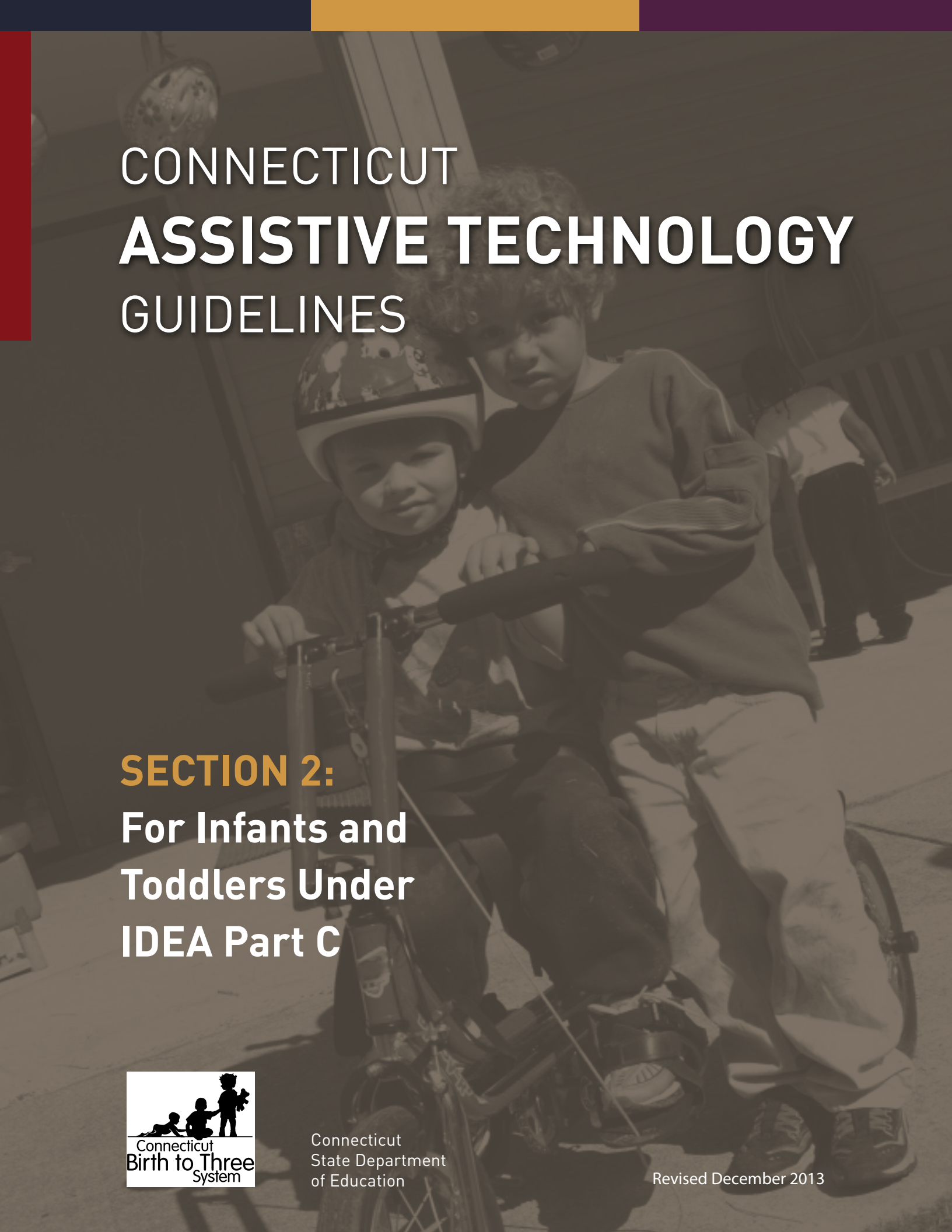

CONNECTICUT
ASSISTIVE TECHNOLOGY
GUIDELINES

SECTION 2:
For Infants and Toddlers Under IDEA Part C

Connecticut Birth to Three System

Connecticut
State Department
of Education

Revised December 2013

Foreword

Technology has long allowed individuals to do things they never thought possible, optimizing their capacity in a range of daily activities and environments. This certainly applies to children with disabilities. Assistive technology (AT) helps these children perform a skill or participate in an activity, increasing access and opportunities for success.

For a long time, individuals with disabilities used technologies designed specifically for them: Braille, TTY, etc. However, more recent advances have narrowed the distinction between technologies used by students with disabilities and their nondisabled peers.

AT guidelines help to define the process for considering, implementing, and evaluating technologies that equalize the learning experience for students of all abilities. These guidelines describe the continuum of AT from low- to high-tech; current federal and state laws and policies to include the Connecticut Birth to Three System through high school (ages 3—21); consideration of AT needs; assessment/evaluation; funding for AT; documentation; implementation and effectiveness; transition planning; administrative responsibilities; universal design for learning; formats for accessible instructional materials (AIM); the National Instructional Materials Accessibility Standard (NIMAS); and resources.

This latest version is intended to be interactive, with Web-based information and hyperlinked appendixes, and will be updated periodically as the AT continuum continues to expand. Hyperlinks to relevant resources and sections can be found in the left margin and periodically throughout the text. To navigate

the document, use the buttons at the top left of each page or the links in the bookmarks panel of the Adobe Reader.

Through a collaborative effort across environments, parents, educators, administrators, and professionals can best determine how to foster the participation and utilization of AT services and devices that will deliver the greatest impact. The AT guidelines facilitate a review of the process, give structure to differing stages of development, offer examples of best practices and the AT continuum, clarify misconceptions, and give direction to ensure that accommodations that are needed to meet goals are attainable.

Success for the child or student with a disability is limited only by opportunity. The newest technologies are designed to facilitate growth and learning in children of all abilities. Opportunity will expand as new technologies continue to emerge, and this new interactive guideline document will lead you along the way.

Acknowledgments

Special thanks to all who had a role in this project.

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Abbreviations and Acronyms

AAC	=	alternative and augmentative communication
AAC-RERC	=	Augmentative and Alternative Communication Rehabilitation Engineering Research Center
ADA	=	Americans with Disabilities Act
ACES	=	Area Cooperative Educational Services
ACOLUG	=	Augmentative Communication Online Users Group
ASHA	=	American Speech and Language Association
AIM	=	accessible instructional materials
ANSI	=	American National Standard Institute
ASD	=	autism spectrum disorder
ASL	=	American Sign Language
AT	=	assistive technology
ATA	=	Alliance for Technology Access
ATAP	=	Association of Assistive Technology Act Programs
ATI	=	Assistive TechnologyTobii
ATP	=	Assistive Technology Professional
ATTO	=	Assistive Technology Training Online Project
BESB	=	Bureau of Education and Services for the Blind
BRS	=	Bureau of Rehabilitative Services
CAST	=	Center for Applied Special Technology
CACIL	=	Connecticut Association of Center for Independent Living
CCSS	=	Common Core State Standards

CEC = Council for Exceptional Children
CES = Cooperative Educational Services
CFR = Certified Federal Registry
COM = community
CSDE = Connecticut State Department of Education
CREC = Capitol Region Education Council
DAISY = Digital Accessibility Information System
DDS = Department of Developmental Services
DME = durable medical equipment
EI = early intervention
EPSDT = Early and Periodic Screening, Diagnosis and Treatment
ESEA = Elementary and Secondary Education Act
FAPE = free and appropriate public education
FERPA = Family Education Rights and Protection Act
FCTD = Family Center on Technology and Disability
GEC = general education classroom
GI = gastrointestinal
HOM = home
ID = intellectual disorder
IDEA = Individuals with Disabilities Education Act
IDELR/EHLR = Individuals with Disabilities Education Law Report/ Education for the Handicapped Law Reporter
ISP = Individualized Service Plan
IEP = individualized education program
IFSP = Individual Family Service Plan
IT = information technology
IWRP = Individualized Written Rehabilitation Program
LEA = local education authority
LD = learning disabilities
LRE = least restrictive environment
LMN = letter of medical necessity
NATRI = National Assistive Technology Research Institute
NCIP = National Center to Improve in Practices in Special Education Through Technology, Media and Materials
NCLB = No Child Left Behind
NEAT = New England Assistive Technology Center
NECTAC = National Early Childhood Technical Assistance Center
NIMAC = National Instructional Materials Access Center
NIMAS = National Instructional Materials Accessibility Standard
NLS = National Library Service
OAT = open source assistive technology
OSEP = Office of Special Education Programs
PandA = Office of Protection and Advocacy
PBS = Public Broadcasting System
PC-OS = personal computer-operating system
PPT = planning and placement team
QIAT = Quality Indicators for Assistive Technologies
RBI = routine-based interview

RESC = regional educational service center
RESNA = Rehabilitation Engineering and Assistive Technology Society of North America
SERC = State Education Resource Center
SETT = Student, Environment, Task, and Tools
SEC = special education classroom
SLP = speech and language pathologist
TATN = Texas Assistive Technology Network
TASC = Technology Assistance for Special Consumers
TnT = Tots and Tech
TTY = tele-printer
UDL = Universal Design for Learning
VI = visual impairments
WATI = Wisconsin Assistive Technology Initiative
YAACK = Augmentative and Alternative Communication Connecting Young Kids

Purpose

The purpose of this document is to help service providers ensure that all infants and toddlers who require assistive technology (AT) as indicated under IDEA Part C receive the appropriate devices. This document also assists parents in understanding how assistive technology is incorporated into early intervention services in Connecticut.

This guideline outlines processes consistent with Quality Indicators for Assistive Technology (QIAT). These include consideration of the need for AT, the assessment process, documentation in the Individualized Family Service Plan (IFSP), implementation, evaluation of effectiveness, transition planning from Birth to Three, and professional development.

Connecticut Birth to Three procedures regarding funding, ownership, maintenance, and repair of assistive technology are incorporated throughout the document.

Assistive Technology as Part C Service

Chapter contents

Assistive technology devices and services should be considered for all children enrolled in Connecticut's Birth to Three System. Every child referred to the Connecticut Birth to Three System must receive a comprehensive, multidisciplinary evaluation of his or her unique strengths and needs to determine eligibility and to plan for early intervention (EI) services appropriate to meet those needs, including the need for assistive technology.

Assistive technology, which includes devices and services, is one of the services required under Part C of the Individuals with Disabilities Education Act (IDEA) of 2004. Children may not be excluded from consideration for assistive technology for any reason (e.g., type of disability, age, cost, lowered expectations, or administrative concerns).

Parent Rights

Parents are an integral part of the process for determining the needs of their child, including the need for assistive technology. Parental participation is vital for the assessment, selection, implementation, and maintenance associated with their child's use of assistive technology. Parents must give consent to the evaluation of their child. They must be included as part of the team that develops the

Individual Family Service Plan. If the family and the early intervention team do not agree on the proposed assistive technology, the family may share its concerns with the Birth to Three program through many informal steps. However, if informal steps do not satisfy the concerns, a family can take other, more formal steps, including a written complaint, mediation, and/or a hearing (Connecticut Birth to Three System, 2011).

Definition of Assistive Technology Devices and Services

Assistive technology in the Individuals with Disabilities Education Act includes both *assistive technology devices* and *assistive technology services*.

Assistive technology devices covered under IDEA

An *assistive technology device* means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability (IDEA 2004, Sec.602(1)A; 34CFR §.300.5).

Assistive technology devices not covered under IDEA

- Devices provided to meet the medical, daily living, or life-sustaining needs of a child.
- Devices that are not specifically designed to increase, maintain, or improve the functional capabilities of a child with a disability.
- A device that is surgically implanted, or the replacement of such device.

Equipment that is not specifically designed to increase, maintain, or improve the functional capabilities of a child, such as car seat or bath chair, and does not meet the definition of AT under IDEA, may still be needed by a child and his or her family. It is the responsibility of the child's service coordinator to coordinate with medical and health providers as well as to assist the family in locating services and devices outside of the Birth to Three System when needed. For example, the family may need a bath seat to help with the bathing routine and to ensure the safety of the child. The bath seat, however, may not contribute toward increasing, maintaining, or improving the functional capabilities of the child. If the family indicates that obtaining a bath seat is a family priority, the service coordinator should assist the family in obtaining a bath seat through other resources.

Assistive technology services

Assistive technology services means 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:

- evaluation of the needs of such child, including a functional evaluation of the child in the child's customary environment;
- purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by such child;
- 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;
- training of child and family; and
- training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of such child (IDEA 2004).

Continuum of Assistive Technology Devices

The complexity and specificity of AT devices proceed along a hierarchy. AT options along the continuum of AT devices ranging from no-tech to high-tech should be considered (Tots 'n Tech Research Institute, 2009).

- NO-TECH Universally designed devices that would be used with all children, with and without disabilities, at a particular age (e.g., booster seat, suction bowl, safety plugs in outlets) (Thomas Jefferson University, 2011). A no-tech device may not be considered AT under Connecticut Birth to Three unless it is something unique and specific to the child's disability and not something commonly used by most parents. Early intervention providers can help parents select and procure such devices when needed and, if they think it is justifiable as an AT device, may purchase such devices if under $250 or may submit request for reimbursement to the Birth to Three System for devices costing $250 or more.
- LOW-TECH Differentiated adaptations and assistive technology that enable children to do something they cannot do and may not be able to do for a while (e.g., loops attached to puzzle pieces, picture communication systems board, rolled towels or foam to enhance sitting posture) (Thomas Jefferson University, 2011).
- MODERATE-TECH Battery-operated or simple electronic devices or adaptations. (e.g., switch-activated toys, cordless remote control to activate appliance/light).
- HIGH-TECH Specialized individual adaptations and assistive technology that would allow a child to do something he or she cannot do otherwise (e.g., gait trainer walker, computerized augmentative communication device, wheelchair, hearing aids) (Thomas Jefferson University, 2011).

Types of Assistive Technology Devices

Assistive technology devices range from the creative use of existing resources in the child's environment (e.g., household items) to the most sophisticated and cutting-edge high technology. Many types of AT are available to address needs in

all areas of development: cognitive, physical, communication, social/emotional, and adaptive.

- Adaptive/self-care (e.g., elastic waist pants, suction bowl, bath mitt).
- Communication (e.g., picture communication boards, single or multiple message devices with switches or more complex augmentative and alternative communication devices).
- Mobility (e.g., self-propelled wheelchairs with seating/safety adaptations, therapeutic walkers, curb cuts).
- Positioning (e.g., positioning pillows or pads, standing aids).
- Sensory enhancers for hearing and vision (e.g., toys with sound or vibrating mechanism, large picture books, hearing aids or other forms of amplification)
- Socialization/play (e.g., Velcro mitt to catch a tennis ball, paper clips separating pages for ease of turning, a ball designed with openings for ease of holding, knobbed crayon, standing devices for peer height interactions).
- Cognition (e.g., switch-adapted toys, touch-screen computers, software).

Determining whether a piece of equipment meets the definition of assistive technology under Part C of IDEA must occur on an individual basis and be based on the child's needs, the family's concerns, and the IFSP outcomes. Some devices might be therapeutic or make caring for the child easier or safer but do not contribute to enhancing or maintaining the child's functional capabilities. Consequently, these may not be AT but may be appropriate to acquire these devices through other medical channels.

Consideration of Assistive Technology

Chapter contents

In the development of the IFSP, the service coordinator can help set the stage for discussing family priorities and needs by having a conversation or conducting an interview about the child's typical participation in everyday activities/routines.

In the IFSP section 4: Daily Activities, this section enables the discussion to identify what is working well during daily activities and what is not. Examples of additional tools that may facilitate this process are the Routines-Based Interview (RBI) (Siskin Children's Institute, 2006—appendix 1 and appendix 2) and the Assessment of Family Activities and Routines (Thomas Jefferson University, n.d.—appendix 3 and appendix 4).

These interview/conversation guidelines assist the provider in understanding:

- how each activity and routine occurs in a household;

- how the child participates in the activities and routines; and
- the extent to which caregivers are satisfied with their child's participation.

This discussion assists the IFSP team to identify what the child needs to accomplish but cannot perform. Parents, along with the service coordinator, will develop outcome statements that reflect what the child's parents see as important for their child and themselves. The IFSP team then will consider whether assistive technology may be needed or helpful to remove barriers to the child's participation in routines and activities and for the accomplishment of IFSP outcomes.

Adaptations should also be considered to make a task easier or simpler to accomplish. Adaptations can be made to the setup of the environment, the child's schedule, the design of the activity, the requirements of the task, the instructions, the materials, or the equipment used. Adaptation strategies alone may enable participation in routines or activities and/or may be combined with AT (Tots 'n Tech Research Institute, 2009).

Principles to Keep in Mind when Considering Assistive Technology for an Infant or Toddler

Assistive technology:

- should increase, maintain, or improve the functional capabilities of a child;
- should enhance a child's participation in a routine or activity (Tots 'n Tech Research Institute, 2009);
- should provide opportunities for learning (Tots 'n Tech Research Institute, 2009);
- should complement existing services;
- should not be used in place of services;
- should be developmentally and age-appropriate;
- should be appropriate for the environment where the child spends his or her day; and
- may be needed by some children from all levels of the continuum, concurrently or consecutively.

Chapter contents

Assessment for Assistive Technology

Assessment Process

Assessment for assistive technology is an ongoing process, not a one-time event. The needs of infants and toddlers change frequently due to:

- rapid growth and development;
- family expectations;
- family circumstances;
- where the child spends his or her day; and
- a change of caregivers.

Therefore, assessment, formal and informal, should occur throughout the child's enrollment in Birth to Three, beginning with the initial assessment.

The type and extent of AT required may not be apparent when a child begins receiving Birth to Three services. In other instances, the need for AT devices and services are unmistakable and immediate. To neglect the AT needs of a child may deprive the child of reaching his or her goals. For example, waiting to fit hearing aids deprives a child of valuable listening time during critical language learning years. Another example is the postponement of introducing an AT ambulatory device needed by a child for independent walking. As a result, the child remains dependent on an adult for mobility. Along the same lines, delaying the

introduction of pictures for communication for a language-delayed child prevents him or her from conveying needs and wants, resulting in unwarranted frustration for the child and family.

AT devices ranging from no-tech to high-tech may be introduced at any point during the child's enrollment. Selecting low- and moderate-level devices may not require formal assessment. In Birth to Three, professionals of many disciplines (e.g., early intervention teachers, occupational therapists, physical therapists, speech and language pathologists, and audiologists) are the Birth to Three providers who typically consider the need and recommend AT for infants and toddlers.

Birth to Three providers will introduce AT, based on the child/family needs and the environments where difficulties exist. "Infants and toddlers are likely to depend on the simpler forms of AT—like towel rolls to provide trunk support when sitting … or a homemade communication device" (Tots 'n Tech Research Institute, 2009).

When it becomes apparent that the child is not progressing toward his or her outcomes, the need for assistive technology should, again, be considered. The IFSP team should examine the barriers to the child performing functional skills or participating in his or her daily routines and activities.

Problem solving may be very simple and accomplished quickly. In other instances, the barriers to the child's participation may be more complex and challenging. When these issues are beyond the scope of the problem solving that occurs as a part of early intervention service delivery, the Birth to Three program should conduct a formal AT assessment and/or arrange for a consultation by an AT specialist.

Assessment Considerations

- Assessment should be conducted by a *team with the collective knowledge and skills needed* to determine possible assistive technology solutions that address the needs and abilities of the child in his or her *natural environment.*
- Besides the early intervention providers, inclusion of parents and caregivers from other settings on the assessment team is highly encouraged. The team may also include an AT Professional (ATP/RESNA*), the child's therapist outside of the Birth to Three System, and a vendor of durable medical equipment (DME), if needed.

The assessment should focus on what the child needs to do that he or she is not currently doing within the routines of the family and those that are a priority for the family.

- The child's developmental performance in his or her natural *environment* should be the basis for assessments.

Tools that may assist in the assessment process include the Routines-Based Interview and the Assessment of Family Activities and Routines.

**Assistive Technology Professional (ATP) Certification by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)*

- What AT has been tried or is currently being used? Consider or reflect on what is working and what is not.

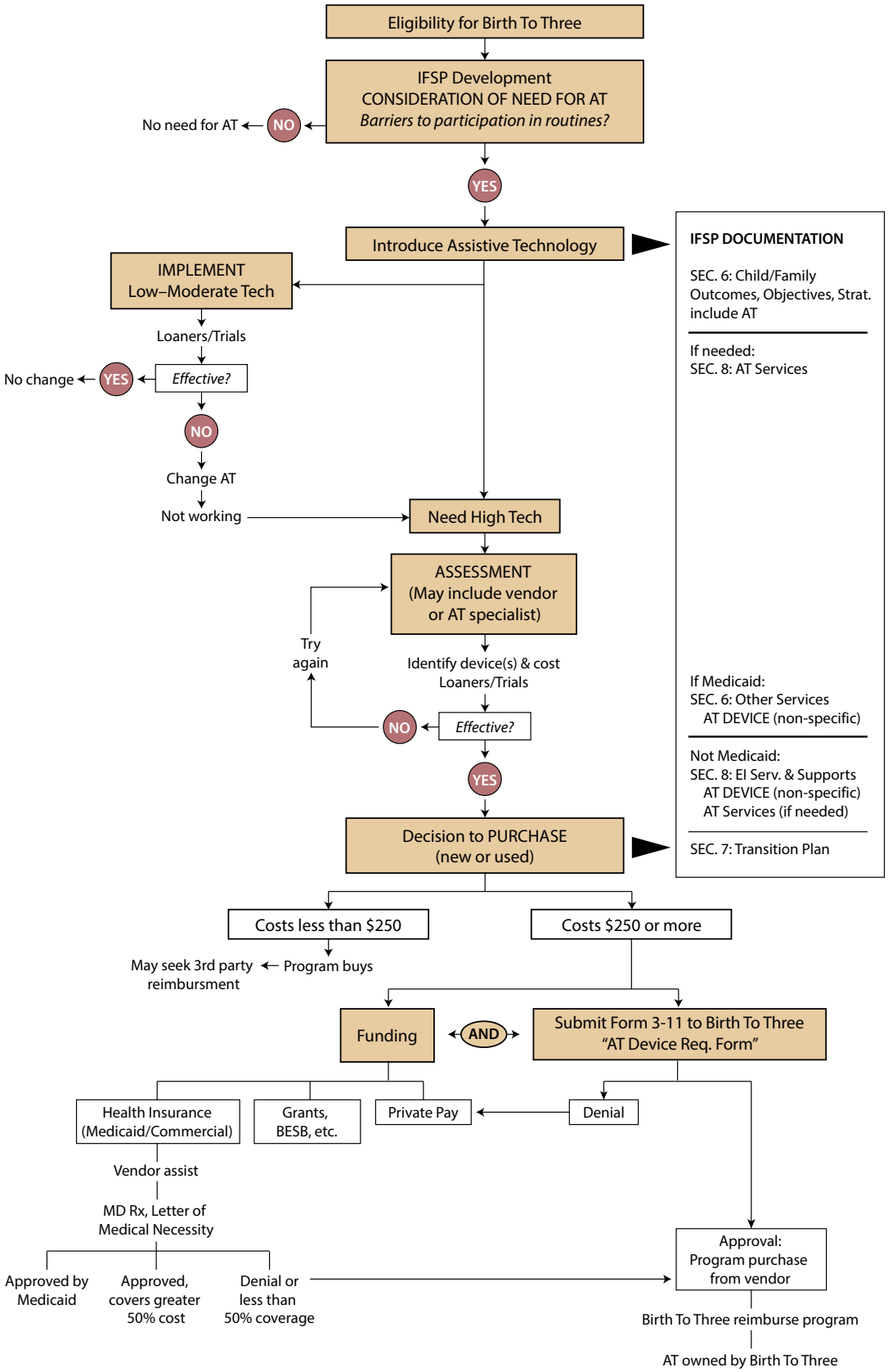
Selection of Assistive Technology

The family's needs and priorities are central to the collaborative decision-making process and will determine the extent to which a child actually uses a particular device within family routines and activities. The assessment consideration for AT devices must include:

- *Caregivers, including family:* practical to use, compatible with their lifestyle, their preferences, the physical environment where the AT is needed and will be used, caregiver comfort level using the AT in other environments in which the child may function.
- *Child:* appropriateness for the child's developmental age, addresses the child's immediate needs, removes identified barriers to participation, supports the child's functional outcomes, comfortable to use.
- *Characteristics of the AT Device:* simple but meets the need, easy to use (does it require more than one person to implement?), dependable, transportable, adaptable, durable, versatile, compatible with other existing or needed AT, offers optimal functional developmental impact on the child.
- *Service System Factors:* availability of re-used devices for trial and/or purchase; availability of short- or long-term loaned devices; funding sources and procurement; provider skills to use the AT and his or her ability to train families and caregivers; transition considerations from Birth to Three; insurance coverage for malfunction, theft, replacement, and damage.

The assessment process should provide the IFSP team with clear recommendations about the purpose, selection, acquisition, and use of assistive technology (figure 3 – page 172). Collaboration and communication with the child's primary medical provider regarding the selected AT is appropriate and necessary. The medical provider is an essential IFSP team member who participates in the procurement process when seeking funding from the child's health insurance carrier, including Medicaid. A detailed medical prescription of the devices is often required to submit a claim to the child's health insurance carrier for approval.

Figure 3. Assessment process



Individualized Family Service Plan (IFSP) Documentation of Assistive Technology

Chapter contents

Once the IFSP team has determined that assistive technology is needed to support the child's outcomes, the assistive technology devices and services should be reflected in the IFSP in as clear a fashion as possible.

If AT is already being used or tried out, a discussion should occur at the IFSP meeting regarding the effectiveness of the AT in supporting the child's outcomes and whether any changes are necessary. If AT devices on the IFSP need to be purchased, the service coordinator must add AT devices and services to the IFSP.

AT and the IFSP Document

When assistive technology is required, (regardless of price) it should be included in several places in the IFSP. At a minimum, AT should be included in the following sections:

- **IFSP Section 6. *Child/Family Outcomes***

  The outcome must be stated to improve, maintain, or increase the

child's functional abilities. "Obtaining the AT" is not an outcome. This section should include:

- The family's stated goals:
  E.g., "We want Jocelyn to be able to play for a while without our help so that she becomes more independent."
- Objectives required to measure progress:
  E.g., Seated in her adaptive chair with tray, Jocelyn will explore her toys for 10 minutes by herself.
  E.g., Jocelyn will activate a simple cause-and-effect toy secured to her tray, using push buttons, pull levers, swiping, and switches.
- Methods and strategies incorporating AT to achieve the outcome:
  E.g., Conduct a trial of adaptive seating devices to determine the most effective.
  E.g., Introduce toys that Jocelyn is able to operate successfully so she can experiment and learn concepts.
  E.g., Train childcare staff in proper positioning in the adaptive seating device and proper placement of toys during free playtime.
- Incorporate type of device (brand not specified), its purpose, and where it is to be used (i.e., activities and routines, location, time of day).

- **IFSP Section 6.** ***Other Services Related to this Outcome that Are in Place or that Are Needed***

  For a child who is covered by Medicaid, Assistive Technology devices, aka Durable Medical Equipment (DME), should be listed because of payment considerations. To be funded by Medicaid, AT devices must specifically address medical problems and be prescribed by a physician[1], or in the case of hearing aids, an audiologist.

- **IFSP Section 7.** ***Plan for Transition from the Birth to Three System***

  The transition plan should clearly address the use of assistive technology and whether devices and services will be needed once the child is no longer enrolled in the Birth to Three System (see Transition Planning for Assistive Technology section).

- **IFSP Section 8.** ***Early Intervention Services and Supports***

  If AT devices and services are included in the IFSP, they must be listed

1. Goeber, G. *Funding Adaptive Mobility Equipment for Young Children with Disabilities.* Rifton, 2009.

as separately in this section even if someone other than Birth to Three is paying for all or some portion of the device.

IFSP Section 8 for Assistive Technology Devices

When the IFSP lists assistive technology devices, the service provider should address the following components:

- ***What is going to happen:*** Assistive technology devices.
- ***Delivered by:*** Vendor, and/or appropriate professional
- ***Location, How Often, How Long:*** May not apply for devices and can be left blank.
- ***Start date:*** the expected date of the delivery of the device(s).

- Just below the services and supports grid, it should be documented that some other entity is paying for all or part of the device in the ***Part C services are paid for by the Birth to Three System unless otherwise indicated here:***.

IFSP Section 8 for Assistive Technology Services

If the IFSP team projects the need for Assistive Technology services beyond routinely scheduled early intervention visits, "Assistive Technology Services" should be added to service grid. The provider(s) of services may be existing IFSP members or specialized "Assistive Technology Professionals."

When the IFSP lists assistive technology services, the service provider should address the following components

- ***What is going to happen:*** Assistive technology services.
- ***Delivered by:*** The appropriate professional should be listed.
- ***Location:*** Should be filled in.
- ***How Often, How Long, Start Date and End Date*** boxes should reflect the amount and duration of AT services that will be required

Following the IFSP review, Assistive Technology devices and services are entered into the Birth to Three data system by checking the box on IFSP screen entitled "Check if IFSP contains an AT device."

Funding Assistive Technology

Chapter contents

Once the appropriate assistive technology device has been determined, the child's Birth to Three program is responsible for putting funding options in place for obtaining the AT, including accessing third-party reimbursement as appropriate. If the device costs less than $250, the program can pay for the device or can attempt to access third-party reimbursement. If the device costs $250 or more, the program should pursue funding as well as submit the "Assistive Technology Device Request Form" Form 3-11 (appendix 5) to the Birth to Three System. The service provider should submit this request form concurrent with the pursuit of third-party reimbursement.

Payer of Last Resort

The Birth to Three System funds assistive technology devices and services as the payer of last resort. This means that it is the responsibility of the family, program,

and vendor to pursue all other funding options. Potential sources of AT or funding for AT include:

- the New England Assistive Tech (NEAT) Resource & Education Center, which also serves as a gateway to vendors;
- commercial health insurance;
- Medicaid as part of the EPSDT Screening (Early and Periodic Screening, Diagnosis and Treatment);
- Children and Youth with Special Health Care Needs; and
- Board of Education and Services for the Blind.

Obtaining Assistive Technology through the NEAT Center

The Birth to Three System contracts with an AT center in Connecticut (currently the NEAT Resource and Education Center) that helps Birth to Three programs obtain AT and training. This center maintains a database of assistive technology devices that the Birth to Three system owns and has available for loan to children enrolled in the system. In addition, the center maintains a database of equipment available for resale. Once it has been determined that a child needs assistive technology to accomplish an outcome, the provider should contact the AT center to borrow or purchase the appropriate assistive technology.

If parents are concerned about the use of reconditioned devices, the service provider should inform them that it is Birth to Three's legal obligation to provide assistive technology devices, not necessarily new devices. The NEAT Center will assist the provider in finding an appropriate vendor who will assist with insurance paperwork, for both used and new equipment, through the family's health insurance, including Medicaid.

Accessing Third Party Reimbursement for Assistive Technology

It is the responsibility of the local Birth to Three program to initiate and participate in the process to bill commercial insurance or Medicaid for AT for those children whose parents have given permission to bill their medical insurance. This process can occur in collaboration with the NEAT Center. Typically, the billing process necessitates engaging a vendor of durable medical equipment who is an approved provider with the family's health insurance, including Medicaid.

Insurance and Medicaid customarily fund equipment that fits under the category of durable medical equipment. Examples may include, but are not limited to aids for daily living and personal care, mobility aids, standing and walking aids, wheeled mobility aids, seating and positioning systems, prosthetics and orthotics, augmentative communication aids, and hearing aids. They are less likely to cover learning and developmental aids such as computers, play equipment, and switch-adapted toys. If commercial insurance pays for all or some of the cost of a device, that amount may be applied against the annual and lifetime caps for durable

medical equipment benefits in the child's health insurance plan.

Insurance Requirements

If the program is working with a vendor of DME, the vendor will likely take responsibility for the insurance billing. To access insurance (for a device costing any amount) or Medicaid funding (for devices over $250), the program and vendor must provide with the insurance claim:

a. A physician's detailed prescription for the devices. To assist, the vendor often provides the specific device and accessories to the primary medical provider.
b. A "Letter of Medical Necessity" (LMN) the Birth to Three provider prepares. Each insurer defines the term "medical necessity" in a different manner. It may be helpful to request the definition from the insurance company or from the vendor participating in the procurement process in order to customize the letter. This letter must be personal, meaningful, and show that the purchase is a worthwhile investment for the payer.

Refer to appendix 6 for a sample letter of medical necessity.

The customary items within the LMN should include (Goebel, 2009):

- Personal benefit: How does this device increase participation in daily activities related to independence, choice, self-determination, reduced costs for caregivers, and living a full, abundant, and dignified life?
- Investment: Besides the health and functional benefits of the device, what are the costs of *not* providing the requested AT? For example, the costs to an insurer of respiratory and gastrointestinal complications, joint malformation, low bone density, etc., far exceed the cost of a suitable standing device for an individual who cannot yet bear weight.
- Equipment choice: Why is this particular equipment the most appropriate choice to address the needs of the child? What features make this equipment the right choice? Can it adapt to the child's needs over time (even though it may cost more initially)?

Based on established fee schedules, vendors have information regarding the amounts that Medicaid and the various commercial insurance carriers will pay toward durable medical equipment. The payment may cover the cost of the device(s) completely or partially. When the vendor has paid for the full cost of the device, the program cannot bill Birth to Three for cost above those allowed. The vendor must accept as payment in full the amount Medicaid reimburses. However, if payment is partial by commercial insurance, the program can submit a request for reimbursement of the balance to the Birth to Three System. The Birth to Three System cannot supplement Medicaid payments.

Accessing Birth to Three Funding

The Birth to Three System is responsible for funding only equipment intended to achieve functional outcomes identified on the IFSP. No new devices or equipment should be requested for children who are 2 years, 9 months of age

or older, as equipment requested during this period would not be available long enough to make progress on identified outcomes. An exception will be made for initial hearing aids if the child is newly enrolled in Birth to Three after age 2 years, 9 months.

The Birth to Three program is advised to submit the Assistive Technology Device Request Form (appendix 5) to the Birth to Three System *while* third party funding is being pursued. A copy of the current IFSP must accompany this form.

Requests should reflect all costs for the acquisition of equipment, including shipping and handling, fitting and customization, and extended warranties. The Birth to Three System has an approved dispensing fee for services needed to acquire hearing technology for young children, and Medicaid has its own rate for dispensing fees.

The Birth to Three central office staff will review the request for AT funding and return a decision to the provider program on Form 3-11 (appendix 5). If approved, Form 3-11 will include the date of approval and the maximum amount of reimbursement allowed.

If the family's health insurance denies payment or approves only partial payment for the AT, the program will pay the vendor directly for the amount not covered. After the family receives the device, the program will submit the final invoice for the device along with the pre-approved Request Form 3-11, showing the result of the third party billing, to the Birth to Three fiscal office. Proof of payment (e.g., copy of check showing cancellation or zero balance invoice from vendor) must be included for reimbursement as part of the regular monthly invoice.

If funding has been requested and approved by the Birth to Three System and a third-party payer covers the full cost of the device, the requesting program should notify the Birth to Three fiscal office so that funds are not set aside unnecessarily.

Maintenance and Repair of Assistive Technology

- The child's Birth to Three program is responsible for the maintenance and repair of the AT device. If any devices or service are part of a child's IFSP, then the technology must be available to the child for fulfilling the outcomes and objectives of the IFSP. If a device needs repair or maintenance, the Birth to Three program is responsible for providing alternative access or temporary use of another device or equivalent during the period of time the regularly used device is out of service.
- The NEAT Center provides minor repair service for AT owned by the Birth to Three System.
- Whenever possible, the local Birth to Three programs should consider obtaining insurance and/or maintenance contracts when purchasing AT. Parents are also requested to insure the AT devices under their homeowner's or renter's insurance policy if possible.
- If the child continues to use assistive technology after age 3, the Birth to Three System will not assume responsibility for any repair or maintenance.

Ownership of Assistive Technology

The party that paid for a majority of a device owns assistive technology devices purchased for children enrolled in the Birth to Three System. If third-party funding ends up paying more than 50 percent of the purchase price of the device, then the device belongs to the family. If Birth to Three funds pay for 50 percent or more of the device, the Birth to Three System owns that device.

Programs are responsible for tagging all equipment purchased with Birth to Three funds with inventory tags the Birth to Three fiscal office supplies. The fiscal office notifies the AT center of the devices purchased along with the address of the family using the AT. This information is maintained in the center's data system.

Implementation of Assistive Technology

The implementation of assistive technology may be long-term or short-term; may require trials with different devices to determine if the AT is accomplishing what was intended; and may require using more than one AT device at the same time.

Parent input is essential. According to the Illinois Early Intervention Assistive Technology Guidelines (2007), "Parents who understand how a device works and believe that it plays an important role in their child's development will provide more opportunities for the child to learn about and use the device(s). Parent preferences and feelings about particular devices often determine whether

implementation and use of devices will be successful."

The implementation of assistive technology involves the child's entire team working together, sharing responsibility, to support the child's use of the assistive technology according to a collaboratively developed written plan. The plan may preclude misunderstandings and ensure consistency. It should delineate the steps of a routine/activity (identified by the family) when AT will be used, the devices that will be used, what the adult will do, and what the child is expected to do as a result of using the AT. The Child Caregiver Interaction Plan (Thomas Jefferson University, n.d.) is an example of an implementation plan. Regardless of the plan's design, it should be easy to understand and accomplish.

For more information about the Child Caregiver Interaction Plan, refer to appendix 7 and appendix 8.

All members of the IFSP team must understand what is expected of them in regard to the implementation of the AT. It should be clear:

- why the AT was selected;
- the purpose the AT serves;
- how it enhances the child's functional skills;
- when and how often it will be used;
- how the AT will be used in combination with other AT;
- which adults are responsible for ensuring that the AT is used as planned; and
- how the AT will be coordinated with other therapies outside of Birth to Three, if any.

Different implementations plans will be warranted depending on the environment. The AT selected for implementation in the childcare setting may differ from the AT selected for use in the home. The plan should consider the time and effort to set up and use the AT as well as ensure caregiver understanding of how to use the AT device.

Training for the child, family, and team are integral to implementation. Early intervention professionals are responsible for providing appropriate instruction and follow-up for all adults who will be involved in using the AT. Training may be ongoing as needs change, participating adults change, and child's abilities change.

As the implementation plan is carried out, the service provider should monitor the child's performance and adjustments then made to support the child's progress. For technology to be effective and successful, devices must be in working order so they are available to the child. Following acquisition of the devices, additional responsibilities of the Birth to Three provider include:

- setup;
- organization of equipment and materials;
- temporary use of a comparable device if the original is unavailable for an extended period of time; and
- timely replacement of a nonrepairable device.

Effectiveness of Assistive Technology

Evaluation of AT effectiveness is a dynamic, responsive, ongoing process. Measuring effectiveness occurs over time. The pursuit and implementation of optimal AT should continue throughout the child's enrollment in Birth to Three.

This process requires answering the questions:

- What is working?
- What is not?
- Why?
- What needs to be changed?

The best device will not work if the child does not use it. Reasons may include:

- It is not enabling the child's participation in routines and activities.
- It may be one of many assistive devices for the child and difficult to embed into daily routines.
- It may be overwhelming for the family and caregivers.
- There may be insufficient physical space to accommodate using the devices.
- "…parents or caregivers may not be adequately trained on how to use the technology" (Illinois Early Intervention Assistive Technology Guidelines, 2007).

The adults who will be assuming responsibility to record information about the child responses to the AT should be clearly determined. Team members should understand what information is to be gathered, who is to provide it, in what form, how often, and for what period. The Birth to Three professional responsible for the AT services coordinates collection of this information and interpretation of changes. Assessing AT effectiveness should occur informally during routine early intervention visits as well as formally at IFSP reviews.

Evaluation of effectiveness includes measuring changes in the child's performance related to his or her functional outcomes. The expected changes may be quantitative in nature. Examples include the distance that a child walked with the walker, how many new pictures the child has used weekly to communicate, and/or the amount of food the child scooped independently. Change can also be measured qualitatively. Examples include the erectness of the child's posture using the seating device during circle time, the accuracy of pointing to small pictures on a communication board, and/or the efficiency with which the child can put on shoes with Velcro fastenersin the morning.

Service providers can collect this information in various ways:

- verbal feedback and/or written notes;
- simple data-keeping chart (prepared by the child's interventionist);
- clinical measurements (e.g., amount of movement, distance walked, clarity of speech); and/or
- observing the child using the AT.

The formal analysis of this collected information may result in changes to implementation of AT and/or changes to AT devices. There may be a recommendation to the IFSP team, at a review, to engage the consultation of a specialist or to schedule a formal assistive technology assessment, if one has not been completed previously.

Transition Planning for Assistive Technology

Chapter contents

All children enrolled in the Birth to Three system are required to have a plan in place to ensure a smooth transition to preschool or other appropriate services and supports. A transition plan must be developed as part of an IFSP meeting (initial, periodic review, or evaluation of the IFSP held at least annually) and can be updated several times to reflect the different stages of the transition planning process.

Transition steps and services should be recorded on section 5 of the IFSP. Transition plans that include assistive technology should clearly address the use of assistive technology and the anticipated need for continued use once the child is no longer enrolled in the Birth to Three System.

When a child exits from the Birth to Three System, assistive technology equipment Birth to Three owns and that the child uses may transition with

him or her so that the child can continue to use the device at home, in school, or in the community as needed and appropriate. Children may keep assistive technology devices the Birth to Three System purchased and owns for as long as they need. However, the Birth to Three System will no longer assume responsibility for repair or maintenance. After exiting from Birth to Three, the New England Assistive Technology Resource & Education Center will routinely contact families for whom assistive technology devices have been purchased to determine whether the devices are still in use. If families are no longer using the devices, the NEAT Center will arrange for pickup and storage of those devices.

The program is advised to notify the NEAT Center if a child who was using a device the Birth to Three System purchased or loaned no longer requires services and/or is not enrolled in Birth to Three or who has passed away. This will enable the center's staff to approach the family with sensitivity and awareness when attempting to retrieve the devices.

Developing a Transition Plan

Transition plans for children who use assistive technology should address the child's use of AT devices and services as the children transfer from one setting to another. The transition plan should list any AT obtained through the Birth to Three System and how it will be used once the child transitions out of the Birth to Three System. It cannot be assumed that assistive technology will automatically go to the school district or local education agency (LEA) for use in the school because it may be more appropriately needed in the home.

Possible items to discuss at the transition meeting and include on the transition plan as appropriate are:

- Who owns the AT?
- Does the child still need the assistive technology device? Why?
- Where will the child use the AT?
- Who will be responsible for the maintenance and repair of the AT?
- What is the status of any warrantees or insurance coverage for the AT?
- Who will be responsible, if anyone, to maintain insurance coverage for the AT?
- Where can the AT be repaired?
- Who will notify the AT center that Birth to Three-owned AT is no longer needed?
- If the child is eligible for preschool special education, will the student need AT to support his or her individualized education program (IEP) goals? (It is the responsibility of the Planning and Placement Team (PPT)/IEP Team to consider and determine if AT is educationally necessary and to include it in the child's IEP.)
- If AT is included in the child's IEP, have provisions been made for training, assignment of responsibilities, subsequent steps in AT use, and follow-up after transition takes place?

Assistive Technology Professional Development

Chapter contents

Scope of Practice

Some assistive technology categories require the inclusion of designated licensed professionals for the assessment, implementation, and evaluation process. This is important to determine appropriateness of a device for a child and to measure effectiveness. For example, an audiologist must select the amplification for a child with a hearing loss. A speech and language pathologist should be part of the process for selecting augmentative and alternative communication (AAC) devices. Physical or occupational therapists have the clinical knowledge and expertise to guide the selection of a mobility device, although they may also assist the speech and language pathologist in the selection of an AAC device for a child with motoric

disabilities. Professionals should examine their own skills in selecting AT devices. The Birth to Three program's responsibility is to locate and engage providers who possess the needed expertise when the program does not possess the competency to select a needed AT device.

Myths and Barriers

Various myths and barriers have influenced early intervention providers' use of assistive technology. To eliminate barriers to good practice and ensure that programs deliver appropriate services that include assistive technology, professional development and training in this area are critical. It is essential that providers are competent in the selection, acquisition, and use of assistive technology and knowledgeable about the array of AT options that are available for infants and toddlers**.** Professionals are encouraged to examine their own skills and knowledge and to engage in ongoing professional learning opportunities to meet their present needs as well as to increase their knowledge of new and emerging technologies and practices. Training increases people's awareness of options and possibilities as well as provides skills in creating and using AT materials or devices. When people feel confident about their knowledge, they are more likely to consider AT as an intervention—as a means to help young children participate and learn (Tots 'n Tech, 2009).

MYTHS: *A widely held but false belief* (Oxford English Dictionary, 2002).

- Children must possess an understanding of cause and effect or other cognitive skills before they can effectively use AT (Dugan, Campbell and Wilcox, 2006).
- Children must have specific speech and language competencies before using an AAC device (Dugan et al., 2006).
- AT means giving up on a child learning to perform specific skills (Dugan et al. 2006).
- Augmentative and alternative communication (AAC) hinders or stops further speech development (Romski and Sevcik, 2005).
- AAC is a "last resort" in speech-language acquisition (Romski and Sevcik, 2005).
- Children have to be a certain age to benefit from AAC (Romski and Sevcik, 2005).

BARRIERS: *A fence or other obstacle that prevents movement or access, a circumstance or obstacle that keeps people or things apart or prevents communication or progress* (Oxford English Dictionary, 2002).

- The professional has limited knowledge about the benefits of using AT (Dugan et al., 2006).
- The provider does not have sufficient knowledge and resources to apply recommended practices (Dugan et al., 2006).
- The provider is fearful of technology (Dugan et al., 2006).
- The provider lacks confidence in delivering AT services (Long and Perry, 2008).

- The provider does not know how to include AT devices and services into the child's early intervention and therefore avoids consideration of need.
- Concerns for costs and funding (Dugan, et al., 2006)

Resources for Professional Development

The Birth to Three System has a contract with NEAT in Connecticut to provide training to all Birth to Three programs as well as assistance in selecting appropriate and cost-effective devices. The center schedules training events each year specific to early interventionists. The Birth to Three System has purchased seating at each workshop, which it offers without cost to Birth to Three providers.

Birth to Three providers should consider a variety of professional development and training options to increase their knowledge of AT. Examples of continuing educational opportunities include:

- Professional organizations such as ASHA, RESNA, or CEC.
- Workshops offered through SERC, NEAT, and private providers of assistive technology devices
- Web-based learning opportunities
- Classes offered at colleges/universities
- Product demonstrations
- Individual mentoring
- Web sites such as Tots 'n Tech

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Appendixes

Appendix 1:

Routines-Based Interview Outline

Routines-Based Interview Outline (McWilliam, 2009)

I. Beginning

a. Who lives in the home with you and the child?
b. Why is the child in special services?
c. What are your main concerns?

II. Home Routines

How does your day begin?

a. Start marking concerns with stars

In each routine...

1. What is everyone else doing?
2. What does the child do?
3. Engagement (How well does the child participate in the activity? Stay involved?)
4. Independence
5. Social Relationships (communication, getting along with others)
6. Rating 1-5: how happy you are with this time of day
7. Transition to next routine: What happens next?

III. Classroom Routines

In each routine...

a. What is everyone else doing?
b. What does the child do?
c. Engagement (How well does the child participate in the activity?
d. Stay involved?)
e. Independence
f. Social Relationships (communication, getting along with others)
g. Rating 1-5: How well does activity work for the child?
h. Back to home routines

IV. The Worry and Change Questions

a. When you lie awake at night, worrying, what do you worry about?
b. If you could change one thing in your life, what would it be?
c. ***Recap:*** Review starred items (concerns). *This is just a reminder; it is not the list of outcomes/goals*

V. Outcome/Goal Selection

a. New sheet of paper: What would you like to work on—to have us help you with?
b. If necessary to get to minimum 6 outcomes/goals, hand notes to family members, showing them the starred items as a reminder
c. If necessary, take back the notes and ask about starred items
d. Once 6-10 outcomes/goals are listed, ask for the priority order in terms of importance

Appendix 2:

Routines-Based Interview Form

RBI Report Form

Including the RBI-SAFER Combo

R. A. McWilliam
2003
Revised January 2006
Vanderbilt Center for Child Development

Directions:

This form is designed to be used to report the findings from the McWilliam model of conducting a routines-based interview. A second person (e.g., someone assisting the lead interviewer) can use the form to summarize the discussion during the interview, or it can be filled out at the end of the interview. Two versions of the routines pages exist: (1) an "open" form that does not specify the routine being discussed is written nor specific questions to ask about; and (2) a "structured" form, on which home routines and specific questions are specified. This structured form is a combination of the Scale for Assessment of Family Enjoyment within Routines (SAFER; Scott & McWilliam, 2000).

1. Complete the information below.
2. For each routine, write a short phrase defining the routine (e.g., *waking up, breakfast, hanging out, circle, snack, centers*).
3. Write brief descriptions about the child's engagement in the Engagement box (e.g., *Participates with breakfast routine, banging spoon on the high chair* or *Pays attention to the teacher; names songs when asked; often leaves circle before it has ended*).
4. If the interview revealed no information about one of the three domains, circle *No information* in that domain for that routine..
5. Write brief descriptions about the child's independence in the Independence box (e.g., *Feeds herself with a spoon; drinks from a cup but spills a lot* or *Sings all the songs with the group, but needs prompting to speak loudly enough*)
6. Write brief descriptions about the child's communication and social competence in the Social Relationships box (e.g., *Looks parent in the eye when pointing to things in the kitchen* or *Pays attention to the teacher at circle but can't stand touching other children*).

Child's Name	
Date of birth	
Who is being interviewed	
Interviewer	
Date of interview	
"What are your main concerns?"	

Star * concerns and likely intervention targets

Routine	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Not at all satisfied	1. Poor goodness of fit
2.	2.
3. Satisfied	3. Average goodness of fit
4.	4.
5. Very satisfied	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Not at all satisfied	1. Poor goodness of fit
2.	2.
3. Satisfied	3. Average goodness of fit
4.	4.
5. Very satisfied	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Outcomes

Before asking the family to select "things to work on," review the concerns identified (i.e., starred) on the previous pages.

Outcome (short, informal version)	Priority Number

RBI-SAFER Combo

Combination of the Routines-Based Interview Report Form (McWilliam, 2003) and the Scale for Assessment of Family Enjoyment within Routines (Scott & McWilliam, 2000)
R. A. McWilliam (2006)

Routine:	Waking up
Could you describe what wake up time is like? Who usually wakes up first? Where does your child sleep? How does your child let you know she is awake? Does she wan to be picked up right away? If so, is she happy when picked up? Or is she content by herself for a few minutes? What does she do? What is the rest of the family doing at this time? Is this a good time of day? If not, what would you like to be different?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	***Classroom***: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Diapering/Dressing
What about dressing? How does that go? Who helps your child dress? Does he help with dressing? How? What can he do on his own? What is his mood like? What is communication like? Does your child wear diapers? Are there any problems with diapering? What does your child do while you are changing him? Does your child use the toilet? How independently? How does he let you know when he needs to use the toilet? How satisfied are you with this routine? Is there anything you would like to be different?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Feeding/Meals
What are feedings/mealtimes like? Does anyone help feed your child? Who? How often does she eat? How much can she do on her own? How involved is she with meals? Where does your child usually eat? What are other family members doing at this time? How does your child let you know what she wants or whether she is finished? Does she like mealtimes? How do you know? What would make mealtimes more enjoyable for you? What are mealtimes like for your child when under the care of others?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Getting ready to go/Traveling
How do things go when you are getting ready to go somewhere with your child? Who usually helps your child get ready? How much can he do on his own? How involved is he in the whole process of getting ready to go? What is communication like at this time? Does your child like outings? How do you know? Is this a stressful activity? What would make this time easier for you? What are drop-off and pick-up times like for your child? Do you or other caregivers have any concerns?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	***Classroom***: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Hanging out/Watching TV
What does your family do when relaxing at home? How is your child involved in this activity? How does your child interact with other family members? Does your family watch V? Will your child watch TV? What does he like to watch? How long will he watch TV? Do you have a favorite show? Is there anything you would like to do in the evening but can't?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	***Classroom***: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Bath time
What is bath time like? Who usually helps your child bathe? How is she positioned in the bathtub? Does she like the water? How do you know? How involved is your child in bathing herself or playing in the water? Does she kick or splash in the water? What toys does she like to play with in the tub? How does she communicate with you? What do you talk about? Is bath time usually a good time? If not, what would make it better?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Nap/Bed time

How does bed time go?
Who usually puts your child to bed?
Do you read books or have some type of ritual at this time?
How does he fall asleep?
How does your child calm himself?
Does he sleep through the night? What happens if he wakes up? Who gets up with him?
Is bedtime an easy or stressful time for your family?
Does he take naps for other caregivers? How does that go?

Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	***Classroom***: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Grocery Store
How are trips to the grocery? Do you bring your child with you? Does she sit in a shopping cart? Does she like being at the store? How is she involved in shopping? Do you have to occupy her or is she pretty content? How does she react to other people in the store? How is she involved in shopping? Do you have to occupy her or is she pretty content? How does she react to other people in the store? How does she communicate with you and others at this time? Is there anything that would make shopping with your child easier?	
Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	*Classroom*: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Routine:	Outdoors

Does your family spend much time outdoors? What do you do?
What does your child do?
Does your child like (the activity)?
How does he get around?
How does he interact with others?
Are there any toys or games he engages with/in?
How does your child let you know when he wants to do something different?
What things does your child like or notice outside?
Is this usually an enjoyable time? Would anything help make this time easier?
What kinds of outdoor activities does she participate in? How much assistance does he need?
How does he interact with his peers?

Notes	
Engagement	No information
Independence	No information
Social Relationships	No information

Home: Satisfaction with routine (CIRCLE ONE)	***Classroom***: Fit of routine and child (CIRCLE ONE)
1. Poor goodness of fit	1. Poor goodness of fit
2.	2.
3. Average goodness of fit	3. Average goodness of fit
4.	4.
5. Excellent goodness of fit	5. Excellent goodness of fit

Domains addressed (CIRCLE ALL THAT APPLY):

Physical Cognitive Communication Social or emotional Adaptive

Appendix 3:

Assessment of Family Activities and Routines

Assessment of Family Activities & Routines

Date:_____Child's name:_____Completed As Guided Interview with_____by Provider Name: _____

DIRECTIONS FOR USING THE ASSESSMENT AS AN INTERVIEW/CONVERSATION WITH CAREGIVERS

1. Ask the caregiver open ended questions about each activity/routine. For example, start by saying "tell me about bathtime and what you and your child do during bathtime." Follow-up by asking additional questions so that you gain an understanding, a picture, of what the routine or activity looks like. Then ask the caregiver to rate the child's participation in terms of the caregiver's expectations (e.g., exceeds, meets, occasionally meets, does not meet). Then, ask the caregiver about satisfaction with how the activity/routine is going.
2. Ask the caregiver to rate the child's use of functional skills (e.g., socializing, communicating) within activities and routines and satisfaction with the child's abilities. You are not trying to find out about the child's deficit or delay (e.g., speech) but rather about the extent to which problems or limitations interfere with a child's participation.
3. Identify any routines which may not be going well (so that you can help families make them go better); Identify routines that are positive for families/children as these will provide a context in which to show families how to teach developmental skills to their children.

	EXPECTATIONS					SATISFACTION				
ROUTINE/ACTIVITY	**Exceeds**	**Meets**	**Occasionally meets**	**Does not meet**	**COMMENTS**	**Very**	**Is OK**	**Somewhat**	**Not**	**Did Not Ask**
BATHTIME										
MORNING ROUTINE (getting up, getting dressed, bathing/washing)										
BEDTIME (getting ready for bed, going to bed, sleeping)										
MEALTIMES (appetite, level of assistance)										

	EXPECTATIONS					SATISFACTION				
ROUTINE/ACTIVITY	**Exceeds**	**Meets**	**Occasionally mees**	**Does not meet**	**COMMENTS**	**Very**	**Is OK**	**Somewhat**	**Not**	**Did Not Ask**
PLAYTIME (Indoor Play)										
STORY TIME										
OUTDOOR PLAY (riding a bike, playing outside, playing on playground equipment, swimming)										
AT HOME CHORES (cleaning, preparing meals, watching TV, caring for pets, etc.)										
LEAVING THE HOUSE										
TRAVEL TIME (riding in a car, bus; walking, etc.)										
RUNNING ERRANDS (grocery store, mall/store shopping, banking, wash/ cleaners)										
OUTINGS (visit a friend/relative, eat at a restaurant/fast food, go to museums, amusement parks, zoo, etc.)										

USE OF FUNCTIONAL SKILLS IN ROUTINES/ACTIVITIES										
SOCIALIZING (interacting with peers and adults)										
COMMUNICATING with peers and adults										
GETTING AROUND (mobility at home/community)										
USING HANDS & ARMS for functional tasks (e.g., reaching, obtaining/holding objects, manipulation)										
PROBLEM SOLVING (figuring out solutions to "problems" – knowing object exists when not in sight; an object is a tool, etc.										
Use blanks to add activities or routines not included in categories										

Based on your answers above, list the routines/activities that <u>do not</u> meet your expectations.

ROUTINE/ACTIVITY	What would you like to *<u>see</u>* happening: What would the child be doing? What would you or other family members be doing? What strategies have you tried?
1.	
2.	
3.	

Based on your answers above, list the routines/activities that are enjoyable for your family and child.

ROUTINE/ACTIVITY	
1.	
2.	
3.	

Additional Comments:

Appendix 4:

Assessment of Family Activities and Routines (Sample)

Assessment of Family Activities & Routines

This questionnaire will help providers get a picture of a child's typical performance in everyday family activities/routines. The best way to use the form is as a guideline for an interview or conversation with the caregiver(s). When used as an interview/conversation guideline, the provider makes sure that s/he learns about how each activity/routine occurs in the household, the child's participation in the activity/routine, and the extent to which caregiver(s) are satisfied with the child's participation. Information from the child's caregivers helps providers determine, with families, (1) routines/activities in which the child's participation could be improved and (2) activities/routines in which the child participates well so that these may be used as a context for practicing or acquiring new skills and abilities. At the end of the interview, providers identify activities/routines that do not meet caregiver expectations and describe what caregivers would like to see happen in the activity/routine. Providers also talk with caregivers to identify the activities/routines that are enjoyable for the Caregiver and child.

Date: 4/7/08 Child's name: PG Age: 17m Completed As: Guided Interview with SG (mother) Provider Name: LLB

DIRECTIONS FOR THE CAREGIVER ASSESSMENT AS AN INTERVIEW/CONVERSATION:

1. Ask the caregiver open ended questions about each activity/routine. For example, start by saying "tell me about bathtime and how your child participates during bathtime." Follow-up by asking additional questions so that you gain an understanding, "a picture", of what the routine or activity looks like. Then ask the caregiver to rate the child's participation in terms of the caregiver's expectations (e.g., exceeds, meets, occasionally meets, does not meet). If you wish, you may ask the caregiver about how satisfied they are with how the activity/routine is going. For some families, this helps them identify where they want to focus.
2. Ask the caregiver to rate their child's use of functional skills (e.g., socializing, communicating) within activities and routines and their satisfaction with the child's abilities. You are not trying to find out about the child's deficit/delay (e.g., speech) but rather the extent to which limitations may interfere with a child's participation.
3. Identify any routines which may not be going well (so that you can help families make them go better); Identify routines that are positive for families/children as these will provide a context in which to show families how to teach their children identified skills

	EXPECTATIONS					SATISFACTION				
ROUTINE/ACTIVITY	Exceeds	Meets	Occasionally Meets	Does not meet	COMMENTS	Very	Is OK	Somewhat	Not	Did Not Ask
BATHTIME			✓		Sitting in tub is problem; Slides under seat belt; does not hold him well enough. Enjoys play with tub toys.		✓			
MORNING ROUTINE (getting up, getting dressed, etc.)			✓		I dress him in the morning – no time and he can help but it takes too long. He wakes up happy and ready to go.		✓			
EVENING ROUTINE (getting ready for bed, going to bed, sleeping)		✓			Watches video and then we read a book in his rocking chair; he enjoys both of these activities and falls asleep easily.	✓				

Child & Family Studies Research Programs, Thomas Jefferson University, Philadelphia, PA

	EXPECTATIONS					SATISFACTION				
ROUTINE/ACTIVITY	**Exceeds**	**Meets**	**Occasionally Meets**	**Does not meet**	**COMMENTS**	**Very**	**Is OK**	**Somewhat**	**Not**	**Did Not Ask**
MEALTIMES (appetite, level of assistance)				✓	Does not finger or spoon feed; can help a little with cup; chews ok but not big pieces; Eats with us and can stay in highchair until everyone is done.			✓		
PLAYING WITH BROTHERS OR SISTERS OR FAMILY MEMBERS			✓		Can't play by self with toys. Can watch video or TV if propped in sitting; has so much trouble moving arms & hands that even big toys need assistance. Likes being read to and watching someone else do the toy.			✓		
PHYSICAL ACTIVITIES (riding a bike, playing outside, playing on playground equipment, swimming)			✓		He is best at swimming – loves the water, can be propped in kiddie pool or I hold him; can't do any riding toy – can't hold on. We have not tried playground equipment. He might like sandbox if I could figure out how to prop him up and have his hands reach the sand.			✓		
AT HOME CHORES (cleaning, preparing meals, watching TV, caring for pets, etc.)	✓				He enjoys TV – especially Sesame, Barney, etc. or children's movies (Disney). Too little to help with other chores.	✓				
LEAVING THE HOUSE TO GO SOMEWHERE	✓				He enjoys going out, riding in car. Does take longer to get him ready, carry to car, put in seat, etc. Does not help at all but does not fuss.		✓			
RUNNING ERRANDS (grocery store, mall/store shopping, banking, wash/cleaners)			✓		I can only go one place at a time if he is with me. Too much time and effort to get him out of the car, in a stroller, etc. & getting too heavy to carry. For multiple errands, I leave him at home.		✓			
OUTINGS (visit a friend/relative, eat at a restaurant/fast food, go to museums, amusement parks, zoo, etc.)		✓			Going out is no problem – visits, eating in restaurants, etc. are things he really enjoys. Sometimes the equipment is a problem or he has to be held. In restaurants, he sits in stroller because cannot sit well enough in most highchairs.	✓				

USE OF FUNCTIONAL SKILLS IN ROUTINES/ACTIVITIES

	EXPECTATIONS					SATISFACTION				
ROUTINE/ACTIVITY	**Exceeds**	**Meets**	**Occasionally Meets**	**Does not meet**	**COMMENTS**	**Very**	**Is OK**	**Somewhat**	**Not**	**Did Not Ask**
SOCIALIZING (e.g., interacting with peers and adults)			✓		Very social – smiles, gets people's attention, makes noises; but in child care, may only play with adult – other children are moving around too much.		✓			
COMMUNICATING with peers and adults		✓			Makes a lot of noises but does not have words yet. Sometimes hard to know what he is trying to get across		✓			
GETTING AROUND (mobility at home/community)				✓	This is becoming bigger problem as he gets older/bigger. Cannot walk yet or really crawl well; needs to be carried a lot; in child care is totally carried.				✓	
USING HANDS & ARMS for functional tasks (e.g., range of motion, holding objects, manipulation)				✓	He can bat at toys if suspended but cannot grasp anything; can bang, push big objects sometimes. Also makes other things hard – eating, bathing, dressing, etc. Needs help with everything				✓	
Use blanks to add activities or routines not included in categories										

Based on your answers above, list the routines/activities that do not meet your expectations.

ROUTINE/ACTIVITY	What would you like to *see* happening: What would the child be doing? What would you or other family members be doing? What strategies have you tried?
1.Mealtimes	Would like to see PG sit next to me or his dad during dinner and try to feed himself either with his fingers or spoon or both and to eat a wider variety of foods other than junior foods or food that I blend or grind.
2. Physical Activities	A lot of the other mothers sit outside with their children while they play in the yard. I would like to be able to do this and would like to see PG playing with other children like on a riding car or in a sandbox.
3. Playing with Family Members (Caregiver)	PG is an only child but we visit my sister(s) quite a bit and both of them have children – one 4 and one 3 and 5. I would like to be able to take him to my sisters and see him playing with his cousins and at home to play with me or his dad with toys without our having to do everything while he just watches.

Based on your answers above, list the routines/activities that are enjoyable for your family and child.

ROUTINE/ACTIVITY	
1. Evening Routine	He especially enjoys being read to and watching an evening DVD to unwind from the day.
2. Leaving the House & Outings	Enjoys going in the car, on visits to my sisters, parents, and to places like the zoo or Children's museum. We often go to the park, zoo, etc. with my sisters and their children and as long as he can be in his stroller, everything goes well although he participates primarily by watching/looking.
3. Watching TV, listening to stories	He really enjoys the children's shows if they have a lot of music and activity. Many DVD shows are also ones he likes. He "sings along" and is very engaged. He is attentive when being read to, makes noises when asked questions about familiar stories, and tries to turn book pages.

Additional Comments: Functional skills of using hands and arms and getting around currently limit PG's participation in some activities and routines. As expectations change as he gets older, these limitations may even further interfere with participation. While he communicates sufficiently with family and child care personnel at this time, his lack of words may eventually become more of a challenge for participation and may influence his ability to participate and socialize with other children.

Appendix 5:

Assistive Technology Device Request Form, CT Birth to Three Form 3-11

ASSISTIVE TECHNOLOGY DEVICE REQUEST FORM

Child's Name:	*Date of Birth:*	*Record #*

Parent (or foster parent or relative) child resides with and address (i.e. where device will be located):	*Telephone #:*

Program Name:	*Telephone #:*

Contact person for this request:	*Contact person's discipline:*	*Date of this request:*

Child's identified need (Attach section 6 of IFSP and outcome page that references assistive technology):

Device requested (Specify model # and any necessary related equipment. Attach specs if needed):

Additional vendors contacted	Model and Order #	Price

Total cost including tax, shipping and handling: $_____
Additional fees for insuring or dispensing technology $_____
Other (specify here or attach description): $_____
Total $

Was Medicaid billed? ☐ Yes ☐ No	*Date:*	*Status or Results:*
Was Insurance billed? ☐ Yes ☐ No	*Date:*	*Status or Results:*
Final Results: ☐ Payment ☐ Denial	*Date:*	*Details (attach written denial):*

For use by the Birth to Three Fiscal Office only:

Date request received	Date request approved	Cost to the state not to exceed	Birth to Three Authorization
		$	
Date invoice received	**Date invoice approved**	**Actual cost to the state**	**Birth to Three Authorization**
		$	

Connecticut Birth to Three Form 3-11 (revised 7/1/11)

Assistive Technology Checklist		Yes	No
1.	Does the IFSP reflect the need for this device or service and has it been indicated in the data system **(**check box on IFSP screen**)**?		
2.	Is information attached that briefly describes why this is the most appropriate equipment and how it will improve the functional capabilities of the child?		
3.	Did the team consider a range of devices from low to high tech?		
4.	Did the NEAT Marketplace have a suitable device ~~is~~ available?		
5.	Is there a loaner device or rental available?		
6.	Is there more than one device or vendor that can meet the need *(e.g. one vendor's prone stander may be the same as another)*?		
7.	Has the family participated in the evaluation or seen the actual equipment being requested?		
8.	Has all provider staff serving this child agreed that this is the most appropriate device to meet the child's need ***(****e.g. Can the communication device be mounted on the mobility equipment)*?		
9.	Have you determined at what point will the child no longer need the equipment?		
10.	Will this device need to be listed on the transition plan?		
11.	Does the vendor offer a maintenance contract?		
12.	Will the parents be able to list the device as part of their homeowner's or renters insurance?		
13.	Does the program need to purchase insurance for the device?		
14.	Have you arranged for training for the parents in the use of the device once it is delivered?		

Additional Comments:

Send this form to the Birth to Three Fiscal Office 460 Capitol Ave Hartford, CT 06106
Fax: 860-418-6003

Connecticut Birth to Three Form 3-11 (revised 7/1/11)

Appendix 6:

Letter of Medical Necessity (Sample)

LETTER OF MEDICAL NECESSITY — SAMPLE

OMNIBUS Rehab, PC
14 Park Rd.
New Haven, CT 06511
(203) 222-6868

June 9, 2011

To Whom It May Concern:

Alexander Potter (D.O.B. – 04/3/2009) is a 2-year, 2 month-old little boy with a diagnosis of Spastic Diplegia. Alexander presents with increased muscle tone in bilateral lower extremities and decreased muscle tone in his trunk, which impairs his ability to move about his home independently.

Alexander recently learned how to crawl on hands and knees however this requires much effort to move from one room to another. He is pulling to stand at a stable object or with support from his parent and is cruising along the couch and walks short distances with both hands held. He wears bilateral solid ankle dynamic foot orthoses to provide proper support and positioning to his ankles and feet to improve his ability to properly bear weight and help prevent orthopedic abnormalities. A pediatric walker has been introduced during his visits and has been loaned to Alexander to promote independent use of the walker in his home for functional mobility.

The **Kaye Child's Walker4 with front swivel wheels,** size **Small,** has proven successful for Alexander in walking short, functional distances in his home. Alexander is preparing to transition to preschool where it will be imperative that he have age appropriate mobility.

The **front swivel wheels** of the walker will allow Alexander to safely turn the walker to the right or left and navigate around obstacles in his path. He is unable to safely pick up and move a walker to turn right or left due to decreased muscle tone in his trunk and increased muscle tone in both legs which in combination impairs his balance and equilibrium reactions.

The above equipment will allow Alexander to be at eye level with his peers, which will benefit his social/emotional developmental. The ability to bear weight through his extremities will assist with bone growth and an upright posture will also benefit his bowel and bladder function and respiratory status.

If there are any questions regarding this request and prescription for durable medical equipment, please do not hesitate to contact me.

Thank you for your consideration in this matter.

Deborah Willey, RPT
Physical Therapist

Appendix 7:

Child Caregiver Interaction Plan

Caregiver-Child Interaction Plan (CCIP)

(The early intervention provider (teacher, therapist, etc.) and caregiver develop this plan together)

Routine/Activity:_____**Location (if outside the home)** _____**Date:** _____
Child: _____**Provider:** _____**Is this routine going well?** Yes No (circle one)

What I would like to see happen during this routine:

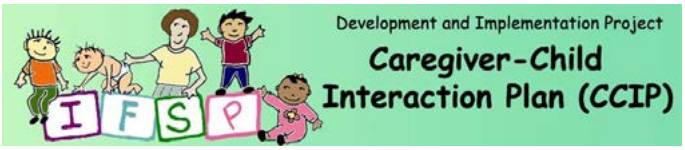
What is the current situation?

Steps in the Routine	Problem (y/n)	Adaptations that will be used	What I will do	What my child is expected to do

Wilcox, M. J. (2005; 2008 revised). Caregiver Child Interaction Plan for Activities and Routines in Early Intervention. Infant Child Research Programs, Arizona State University, Tempe, AZ 85287-1908.

Appendix 8:

Child Caregiver Interaction Plan (Sample)



Caregiver-Child Interaction Plan Sample

(This plan and the analysis of effectiveness are to be completed by the early interventionist and caregiver together)

Routine/Activity: Meal-time **Location** (if outside the home): _____

Is this routine going well? Yes **No** (circle one) **Focus:** **Routine** or Creating Opportunities (circle one)

What I would like to see happen during this routine: I would like Brian to be able to participate in mealtime by sitting in his highchair.

What is the current situation? Brian does not like to sit in his high chair. He is uncomfortable and cries to be taken out of the chair.

Steps in the Routine	Problem (y/n)	Adaptations that will be used	What I will do	What my child is expected to do
Put Brian in his high chair.	Y	Foam insert for stability.	Put Brian in his high chair and insert the foam around his legs and at his back to keep him seated comfortably.	Nothing.
Position toys on Brian's tray	Y	Double sided Velcro tape to keep toys on the tray	Tape a favorite toy of Brian's onto the high-chair tray.	Nothing.
Play with toy with Brian.	N		Play with the toy with Brian for as long as he is enjoying it (no longer than 5 minutes). Reinforce Brian when he plays (or tries to play) with the toy.	Play with the toy.
Feed Brian	N	Food will be cut into small pieces Use shelf liner to secure plate/ bowl to tray	Leave toy on tray for Brian to play with. Put food either directly on tray or in a bowl/plate. Feed Brian food that requires utensils.	Eat finger food
Clean Up	N		Leave toy for Brian to play with. Take food away. Wipe Brian's face/hands.	Play with toy
Take Brian out of the high chair.	N		Take Brian out of the high chair.	Nothing.

Note: If the routine is not going well, planning focuses on completing the routine; if the routine is going well, planning focuses on embedding learning opportunities within the routine.

Wilcox, M. J. (2005; 2008 revised). Caregiver Child Interaction Plan for Activities and Routines in Early Intervention. Infant Child Research Programs, Arizona State University, Tempe, AZ 85287-1908.

Child: Brian *Provider:* Therapist X