receiving") local system prior to the date that the child will be starting services within the new local system.
- When a child transfers from one local system to another, the start date for the Medicaid EI benefit under the new, "receiving" local system must be after the discharge date from the original, "sending" local system.
- There must not be two open records in TRAC-IT for the same child.

If the local system is responsible for Medicaid/FAMIS not being available to reimburse for services (through failure to enter child information in TRAC-IT on time or to notify the Infant & Toddler Connection of Virginia Office if a child has lost Medicaid/FAMIS and then regained it or to request on time that the Infant & Toddler Connection of Virginia Office add the Medicaid EI benefit), the funds that can be used to pay for services are local funds or revenue from private insurance, Medicaid/FAMIS, other third party payors, or family fees. If funds from these sources are not adequate to pay for the service(s), then the local system manager must contact his/her Infant & Toddler Connection of Virginia Technical Assistance Consultant.

Private Insurance and TRICARE

1. Providers bill third party payors according to the requirements (including billing codes and forms) of the payor. Third party payors other than Medicaid may or may not reimburse for early intervention services delivered via telehealth, and their billing codes and processes may vary.

2. Virginia has enacted third party payor regulations that mandate coverage for early intervention services. Insurance companies that are domiciled in Virginia and that are part of the fully insured market must include coverage for physical therapy, occupational therapy, speech-language therapy and assistive technology for infants and toddlers enrolled in the Infant & Toddler Connection of Virginia.

    a. The benefit is capped at $5,000 per year.
    b. The mandate specifies that money paid through this benefit cannot be applied to the insured's lifetime maximum benefit.
    c. Organizations who contract with insurance companies to manage their employee health benefits, but who "self-fund" the benefit are exempt from the mandate.
    d. A similar mandate is included for insurance for state employees.

    Insurance companies based outside of Virginia (even if operating and covering services provided in Virginia) as well as self-insured policies are not covered by the early intervention insurance mandate. For more information on these insurance mandates visit the *Code of Virginia* § 38.2-3418.5. Coverage for early intervention services.

3. Private insurance plans may not be billed for services where no consumer liability can be established (i.e., where services must be provided at no cost to the family).

4. TRICARE is the uniformed services health care program for active-duty service members and their families, retired service members and their families, members of the National Guard/Reserve and their families, survivors and other eligible beneficiaries. TRICARE is a ***public*** third-party payor. As such, TRICARE can be billed for assessments conducted under Part C (whereas private insurance cannot). Visit TRICARE online to learn more about TRICARE, including information about the managed care support contractor for TRICARE North Region, which includes Virginia.
5. Since private insurance companies typically do not reimburse for the increased costs incurred when services are provided in natural environments, Part C funds are used to bring the reimbursement to the provider up to the standard early intervention rate or up to the rate charged by the provider, whichever is less.

Part C Funds

1. To receive Part C reimbursement as the payor of last resort (e.g., for services not covered by third party payors or to bring provider reimbursement up to the standard rate), providers must have a contractual relationship with the local Infant & Toddler Connection system.

2. Providers are required to enter/upload contact notes to TRAC-IT in a timely manner, no more than 7 business days from the time of the contact.

3. Part C funds cannot be used to reimburse a provider for a Medicaid billable service when the child has Medicaid/FAMIS, except when necessary to prevent a delay in the timely start of services. Once Medicaid funds are received, they must be used to reimburse the local system for the Part C funds originally paid. For example, suppose a family is in the process of applying for Medicaid/FAMIS when an early intervention service begins on March 16. The child's Medicaid/FAMIS eligibility is established on April 1 and coverage is backdated to March 1. If Part C funds were used to pay the provider for the service delivered on March 16, then DMAS must be billed for that service and the local system must be reimbursed for the Part C funds originally used to pay for that service.

4. Sample billing and reimbursement scenarios are provided on the next page to illustrate use of Part C funds as payor of last resort when the family allows their private insurance to be billed for early intervention services.

Purchase of Assistive Technology Devices

1. Public procurement policies must be followed when using public funds to pay for all or part of an assistive technology device.

2. If purchased with the family's health insurance (public or private), the equipment belongs to the family, and they may keep it when they leave the Infant & Toddler Connection of Virginia system.

3. If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at $5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:

    a. The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or a trial basis.
    b. If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it if the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.
    c. If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.

4. Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.

5. The Local Lead Agency must maintain a comprehensive, up-to-date inventory of all assistive technology devices purchased with federal or state Part C funds paying more than 50% of the cost and valued at $5,000 or more. This inventory will cite the device, appropriate serial numbers, location of the device, and anticipated disposition of the device including timeline.

6. Please see the text box titled "When considering the purchase of an Assistive Technology Device" in "The Initial IFSP Meeting" section of Chapter 7 for information about what is considered an assistive technology device under Part C.

Sample Billing/Reimbursement Scenarios

FCS Agreement Form Says	Charges and Reimbursement	
Scenario 1 • Private insurance (w/ permission to bill) • Full fee	Provider Charge	$180.00
	Insurance Copay	$20.00
	Insurance Deductible	$500.00
	Insurance Allows	$95.00
	Amount Applied to Deductible	$0.00
	Part C Standard Rate	$168.76
	Insurance Pays	$75.00
	Family Pays	$20.00
	Part C Pays	$73.76
Scenario 2 • Private insurance (w/ permission to bill) • Fee Cap = $0	Provider Charge	$180.00
	Insurance Copay	$25.00
	Insurance Deductible	$1,000.00
	Insurance Allows	$90.00
	Amount Applied to Deductible	$0.00
	Part C Standard Rate	$168.76
	Insurance Pays	$65.00
	Family Pays	$0.00
	Part C Pays	$103.76
Scenario 3 • Private insurance (w/ permission to bill) • Family has PPO allowing balance billing • Fee Cap = $0	Provider Charge	$180.00
	Insurance Copay	$0.00
	Insurance Deductible	$1,000.00
	Insurance Allows	$80.50
	Amount Applied to Deductible	$80.50
	Part C Standard Rate	$168.76
	Insurance Pays	$0.00
	Family Pays	$0.00
	Part C Pays	$168.76
Scenario 4 • Private insurance (w/ permission to bill) • Fee Cap = $0	Provider Charge	$180.00
	Insurance Copay	$25.00
	Insurance Deductible	$1,000.00
	Insurance Allows	$180.00
	Amount Applied to Deductible	$180.00
	(co-pay amount included in deductible)	
	Part C Standard Rate	$168.76
	Insurance Pays	$0.00
	Family Pays	$0.00
	Part C Pays	$180.00*

Sample Billing/Reimbursement Scenarios
* Deductibles and co-payments cannot be bound by the contract rate that the Infant & Toddler Connection system has with a private agency for direct services that are not covered by insurance since the insurance reimbursement rates, and co-payment and deductible amounts are determined and set by the insurer. Deductibles and co-payments are an obligation between the subscriber (family) and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-payment from the family. These cannot be waived. Therefore, the full deductible and co-payment (minus the amount the parent pays that month) is the responsibility of Part C.

Reimbursement Sources and Medicaid EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage

Step			Medicaid EI TCM	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds*	Part C – POLR
Referral Steps							X	X
Intake			X		T2022		X**	X**
Developmental Screening			X		T2022		X**	X**
Hearing and Vision Screening			X		T2022		X**	X**
Eligibility Determination	SC		X		T2022		X**	X**
	EIP						X	X
Assessment for Eligibility	SC		X		T2022		X**	X**
	EIP– Combined w/ASP and Child found eligible	PT, OT, SLP, N		X	T1023 U1			
		Other EIP		X	T1023			
	EIP – Separate from ASP or Child found not eligible						X	X
Assessment for Service Planning	SC		X		T2022		X**	X**
	EIP	PT, OT, SLP, N		X	T1023 U1			
		Other EIP		X	T1023			
Initial and Annual IFSP Meeting	SC		X		T2022		X**	X**
	PT, PTA, OT, OTA, SLP, N			X	T1023 U1			
	Other EIP and EIS			X	T1023			
Provide Individual EI Services in Natural Environments	PT, PTA, OT, OTA, SLP, N			X	G0151 U1 G0152 U1 G0153 U1 GO495 U1-			
	Other EIP			X	T1027 U1			
	Other Disc: AUD, Diet., etc.					X	X	X
	EIA, Nurse Aide			X	T1027 & T1027 U1			
Provide Group (Congregate) EI Services in Natural Environments	PT, PTA, OT, OTA, SLP, N			X	G0151,G0152, G0153, G0495			
	Other EIP			X	T1027			
	Other Disc: AUD, Diet., etc.					X	X	X
	EIA, Nurse Aide			X	T1027			
Provide Individual EI Services in Center Setting	PT, PTA, OT, OTA, SLP, N			X	T1026 U1			
	Other EIP			X	T1015 U1			
	Other Disc: AUD, Diet., etc.					X	X	X
	EIA, Nurse Aide			X	T1015 U1			

Reimbursement Sources and Medicaid EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage

Step		Medicaid EI TCM	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds*	Part C – POLR
Provide Group (Congregate) EI Services in Center Setting	PT, PTA, OT, OTA, SLP, N		X	T1026			
	Other EIP		X	T1015			
	Other Disc: AUD, Diet., etc.				X	X	X
	EIA, Nurse Aide		X	T1015			
IFSP Review Meeting: Family present	PT, PTA, OT, OTA, SLP, N		X	T1024 U1			
	Other EIP and EIS		X	T1024			
Consultation: without child/family	EIP and EIS					X	X

PLEASE NOTE that federal regulations and Virginia policies and procedures require that no services that a child is entitled to receive are delayed or denied because of disputes between agencies regarding financial or other responsibilities.

Key

*	State and local non-Part C funds, grants, donations, etc.
**	For children receiving therapeutic foster care
POLR	Payor of Last Resort
AUD	Audiologist
Diet	Dietician
ECE	Early Childhood Educator
EIP	Early Intervention Professional (PT, OT, ECSE, etc.)
EIS	Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide, etc.)
Other EIP	Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners
SC	Service Coordinators
TCM	Targeted Case Management

NOTE: Other EIP are early intervention professionals who fall in Medicaid's Category 2 classification

Reimbursement Sources for Components of the Early Intervention Process for Children with TRICARE, Private Insurance or No Third Party Payor Source

Step			TRICARE	Private Insurance	Other Funds*	Part C - POLR
Referral Steps					X	X
Intake					X	X
Developmental Screening					X	X
Hearing and Vision Screening					X	X
Eligibility Determination	SC				X	X
	EIP				X	X
Assessment for Eligibility	SC				X	X
	EIP– Child found eligible	PT, OT, SLP, N	X		X	X
		Other EIP			X	X
	EIP – Child found not eligible		X		X	X
Assessment for Service Planning	SC				X	X
	EIP	PT, OT, SLP, N	X		X	X
		Other EIP			X	X
Initial and Annual IFSP Meeting	SC				X	X
	PT, PTA, OT, OTA, SLP, N				X	X
	Other EIP and EIS				X	X
Provide Individual EI Services in Natural Environments	PT, PTA, OT, OTA, SLP, N		X	X	X	X
	Other EIP				X	X
	Other Disc: AUD, Diet., etc.		X**	X**	X	X
	EIA, Nurse Aide				X	X
Provide Group EI Services in Natural Environments	PT, PTA, OT, OTA, SLP, N		X	X	X	X
	Other EIP				X	X
	EIA, Nurse Aide				X	X
Provide Individual EI Services Center	PT, PTA, OT, OTA, SLP, N		X	X	X	X
	Other EIP				X	X
	Other Disc: AUD, Diet., etc.		X**	X**	X	X
	EIA, Nurse Aide				X	X
Provide Group EI Services in Center Setting	PT, PTA, OT, OTA, SLP, N		X	X	X	X
	Other EIP				X	X
	EIA, Nurse Aide				X	X
IFSP Review Meeting: Family present	PT, PTA, OT, OTA, SLP, N				X	X
	Other EIP and EIS				X	X
Consultation: without child/family	EIP and EIS				X	X

Key

*	State and local non-Part C funds, grants, donations, etc.
**	**Reimbursement depends on the child's third party payor policy**
POLR	Payor of Last Resort
AUD	Audiologist
Diet	Dietician

ECE	Early Childhood Educator
EIP	Early Intervention Professional (PT, OT, ECSE, etc.)
EIS	Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide, etc.)
Other EIP	Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners
SC	Service Coordinators
TCM	Targeted Case Management

Medicaid Early Intervention Services Program Reimbursement Information

Code	Rate	Who bills	When is This Used	Location	Limits
T2022	148.50/mo	Service Coordinator	• Service coordination	N/A	1 charge/child/month
T1023	30.94/unit	Reimbursement Category 2 Providers	• Initial Assessment for Service Planning • Development of initial IFSP • Annual IFSP	Natural Environments or Center-based	24 units/day and 36 units/year
T1023 U1	42.19/unit	Reimbursement Category 1 Providers			
T1024	30.94/unit	Reimbursement Category 2 Providers	• Team Treatment activities (more than one professional providing services during same session for an individual child/family • IFSP **Review** Meetings (must be in person) • Assessments that are done ***after*** the initial Assessment for Service Planning	Natural Environments* for team treatment activities; NE or center for IFSP reviews and assessment	The maximum daily units/per child/ per (service) code/ per individual practitioner is **6 units** with a maximum of **18 units** (for any combination of codes) per day per child for all agency/providers combined. [The 18 units can be a combination from 2 or more agencies/providers or can be all from one agency as long as no individual practitioner exceeds the 6 units/individual practitioner/per day limit]
T1024 U1	42.19/unit	Reimbursement Category 1 Providers			
T1027	20.73/unit	Reimbursement Category 2 Providers	• Developmental Services and other early intervention services provided for more than one child, in a group (congregate), by one Reimbursement Category 2 Certified EI Provider	Natural Environments*	
T1027 U1	30.94/unit		• Developmental Services and other early intervention services provided for one child by one Reimbursement Category 2 Certified EI Provider		
T1026	8.36/unit	Reimbursement Category 1 Providers	• Center-based group (congregate) early intervention services	Center-based	
T1026 U1	25.31/unit		• Center-based individual early intervention services	Center-based	
T1015	6.12/unit	Reimbursement Category 2 Providers	• Center-based group (congregate) early intervention services	Center-based	
T1015U1	18.55/unit		• Center-based individual early intervention services	Center-based	

Medicaid Early Intervention Services Program Reimbursement Information

Code	Rate	Who bills	When is This Used	Location	Limits
G0151	28.27/unit	Physical Therapists, PTAs (RC 1)	• Group (congregate) PT	Natural Environments*	
G0151 U1	42.19/unit		• Individual PT		
G0152	28.27/unit	Occupational Therapists, OTAs (RC 1)	• Group (congregate) OT	Natural Environments*	
G0152 U1	42.19/unit		• Individual OT		
G0153	28.27/unit	Speech Language Therapists (RC 1)	• Group (congregate) SLP	Natural Environments*	
G0153 U1	42.19/unit		• Individual SLP		
G0495	28.27/unit	RN or RNP (RC 1)	• Group (congregate) Nursing Services or Developmental Services provided by a nurse	Natural Environments*	
G0495 U1	42.19/unit		• Individual Nursing Services or Developmental Services provided by a nurse		

* May include rare situations where services are provided in a center with acceptable justifications ***AND*** for which travel by the provider is required. See Infant & Toddler Connection of Virginia Practice Manual for information.

Chapter 12: Personnel

Practitioner Qualifications

1. Personnel providing Part C early intervention supports and services in Virginia must meet the discipline-specific qualifications specified in Table C at the end of this chapter.

2. Individual practitioners of early intervention services, except physicians, audiologists and registered dietitians, must be certified by the State Lead Agency as an Early Intervention Professional, Early Intervention Specialist, or Early Intervention Case Manager[6]. Audiologists who provide early intervention services other than audiological testing are strongly encouraged to become certified as Early Intervention Professionals.

3. To provide both service coordination and another early intervention service, a practitioner must be certified as both an Early Intervention Professional and an Early Intervention Case Manager or as both an Early Intervention Specialist and an Early Intervention Case Manager.

   Individuals interested in providing early intervention services in Virginia can find step-by-step instructions on certification by visiting the Infant & Toddler Connection of Virginia website.

   NOTE: To allow Medicaid reimbursement for service coordination provided to children with Medicaid/FAMIS through the Early Intervention Targeted Case Management (EI TCM) program, the legislative terminology of “case manager” must be used for the certification. The service provided by certified Early Intervention Case Managers is service coordination.

[6] To allow Medicaid reimbursement for service coordination provided to children with Medicaid/FAMIS through the Early Intervention Targeted Case Management (EI TCM) program, the legislative terminology of “case manager” must be used for the certification. The service provided by certified Early Intervention Case Managers is service coordination.

Scope of Practice

1. Qualified practitioners have those responsibilities designated in Table C.

2. Certified Early Intervention Specialists must work under the supervision of an Early Intervention Professional who has completed the Infant & Toddler Connection of Virginia supervision training module and passed the competency test with at least 80% accuracy. Early Intervention Specialists may be supervised by an Early Intervention Professional from any discipline unless discipline-specific regulations specify otherwise.

3. Certified Early Intervention Case Managers who have completed the supervision training module may supervise other certified Early Intervention Case Managers only.

Early Intervention Certification

There are three early intervention certifications: Early Intervention Professional, Early Intervention Specialist, and Early Intervention Case Manager. Certifications are granted for a three-year period. The date an individual initially receives his/her first certification (regardless of whether that's Early Intervention Practitioner, Early Intervention Specialist or Early Intervention Case Manager) will determine the 3-year certification cycle. If an additional certification is issued to that practitioner within that 3-year cycle, then the new certification will expire on the same date as the original certification.

Requirements and Process for Initial Certification as an Early Intervention Professional or Early Intervention Specialist

1. Practitioners interested in providing early intervention services in the Infant & Toddler Connection of Virginia system are required to complete an online application. The applicant must:

    a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline; and

    b. Complete the following Infant & Toddler Connection of Virginia online training courses, passing the competency test for each with at least 80% accuracy:

i. Overview: Mission and Key Principles of Early Intervention
ii. The Early Intervention Process
iii. Effective Practices for Implementing Early Intervention
iv. Responsibilities of Early Intervention Practitioners
v. Child Development;
vi. Authentic Assessment for Early Intervention; and

c. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the practices specified in the *Infant & Toddler Connection of Virginia Practice Manual*.

2. Once the online application is submitted, the applicant will receive an email confirmation that the application has been submitted.

3. The applicant is notified of the status of his/her application:

   a. If the applicant has met all certification requirements, then the applicant receives notification that certification is granted.

   b. If the applicant does not meet all certification requirements or the application is incomplete, then the applicant receives notification that the request for certification is denied.

Requirements and Process for Initial Certification as an Early Intervention Case Manager

1. The requirements and process for initial certification as an Early Intervention Case Manager are the same as those for an Early Intervention Professional or Specialist except that:

   a. Instead of meeting the discipline-specific licensure/certification requirements that apply to his/her discipline, the applicant must hold:

      i. A minimum of a bachelor's degree in any of the following fields:

         (1) Allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;
         (2) Child and family studies;

(3) Counseling;
(4) Early childhood;
(5) Early childhood growth and development;
(6) Early childhood special education;
(7) Human development;
(8) Human services;
(9) Music therapy;
(10) Nursing;
(11) Psychology;
(12) Public health;
(13) Social work;
(14) Special education – hearing impairments;
(15) Special education – visual impairments;
(16) Other related field or interdisciplinary studies approved by the State Lead Agency; or

ii. An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing; or

iii. A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, plus three years' full-time experience coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements. Parents' experience coordinating their child's services in Part C early intervention and in Part B early childhood special education will be considered to meet the requirement for full-time experience, and both the time coordinating their child's services in early intervention and in Part B will count toward the requirement for three years' experience.

(1) Three years means 36 months or more;
(2) Full-time means 32 hours/week.

b. The applicant must complete the following Infant & Toddler Connection of Virginia online training courses, passing the competency test for each with at least 80% accuracy:

i. Overview: Mission and Key Principles of Early Intervention
ii. The Early Intervention Process
iii. Effective Practices for Implementing Early Intervention
iv. Responsibilities of Early Intervention Practitioners
v. Child Development
vi. Authentic Assessment for Early Intervention
vii. The Many Facets of Service Coordination

Requirements and Process for Recertification

1. Practitioners interested in renewing their certification to provide early intervention services in the Infant & Toddler Connection of Virginia system complete an online application in TRAC-IT at least 30 business days before their current certification expires. The applicant must:

    a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline;

    b. Complete 30 hours of training over the 3-year certification period with content that addresses one or more of the following and is applicable to early intervention:

        i. Evidence based practices;
        ii. Changes in policies, procedures and practices;
        iii. Topics identified on a practitioner's own professional development plan; and
        iv. Training needed for new responsibilities.

    c. Complete Kaleidoscope training within 15 months of initial certification as an Early Intervention Case Manager unless the applicant completed this training prior to certification. When completed after certification, the Kaleidoscope training counts towards the 30 hours of training required for the practitioner's first recertification.

    d. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the practices specified in the Infant & Toddler Connection of Virginia Practice Manual.

2. Once the online application is submitted, the applicant will receive a confirmation email that the application has been submitted.

3. The applicant is notified of the status of his/her application:

    a. If the applicant has met all certification requirements, then the applicant receives notification that the certification is granted.

    b. If the applicant does not meet all certification requirements or the application is incomplete, then the applicant receives notification that the request for certification is denied.

Lapsed Certification

A practitioner with a lapsed certification may neither provide nor bill (Part C or DMAS) for early intervention services until his/her certification has been restored.

Restoration of Lapsed Certification

1. The State Lead Agency may restore an expired certification under the following conditions and with the following documentation from the practitioner:

    a. The individuals' certification has lapsed for a period less than one year; and

    b. The certification has lapsed because:

        i. The practitioner failed to complete the three-year recertification requirements and the individual provides documentation to the State Lead Agency demonstrating (i) he/she meets the discipline-specific licensure/certification requirements that apply to his/her discipline , and (ii) he/she has completed at least 30 hours of training related to evidence-based practices in early intervention; changes in policies, procedures and practices; topics identified on the practitioner's professional development plan; or training needed for new responsibilities; or

        ii. The practitioner's discipline-specific qualifications expired and the practitioner documents that he/she now holds a current license,

certification, endorsement, or other qualification for the practice of his/her discipline or profession in the Commonwealth of Virginia.

2. When a practitioner's certification is restored, he/she is restored to active status in the practitioner database.

Termination of Certification

1. A practitioner's early intervention certification will be terminated if:

    a. The practitioner's discipline-specific license, certification, or endorsement has been suspended or terminated; or

    b. The practitioner, after a year of having a lapsed certification, fails to comply with the recertification requirements; or

    c. The practitioner fails to comply with the signed assurances.

Procedures for Reconsideration of Decision to Deny or Terminate Certification:

1. If a practitioner disagrees with the decision to deny or terminate certification, he/she may request reconsideration by the commissioner of the State Lead Agency. The request must be made in writing within 30 days of the date of the written notice of denial or termination and may include relevant additional information or documentation to support the request.

2. The commissioner will review the request for reconsideration and information presented and will issue a decision in writing within 30 business days following receipt of the request. The decision of the commissioner is a final case decision that may be appealed under the Virginia Administrative Process Act.

Responsibilities of Certified Practitioners

1. Certified Early Intervention Professionals who provide supervision of certified Early Intervention Specialists must document their ongoing clinical supervision of services provided by the early intervention specialist and must maintain that documentation for at least 3 years. Although the Infant & Toddler Connection of Virginia does not prescribe the frequency of supervision, there must be

documentation that the supervision is ongoing and that supervision is at a clinical level and not just an administrative level (i.e., documentation of annual or semi-annual performance reviews is not adequate). If an Early Intervention Professional observes an Early Intervention Specialist during a service session, then the Early Intervention Professional must be listed in the "Participants" field of the contact note and may co-sign the note or, if the note is created outside of TRAC-IT, both the Early Intervention Professional and the Early Intervention Specialist can sign the contact note for that session.

2. Complete 30 hours of training every 3 years that meets the recertification requirements specified above. All training hours completed count toward all certifications held by the practitioner (e.g., it is not necessary to complete 30 hours for the Early Intervention Professional recertification and another 30 hours for Early Intervention Case Manager recertification).

    a. What Constitutes a Training Activity: To count toward the required hours for recertification, a training activity must be at least 15 minutes in length.

    b. Training Opportunities: The State Lead Agency provides information to local systems and practitioners about available training opportunities that have been made known to the Infant & Toddler Connection of Virginia Office, which include a mix of trainings that are free and those that require a fee. It is expected that practitioners will also investigate additional available training opportunities. Most, if not all the training required to maintain early intervention certification also will meet discipline-specific continuing education requirements.

    c. Documentation of Completed Training: For each training activity, documentation maintained by the practitioner must include a description of the activity and sponsoring organization, if applicable; the date or dates of training; the number of hours; and a copy of a certificate or verification of attendance, if applicable. Practitioners are required to retain documentation of successful completion of the 30-hour training requirement for recertification for three years following issuance of the renewal certification (i.e., until the issuance of their next renewal certification). That documentation must be made available to the State Lead Agency upon request.

    d. Types of Training Allowed: Table A following this section specifies the categories of training activities that may be completed as part of the 30

hours of training required for recertification. Following the table is a text box that addresses Frequently Asked Questions about what counts and what does not count as training for Part C recertification.

3. All certified Early Intervention Specialists and Early Intervention Professionals who provide services other than eligibility determination and assessment for service planning must complete fidelity assessment requirements as follows:

    a. New practitioners who are hired by or contract with a local Infant & Toddler Connection system must, in each of their first two years in the Infant & Toddler Connection of Virginia, complete at least 2 self-assessments using the *Coaching in Action* checklist and be observed at least once by a qualified observer. In the first year, one of the self-assessments and the observation may be completed using the requirements detailed in the *Orientation to Coaching and Natural Learning Environment Practices* checklist instead of using the *Coaching in Action* checklist.

    b. Once the requirements are met in the second year, the need for and frequency of additional self-assessment and observation will be determined by the supervisor for each individual practitioner based on the results of the year two self-assessments, observation, record reviews, and ongoing supervision. Please note that practitioners who work for more than one local Infant & Toddler Connection system are not required to complete the fidelity assessment requirements separately for each local system with which they work. Table B, at the end of this section, provides further details regarding fidelity assessment requirements.

4. Complete the *Early Intervention Training Record* form, which is available along with a sample, partially completed form at ITCVA Resource Library - ITCVA, under Professional Development. Practitioners must use this form to track the professional development activities completed during each 3-year certification cycle. Practitioners must retain a copy of the completed training record form for three years following issuance of the recertification that is based on that training record.

    a. The practitioner's supervisor must sign off on each line of the training record to indicate his/her awareness of the trainings/activities the employee is accessing as well as approval of the activities.

b. Independent practitioners who practice without a supervisor are required to obtain the initials of the local system manager or designee in at least one of the local Infant & Toddler Connection systems in which they work.

5. Ensure the correct and current profile information (name, contact information, etc.) is entered in TRAC-IT. This includes ensuring correct and current discipline-specific licensure, certification or endorsement information, updating the expiration date for each qualification (license, certification or endorsement), as needed, to match the date on the most current license, certification or endorsement. For more specific instructions, practitioners can go to the Help tab of TRAC-IT and refer to the Quick Reference Card: Certifications.

6. Immediately notify the State Lead Agency of any change that may affect their certification status or their participation in the Infant & Toddler Connection of Virginia.

Table A: Types of Training Allowed

Category	Description	Hours	Documentation Required
College courses	• Must be earned at a regionally accredited 2-year or 4-year college; • Must be taken for credit; • Must earn passing grade; • Could be pass-fail.	1 semester hour = 10 hours	Transcript
Professional development activities	• Self-study: online; journal; book group; may be group or individual. • Mentoring • Online training • In-service training: Examples include a training within the practitioner's own agency; attending a meeting with speaker (only the time when the speaker is presenting counts as training); a brown bag lunch series; etc. • Fidelity self-assessment and/or observation	Hours based on amount of time spent (1 hour spent = 1 hour) **Maximum of 5 hours of training per 3-year period may be self-study** **Maximum of 15 hours per 3-year period may be claimed by qualified observer for time spent doing observation**	• Self-study: Written summary of what was done, amount of time spent, sources used • Mentoring: Written summary of activities completed, amount of time spent, name and qualifications of mentor • Online training: Printed certificate, if available, or printed summary of training topic, sponsor organization, training content • In-service training: Certificate, if available, or written summary of training topic, sponsor organization, training content • Fidelity assessment: Copies of completed fidelity checklists, written record of amount of time spent
Professional conference	4 or more hours in length	Certificate will give # of hours, which will include time in conference sessions, not counting breaks or meals	Certificate

Frequently Asked Questions about What Counts as Training for Recertification

1. **Is it possible to use an observation as a training activity (i.e., someone wants to learn about how speech therapy works by observing a therapist)?**
   To be considered as part of the 30 hours, the experience would need to be more structured than simply observing. For example, the activity might include preparation of the learner prior to the observation (reading materials, identification of what to be on the lookout for during the observation) and follow up discussion/mentoring after the observation.

2. **How much flexibility do we have in using coordination with those who have expertise in a particular area — i.e., scheduling 1:1 to meet with a system manager about Part C updates?**
   One-on-one training with individuals with the expertise the learner is seeking makes sense. However, discussion with system managers about Part C Updates would not meet the intent of the training requirements.

3. **To what extent can meetings serve as trainings – particularly around updating on Part C — i.e., council meetings, service coordination meetings?**
   Meetings do not count toward the 30 hours of required training.

4. **When a service coordinator attends Kaleidoscope I and II, does that count towards her 30 hours?**
   Yes

5. **Does it count toward my 30 hours if I'm the one providing the training?**
   Being the trainer does not give you hours toward recertification.

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Table B: Fidelity Assessment Requirements

Practitioner Responsibilities

- Ensure required self-assessments are completed at least 4 months and no more than 6 months apart, unless completing more than 2 self-assessments per year.
- Record the amount of time spent completing the self-assessments and reviewing the results of the self-assessment and observation with supervisor and/or observer for credit toward the 30 hours of professional development required for EI certification.
- Maintain a copy of the completed checklists (self-assessments and observation) for at least 3 years and make available to the local system manager and the State Lead Agency upon request.
- Share results of the self-assessment with his/her supervisor and revise his/her Professional Development Plan as needed, based on the self-assessment and/or observation results and need for additional professional development and support.

Qualified Observer Responsibilities

- Meet one of the following qualifications:
    - Master Coach plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions. For purposes of this qualification, Master Coach is defined as an individual who has completed the 3-day face-to-face Master Coach training by Dathan Rush and M'Lisa Shelden and the 6-month community of practice following that training (completing coaching logs and participating in the monthly technical assistance call in at least 4 of the 6 months). This training may have occurred in Virginia or elsewhere. Documentation of completion may include a certificate of participation, a letter of commendation from Catherine Hancock (that was sent to Virginia Master Coaches after completion of the community of practice), or other records maintained in the individual's personnel file documenting completion of these requirements at the time they were completed.

Table B: Fidelity Assessment Requirements
○ At least 6 months' experience using Rush and Shelden or similar model of coaching plus 8 hours of professional development* on coaching plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions. ○ At least 4 months experience using Rush and Shelden or similar model of coaching plus 4 hours of professional development[7] on coaching and observed plus approved by master coach or other qualified observer plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions. • Maintain documentation of his/her qualifications to be an observer for fidelity assessment and produce those upon request by the local or state lead agency. To document completion of the Texas Early Childhood Intervention Coaching Families Module, document the time spent and date completed and keep the Coaching in Action checklists (one for Henley and one for Lennox) filled in during the Practice Activities section of the module. • When the observer is not the practitioner's supervisor, coordinate with the practitioner and supervisor to ensure information from the observation is shared and used to identify and meet the practitioner's need for ongoing supervision, professional development and support related to coaching. • Record the amount of time spent completing the observation and reviewing the results of with the practitioner and/or his/her supervisor for credit (up to 15 hours) toward the 30 hours of professional development required for EI certification.
Supervisor Responsibilities • Review results of the self-assessments and observation to inform ongoing supervision and support.

[7] Professional development may include but is not limited to: Rush and Shelden regional training, book study of *Early Childhood Coaching Handbook*, Coaching Implementation Project participation, local or regional coaching training, participation in coaching community of practice, book study, classes, webinars, supervision of and feedback on your own coaching practices, observation/work with mentor.

Table B: Fidelity Assessment Requirements
• Review the practitioner's Professional Development Plan to determine the need to add activities related to coaching.
Local System Manager Responsibilities • Submit fidelity assessment data to the State Lead Agency as required by the terms of the *Local Contract for Participation in Part C Early Intervention*. • Use fidelity assessment results to identify and address local professional development needs related to coaching.

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Audiologist										
Audiologist	Licensure in Audiology by the Board of Audiology and Speech-Language Pathology	X		X	X	X	X	X	X	Audiology, Developmental Services, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services
Assistant Behavior Analyst										
Assistant Behavior Analyst	Licensed as Assistant Behavior Analyst by the Virginia Board of Medicine		X	X w/training			X w/supervision	X		Developmental Services
Behavior Analyst										
Behavior Analyst	Licensed as Behavior Analyst by the Virginia Board of Medicine	X		X	X	X	X	X	X	Developmental Services
Certified Therapeutic Recreation Specialist										
Certified Therapeutic Recreation Specialist	Certification through the National Council on Therapeutic Recreation Certification	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Child Life Specialist										
Child Life Specialist	Certification by the Association of Child Life Professionals, Child Life Certification Commission	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Counselor										
Licensed Professional Counselor	Licensure as Licensed Professional Counselor by the Virginia Board of Counseling	X		X	X	X	X	X	X	Counseling Services
School Counselor	Licensure with an endorsement as a School Counselor (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Counseling Services
Early Intervention Assistant										
Early Intervention Assistant	GED, High School Diploma or College Degree		X	X w/training			X w/supervision	X		Developmental Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services
Early Intervention Service Coordinator										
Early Intervention Service Coordinator	Combination of education and experience that meets requirements specified earlier in this chapter	N/A	N/A	X w/training			X	X	X other SCs	Service Coordination
Educator										
Early Childhood Special Education	Licensure with an endorsement in Special Education - Early Childhood (birth-5) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Educator	Licensure with endorsement in Early/Primary Education (PreK – 3) or NK-4 or elementary education (PreK-6) by the Virginia Board of Education Licensure with endorsement in adapted curriculum (K-12) or general curriculum (K-12) Licensure with endorsement in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education Technical Professional License in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Educator of the Hearing Impaired	Licensure with endorsement in Special Education - Hearing Impairments (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Educator of the Visually Impaired	Licensure with endorsement in Special Education - Visual Impairments (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Vision Services, Assistive Technology Services
Teacher of English as a Second Language	Licensure with endorsement in English as a Second Language by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Family and Consumer Science Professional										
Family and Consumer Science Professional	Employed in Virginia's Part C system before July 1, 2009: Certification through the American Association of Family and Consumer Sciences. Employed on or after July 1, 2009: Certification with successful completion of the concentration examination in human development and family studies through the American Association of Family and Consumer Sciences.	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Family Therapist										
Family Therapist	Licensure as Marriage and Family Therapist by the Virginia Board of Counseling	X		X	X	X	X	X	X	Counseling Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Music Therapist										
Music Therapist	Certification by Certification Board for Music Therapy (MT-BC)	X		X	X	X	X	X	X	Developmental Services
Nurse										
Registered Nurse	Licensure by the Virginia Board of Nursing as a registered nurse or Licensure by the Virginia Board of Nursing as a nurse practitioner	X		X	X	X	X	X	X	Nursing Services, Developmental Services, Assistive Technology Services
Nurse Practitioner	Licensure by the Virginia Board of Nursing as a registered nurse or Licensure by the Virginia Board of Nursing as a nurse practitioner	X		X	X	X	X	X	X	Nursing Services, Developmental Services, Assistive Technology Services
Licensed Practical Nurse	Licensure as Practical Nurse by the Virginia Board of Nursing		X	X w/training			X w/supervision	X		Nursing Services, Developmental Services
Certified Nurse Aid	Certification as Nurse Aide by the Virginia Board of Nursing		X	X w/training			X w/supervision	X		Nursing Services, Developmental Services
Occupational Therapist										
Occupational Therapist	Licensure as Occupational Therapist by the Virginia Board of Medicine	X		X	X	X	X	X	X	Occupational Therapy, Assistive Technology Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Occupational Therapy Assistant										
Occupational Therapy Assistant	Licensure as Occupational Therapy Assistant by the Virginia Board of Medicine		X	X w/training			X w/supervision	X		Occupational Therapy, Assistive Technology Services
Orientation and Mobility Specialist										
Orientation and Mobility Specialist	Certification by the National Blindness Professional Certification Board as a National Orientation and Mobility Certificant (NOMC); OR certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as a Certified Orientation and Mobility Specialist (COMS)	X		X	X	X	X	X	X	Developmental Services, Vision Services, Assistive Technology Services
Physical Therapist										
Physical Therapist	Licensure as Physical Therapist by the Virginia Board of Physical Therapy	X		X	X	X	X	X	X	Physical Therapy, Assistive Technology Services
Physical Therapist Assistant										
Physical Therapist Assistant	Licensure as Physical Therapist Assistant by the Virginia Board of Physical Therapy		X	X w/training			X w/supervision	X		Physical Therapy, Assistive Technology Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Physician										
Physician	Licensure in Medicine or Osteopathic Medicine by the Virginia Board of Medicine	X		X	X	X	X	X	X	Medical Services, Health Services, Developmental Services
Psychologist										
Clinical psychologist	Licensure as Clinical Psychologist by Virginia Board of Psychology	X		X	X	X	X	X	X	Psychological services
School psychologist	Licensure with endorsement in School Psychology through the Virginia Board of Education	X		X	X	X	X	X	X	Psychological services
Applied psychologist	Licensure as Applied Psychologist by Virginia Board of Psychology	X		X	X	X	X	X	X	Psychological services
Qualified Mental Health Professional or Qualified Mental Health Professional-Trainee										
Qualified Mental Health Professional or Qualified Mental Health Professional-Trainee	Approved and registered by the Virginia Board of Counseling		X	X w/training			X w/supervision	X		Counseling Services, Developmental Services
Registered Dietitian										
Registered Dietitian	Registration by the Commission on Dietetic Registration	X		X	X	X	X	X		Nutrition Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Resident in Counseling										
Resident in Counseling	Temporary licensure as a resident in counseling by the Virginia Board of Counseling		X	X w/training			X w/supervision	X		Counseling Services
Resident in Psychology										
Resident in Psychology	Registration of residency in clinical or school psychology by the Virginia Board of Psychology		X	X w/training			X w/supervision	X		Psychological Services
Social Worker										
Licensed Social Worker	Licensure as Licensed Social Worker by the Virginia Board of Social Work		X	X w/training			X w/supervision	X		Social Work Services
Licensed Clinical Social Worker	Licensure as Licensed Clinical Social Worker by the Virginia Board of Social Work	X		X	X	X	X	X	X	Social Work Services
School Social Worker	Licensure with endorsement as a school social worker by the Virginia Board of Education	X		X	X	X	X	X	X	Social Work Services
Supervisee in Social Work	Registration of supervised experience by the Virginia Board of Social Work		X	X w/training			X w/supervision	X		Social Work Services

Table C: Practitioner Qualifications and Responsibilities

		Practitioner Level		Scope of Responsibilities						
Discipline	**Qualifications**	**Professional**	**Specialist**	**Screening**	**ED**	**ASSMT**	**Direct Child/Family**	**Teaming**	**Supervise Staff**	**EI Services**
Speech-Language Pathologist										
Speech-Language Pathologist	Licensure in Speech-Language Pathology by the Virginia Board of Audiology and Speech-Language Pathology	X		X	X	X	X	X	X	Speech-Language Pathology, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services
Speech-Language Pathology Assistant										
Speech-Language Pathology Assistant	Meeting the qualifications of, and supervised in accordance with, 18VAC30-21-140		X	X w/training			X w/supervision	X		Speech-Language Pathology, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services

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Glossary

Activity setting — A situation specific experience, opportunity, or event that involves a child's interactions with people and the physical environment; the social and physical places where learning takes place (from Dunst and Bruder, Family and "Community Activity Settings, Natural Learning Environments, and Children's Learning Opportunities," Children's Learning Opportunities Report, 1999, vol. 1, number 2)

Assessment — The ongoing procedures used by qualified early intervention service providers to identify (i) the child's unique strengths and needs and the concerns of the family; (ii) the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under Part C; and (iii) the resources, priorities, and supports and services necessary to enhance the family's capacity to meet the developmental needs of the child

Assistive technology device — Any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, fabricated or customized, that is used to increase, maintain, or improve functional capabilities of children with disabilities. The term does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping), maintenance or replacement of that device

Assistive technology services — Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include:

- Evaluating the needs of a child with a disability, including a functional assessment of the child in the child's customary environment;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Providing training or technical assistance for a child with disabilities, that child's family; and
- Providing training or technical assistance to professionals (including individuals providing education or rehabilitation services) or other individuals who provide

services to or are otherwise substantially involved in the major life functions of the child.

Audiology —

- Identification of children with auditory impairment, using at risk criteria and appropriate audiological screening techniques;
- Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological assessment procedures;
- Referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;
- Provision of services including auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services;
- Provision of services for the prevention of hearing loss; and
- Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

Charges — The rates established for each service. Charges form the basis for the anticipated payment for services. Charges are generally established as the unit cost of providing care.

Child find — A comprehensive and coordinated system to locate, identify, refer and evaluate (determine eligibility) for all infant and toddlers with disabilities in Virginia who are eligible for services under Part C.

Co-payments and deductibles — The amount the family must pay as a cost share to use their insurance.

Consent — Means that:

- The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication;
- The parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and
- The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

Contact note — The term used to describe how Part C service provision, including service coordination, is to be documented. The term "contact note" is intended to be interchangeable with other commonly used terms such as "progress note," "case note," or "service coordination note."

Counseling services —

- Assessment and treatment of mental, emotional, or behavioral disorders and associated distresses that interfere with mental health;
- Individual and/or family group counseling with the parent(s) and other family members;
- Collaborating with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP; and
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her needs related to development, behavior or social-emotional functioning and to enhance his or her development.

Delinquent account — An account that is unpaid after 30 days. When amount due by the family has been established under the family cost share practices and the family does not pay after 30 days, the account is delinquent.

Developmental services —

- The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;
- Curriculum planning, including planned interaction of personnel, materials, and time and space that leads to achieving outcomes in the IFSP;
- Providing families with information, skills, and support related to enhancing the skill development of the child; and
- Working with the child with a disability to enhance the child's development.

Discipline — A specific occupational category that may provide early intervention supports and services to eligible children under Part C of the Individuals with Disabilities Education Act and their families

Early intervention services — Services provided through Part C designed to meet the developmental needs of children and families and to enhance the development of children from birth to age three years who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Early intervention services

provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in the *Code of Virginia* § 32.1-162.7.

Eligibility determination — The evaluation procedures used by qualified early intervention service providers to determine a child's initial and continuing eligibility under Part C

Family — Defined according to each family's definition of itself

Family assessment — The ongoing procedures used by appropriate qualified practitioners throughout the period of a child's eligibility for early intervention supports and services to identify the family's resources, priorities and concerns relative to enhancing the development of the child

Family fees — amounts based on the accrued charges and co-payments that may be charged to families for services that an infant or toddler with a disability and family receive each month. The family fee may not exceed the monthly cap.

Fee appeal process — The process used when it can be determined that families have a demonstrated financial hardship and the discounted fee from the sliding fee scale also represents a financial burden

Financial hardship — A personal economic condition that may prevent a family from obtaining full and necessary services. The parameters defining financial hardship must correspond to the family size and family taxable income found in the family cost share fee scale. Financial hardship may also be created by co-payment and deductible requirements.

Health services — Services necessary to enable a child to benefit from the other early intervention supports and services during the time that the child is eligible to receive the early intervention supports and services. The term includes:

- Consultation by health care professionals with other service providers concerning the special health care needs of the infant or toddler that will impact or need to be addressed during the provision of other early intervention services; and
- Provision of such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services.

The term does not include:

- Services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of

medicine or drugs for any purpose); or related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including cochlear implants;
- Devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; or
- Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children

Income — Wages and salaries that are consistent with the Federal definition of taxable wages. Income to be considered for family cost share purposes is that of the mother, father, and/or legal guardian of the family as is consistent with parental liability in the Code of Virginia.

Individualized Family Service Plan (IFSP) — A written plan for providing early intervention supports and services to eligible children and families that:
- Is based on evaluation for eligibility determination and assessment for service planning;
- Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and
- Is implemented as soon as possible once parental consent is obtained.

Informed clinical opinion — The use of professional expertise and experience in combination with information gathered through eligibility determination or assessment for service planning, or both, to determine the child's developmental status and eligibility under Part C.

Intensity — Whether a service will be provided on an individual or group basis

Length — The length of time a service is provided during each session of that service (such as an hour or other specified period)

Local lead agency — Entity that, under contract with the State Lead Agency, administers a local early intervention system

Medical services — Services provided by a licensed physician for diagnostic or eligibility determination purposes to determine a child's developmental status and need for early intervention supports and services

Monthly cap — The maximum amount that a family will be required to pay per month for early intervention services regardless of the charge(s) or number of different types, frequency or length of services a child and family receive.

Multidisciplinary — The involvement of two or more separate disciplines or professions and with respect to –

- Eligibility determination and assessments of the child and family, may include one individual who is qualified in more than one discipline or profession; and
- The IFSP team must include the involvement of the parent and two or more individuals from separate disciplines or professions and one of these individuals must be the service coordinator.

Native language — The language or mode of communication normally used by the parents of the child or, for evaluation for eligibility determination and assessments of the child, the language or mode of communication normally used by the child if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.

Natural environment(s) — Settings that are natural or typical for a same-aged child without a disability and may include the home or community settings

Nursing services —

- The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;
- The provision of nursing care to prevent health problems, restore or improve functioning and promote optimal health and development; and
- The administration of medications, treatment, and regimens prescribed by a licensed physician.

Nutrition services —

- Assessment of the child's nutritional history and dietary intake; anthropometric, biochemical and clinical variables; feeding skills and feeding problems; and food habits and food preferences;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;

- Development, implementation and monitoring of appropriate plans to address the nutritional needs of children eligible for early intervention supports and services, based on the findings of individual assessments; and
- Referral to community resources to carry out nutritional goals and referrals for community services, health or other professional services, as appropriate.

Occupational therapy — Services that are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

- Identifying and assessing the child's functional needs and providing interventions related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development;
- Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

OSEP child indicators — The measures of child progress on which states must annually report to the Office of Special Education Programs (OSEP). The indicators are the percentage of infants and toddlers with IFSPs who demonstrate improved:

- Positive social-emotional skills (including positive social relationships)
- Acquisition and use of knowledge and skills (including early language/communication); and
- Use of appropriate behaviors to meet their needs.

Parent —

- A biological or adoptive parent of a child;
- A foster parent, unless contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
- A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);
- An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare); or
- A surrogate parent.

If a judicial decree or order identifies a specific person or persons listed above to act as the "parent" of a child or to make educational or early intervention service decisions on

behalf of a child, then such person or persons shall be determined to be the “parent” for Part C purposes. Otherwise, the biological or adoptive parent, when attempting to act as the parent and when more than one party is qualified under the definition of “parent,” must be presumed to be the parent unless the biological or adoptive parent does not have legal authority to make educational and early intervention service decisions for the child. The term “parent” does not include any local or state agency, or their agents, including the Department of Social Services and their local departments, if the child is in the custody of said agency.

Part B — The part of the Individuals with Disabilities Education Act that governs special education and related services for children and youth with disabilities

Part C — The part of the Individuals with Disabilities Education Act that governs early intervention services for infants and toddlers with disabilities and their families

Personally identifiable information —

- The name of the child, the child's parent, or other family member;
- The address of the child or child’s family;
- A personal identifier, such as the child's or parent's social security number; or
- A list of personal characteristics or other information that, alone or in combination, could be used to identify the child or the child's parents or other family members

Physical therapy — services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

- Screening, evaluation for eligibility determination, and assessment of children to identify movement dysfunction;
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems;
- Adapting the environment and selecting, designing, and fabricating assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems.

Practitioner — An individual who is qualified to provide supports and services

Provider (Service provider) — A practitioner selected to deliver early intervention supports and services

Psychological services —

- Administration of psychological and developmental tests, and other assessment procedures;
- Interpretation of assessment results;
- Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and
- Planning and management of a program of psychological services, including psychological counseling for children and parent(s), family counseling, consultation on child development, parent training, and education programs.

Service coordination — The activities carried out by a service coordinator to assist and enable a child eligible for early intervention supports and services and the child's family to receive the rights, procedural safeguards, and supports and services that are authorized to be provided under Virginia's early intervention program

Sign language and cued language services — Teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.

Single point of entry — The single entity designated by the local lead agency in each local Part C system where families and primary referral sources make initial contact with the local Part C system

Sliding fee scale — A matrix utilizing taxable family income in conjunction with family size to determine the monthly cap to be paid that is less than the full charge. In the Infant & Toddler Connection of Virginia, the sliding fee scale is referred to as the family cost share fee scale.

Social work services —

- Home visits to evaluate a child's living conditions and patterns of parent-child interaction;
- Social or emotional developmental assessment of the child within the family context;
- Individual and family-group counseling with parent(s) and other family members, and appropriate social skill-building activities with the child and parent(s);

- Intervention to address identified problems in a child's and family's living situation (home, community, and any other location where early intervention supports and services are provided) that affect the child's use of early intervention supports and services; and
- Identification, mobilization, and coordination of community resources and services to enable the child and family to receive maximum benefit from early intervention supports and services.

Speech-language pathology —

- Identifying children with communication or language disorders and delays in development of communication skills and identifying and appraising specific disorders and delays in those skills
- Referral for medical or other professional services necessary for the habilitation or rehabilitation; and
- Providing services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

Surrogate parent — A person assigned by the local lead agency or its designee to ensure that the rights of a child are protected when no parent can be identified; the lead agency or other public agency, after reasonable efforts, cannot locate a parent; or the child is a ward of the state

TRAC-IT (Tracking, Reporting and Coordinating for Infants and Toddlers) — The secure online statewide early intervention data system for the Infant & Toddler Connection of Virginia

Transition — The entry or exit of children and families to and from early intervention supports and services

Transportation and related costs — The cost of travel (e.g., mileage, or travel by taxi, common carrier, or other means) and other costs (e.g., tolls and parking expenses) that are necessary to enable a child eligible for early intervention supports and services and the child's family to receive early intervention supports and services

Vision services —

- Evaluating and assessing visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development;

- Providing communication skills training, orientation and mobility training for all environments, visual training, and additional training necessary to activate visual motor abilities; and
- Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both.

Visit — A face-to-face encounter with the child with a disability or his parent, another family member, or caregiver, or both, for the purpose of providing early intervention supports and services.

Ward of the state — A child who, as determined by Virginia, is a foster child or is in the custody of a public children's residential facility. The term does not include a foster child who has a foster parent who meets the definition of *parent*.

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