

Title: ABUSE AND NEGLECT

Purpose: *In accordance with the Connecticut General Statutes, Section 17a-101, all early intervention personnel are mandated to report suspected abuse or neglect of children.*

Overview

The Child Abuse and Neglect Careline, 1-800-842-2288, is the Department of Children and Families' (DCF) 24-hour, seven days a week, toll free number for the reporting of suspected abuse, neglect or imminent risk of serious harm of children. It is also the single point of entry number for all other DCF services. Additional information from DCF can be accessed from their website: <https://portal.ct.gov/DCF/1-DCF/Reporting-Child-Abuse-and-Neglect>.

Reporting Abuse

Under Connecticut general statute, section 17a-101, the following are considered mandated reporters: Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, any licensed practical nurse, any medical examiner, any dentist, any dental hygienist, any psychologist, any school employee, as defined in section 53a-65, any social worker, any person who holds or is issued a coaching permit by the State Board of Education, is a coach of intramural or interscholastic athletics and is eighteen years of age or older, any individual who is employed as a coach or director of youth athletics and is eighteen years of age or older, any individual who is employed as a coach or director of a private youth sports organization, league or team and is eighteen years of age or older, any paid administrator, faculty, staff, athletic director, athletic coach or athletic trainer employed by a public or private institution of higher education who is eighteen years of age or older, excluding student employees, any police officer, any juvenile or adult probation officer, any juvenile or adult parole officer, any member of the clergy, any pharmacist, any physical therapist, any optometrist, any chiropractor, any podiatrist, any mental health professional, any physician assistant, any person who is a licensed or certified emergency medical services provider, any person who is a licensed or certified alcohol and drug counselor, any person who is a licensed marital and family therapist, any person who is a sexual assault counselor or a domestic violence counselor, as defined in section 52-146k, any person who is a licensed professional counselor, any person who is a licensed foster parent, any person paid to care for a child in any public or private facility, child care center, group child care home or family child care home licensed by the state, any employee of the Department of Children and Families, any employee of the Department of Public Health, any employee of the Office of Early Childhood who is responsible for the licensing of child care centers, group child care homes, family child care homes or youth camps, any paid youth camp director or assistant director, the

Child Advocate and any employee of the Office of the Child Advocate, any person who is a licensed behavior analyst, any family relations counselor, family relations counselor trainee or family services supervisor employed by the Judicial Department, and any person employed, including any person employed under contract and any independent ombudsperson, to work at a juvenile detention facility or any other facility where children under eighteen years of age are detained and who has direct contact with children as part of such employment^{17a-101},

As soon as practical, but not later than 12 hours after having reasonable cause to suspect or believe that a child has been abused, neglected or placed in imminent risk of serious harm by a person responsible for the child's health, welfare or care or by a person given access to the child by the responsible person (i.e. non relative caregivers, live-in boyfriends or girlfriends) a mandated reporter will notify DCF via the Careline or a law enforcement agency (local or state police). Within 48 hours of making the oral report they will also submit a written report to DCF using the *Report of Suspected Child Abuse/Neglect*, [DCF Form 136](#). DCF is required to tape record all reports to the Careline. Although a mandated reporter is required to give his or her name, the reporter can request anonymity. DCF can never absolutely assure anonymity, especially if the case results in criminal prosecution or is taken to court. Each Birth to Three program must have an internal policy on reporting abuse and neglect. The report should be filed in the child's record. The name of the person who made the report can be redacted on the form.

It is the responsibility of all mandated reporters to immediately report suspicion of abuse, neglect, or imminent risk of serious harm not to decide if it has occurred. Upon receiving the report, DCF will determine what has occurred. DCF and the police are the lead agencies for the investigation of any suspected abuse or neglect. If there is any doubt about making a report, such doubt is resolved in favor of the child and the report is made. No person at any level of authority or from any other agency has the legal right to prohibit or interfere with a referral or report to DCF. If a Birth to Three program has a policy that requires staff to first notify their program director before notifying DCF, it is still by law the responsibility of the mandated reporter who suspects abuse to make the report. Any mandated reporter, who in his/her professional capacity has reasonable cause to suspect or believe that any child has been abused, neglected or placed at imminent risk of serious injury, and who fails to make such a report shall be fined not less than \$500 nor more than \$2,500. They may be subject to civil or criminal charges and may also face disciplinary action from their professional licensing agent. They shall also be required to participate in an educational and training program.

According to the DCF Careline, if staff members witness a restraining order being violated they should contact the police and then report it to DCF.

Under Connecticut general statute, **Sec. 17a-101c**. Not later than forty-eight hours after making an oral report, a mandated reporter shall submit a written or electronic report to the Commissioner of Children and Families or the commissioner's designee. Such reports shall be made in a manner prescribed by the commissioner. When a mandated reporter is a member of the staff of a public or private institution or facility that provides care for such child or public or private school the reporter shall also submit a copy of the written or electronic report to the person in charge of such institution, school or facility or the person's designee. In the case of a report concerning a school employee holding a certificate, authorization or permit issued by the State Board of Education under the provisions of sections 10-144a to 10-146b, inclusive, and 10-149, a copy of the written or electronic report shall also be sent by the Commissioner of Children and Families or the commissioner's designee to the Commissioner of Education or the commissioner's designee. In the case of an employee of a facility or institution that provides care for a child which is licensed by the state, a copy of the written or electronic report shall also be sent by the Commissioner of Children and Families to the executive head of the state licensing agency. A copy of the DCF Form 136 should be placed in the early intervention record. However, as with everything in the record, information, including this form, can only be released to a third party with parent consent.

Immunity for Reporting Abuse and Neglect

Immunity from civil or criminal liability is granted to people who make required reports in good faith.

Definitions of Abuse and Neglect

Abuse

Abuse is a non-accidental injury to a child which, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care it includes: any injury which is at variance with the history given; maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

Neglect

Neglect is the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education. A child may be found neglected who: has been abandoned, is being denied proper care and attention physically, educationally, emotionally, or morally, is being permitted to live under conditions, circumstances or associations injurious to his well-being, is being abused.

Physical Assessment in Suspected Abuse

If physical assessment of a child is indicated, it must be performed by a person (such as a nurse) who knows what is required and will make a credible witness in court. Physical assessment is determined to be appropriate when:

- a child has, by word or action, identified a particular injury which can only be determined by removing the child's clothing and
- the examination is necessary to determine if medical attention is required.

The person performing the assessment may determine that it is appropriate to have a witness (preferably another health professional) present during the physical assessment. The witness can be in the proximity of the examining area, that is, able to hear the interaction rather than in direct sight, in order to protect the child's privacy.

Unsafe Conditions that Put a Child a Risk

Early intervention personnel who find a child unsupervised or in an unsafe situation will, in consultation with their provider program, contact the Careline. The reporter will remain with the child until assistance from DCF or the local police arrive.

Training on Abuse Reporting

It is the responsibility of programs to ensure that their staff and subcontractors are adequately trained in the reporting of abuse and neglect.

The Commissioner of Children and Families has an educational training program and refresher training program for the accurate and prompt identification and reporting of child abuse and neglect. Such training program and the refresher training program is made available to all persons mandated to report child abuse and neglect at various times and locations throughout the state as determined by the Commissioner of Children and Families. For more information, go to portal.ct.gov/DCF/Mandated-Reporter-Training/Home.

Department of Children and Families Definitions of Child Abuse and Neglect

The following operational definitions are working definitions and examples of child abuse, neglect, and in danger of abuse.

- For the purposes of these operational definitions, the term child refers to any person under 18 years of age or any person under 21 years of age who is a DCF client.
- A person responsible for a child's care includes the child's parent, guardian, foster parent, an employee of a public or private residential home, agency or institution or other person legally responsible under State

law for the child's welfare in a residential setting; or any staff person providing out-of-home care, including center-based child day care, family day care, or group day care.

- A caretaker is an individual in whose care a biological or adoptive parent or legal guardian has left a child on an extended basis and who exercises parental authority in the capacity of a guardian.
- The phrase perpetrator given access to the child by the person responsible for the child's care refers to those circumstances when the person responsible for the child's care uses poor judgment in entrusting the child to another individual who then causes injury to the child.

ABUSE

- is a non-accidental injury to a child which, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care
- includes:
 - any injury which is at variance with the history given
 - maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

TYPES OF ABUSE

Description/Examples: Physical Abuse

Physical abuse is any physical injury inflicted other than by accidental means, any injury at variance with the history given of them, or a child's condition which is the result of maltreatment such as malnutrition, deprivation of necessities or cruel punishment. Examples of injuries which may result from physical abuse include:

- head injuries
- bruises, cuts, or lacerations
- internal injuries
- burns, scalds
- reddening or blistering of the tissue through application of heat by fire, chemical substances, cigarettes, matches, electricity, scalding water, friction, etc.
- injuries to bone, muscle, cartilage, ligaments fractures, dislocations, sprains, strains, displacements, hematomas, etc.
- death

Description/Examples: Sexual Abuse and Exploitation

Sexual Abuse is any incident of sexual contact involving a child that is inflicted or allowed to be inflicted by the person responsible for the child's care.

Sexual abuse includes, but is not limited to, the following:

- rape
- intercourse

- sodomy
- fondling
- oral sex
- incest
- sexual penetration: digital, penile, or foreign objects.
- Sexual exploitation of a child includes permitting, allowing, coercing or forcing a child to:
 - participate in pornography
 - engage in sexual behavior.

Description/Examples: Emotional Abuse or Maltreatment

Emotional abuse or maltreatment is the result of cruel or unconscionable acts and/or statements made, threatened to be made, or allowed to be made by the person responsible for the child's care that have a direct effect on the child.

The observable and substantial impairment of the child's psychological, cognitive, emotional and/or social well-being and functioning must be related to the behavior of the person responsible for the child's care.

Emotional abuse or maltreatment may result from:

- repeated negative acts or statements directed at the child
- exposure to repeated violent, brutal, or intimidating acts or statements among members of the household
- cruel or unusual actions used in the attempt to gain submission, enforce maximum control, or to modify the child's behavior
- rejection of the child.

NEGLECT

Neglect is the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education.

A child may be found neglected who:

- has been abandoned
- is being denied proper care and attention physically, educationally, emotionally, or morally
- is being permitted to live under conditions, circumstances or associations injurious to his well-being
- is being abused.

TYPES OF NEGLECT

Description/Examples: Physical Neglect

The following are examples of physical neglect:

- the failure to provide adequate food, shelter, and clothing appropriate to the climatic and environmental conditions
- the failure to provide, whether intentional or otherwise, supervision or a reliable person(s) to provide child care

- leaving a child alone for an excessive period of time given the child's age and cognitive abilities
- holding the child responsible for the care of siblings or others where beyond the child's ability
- the person responsible for the child's care displays erratic or impaired behavior
- the person responsible for the child's care is unable to consistently perform the minimum of child-caring tasks
- death.

Description/Examples: Medical Neglect

Medical neglect is:

- the refusal or failure on the part of the person responsible for the child's care to seek, obtain, and/or maintain those services for necessary medical, dental, or mental health care
- withholding medically indicated treatment from disabled infants with life-threatening conditions.

Note: *Failure to provide the child with immunizations or routine well child care in and of itself does not constitute medical neglect.*

Description/Examples: Educational Neglect

Educational neglect occurs when, by reason of the actions or inaction on the part of the person responsible for the child's care, a child age seven (7) years old through fifteen (15) years old either:

- is not registered in school; or
- is not allowed to attend school.

Description/Examples: Emotional and Moral Neglect

Emotional and Moral Neglect is the denial of proper care and attention to the child, emotionally and/or morally, by the person responsible for the child's care that may result in the child's maladaptive functioning.

Harmful behaviors by the person responsible include, but are not limited to, the following:

- encouraging the child to steal or engage in other illegal activities
- encouraging the child to use drugs and/or alcohol
- recognizing the child's need but failing to provide the child with emotional nurturance
- having inappropriate expectations of the child given the child's developmental level.

Note: *For court intervention regarding emotional neglect, a statement from a mental health provider documenting the condition is required.*

Circumstances Injurious

Description/Examples: In Danger of Abuse

In danger of abuse includes:

- actions or statements conveying threats of physical or mental injury
- a real threat to the child's well-being as perceived by the child
- the person responsible for the child's care exposing the child to dangerous and/or violent situations.

Description/Examples: High Risk Newborns

Newborn children will be considered to be at risk because of a combination of both their own special needs and their mother's condition or behavior.

Indicators of special needs newborns include, but are not limited to:

- a positive urine or meconium toxicology for drugs
- a positive test for HIV virus
- a serious medical problem.

Indicators in the mother's condition or behavior include, but are not limited to:

- substance abuse
- intellectual limitations which may impair the mother's ability to nurture or physically care for the child
- major psychiatric illness
- young age, causing inability to care for self or newborn.

Title:

ACCOUNTABILITY AND MONITORING

Purpose: *The Birth to Three System must ensure that all comprehensive programs comply with federal and state standards and requirements as well as evaluate success in achieving desired outcomes for families and children.*

Overview

Each lead agency for Part C under the Individuals with Disabilities Education Act (IDEA) is responsible for the public supervision and monitoring of programs that provide services to eligible children. In fulfillment of this requirement, CT Birth to Three programs will participate in a variety of integrated monitoring activities including self-assessments, data verification, and focused monitoring. The goal of all accountability and monitoring activities is to improve the quality of services to children and families as well as to ensure compliance with federal and state laws.

Federal Monitoring of States

The U. S. Department of Education, Office of Special Education Programs (OSEP) is dedicated to improving results for infants and toddlers with developmental delays and disabilities and their families. The Monitoring and State Improvement Planning Division (MSIP) carries out major activities related to the implementation of Part C of the IDEA which is called Birth to Three in Connecticut. MSIP works with states and territories to ensure consistency with Federal requirements and to ensure that systems are designed to improve results for infants and toddlers and their families.

Federal Reporting Requirements

There are three primary mechanisms states use to report data to the federal government about the implementation of Part C of the Individuals with Disability Education Act (IDEA.) There are requirements for both Part B of the IDEA (ages 3-21) and for Part C (birth through age 2.) This procedure is for the Part C system only.

State Performance Plan (SPP) / Annual Performance Reports (APR)

Section 616 of the IDEA requires that the state submit an SPP and APR. Each year in the APR the state reports progress toward targets as listed in the SPP as well as any changes to improvement strategies. This data is tracked from year to year by OSEP. The Connecticut Birth to Three SPP and APRs are posted on Birth23.org under "How are we Doing?"

Public Reporting of APR Data by Program

Section 616 also requires that each year states report APR data to the public for each early intervention program or county as appropriate. Connecticut posts this data by indicator along with the state targets on Birth23.org. The indicators that track child find and Local Education Agency (LEA) notification are reported by county since they are the responsibility of the lead agency and program catchment areas overlap.

Child Count or 618 Data Tables

Section 618 of the IDEA requires that states report data to the U. S. Department of Education, Office of Special Education Programs (OSEP) for the department's Annual Report to Congress. This may be referred to as "December 1" data because in Connecticut these reports include a count of the number of all eligible children with IFSPs on December 1 of each year. States are also required to report the primary settings in which children receive services, information about why children exit, and the outcomes of formal complaints. This data is posted on Birth23.org.

Determinations

Every year after reviewing the Annual Performance Reports (APR), OSEP makes determinations about how each state is meeting the requirements of the IDEA. The four determinations are:

- Meets Requirements;
- Needs Assistance;
- Needs Intervention; or
- Needs Substantial Intervention.

Section 616 of the IDEA also requires that the Part C lead agency makes the same determinations about local programs. In determining how well Birth to Three programs in Connecticut meet the requirements of the IDEA, OSEP requires that states use the most recent APR data from four compliance indicators in the State Performance Plan (SPP). Those four indicators are:

- Timely Services (Indicator #1)
- Timely Initial IFSPs (Indicator #7)
- Transition Plans (Indicator #8a)
- Timely Transition Conferences (Indicator #8c)

OSEP also encourages states to look at other optional data such as:

- Current Data on the four SPP/APR Compliance Indicators listed above
- Correction of Non-Compliance within 12 months (SPP Indicator #9)
- Timely and Accurate Data (SPP Indicator #14)
- Parent Complaint/Concern data
- Other monitoring data

In reviewing programs to make these determinations each Spring, Connecticut collects all available information and uses the four required compliance indicators listed above as well as the five optional components.

All programs are reviewed using a 4-step process:

1. The four required SPP/APR indicators listed above are reviewed using the previous year's APR data. More recent data is also reviewed in case the data indicates that the indicator has been substantially corrected.

2. Any non-compliance that was identified more than 12 months before the determinations are made is checked for verification of correction within 12 months.
3. Responses to emails about non-systemic data verification and all noted data errors are reviewed and programs are compared to the mean for the state.
4. Data about parent complaints and concerns is reviewed and programs are compared to the mean for the state.

For more information about how Connecticut makes Local Determinations visit Birth23.org and select “How are we doing?” or For Providers and then Training Opportunities.

Connecticut’s four determinations are further explained as follows:

1) Meets Requirements

Factors the lead agency will consider in determining whether an EI program meets the requirements and the purposes of IDEA, include the following:

- ~ The program demonstrates substantial compliance on ALL compliance measures.
- ~ The program demonstrates that it corrects noncompliance in a timely manner.
- ~ Timely and accurate data and identified data errors
- ~ The number and nature of complaints

2) Needs Assistance

Factors the lead agency will consider in determining whether an EI program needs assistance in implementing the requirements of IDEA include:

- ~ The program does not demonstrate substantial compliance on one or more of the compliance measures.
- ~ The program has not corrected identified noncompliance in a timely manner.
- ~ Data is determined not to be timely or accurate
- ~ There are more complaints than would be expected or even one is egregious.
- ~ The program has an active corrective action plan or compliance agreement.

3) Needs Intervention

Factors the lead agency will consider in determining whether an EI program needs intervention in implementing the requirements of IDEA include the following:

- ~ The EI program has needed assistance for at least 2 years.
- ~ The EI program does not demonstrate substantial compliance on one or more of the compliance measures.
- ~ The program has not corrected identified noncompliance in a timely manner.
- ~ Data is determined not to be timely or accurate and improvements are not seen.
- ~ There are more complaints than would be expected or one is egregious.
- ~ The program has an active corrective action plan or compliance agreement.

4) Needs Substantial Intervention

If the lead agency determines, at any time, that an EI program needs substantial intervention in implementing the requirements of Part C or that there is a substantial failure to comply with a corrective action plan, the lead agency will designate the EI

program as in need of substantial intervention. Among the factors that the lead agency will consider are:

- ~ The program has an active corrective action plan or compliance agreement and has not made corrections as identified in the plan.
- ~ The EI program fails to demonstrate substantial compliance on one or more of the compliance measures or other measures which significantly affect the core requirements of the program, such as the delivery of services to children with disabilities.
- ~ The EI program has needed intervention for at least 1 year and the program has not corrected identified noncompliance in a timely manner.
- ~ Data is determined not to be timely or accurate and improvements are not seen.
- ~ There are more complaints than would be expected or one is egregious.
- ~ The EI program has informed the lead agency that it is unwilling to comply.

After the review process programs are mailed determination letters along with data summary sheets highlighting the reason(s) for the determination. If a program is determined to Need Assistance a meeting is held with the program to develop a corrective action plan if one is not already in place. If a program is determined to Need Intervention or Need Substantial Intervention, a compliance agreement is developed.

Once determinations are made a review process is available but new determinations are not made until the following year even if the program corrects non-compliance or is found to be substantially in compliance shortly after the determination is made.

For each determination the lead agency has a number of enforcement actions available. For more information, refer to the Sanctions and Incentives section in this procedure.

State Monitoring of Local Programs

There are a number of components of the Connecticut Part C Accountability and Monitoring System.

- Determinations
- Public Reporting of APR and Data
- Every Birth to Three program completes a cyclical self-assessment.
- Improvement plans track identified correction as needed.
- The lead agency verifies the data for accuracy and timeliness.
- The lead agency also uses a focused monitoring process to evaluate more deeply the quality of service provided.
- Complaints or due process hearings received at any time also help to identify areas that require a new or revised improvement plan.

These are not the only ways Connecticut provides general supervision to programs. General supervision includes: policies, procedures and guidelines; training and technical assistance; supervision of new programs; provider updates and meetings; and contract management.

Program Self-Assessment

Since the lead agency for Part C has the responsibility for “general supervision” of programs, both compliance and quality measures must be monitored. Most monitoring measures can be referenced directly to federal and state laws and regulations. For a list of the Current Monitoring Measure visit Birth23.org and select “How are we Doing?” In addition to an excel file there is an interactive learning module about the measures available on the same webpage. Periodically parents, providers and lead agency staff will review the results from all Part C monitoring activities. Measures may be adjusted as needed. As research in the field of early intervention continues to identify and clarify best practices, and as regulations change, the current measures will be modified.

Programs submit self-assessment data electronically. An introduction to the self-assessment process is available on Birth23.org > “How are we Doing?”. Upon completion of the self-assessment, the lead agency reviews the data and identifies in writing any non-compliance that must be addressed in an improvement plan. The written identification also call a Finding’s Letter includes the measure, the regulatory or procedural reference, the data that supports the non-compliance or need for improvement and the due date for correction as applicable. Correction of identified non-compliance must be verified by the lead agency no more than 1 year from the date of the written notification of findings. To give the lead agency time to verify sustained correction, a due date for submitting evidence of correction is set at approximately 9 months after the date on the findings letter. Programs are directed to develop an electronic improvement plan within 30 days of receiving the notice.

Improvement Plans

Each plan includes all measures that the program is working to improve or correct whether the measure was identified based on an APR report, Self-assessment or a Focused Monitoring Visit. Each measure has the same requirements.

- Strategies should describe what the program will do or change to impact the previous results. Examples include developing internal tracking systems, training staff, restructuring, and any TA arranged with the lead agency or other sources.
- How many records will be reviewed and how many will meet the requirements over which time period (10/10 records will have XYZ each month from May-July).
- A due date for correction of each measure as identified in “Finding Letter(s)”.

Once the strategies have been implemented programs are required to collect data for 3 consecutive months to provide evidence that not only has the measure been corrected but that the correction has been sustained. The standard is to review 10% of the number of eligible children enrolled in the program with a minimum of 10 each month for 3 consecutive months. Depending on the size of the program the events for some measures may not occur often enough for 10% or a minimum of 10 each month in which case programs are to review ALL occurrences during the month (i.e. periodic reviews of IFSPs or children exiting Birth to Three).

Progress updates should be submitted by 6 months after the letter identifying findings is received and earlier if possible. This process assures that Technical Assistance if needed can be made available prior to the 12 month deadline for the verification correction of non-compliance.

Once a program submits evidence of correction, the lead agency establishes how the correction will be verified. This varies by measure and includes faxes, emails, data reports and on-site visits. Once verification of correction is completed, the lead agency notes that in the online improvement plan.

Data Verification

As another component of Connecticut's Birth to Three Accountability System, data is collected and verified for accuracy and timeliness at many points during the year. The centralized database is a quality assurance tool and data is routinely made public. As a result timely and accurate data is critical. Several methods for data verification are available to the lead agency and local programs. It is important to note that "data" is not only the child specific information entered into the Birth to Three Data System, but also information from self-assessments and improvement plans.

Built-in Edits

The Connecticut Birth to Three Data System includes "business rules" that require specific information in various fields. A Data Users' Group that meets on a regular basis reviews these as needed. Pop-ups that ask "Are you really, really sure?" are familiar to many data system users. A detailed list of these edit checks is available in the Online Data User's Manual on Birth23.org under For Providers. In some cases the reason for a missed timeline can be recorded directly into the data system

Verification of Annual Performance Report (APR) Data

Twice per year the lead agency runs data related to APR indicators. Lists are emailed to any program that has missing data or data that indicates that a required deadline was not met. Programs are required to respond as quickly as possible with the reasons. For purposes of IDEA Determinations data errors are recorded as such. The program is asked to correct the data if possible. A record of all data verification responses is saved for each indicator for each year.

Public Reporting of Annual Performance Report (APR) Data

As a data verification tool, this provides a direct connection between the state targets and performance at the local level and on select indicators. The reports are posted annually on Birth23.org by indicator and by program.

Verification during On-site Monitoring Visits

As part of on-site visits, discussions with program administrators and data entry staff address how data is collected and entered. Data summary pages are produced for each record being reviewed. Dates and other information in the child's record are compared to the information in the data system.

Verification of Correction of Non-Compliance

After identified non-compliance has been reported as corrected, the Accountability Unit contacts programs to verify that the correction occurred as reported and that it was sustained for at least 3 months. This verification varies by measure and may be done through analyzing the available data in the Birth to Three database, faxes, mailings, parent interviews, and/or on-site visits. During an on-site data verification visit for the records used by the program to demonstrate correction are reviewed as well as a new sample of records.

Special On-Site Reports and Visits

From time to time the lead agency runs data reports on various measures by program. These reports by program are posted on the Data Verification section of www.Birth23.org under Accountability. Outliers receive phone calls or emails to help confirm the accuracy of the data. If, over time, it is routinely observed that a program remains a consistent outlier or that data is not entered in an accurate and timely manner, a data verification visit may be made by the lead agency to determine the root cause of the issue(s).

Focused Monitoring

With support from the National Center for Special Education Accountability and Monitoring (NCSEAM), Connecticut developed a focused monitoring system. Focused Monitoring is defined as:

“A process that purposefully selects priority areas to examine for compliance/results while not specifically examining other areas for compliance to maximize resources, emphasize important variables, and increase the probability of improved results.” - NCSEAM Advisory Board

Stakeholders Group

The State Interagency Coordinating Council (ICC) serves as the base for a focused monitoring stakeholders group, with the addition of parents, a representative from the Part B focused monitoring staff, and a special education director from a local school district who is also on the Part B stakeholders group. The stakeholders group is responsible for advising the lead agency on priority areas and measures to be monitored each year as well as reviewing progress on the priority areas for the state as a whole.

Indicators and Selection Measures

The stakeholders review the priority areas that are of critical importance for quality and compliance. Performance in these areas is measured using data that can be aggregated centrally. The stakeholders define program selection measures and develop the protocols for the on-site visits. The protocols identify what to look for and where to look.

Grouping and Selecting Programs

To select which programs to visit, programs or agencies are first grouped by size. Three groups were identified based on the number of eligible children with IFSPs in each program on a given date. This type of grouping allows programs to be compared to similar sized programs. The current size groupings are posted on Birth23.org

For each selection measure, the programs are then ranked by size group. Programs with the lowest rank in each group will be contacted for an on-site inquiry visit or data-verification. If a program has already received an on-site visit, the next lowest program will be selected. Programs may also be selected at random.

The Focused Monitoring Team

The base membership of each focused monitoring team includes the Birth to Three administrator(s) for the program being visited, parent team members and the manager for accountability and monitoring. A provider from another Birth to Three program serving different towns is invited to participate as a peer member of the team as well. Other lead agency staff members are included in components of the visit as needed.

The Focused Monitoring Cycle

Programs are ranked and selected to receive on-site inquiry visits. Each program that is selected receives a phone call as the selections are made. The programs that are selected are also notified in writing. All programs are provided copies of the ranking tables and they are posted on Birth23.org.

The components of a focused monitoring inquiry visit includes

Pre-planning calls

The accountability and monitoring manager calls each program to set tentative dates approximately 1-2 months in advance. This is an opportunity for the program to ask questions and prepare staff.

Desk Audit (before the on-site visit)

Prior to an inquiry visit, the monitoring team meets to review all available data about the program. Available data includes; previous monitoring results and correction, any complaint data, family survey data, existing reports, Section 616 determinations, and any new analysis as needed. The outcome of the desk audit is to define a number of hypotheses about the challenges that specific program may be facing related to the priority area. It is these hypotheses that drive the activities and findings of the inquiry visit. The manager arranges a conference call with the program administrator at the end of the desk audit to discuss the hypotheses and to assure that any hypotheses the program may have developed based on its own analysis are included.

Planning and Scheduling

During a number of planning phone calls and emails before the on-site visit, the program administrator(s) and the accountability and monitoring manager decide the

best methods and days for gathering information from staff or other key people as related to the hypotheses.

Inquiry Visit (on-site)

Even though the inquiry visit is tailored for each program based on the desk audit, components of every visit include meetings with the agency administrator(s), record reviews, family interviews and staff interviews. Some visits may include interviews with Local Education Agency (LEA) staff or other community providers.

The most important aspect of focused monitoring is that each inquiry visit will be unique. The goal of focused monitoring is to determine whether the hypotheses about the priority area are true or not and, if needed, to develop a technical assistance plan with strategies that will have a high probability of improving a program's quality and compliance.

At the end of each day during the on-site visit, the FM team, the program administrator(s), and the monitoring team meet to review findings and confirm the validity of the visit components as related to the hypotheses.

Exit Meeting/Preliminary Report

On the last day of the inquiry visit, the focused monitoring team meets to summarize the data gathered in a preliminary report. An exit meeting is held in the afternoon with other lead agency staff to explain how a Technical Assistance (TA) request or a required TA plan might be developed.

Final Summary Report

No more than 90 days after the exit meeting, the accountability and monitoring manager sends written identification of any findings of non-compliance in a final report to the program along with a form requesting feedback on each of the visit components. None of the information in the report should be new to the program as the findings are discussed during the end of day meetings and the exit interview.

Impact on Improvement Plans

Within 2-3 weeks of receiving the summary report, if needed, the program will create or update an Improvement Plan. The due date for the correction of identified non-compliance is identified in the final.

Verification of Correction

Verification by the lead agency of the correction is required as soon as possible but no more than 12 months from the data on the final report. Correction of non-compliance specific to a child or family must be corrected within 45 days of identification as applicable.

Role of Complaints, Due Process Hearings, and Fiscal Audits

As a result of any formal or informal complaints, due process hearings, fiscal audits or any other activities that identify an area of concern, the lead agency staff may work with

a program to create an improvement plan if none exists or to revise an active improvement plan.

Aggregating Statewide Complaint Data

The Connecticut Birth to Three Procedures Manual has detailed descriptions about how the lead agency manages formal and informal complaints in the Complaints and Dispute Resolution procedures.

Fiscal Audits

The primary method for auditing reimbursement to local programs is through the monthly invoice for services delivered in the previous month. The Connecticut Birth to Three Data System includes business rules for required fields and internal checks before the data that impacts a monthly invoice can be committed. Once an invoice is received, and an electronic signature is confirmed, staff from the Fiscal Unit reviews it for accuracy. Summary reports are available in the data system to assist with this process.

- Invoice Summary Report Attendance Sign-off
- Invoice Tracking Services Suspended List
- Regional transfer report

The Fiscal Unit shall select programs on a random basis to review supplemental services, insurance receipts, and general ledger cost centers at the programs location. The following information will be reviewed for the categories selected:

Supplemental Payments:

Supplemental payments are reviewed monthly to ensure that services invoiced and paid at a supplemental rate were appropriately requested, authorized and calculated. The review will test that the proper request and authorization were received and granted, attendance sheets are signed off, visits are supported by progress notes, and type and frequency of services match an approved IFSP.

Insurance Receipts:

Insurance receipts are reviewed to ensure that all receipts are properly credited on the monthly invoice and that the correct billing rates are being used. The review will: compare services per the attendance form to the IFSP and CMS 1500, verify that correct rates are billed on the CMS 1500, that receipts are matched to the appropriate CMS 1500, that invoiced insurance receipts match the programs receipts journal and that the general ledger includes and matches the receipts.

Cost Centers:

The Birth to Three System requires, per the contract, that all programs have a separate cost center for Birth to Three activities. The review will test to see if there are separate cost centers for Birth to Three in the general ledger and review activity coded to them.

Sanctions and Incentives

If through the determination process or at any other time, the lead agency determines that a program needs assistance, the lead agency shall take one or more of the following actions:

- Advise the program of available sources of technical assistance.
- Provide the program with technical assistance.
- Update state policies / procedures / advisories / training
- Modify the Birth to Three Data System
- Seek to recover funds as related to the specific noncompliance.
- Develop a corrective action plan.

Corrective Action Plans

As needed, a corrective action plan will be developed that clearly records the actions to be taken by the program, including timelines, as well as any assistance to be provided by the lead agency. The program and lead agency will follow the agreed upon action steps and monitor progress often. The results of the corrective action plan will lead in one of two directions:

1) The program will demonstrate substantial compliance with the IDEA within the identified timelines.

OR

2) The lead agency will determine that the program is in need of substantial intervention and a compliance agreement will be developed that includes monetary sanctions for non-compliance.

If through the determination process or at any other time, the lead agency identifies that a program needs intervention, the lead agency may take any of the actions described above and may take one or more of the following enforcement actions:

- Require the program to use its own funds for required technical assistance.
- Require the program to use its own funds to hire an external monitor.
- Withhold referrals to the program.
- Withhold a percentage of funds to the program pending evidence that the program has completed the corrective action plan.
- Amend the contract to shorten the term of the contract.

If through the determination process or at any other time the lead agency determines that a program needs substantial intervention, the lead agency may take any of the previously described actions and may take one or more of the following enforcement actions and provide an opportunity for a hearing:

- Seek to recover funds as related to failure to meet the requirements of the contract.
- Withhold any further payments to the program.
- Initiate the process to cancel or not renew the contract.
- Develop a compliance agreement.

Compliance Agreements

A compliance agreement is developed (with input from families and staff) with the individual that signed the contract that clearly records the actions to be taken by the program and the lead agency. Possible monetary sanctions include:

The program may be required to commit resources for an external monitor to intensively track progress.

A percentage of the program's monthly payments (or funding) will be withheld pending evidence that the program has completed the compliance agreement. If successfully completed, the withheld funds will be forwarded to the agency.

The results of the compliance agreement will lead in one of two directions:

1) The program will take specific steps to demonstrate sufficient progress within the identified timelines to assure substantial compliance with the IDEA.

or

2) A determination that the program continues to need substantial intervention and the lead agency will begin the process to cancel or not renew the contract.

The enforcement actions are included in the contract between the lead agency and provider agencies. This section matches the current contract language as of July 2013.

2. Quality Assurance:

e. Enforcement Actions:

The Lead Agency reserves the right to use any appropriate enforcement actions to correct persistent deficiencies related to compliance with the IDEA or 17a-248 C.G.S., et seq. Persistent deficiencies are defined as substantial non-compliance issues identified by the lead agency either through data reports or on-site review or other quality assurance activities that have continued after being identified and noticed in writing to the Contractor for at least six months without significant improvement as determined by the Lead Agency.

Enforcement actions by the Lead Agency under this Section may include:

- denying or recouping payment for services for which non-compliance is documented.
- halting all new referrals until the deficiency is substantially remediated by the Contractor
- amending the contract to reduce its length by revising the ending date.
- termination or non-renewal of the contract in accordance with Part I of this contract.

After written notification by the Lead Agency of impending enforcement action, the Contractor will have the opportunity to meet with lead agency staff to review the available data, explain what will be necessary to achieve compliance, and review the evidence of change that will be necessary to demonstrate sufficient improvement to reverse the enforcement action, if appropriate.

Incentives

General supervision is required by the IDEA to assure compliance with statutes and regulations. However, Connecticut's Birth to Three System is primarily comprised of programs with a long standing commitment to excellence. Their primary incentive is always to provide the best supports possible to families in order to enhance each child's development. Programs that are in compliance, achieve acceptable performance levels on all of the current self-assessment measures, and have few if any parent complaints, are not required to develop an improvement plan. These programs will only have to periodically complete a self-assessment and as need respond to data verification emails related to the Annual Performance Report and 618 data tables.

Unless selected randomly, programs that rank high on focused monitoring selection measures will not receive on-site visits.

Additional incentives include highlighting the excellent performance of a particular program in the Birth to Three Provider Update or on the website. In addition, programs with promising practices are offered funding to provide training or technical assistance to other programs or to mentor new programs.

It is the goal of Connecticut's Part C Accountability and Monitoring System to assist all programs to achieve high levels of performance and to continually improve as new practice-based evidences are identified.

Title: ASSISTIVE TECHNOLOGY

Purpose: *Ensure that children receive assistive technology devices and services when needed.*

Overview

Assistive technology, devices and services, is one of the services required under Part C of the 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”
- “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....”

Another way to look at what constitutes assistive technology is to see if the answer is yes to the following three questions:

1. Does the child have a disability or a significant delay in the area of development?
2. Is this a device or adapted material?
3. Will the device or adapted material support the child’s active participation in an everyday activity of the child and family?

A device is considered a required assistive technology device only if it relates to the developmental needs of the child. It is *not* required if the device is provided to meet the medical, daily living, or life-sustaining needs of a child.

New England Assistive Technology (NEAT) Contract

The Birth to Three System has a contract with NEAT and pays the membership fee for all Birth to Three programs. Birth to Three program members can access the following NEAT benefits:

- Purchasing Assistance - Support regarding the selection of appropriate devices via email, phone and/or video conferencing
- Equipment Loan or Trial - The CT Birth to Three System owns an extensive inventory of equipment available for loan to a child until they are no longer using/needing it. This loaned inventory is stored, cleaned, repaired, and managed by the Equipment Restoration Center (ERC) at NEAT. Some additional pieces of equipment owned by manufacturers are available for short-term trial for assessment purposes. The trial assistive technology device or equipment will only be left with the family for a maximum of 4 weeks in order to assess its appropriateness.
- AT Lending Library - Loan of assistive technology devices including communication devices, switches, and adaptive toys. All devices loaned from

NEAT's lending library are available for short-term loan to therapists only, this includes iPads for communication for assessment purposes.

- Long Term Loan of iPad – once a communication system is determined, a long term loan of an iPad can be arranged. iPads for communication owned by the CT Birth to Three System are available for use by the child until they are no longer using/needing it.
- Training - regarding assistive technology (with approval of Birth to Three Provider Support Team Manager or designee) including sponsored seats in NEAT workshops appropriate to Birth to Three providers.
- Governor's Education Emergency Relief fund (GEER) – NEAT manages the inventory of GEER iPads secured through GEER funds to provide all families equal access to education. These iPads provide families a way to access remote Early Intervention Visits.

Assistive Technology Assessment

1. Assistive Technology Assessment by Programs:

Any time that a child's IFSP team thinks that a device may be needed to increase, maintain or improve a child's functional participation in order to achieve an IFSP outcome an assistive technology assessment should be performed in the environment(s) where the child will be using the device. This assistive technology (AT) assessment is performed by Birth to Three program staff from the appropriate discipline related to the device (i.e. Speech Pathologist for communication devices, motor therapist for adaptive equipment). Information from the whole team including the parent should be considered. It is possible that much of the information for the assistive technology assessment can be gathered from ongoing assessment and intervention information already available. The AT assessment can happen during a regularly scheduled home visit (documented on the visit note) or can be part of a more formal assessment that generates a written report that is separate from the visit note. These more formal assessments may be subject to prior authorization per the *Payment Procedure*.

A formal AT assessment report should include information regarding the need for assistive technology, the child's level of functioning, environmental considerations, the type of device, and what functional outcome (activity) the child will be able to actively participate in because of the assistive technology.

Assistance with selection of an appropriate AT device is available from NEAT. Consideration should be given for assistive technology devices ranging from low to high tech. A low tech device enables 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 picture systems board, rolled towels or foam to enhance sitting posture to increase participation in an activity). A high tech device involves more advanced supports to increase a child's functional capabilities (e.g., gait trainer, walker, computerized communication device, wheelchair, or hearing aids).

2. Trial of AT Devices as part of the AT Assessment process:

IPads with a variety of communication apps are available for short term (MAXIMUM one month) trial as part of an assessment process.

Also as part of the AT assessment process, NEAT Marketplace has a limited supply of devices from vendors available to Birth to Three providers for trial purposes. The trial assistive technology device or equipment will only be left with the family for a maximum of 4 weeks. The process for requesting items for trial from NEAT is as follows:

- a) The program staff person requesting trial equipment/devices fills out the *Trial Agreement Form*, Form 3-13, including program staff and director signatures.
- b) The trial assistive technology equipment/devices will only be left with the family for maximum of 4 weeks. It is the program's responsibility to ensure the timely return of the device. The program is responsible for dropping the trial device off to NEAT or their satellite offices. Large trial equipment can be picked up by NEAT at the family's home with the program staff present, per stipulations on Form 3-13.
- c) The cost to replace trial assistive devices/equipment that is not returned to NEAT will be charged to the program. Responsibility for damaged equipment will be assessed on a case by case basis by Birth to Three Lead Agency.
- d) Assistive devices or equipment not returned within 4 weeks may result in the program losing borrowing privileges.

3. Assistive Technology Assessment When Additional Expertise is Needed By Program

A child's AT needs can typically be best assessed by the Birth to Three program staff from the appropriate discipline related to the AT device, with input from the full team. At times, a program may need additional expertise that is not available through their own staff. In order to provide this additional expertise, programs could establish an arrangement with NEAT (contract, purchase order). Appropriate program staff should participate in the Assistive Technology assessment along with NEAT staff since they know the child and family best. An assessment report must be written with signatures from all staff that participated. (See *Payment Procedure*)

An Assistive Technology assessment by someone who is certified by RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) is a very lengthy, extensive process that is rarely needed for a child under 3 years of age. However, if desired, the program may seek a RESNA assessment. Names of available assessors should be obtained through the NEAT or on the RESNA website (RESNA.org). Some of the larger Durable Medical Device vendors may also employ RESNA certified professionals. Unless the agency doing the AT assessment/RESNA assessment will be billing Medicaid directly, the program would follow the steps outlined in the preceding paragraph and in the *Payment Procedure*.

Including Assistive Technology “Devices” on the IFSP

Because Assistive Technology is a Part C service, all AT, regardless of cost, must be necessary for attainment of an Outcome and written on the outcome page of the IFSP as well as in the Supports and Services Section. “Assistive Technology Device” should be listed in Supports and Services Section and the assistive technology must be listed in an Outcome, with general information about the device (i.e. hearing aid vs. the specific type, mobility device rather than the specific type of gait trainer and accessories). More specific information about the type of device can be listed if known. The specific device information will be required as part of the Durable Medical Equipment reimbursement process (see *Payment Procedure*). If insurance, including Medicaid, is paying for all or part of the device that information should be noted in the box: *“Part C supports are paid for by the Birth to Three System unless otherwise indicated here.”*

“Assistive technology device” should be listed in “What is going to happen”. The “Delivered by” box should list the discipline responsible for overseeing use of the device. The boxes for location, how often, how long, and end date may not apply and can be left blank. The box for start date should note the expected date of delivery of the device or service, allowing for processing of insurance claims and ordering time. Transportation is a required Part C service and should be added to the IFSP when the child will need to travel in order to receive the AT device or service.

Including Assistive Technology “Services” on the IFSP

“Assistive technology services” assist with the selection, development, maintenance, repair, and training in the use of the device. Most often this will be addressed by Birth to Three program staff. If desired, “assistive technology services” can be included on the Supports and Services section of the IFSP “What is going to Happen”, or it may also be rolled into the Early Intervention visits already being provided by the interventionist responsible for supporting use of the device and not specifically written on the IFSP.

Acquisition of Assistive Technology Devices

As soon as the specific assistive technology device is determined, the process should be started to obtain that device. The program staff person whose area of expertise falls in the area related to the device is responsible for obtaining the device and setting up appropriate training in use of the device. When a child’s IFSP team is considering an AT device for a child, they should first contact NEAT to inquire about whether the device or similar but appropriate device is available for loan. There are three possible processes necessary for obtaining AT devices:

- A. Loan – from Birth to Three via NEAT
- B. Purchasing - through an approved Durable Medical Equipment (DME) vendor
- C. Reimbursement – through Birth to Three for costs not covered by insurance

A. Long Term Loan of Assistive Technology Devices from Birth to Three System via NEAT

Equipment - The Birth to Three system has an assistive technology inventory managed by NEAT and available to providers. As appropriate, prior to purchasing an AT device for a child, the provider should see if NEAT has the device or a similar device available for loan. A child may keep the loaned assistive technology device as long as he/she needs it, regardless of whether they have exited the Birth to Three System. The Birth to Three System will not be responsible for any service or upgrade after the child exits. For Loan of Assistive technology devices:

- Prior to a loan request from NEAT, an AT assessment is completed and documented (on visit note or formal written report), and “AT Device” is included on the IFSP (see p.3 of this procedure).
- Interventionist completes *Loan Agreement*, Form 3-14 and SECURELY emails to NEAT. See addendum.
- Devices will NOT be loaned without a completely filled out Form 3-14, including program signature.

iPads and other Hand Held Electronic Devices as Assistive Technology for Communication

1) Family owned device: If a Birth to Three team recommends as part of the IFSP meeting that a child needs an assistive technology in the form of an app on a handheld electronic device that the family owns, the program would be responsible to purchase and seek reimbursement (see above: *C. Accessing funding/reimbursement from Birth to Three*)

- 2) Long Term Loan of an electronic device and app(s) owned by Birth to Three System:
- During an IFSP meeting, the Birth to Three team identifies the need to support communication through assistive technology in order to address a functional outcome(s) on the IFSP.
 - The team completes an assessment (possibly through use of a short term loan of iPad from NEAT with various apps installed) and consults with NEAT as needed. The assessment should include consideration of the child’s ability to use low and high tech devices.
 - The program will contact NEAT using AT Loan Form 3-14. NEAT will:
 - Load the app(s) and restrict the use of the device to only the specified app(s) for communication.
 - Activate the GPS feature if available on the device.
 - Apply or attach any protective covers as appropriate to the device.
 - Mail the iPad to the Program
 - Track the app(s) that are loaded onto Birth to Three purchased devices, and arrange to update the device or app as appropriate while the child is still enrolled in the Birth to Three System.

-Continue to contact the family after the child is no longer in Birth to Three to determine whether the specific app(s) are still in use. If not, NEAT will make arrangements to retrieve the device for recycling.

The Birth to Three program that requests a handheld electronic device as a piece of AT is responsible to:

- Make sure that the family understands that the device, when loaned by Birth to Three, is a dedicated device solely for communication, and they will be able to use it for only this purpose.
- Ensure that the transition plan lists the loaned device and that a plan is made for securing an appropriate device after the child exits Birth to Three. The child can continue to use a device with app(s) loaned by Birth to Three after exiting until another device is secured. However, the device will not be updated and Birth to Three will not be responsible for maintenance of the device after the child exits.
- Notify the parent that when that particular device or app no longer meets the child's needs or the child is no longer in Birth to Three, they will need to return it to NEAT so that it can be recycled for someone else to use.
- Contact NEAT if the device is lost or damaged.

B. Purchasing of AT Devices by Birth to Three Programs through Durable Medical Equipment (DME) Vendor

Regardless of funding, if it is determined that an AT device will be purchased for a child, the Birth to Three Program will need to work with a vendor of durable medical equipment (DME). The vendor will be responsible for insurance billing. Additional paperwork from the Birth to Three provider (letter of medical necessity, insurance forms, etc.) will be needed by the vendor in order to facilitate insurance approval. For Medicaid, DME vendors must accept Medicaid state rates as full payment. For commercial or no insurance, DME vendors may invoice programs for costs not covered by insurance, up to the state rate. Programs may seek reimbursement from Birth to Three for costs up to these published state rates. Birth to Three providers can contact CHNCT member services number for a list of participating Medicaid enrolled DME providers at 1-800-859-9889.

Insurance and Medicaid customarily fund equipment that fits under the category of DME which may include, but is not limited to, aids for daily living and personal care, mobility aids, standing and walking aids, wheeled mobility aids, seating and positioning systems, augmentative communication aids, and hearing aids.

Products that are life-sustaining are typically covered by insurance and Medicaid, but are not considered assistive technology devices and therefore *not* reimbursable by the Birth to Three System. Life-sustaining equipment that is considered medical in nature includes, but is not limited to, suction machines, glucose monitors, feeding pumps, apnea monitors, enteral and parental solutions and supplies, nebulizers and ventilators.

C. Accessing Birth to Three Funding/Reimbursement for Assistive Technology Devices

Programs may seek reimbursement for costs up to the published state rates for AT devices that are not fully covered by insurance. This will most often involve those with commercial insurance or no insurance, or if Medicaid denies payment for an approved AT device.

Prior to purchasing a device, programs should check with NEAT for devices that are already in the Birth to Three inventory for loan, or for reconditioned equipment for sale. If parents are concerned about the use of reconditioned devices, they should be informed that Birth to Three's legal obligation is to provide appropriate Assistive Technology devices, not necessarily new devices, and certain pieces of equipment will not be funded by Medicaid unless refurbished equipment had been tried first.

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 investigate all other funding options *prior* to receiving funding from the Birth to Three System. Potential payment sources could include commercial insurance, Medicaid as part of the EPSDT Screening (Early and Periodic Screening, Diagnosis and Treatment), Children with Special Health Care Needs or Board of Education and Services for the Blind.

The Birth to Three System reimburses programs for the costs of assistive technology devices that are not covered by third party payers up to the published state rates. For Medicaid as well as commercial insurance, Durable Medical Equipment (DME) vendors must accept Medicaid state rates as full payment. For commercial or no insurance, DME vendors may invoice programs for approved AT devices for costs not covered by insurance, up to the state rate. If Birth to Three pays for 51% or more of the cost of the device, it is considered the property of the Birth to Three System and must be returned to the system when the child no longer needs the device.

The assistive technology device must be identified in the IFSP as a way to address an outcome, listed on the outcome and supports and services pages, and indicated on the IFSP screen in the data system as a plan including an assistive technology device. Additionally if a program will be requesting reimbursement from the lead agency for all or part of the cost of the AT device, Form 3-11 must be submitted and approved by the lead agency, by SECURELY emailing with any attachments to CTBirth23@ct.gov prior to ordering of the AT. The prior authorization requirements for AT devices are further defined in the *Payment Procedure*.

Repair of AT Devices

The CT Birth to Three system will repair AT devices that were authorized and purchased by the system unless the damage was caused by gross neglect by the family. If the AT device was provided by NEAT, the program should contact NEAT to secure the necessary repairs. If the device was paid for with Birth to Three funds, the lead agency should be contacted to approve authorization for the repairs. If the family's insurance paid for more than 50 percent

of the cost of the device that device is owned by the family and the family should contact the vendor for necessary repairs.

Assistive Technology and Transition Planning

Children may keep assistive technology devices purchased or loaned by the Birth to Three System as long as the family is using the device with the child. When a child is transitioning, the device must be listed on the transition plan on the IFSP and addressed at the transition meeting with the LEA, in order to get a plan in place for the LEA to provide the necessary AT. If a child continues to use equipment after exiting Birth to Three, the Birth to Three System will not assume responsibility for repair or maintenance.

The Birth to Three System is responsible for funding assistive technology devices necessary to achieve functional outcomes identified on the IFSP. With the exception of hearing aids, no new devices or equipment should be requested for children who are less than 45 days from their 3rd birthday or 45 days from the start date of their IEP for children who qualify for Early Intervention Services (EIS) over 3 services and supports. Children with less than this amount of time remaining in Birth to Three, would not be able to use the AT device long enough to make progress on identified outcomes.

For late referrals, no new devices or equipment should be requested less than 45 days from the start of their IEP. Through a Memorandum of Understanding between the lead agency and the State Department of Education, children who

- a) qualify for EIS Over 3 based on their birth date,
- b) are referred to Part C between 97 and 46 days before their third birthday,
- c) are determined to be eligible for Part C,

will be considered to be eligible for Part B on an interim basis until the LEA completes its eligibility determination. Refer to Exit – Transition procedure for more information on EIS over 3.

The program must notify NEAT of the exit of a child for whom Birth to Three has purchased or loaned equipment. After exit from Birth to Three, NEAT will routinely contact families for whom assistive technology devices have been purchased or loaned to determine whether they are still in use. They will arrange for pick-up or shipping of devices that can be returned to Birth to Three.

Governor's Education Emergency Relief Fund (GEER)

Effective in 2021, iPads were made available to Birth to Three families for the purpose of equal access and participation in education. This allows loan of iPads to families needing them to access remote Early Intervention visits. Programs can request an iPads for this purpose from NEAT for a specific family using Form 3-14 and noting on the form that they are requesting a GEER iPad.

Information Regarding Hearing Aids

Pre-requisites for Hearing Aid Fitting Process

- Hearing loss has already been diagnosed by an audiologist.
- Hearing aid use is recommended by an audiologist.
- Family has obtained prescription for hearing aids from an ENT.

Hearing aids and related listening devices, supplies and dispensing fees are considered Assistive Technology Devices and should follow the same procedures for AT Assessment and Adding AT to the IFSP as outlined previously. The process for purchasing hearing aids and seeking reimbursement from Birth to Three is outlined in the Payment procedure.

Process for Birth to Three comprehensive program to request the purchase and fitting of a hearing aid by a Birth to Three program that specializes in hearing:

1. Comprehensive program lists "Assistive Technology Device" on the IFSP: "AT device - hearing aid" should be listed as a means to achieve a functional outcome(s) and included in the Supports and Services section. See *Including Assistive technology Devices on the IFSP* (p. 3) of this procedure for more information.
2. Transportation is a required Part C service and should be added to the IFSP when the child will need to travel in order to receive the AT device or service.
3. Comprehensive program discusses options for getting hearing aids with parents.
4. Comprehensive program calls the Birth to Three program that specializes in hearing with whom they would like to share the child to discuss the fact that they have a child with hearing loss who needs hearing aids.
5. In the Birth to Three data system, on the child's "case info" tab, the comprehensive program chooses "hearing aid purchase and fitting", chooses one of the programs that specialize in hearing, and enters the date. The program that specializes in hearing will then see "hearing aid purchase and fitting (P&F)" on their screen, and will be able to see the child's information.
6. The audiologist from the program that specializes in hearing will set the appointment with the parent.

THE FOLLOWING STEPS WILL BE COMPLETED BY BIRTH TO THREE PROGRAM THAT SPECIALIZES IN HEARING AS PART OF THE DISPENSING FEE (3 appointments)

1. At the 1st audiological appointment, review audiological record with parent; reassess hearing, as needed; explain the hearing loss and discuss hearing aids with family; do tympanometry; make ear molds; select hearing aids.
2. Order the hearing aids, maintenance supplies, batteries.
3. Follow procedures for submitting the paperwork to insurance and/or the Birth to Three Administration for reimbursement.
4. Provide 2nd audiological appointment to dispense hearing aids, introduce parents to how to put them on/take them off, maintain hearing aids in good working condition.

5. Provide 3rd audiological appointment together with the service coordinator or a team member from the comprehensive program to adjust hearing aids, test child's responses in audiological booth, as appropriate; counsel parents and service coordinator on hearing aid use and future audiological needs; demonstrate troubleshooting. An IFSP review may happen here to ensure appropriate services are on the IFSP.

Unless the comprehensive program makes arrangements with program that specializes in hearing to continue providing services, this ends the services provided under this arrangement. The program that specializes in hearing will enter the date of hearing aid fitting was complete in the data system and the child's information will no longer be viewable by the program that specializes in hearing. It is recommended that comprehensive programs review the IFSP with the program that specializes in hearing at this juncture, as it is necessary for children to continue to be monitored for audiological needs.

Additional ongoing needs for IFSP team to address*:

1. Ongoing computer verification to ensure optimal functioning of hearing aids
2. Ongoing hearing aid programming, as needed
3. Ear molds (approximately six per year —more often for small babies whose ears are growing quickly)
4. Audiological evaluation (minimally four times per year until exit from Birth to Three)
5. Batteries and supplies
6. Plan for maintenance and repair of the hearing aids
7. Parents' need for additional information and guidance regarding troubleshooting and maximizing the use of the hearing aids
8. Determination if additional assistive technology is necessary
9. Original program staff's need for more information about hearing loss, technology, process of learning to listen and talk
10. Child's need to learn to listen with the device
11. Child's need for ongoing spoken language intervention through listening
12. Determination of whether device is adequate for meeting child's needs, or if different technology should be considered

*Please note that these needs can be met by continued services from a Birth to Three Program that specializes in hearing or from medically-based pediatric audiologists.

Reimbursement for Hearing Aids, Dispensing Fees, and Transportation

Refer to Payment procedure for details on submitting for reimbursement from Birth to Three for hearing aids, supplies, dispensing fees, and transportation reimbursement.



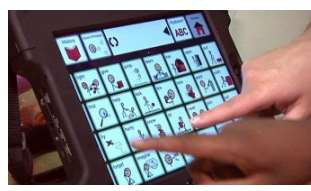

ADDENDUM



NEAT (AT) Services Available to Birth to Three Providers

Contact NEAT 860-243-2869 | NEAT.B23@oakhillct.org



Service	NEAT Lending Library Short Term Loans	Birth to Three Inventory Long Term Loans		
Description	 <p>Assessment & Decision Making Borrow iPads with a variety of communication apps as well as other AT to help the assessment process (i.e., switches, adapted toys, communication devices, & more)</p>	 <p>Remote Early Intervention Visits Borrow a GEER iPad for loan to a Birth to Three family in need of remote access for EI visits</p>	 <p>iPads for Communication Provide access to a child who needs an iPad for communication with a long-term loan; request for specific communication app comes from provider's assessment</p>	 <p>Adaptive Equipment Birth to Three owns an inventory of adaptive equipment which can be borrowed (and returned) at The NEAT Center, Oak Hill 33 Coventry St. Hartford, CT 06110</p>
Forms Required	NEAT Lending Library Loan Form	Long Term Loans: Birth to Three Loan Agreement Form (3-14) Trial of Vendor Equipment: AT Device Vendor Trial Form (3-13)		

Reimbursement Information for Birth to Three:

- Do NOT submit reimbursement form [CT Birth to Three Form 3-11](#) to NEAT.
- Submit Form 3-11 to the CT Birth to Three System CTBirth23@ct.gov when seeking reimbursement for AT.
- Refer to [CT Birth to Three Assistive Technology Procedure](#).

Title: USE OF AVERSIVE TECHNIQUES

Purpose: *The lead agency for Birth to Three in Connecticut has a firm commitment to positive behavioral supports*

Overview

Aversive techniques are those that may be “unpleasant, noxious or otherwise cause discomfort” to the child when used to “alter the occurrence of a specific behavior.” These might include the planned use of physical isolation (e.g. time out), holding a child’s hands or arms down or mechanical restraint such as lap belts for other than physical therapy needs. It may also include the use of a verbal reprimand such as “No” said in a loud voice or directly in a child’s face. Each emergency as well as planned and approved use of an aversive technique must be documented in the child’s early intervention record.

The Lead Agency reviews individual requests on the planned use of aversive techniques to ensure that they are clinically sound, supported by proper documentation, and are in conformance with the lead agency’s policies. A Birth to Three program wishing to propose use of aversive techniques must gain the prior approval before implementation of the technique.

In order to propose an aversive technique, the child’s team consisting of the child’s family, service coordinator and other appropriate persons who work directly with the child, must develop a “behavioral support plan” that is based on a functional analysis of the behavior and is referenced in and attached to the child’s IFSP. The functional analysis is a systematic observation of the immediate antecedent event associated with the behavior, communicative intent of the behavior, settings in which the behavior occurs and the consequence following display of the behavior.

Behavioral Support Plan

A behavioral support plan based on the functional analysis and emphasizing positive behavioral interventions shall be written and will include:

- baseline data
- positive methods previously tried with supporting data
- informed consent of the child’s parent or guardian
- a statement from the child’s doctor that the proposed aversive procedure is not medically contraindicated
- methods for increasing positive behavior
- methods for measuring the undesirable behavior
- plans for reducing the aversive technique
- the circumstance under which the aversive would be used
- training for staff who will implement it

- the name of the person responsible for monitoring the plan
- data summary of positive and undesirable behavior, over the life of the intervention

Emergency Use of Physical or Mechanical Restraint

Physical or mechanical restraint may be employed when an emergency exists in which a child is in jeopardy of harming himself or others and approved individual programs and non-aversive measures are ineffective to control the situation. No aversive procedure other than physical or mechanical restraint may be employed in an emergency. Each program shall establish general written procedures to be used in emergencies and shall identify the techniques, devices and equipment that may be used. . Each occurrence of an emergency restraint must be followed by a meeting of the child's team within three working days to review the child's program and determine whether the aversive technique is thought to be needed on a continuing basis or other behavioral supports should be considered. If the continued use of aversives is recommended, the steps outlined in the beginning of this procedure must be followed.

If physical or mechanical restraint is used on an emergency basis three or more times in a thirty day period or one or more times in three consecutive thirty day periods the child's team must review the child and his environment to address the behavior that caused the use of the restraint. If the continued use of aversives is recommended, the steps outlined in the beginning of this procedure must be followed.

Corporal Punishment

The Birth to Three System forbids the use of corporal (physical) punishment.

Title: **Child Outcome Summary (COS)**

Purpose: In order to report child outcome data in the Annual Performance Report, the Birth to Three System is tracking child progress on three outcomes that were identified by the Office of Special Education Programs (OSEP).

Overview

The three functional outcomes that follow are not required to be the IFSP:

1. Positive social-emotional skills (including social relationships);
2. Acquisition and use of knowledge and skills (including early language/communication);
3. Use of appropriate behaviors to meet their needs.

Complete the Form 3-18 "Child Outcomes Summary (COS)" with the family for any child less than 30 months of age at entry. To measure change over time as part of Connecticut's Part C State Systemic Improvement Plan (SSIP) ask families to respond to the following statement on the form *"I can clearly describe my child's abilities and challenges with family, friends, medical providers and others in our community."*

To determine how the child is functioning *compared to same aged peers*, the process will identify a rating from 1 to 7 for each outcome. At exit (if at least six months have elapsed from the first service) programs must complete a NEW form with the family both to determine how the family responds at exit about the family outcome statement and to determine how the child is functioning *compared to same aged peers*. If the exit rating for any outcome is less than 7 ("at age level") the program must answer "yes" or "no" to the question: "Has the child shown any new skills or behaviors since the last outcomes summary?"

Providers should team with families using the information gained from the initial eligibility evaluation and curriculum-based assessment to inform the entry COS process within the initial three months of service beginning. At exit, the COS Form will be informed by going through the form with the family and by the data from the curriculum that has been used in an ongoing manner to document progress. Crosswalks of the items from each of the curriculum-based assessments are at: <http://ectacenter.org/eco/pages/crosswalks.asp>.

If for any reason it is not possible to meet with the family to complete the COS before the child exits the system, the scores should not be entered into the data system. A blank COS form (Form 3-18) should be used at Entry and Exit so that the process the conversation with families at both points is unique as to how the child is doing at that time *compared to same aged peers*. If a child has an initial set of COS scores, exits the Birth to Three System and returns, when possible enter the child's original COS scores in the data system. In addition, when transferring a child to another program, the entry scores should be entered before committing the transfer in the data system. Since child outcome data is used for the state's Annual Performance Report (APR), reported to the public, it is important to enter complete COS scores as you close a child's record in the data system. The family outcome statement as used in the SSIP is also part of the APR but is not reported to the public.

Title: Children Who Are Homeless

Purpose: *Insure that all eligible children receive timely assessment, appropriate early intervention services, continuity of services, and transition supports regardless of temporary or chronic homelessness.*

Overview

IDEA 2004, Sec. 602(11) states that the term “homeless children” has the meaning given in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a). It also requires that a state policy be in effect, “that ensures that appropriate early intervention services based on scientifically based research, to the extent practicable, are available to all infants and toddlers with disabilities and their families, including...infants and toddlers with disabilities who are homeless and their families.”

Definition of “Homeless”

The federal McKinney-Vento Homeless Assistance Act of 2002 Title X, Part C of the *No Child Left Behind Act*, Sec. 725 defines homeless children as “individuals who lack a fixed, regular, and adequate nighttime residence...” including those who:

1. are sharing the housing of other persons due to loss of housing, economic hardship, or similar reason
2. are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations
3. are living in emergency or transitional shelters
4. are abandoned in hospitals
5. are awaiting foster care placement
6. have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
7. are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus, train stations, or similar settings
8. migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described above.

All procedural safeguards and Birth to Three procedures apply to a child who meets these criteria and his parents whether or not the parent(s) defines their family as homeless. Children who are homeless do have a higher priority status than other children who are transferring programs or waiting for initial assignment to a program. During initial intake, if Child Development Infoline staff determines that a child is homeless, they will enter the information in the notes section of the Child Info Screen of the data system. If homelessness is identified after enrollment, the service coordinator will note this in the data system. The purpose for doing this is to alert the receiving service coordinator to take extra measures to ensure completion of visits, managing no shows without a quick exit, and keep the transition plan up to date at all times.

Timely evaluation and assessment

The timelines, evaluation tools, criteria and personnel involved in completing an eligibility evaluation or assessment for a referred or enrolled child are exactly the same for a child identified as homeless as for any other child who is referred to, or enrolled in, the Connecticut Birth to Three System. Refer to the procedures for Evaluation, Assessment, Transfer, Transition, and Family Handbooks and Videos for more details.

Evaluations or assessments should be completed in the child's natural environment, which may include a homeless shelter, domestic violence shelter, or substance abuse rehabilitation shelter. The location of the evaluation or assessment should be chosen with the parent after discussion and consideration of the level of distractions, familiarity and comfort for the child, privacy and safety, and confidence that the testing situation permits a valid indication of the child's current abilities and areas of need.

Appropriate Early Intervention Services and Placement

Eligible infants and toddlers must receive the same types of services that the parent's values and priorities, the child's needs, and research-based practices indicate as being appropriate without consideration to homeless status. An IFSP must be developed according to procedural timelines and implemented accordingly. Services must be provided in a natural setting which may include a shelter or other location where children without disabilities live, learn and play, unless the child's early intervention outcomes cannot be achieved in a natural environment.

For homeless families residing in a shelter, parental permission may be sought to include shelter staff on the IFSP team, if appropriate, especially to reduce the possibility of parallel efforts to secure parental employment or housing if they are desired family outcomes. Birth to Three providers should be aware of and sensitive to the possibility that the parent may be more concerned about securing housing or other basic needs for themselves and their child than about any particular developmental progress or regression the child may be showing.

Birth to three providers should also be aware and respectful of the possibility that the parent does not see themselves as being homeless despite meeting the federal definition. This is particularly applicable to parents who are sharing housing, or "doubled-up". When discussing family goals during IFSP development or review, the parent may or may not choose to list "find and secure stable housing" on the IFSP. Since the word "homeless" is often stigmatizing, it may be best to avoid it entirely, focusing instead on accessing appropriate community services to meet family outcomes.

Continuity of Services on IFSP

Children who are homeless may experience a number of relocations during their period of enrollment. Some relocations are due to maximum length of stay residency limits imposed

by the shelter. Families who are “doubled-up” may be welcome to stay with a family member for a while, and then may be asked to leave. Families living in a campground will need to leave at the end of the camping season, typically when the weather becomes colder.

A service coordinator should discuss with the parent how important it is to inform her or him ahead of time of any anticipated change in address. If the parent and child’s address is expected to change to a town that the provider program does not serve, the “Transfer of a Child from One Program to Another” procedure must be followed quickly in order to reduce or eliminate any gap in service provision. The service coordinator should facilitate the parent’s choice of a Birth to Three program that serves their new town.

No program can decline to accept a child being transferred if they are in rotation. If there are no programs in rotation serving the town of the family’s new address, the sending program will contact the Family Liaison who will identify a program for the specific purpose of preventing a gap in service for this homeless child and family. The receiving program will make every effort to review the existing IFSP with the parent, discuss any proposed changes, and write a revised IFSP within one week of receipt of the transfer. The transition plan must be discussed and updated at every IFSP review. The service coordinator will facilitate selection by the parent of a new medical provider, if needed.

Families who relocate precipitously due to unforeseen events, such as eviction or domestic violence, or who do not give prior notice of relocation will appear to be “missing scheduled visits”. This may apply to a family that has a history of homelessness as well as to those who are experiencing homelessness for the first time since enrollment in Birth to Three. The service coordinator should make reasonable efforts to obtain the parent and child’s new contact information. Strategies may include calling secondary phone numbers (cellular or office) and extended family members whose information was recorded at intake, contacting community agency staff for whom a release of information has been granted or, if appropriate, discreetly inquiring with a known community support person such as a minister. If these efforts do not produce a successful contact with the parent and three or more scheduled visits are missed, the service coordinator will follow the Exit procedure for “children whose families consistently miss scheduled visits”.

Communication with School Districts

The Birth to Three System must provide the State Department of Education and nexus school districts with notification of children who will soon turn three, (See Notification to School Districts procedure.) The reports are posted on The Special Education Data Application and Collection (SEDAC) secure website, which is password protected and only accessible to designated school district personnel. It is critical that service coordinators ensure timely updates to the child info screen in the data system so that the responsible school district is correctly identified. This will help to ensure a timely and smooth transition from Birth to Three to the school district.

Service coordinators should discuss any applicable school choice options with a parent, recognizing that both the McKinney-Vento Act and IDEA mandate protections and

services for children and youth who are homeless. Generally, children and youth experiencing homelessness have the right to attend either the “school of origin” or the local attendance area school. However, the “school of origin” provision of the McKinney-Vento Act technically applies only to children who have been both enrolled and attending a public school. No statutory obligation exists for a school district to recognize a “school of origin” for children who have never attended school. For children younger than three years receiving Birth to Three services, Form 3-8 should be completed and sent to the school district in which the child resides at the time of referral.

The service coordinator should request parental consent to contact any applicable school district’s McKinney-Vento Coordinator identified on the State Department of Education website. Although no statutory requirement may be applied with regard to “school of origin” for most children transitioning from Birth to Three to the public school system, any district may elect to apply the “origin” provision. Considering the complex and unique needs of young children experiencing homelessness, the State Department of Education encourages districts to explore the family’s current situation and examine the feasibility of enrolling them in the district where the family was last considered permanently housed.

Service coordinators are strongly encouraged to provide parents who are homeless with additional information regarding the McKinney-Vento Act and its provisions. This information may be obtained from the State Department of Education website at www.ct.gov, then type “homeless education” in the search box. Additional assistance in effectively engaging a school district’s homeless liaison may be available from the Connecticut State Coordinator of Education for Homeless Children and Youth at the State Department of Education.

Title: COMPLAINTS

Purpose: *The Department of Developmental Services-, as lead agency, is responsible to review, investigate and act on any complaints or allegations of noncompliance with Part C of IDEA or with Connecticut Birth to Three standards, policies, or procedures by any public or private Birth to Three program.*

Overview

Any public agency, public employee, parent, private individual or organization may file a written complaint alleging that there has been an instance of noncompliance with IDEA Part C or with Connecticut's Birth to Three System standards, policies, or procedures by any public or private service provider. The Birth to Three System will investigate the facts and, within sixty calendar days, will issue a written decision to the complainant. There may be an extension of that timeframe if exceptional circumstances exist. Any necessary extension shall be agreed upon by both parties and will not exceed sixty calendar days. Parents are notified of these procedures through two Family Handbooks that they receive as part of the intake process, the Birth to Three website, the Welcome Video, and through the "Parents Rights Under IDEA Part C" booklet that they receive initially and annually from their Birth to Three program. Other organizations, such as the Connecticut Parent Advocacy Center, the Office of Protection and Advocacy, and the Independent Livings Centers, are also notified of this procedure.

Formal Complaint Process

1. The organization or individual filing the complaint must submit a signed written complaint to the Director of the Connecticut Birth to Three System and forward a copy of the complaint to the public agency or Birth to Three provider serving the child at the same time.

Per Section 303.434 of the Part C Regulations the written complaint must include:

- (1) A statement that the lead agency, public agency, or Birth to Three provider has violated a requirement of Part C of IDEA that occurred not more than one year prior to the date that the complaint is received;
- (2) The facts on which the statement is based;
- (3) The signature and contact information for the complainant; and
- (4) If alleging violations with respect to a specific child—
 - (i) The name and address of the residence of the child;
 - (ii) The name of the Birth to Three provider serving the child;
 - (iii) A description of the nature of the problem of the child, including facts relating to the problem; and
 - (iv) A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

If any of these items are not addressed in the written complaint the Family Liaison will address them as part of the investigation.

1. The Birth to Three Director will ask the Family Liaison to conduct an investigation of the complaint through interviews and a review of the early intervention record(s) or the Birth to Three Director may determine that an independent on-site investigation is necessary. The complainant will be given the opportunity to submit additional information orally or in writing within the required timeline.
2. When the liaison or independent person is investigating, programs will cooperate by providing full access to all records and personnel involved.
3. The Birth to Three Director will review all relevant information and determine whether the public or private agency is violating a requirement of the Birth to Three System. She will submit her findings to the Commissioner of the Department of Developmental Services and will issue a written decision within 60 days. A time extension may be permitted if exceptional circumstances exist with respect to a particular complaint
4. The written decision will address each allegation in the complaint and will contain the following:
 - findings of facts and conclusions
 - the reasons for the lead agency's final decision
 - the corrective actions needed to achieve compliance, including, as appropriate, the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family. This includes corrective actions required of the system or of a program or termination of a program's contract for cause.
5. The Accountability and Monitoring Office will document that any corrective action required of a program has been implemented. The Personnel and Practice Office will be responsible for needed technical assistance activities.

Formal Complaint Time Frames

The alleged violation must have occurred not more than one year prior to the date that the complaint is received. Allegations of violations outside of this time frame will not be accepted by the Birth to Three System.

Informal Complaints

Parents and others are encouraged, if they have a complaint, to attempt to resolve it by speaking to their service coordinator, program director, or the Family Liaison at Central Office before filing a formal complaint or requesting mediation or a hearing. Programs, along with the Family Liaison, or Central Office, are expected to maintain logs of such informal complaints, including how and when each was resolved. It is only by logging

such complaints and analyzing them for issues and trends that we can understand where improvements need to be made at either the program or system level.

When a parent calls or the Family Liaison, at Central Office to voice a concern, the Family Liaison will investigate, with the parent's permission, and try to resolve the issue, if possible.

References:

34 CFR 303.432–303.434

17a-248-10 of the Regulations of CT State Agencies

A Family Handbook: Guide I Referral and Eligibility

A Family Handbook: Guide II Orientation to Services

Parents Rights Under IDEA Part C booklet

Title: DISPUTE RESOLUTION: MEDIATION AND HEARING

Purpose: *Details the steps available to families who disagree with a decision made by a Birth to Three program or by the Birth to Three System.*

Overview

In addition to filing a written complaint, families have two other formal avenues with which to resolve a dispute over their child's eligibility or their IFSP or service delivery within the Birth to Three System. These are requesting either mediation or a hearing or both.

Parent Notification of Dispute Resolution Rights

Prior to the evaluation of a child to determine eligibility for the Birth to Three System (and annually thereafter for eligible children), the service coordinator will provide parents with a copy of the booklet "Parents Rights Under IDEA Part C" and explain, in their preferred language or mode of communication, their rights which include the right to request mediation or request a hearing.

Mediation

Parents may request mediation with regard to:

1. a proposal to initiate or change the identification, evaluation or early intervention services of their child;
2. refusal to initiate or change the child's identification, evaluation or early intervention services of their child.

Mediation is an optional process offered to two parties with differing viewpoints. The process is an informal way of resolving differences through understanding and compromise of the differing viewpoints. If mediation is successful, then there is no need for a hearing.

Mediation shall be offered to any parent by the Family Liaison when a parent has been unable to reach agreement with their Birth to Three program regarding identification or early intervention services. The Family Liaison will instruct the family to make the request in writing and will send the parent the brochure "The Principles of Mediation". If the parent selects mediation, it is expected that the families' Birth to Three program will participate in the mediation. The program will need to identify who will represent the agency during the mediation. This must be someone who can make decisions on all issues and can sign agreements. If any party other than the parent requests mediation, it may only be initiated with the consent of the parent(s).

The Family Liaison will inform the Birth to Three Director of the request and she will assign an impartial mediator. The assigned mediator will contact both the parent(s) and the program as soon as possible to determine a convenient time and location for the mediation. The service coordinator or another direct service provider may join the program director in the mediation. The mediator can help the program and the family decide who should participate in the mediation. Others, such as an agency director or legal counsel, may be available by telephone for caucus during the mediation session.

Discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearing or civil proceeding of any Federal court or State court of a State receiving assistance under this part.

Prior to the beginning of the mediation process, all parties must sign a legally binding agreement that states that all discussions that occurred during the mediation process will remain confidential and may not be used as evidence in any subsequent due process hearing or civil proceeding. This agreement is signed by both the parent and a representative of the Birth to Three program who has the authority to bind their agency.

1. Role of the Mediator

- a. The mediator will contact both parties and schedule the session.
- b. The mediator helps both sides to discuss their differences. The mediator will help them to find points they agree on and see other choices they may have.
- c. The mediator may hold private discussions with either party during the course of the mediation.
- d. No material needs to be sent to the mediator. All pertinent documents and records are shared at the mediation session. Each party may bring any information they feel will be relevant in reaching a resolution.

2. Results of Mediation

- a. Agreement - the parties reach agreement and sign a mediated statement that commits all parties to the terms of the agreement. A copy is sent to the Birth to Three Director.
- b. Non-agreement - if the parties fail to reach an agreement within 30 days of the request, the mediator certifies in writing that mediation has been unsuccessful and either party may request a hearing.
- c. Partial agreement - If the parties are unable to resolve all issues, a partial agreement may be written with consent. Either party may then request a hearing for any unresolved issues.
- d. Any changes in services as a result of the mediation must be documented in a revised IFSP.
- e. The lead agency will ensure that the results of the mediation are implemented.

Hearing

A hearing is a formal review of the problem identified by the parent, all data related to the problem and testimony from the parties concerned.

Parents may request a hearing with regard to:

1. a proposal to initiate or change the identification, evaluation or early intervention services of their child;
2. refusal to initiate or change the child's identification, evaluation or early intervention services of their child.

Parents also have the right to request a hearing if they have requested that information in their child's record be amended and the program refuses to amend the record in accordance with the request (see Records procedure).

Parents must request a hearing in writing to the Family Liaison on these issues. Upon receipt of the signed written request, the Family Liaison shall notify the Birth to Three Director of the request.

The Family Liaison shall forward the written request for a hearing to the Birth to Three Director. The Birth to Three Director shall, upon receipt of a written request for a hearing, appoint an impartial hearing officer, knowledgeable about the provisions of the Birth to Three regulations and the needs of and services available for eligible children and their families. The hearing will be scheduled at a time and in a location that is convenient to the parents. The hearing officer will issue a written decision within 30 days of the written request. The 30-day timeline may be extended by the hearing officer at the request of either party.

1. Role of the Hearing Officer. The hearing officer:
 - a. shall not be an employee of any public or private agency or program involved in the provision of early intervention services or care of the child, nor have a personal or professional interest that would conflict with his or her objectivity in implementing the process. A person who is paid to serve as a hearing officer is not deemed to be an employee of a public agency.
 - b. listens to the presentation of viewpoints concerning the matter under review, examines all information relevant to the issues, and seeks to reach a timely resolution of the matter.
 - c. will hold a preliminary conference by telephone to clarify the issues, review rights and procedures and settle issues not in dispute.
2. Rights of the Parents. Parents have the right to:
 - a. receive 10 days' written notice of the date, time and place of the hearing.
 - b. agrees or not agree to a preliminary conference with the hearing officer.

- c. be accompanied and advised by counsel and individuals with special knowledge or training with respect to early intervention services for eligible children.
 - d. present evidence and confront, cross-examine and compel the attendance of witnesses.
 - e. prohibits the introduction of any evidence at the hearing that has not been disclosed to them at least five days before the proceeding.
 - f. obtains a written or electronic verbatim transcription of the proceedings.
 - g. obtains written findings of fact, conclusions of law and decisions and
 - h. have the child present at the hearing.
3. Results of the Hearing
- a. The hearing officer informs the parents or guardians and lead agency of their decision in writing within 30 days of the request.
 - b. Appeals from the decisions of the hearing are to the superior court in the child's district of residence within 30 days after mailing of the notice of the final decision of hearing. An alternative is to appeal to federal district court.
 - c. Any changes in services as a result of the hearing must be documented in an IFSP as part of an IFSP review meeting.
 - d. The lead agency will ensure that the results of the hearing are implemented.

A child remains in his current program pending a hearing unless the parent and the Lead Agency agree otherwise. If the hearing involves agreement on the initial IFSP, the child shall receive those services that are not in dispute. A child who is no longer eligible for Birth to Three will not continue to receive Birth to Three services while a hearing either with Birth to Three or with the LEA is being adjudicated.

Responsibility of Programs Prior to and During a Hearing

If a parent of a child enrolled in the Birth to Three System has requested an impartial hearing, the service providing agency shall submit to the Lead Agency within two working days two copies of the child's entire early intervention record in a format required by the attorney for the Lead Agency.

Program directors or staff or both may be subpoenaed to testify at the hearing. They will most likely be asked about their level of experience and expertise in providing early intervention services as well as their experience in providing services to the child in question.

Evaluation & Assessment Guidance

Purpose: This guidance document addresses quality and best practice and provides further clarification of the *Evaluation & Assessment Procedure*.

Refer to the *Evaluation & Assessment Procedure* for all procedural requirements and timelines. These are NOT included in this document.

Overview

Federal Regulations make a distinction between evaluation and assessment. "Evaluation means the procedures used by qualified personnel to determine a child's initial and continuing eligibility" for Part C services. Assessment is "the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility". It includes "the assessment of the child and the assessment of the child's family" (IDEA Part C 303.21).

All children referred due to a developmental concern receive an eligibility evaluation. Children are eligible if they are under the age of three, live in Connecticut, and have either:

1. A significant developmental delay (-2 SD in one developmental domain, or -1.5 SD in two or more domains)
- OR
2. A diagnosed physical or mental condition with a high probability of resulting in a developmental delay

Evaluation for Initial Eligibility determination may occur through:

- Substantiating a significant developmental delay (as noted in 1 above) through:
 - Standardized testing
 - Acceptance of medical records confirming delay
 - Clinical opinion
- Confirmation of a diagnosed medical condition that confers automatic eligibility per CT Birth to Three System – *applies to 2, above*

Composition of Initial Eligibility Evaluation/ Assessment Teams

Evaluation team members should be chosen based on:

- the developmental domains cited as referral concerns
- the program's initial conversation with the family that identifies family concerns, priorities, resources, child's history, and other pertinent developmental and family information
- considerations as to who might be considered as a primary service provider if the child is eligible.

If the discussion with the family regarding their priorities and developmental concerns results in a choice of team members for the eligibility evaluation that differs from the initial referral concerns, this should be documented in the child record or in the notes box on the eligibility screen in the data system.

For children who are NOT eligible based on a multi-domain SNR instrument, the evaluation team must assure that a domain specific tool was completed for the primary area of concern, by someone with professional expertise in that area.

Example: for a child with only communication concerns, if a teacher and a SLP complete the initial evaluation using a multi-domain tool and the child is NOT eligible on this tool and then the SLP completes a domain specific instrument for communication such as the PLS, and the child does not meet the eligibility criteria on this tool, then they have assured that the child is in fact not eligible. If the initial team including the parent has no concerns in other domains, then there would be no need to send an additional evaluator out.

However, if during the evaluation the child is determined not eligible, but the team has concerns about other areas such as the child's motor control or social-emotional behaviors, the program needs to send out a motor specialist or mental health clinician to complete a domain specific tool, to assure that the child is not eligible based on motor or social/emotional development.

When more than two areas of concern are identified at referral and/or through in-depth discussion with the family, the evaluation team should include at least two professionals who can address the primary areas of concern. If the child is not eligible, the team must determine whether a discipline not on the initial evaluation team is needed to administer another tool to assure that the child is in fact not eligible for Birth to Three. Refer to example above - this occurs less than 1% of the time.

Initial Contacts with Family

The very first call to the family is the beginning of your foundation for working with this family during their tenure in Birth to Three. The program must:

1. contact the family within one working day of receiving a referral,
2. inform them that their referral was received and provide their program contact information.
3. review all information collected at Intake along with reviewing the family's concerns and priorities, and use this to determine the most appropriate evaluation/assessment team (Refer to *Composition of Initial Eligibility Evaluation/ Assessment Teams*)
4. discuss appointment time(s) and location that is convenient for the family, scheduling appointment as soon as possible
5. explain the evaluation process including the family's role.

Begin explanation of what Birth to Three supports look like based on best practices in Early Intervention. Refer to www.birthe23.org/looklike

Initial Eligibility Due to a Diagnosed Condition

The diagnosed conditions list is not exhaustive and may be edited with review by the lead agency. Providers with questions about a child's eligibility due to diagnosed condition may contact CTBirth23@ct.gov.

Documenting a Diagnosed Condition:

In most cases the parent or health care provider can provide documentation of the diagnosis via the referral form sent to Child Development Infoline.

Requirements for the following diagnosed conditions include:

- Hearing impairment requires an audiology or physician report
- Visual impairment requires a medical provider report
- Childhood apraxia of speech, stuttering-like disfluency (childhood onset fluency disorder), or a speech sound disorder requires a speech language pathologist report documenting alignment with Birth to Three eligibility criteria. Please refer to *Service Guideline 3: Children Referred for Speech Delays* for specific eligibility criteria.
- A diagnosis of Autism Spectrum Disorder (ASD) must include documentation of tools used to arrive at the diagnosis of ASD and how the child performed in each core deficit area of ASD. In addition, the ASD diagnosis must match the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*. A physician, licensed clinical social worker or licensed clinical psychologist must diagnose an ASD. Refer to *Service Guideline 1: Autism Guideline* for more information.

When diagnosed condition is used to determine eligibility, the multi-disciplinary team would then proceed with completing an initial assessment of the child in all five areas of development.

Eligibility Due to Developmental Delay

Developmental delay can be substantiated by an appropriately composed evaluation team noting:

- Standard deviation scores determined during eligibility evaluation that meet Connecticut's eligibility criteria, or
- Documentation of standard deviation scores in one or more areas that meet eligibility criteria from current (within 3 months) medical or other report, or
- Clinical opinion substantiating a significant delay that meets Connecticut's eligibility criteria.

Eligibility for Children with Referral Concerns in Specific Domains**1. Expressive Communication Only**

A child whose delay in expressive communication is at least 2 SD below the mean, but whose combined communication score is not 2 SD below the mean, **is** eligible if a speech language pathologist identifies one of the following risk factors:

- Oral motor disorders
- Moderate to severe phonological impairment (fewer than 65% of consonants correct in a 5-minute continuous speech sample)
- Chronic otitis media for duration of six months or longer
- Family (parents or sibling) history of language impairment or developmental delay
- Significant birth history including: congenital infection; craniofacial anomalies including cleft lip; birth weight less than 1500 grams; hyperbilirubinemia at a level requiring exchange transfusion; ototoxic medications; bacterial meningitis; Apgar scores of 0-4 at one minute and 0-6 at five minutes; mechanical ventilation lasting more than five days; head trauma associated with loss of consciousness or skull fracture.

- Ongoing concerns by the family or the evaluator about the child's qualitative performance in the areas of social/emotional, interpersonal skills, play interest, or sensory concerns

Biological risk factors must be documented through medical records, additional assessment, or behavioral observations. Family report is acceptable in the case of family history of language impairment or developmental delay.

Important considerations for children with communication delays:

- An audiological evaluation is critical.
- Prior to the child being found ineligible with use of a multi-domain tool, a speech-language standardized tool (such as the most recent version of Preschool Language Scale or Receptive-Expressive Emergent Language Test) must be administered by a speech language pathologist. Refer to *Composition of Eligibility Evaluation/Initial Assessment Teams* (page 2).
- For a child who lives in a home in which English is not the primary language, the evaluator must be able to demonstrate that the child has a significant delay in communication in his or her primary or dominant language. Use of an interpreter may be necessary as well as use of a tool normed in the child's language, if available.
- A child recently adopted from a non-English speaking country will not be eligible due to a significant delay in English communication until at least six months' post-adoption. They should be given a complete multidisciplinary evaluation in all 5 areas using their native language, if possible, which may identify significant delays.

Further information is provided in *Service Guideline #3: Children Referred with Speech Delays*.

2. Eligibility for Children with Motor Delays

For purpose of eligibility determination, the Connecticut Birth to Three System considers Gross and Fine Motor to be separate developmental areas. A child is eligible with:

- A delay of 2 or more standard deviations below the mean in either gross or fine motor OR
- A delay of 1.5 SD below the mean in both gross and fine motor

Prior to the child being found ineligible with use of a multi-domain tool, a standardized motor tool (such as the most recent version of the Alberta Infant Motor Scale or Peabody Developmental Motor Scales) must be administered by a motor therapist. Refer to *Composition of Eligibility Evaluation/Initial Assessment Teams* (page 1).

It is recommended that the medical history be considered, along with other early signs of motor dysfunction in areas of reflexes, tone, posture, decreased motor activity, decreased movement variability. This information could result in determining that a child with undiagnosed neurological disorder is eligible due to clinical opinion that substantiates a delay meeting Connecticut's eligibility criteria. In this case, one of the evaluators must be an Occupational or Physical therapist.

3. Eligibility for Children Born Prematurely

Refer to the diagnosed conditions list on the Birth to Three website, under Referrals, for gestational and weight parameters that confer automatic eligibility. See Insurance Procedure for more information.

A child who was automatically eligible by meeting gestational and weight parameters in the diagnosed conditions list remains eligible if the IFSP team has a concern about development or until functioning at age level in all areas of development. However, for insurance purposes, by 12 months of chronological age, a child who was is eligible due to prematurity or extremely low birthweight will need an additional ICD code entered into the data system. Do not change the original eligibility ICD code for gestational age or birth weight that conveyed automatic eligibility.

For a child with a history of prematurity that does not meet automatic eligibility due to diagnosed condition eligibility criteria, refer to above section on motor delays for more information. It is essential that an appropriate tool is used for eligibility determination along with assessment of early signs of motor dysfunction.

4. Eligibility for Children with Social Emotional Concerns

Prior to the child being found ineligible through use of a multi-domain tool, a domain specific tool such as the (Devereux Early Childhood Assessment-Infant/Toddler or Developmental Assessment of Young Children) must be administered by a mental health clinician such as a social worker, counselor, psychologist or other licensed mental health clinician. Refer to *Composition of Eligibility Evaluation/Initial Assessment Teams (page 1)*.

If the child is found not eligible for Birth to Three but mental health concerns are identified, the program, with parental permission, must refer the child to a licensed mental health care provider for evaluation and treatment, as noted per Connecticut Public Act 13-178. If permission for referral is refused, the program should record this in the child's record and leave information on mental health resources with the parent.

Children in foster care have experienced some kind of significant family disturbance and are at risk for social/emotional delays. Further information is provided in *Guideline 4: Infant Mental Health* on examples of behaviors that signal concerns and specific social/emotional assessment tools that assist in determining eligibility.

FAMILY SITUATIONS

1. Custody Issues and Permission to Evaluate/Assess

Child Development Infoline (CDI) gathers information at the time of referral regarding custody issues and decision-making authority. Providers must confirm the validity of this information during their first call to the family.

- Written Prior Notice (Form 1-6) must always be sent to BOTH parents, unless parental rights have been terminated.
- Regardless of divorce or separation, either parent can give written consent for an evaluation/assessment except:
 - If one parent's parental rights have been terminated
 - If there is a State Court custody order that requires decisions be made jointly
 - If the custody order gives sole decision-making authority to one of the parents
- If the referring parent has indicated that joint decision-making is required, the evaluation consent form (Form 1-4) should be sent out ahead of time to both parents however, the evaluation can proceed as long as one parent gives permission.

- Regardless of marital status, if there is disagreement between parents, the evaluation can proceed with permission from only one parent.
- If there is another parent listed at a separate address, both the written prior notice and the evaluation report must be sent to that second parent.

2. Eligibility for Children Who Move to Connecticut

Children who move to Connecticut from another state where they were eligible continue to be eligible for Part C in Connecticut if:

- they have a diagnosed condition that is on the Connecticut list
- they were significantly delayed at the time of their referral to the other state's program (e.g., 2 SD or 30% delay in one area or 1.5 SD or 25% delay in two areas) and are not functioning at age level in all five areas of development

They are not eligible in Connecticut if

- the diagnosed condition in the state they are leaving is not on Connecticut's list
- they were eligible based on developmental delay in the state they are leaving and are now functioning at age level in all five areas of development
- they were eligible based on being "at risk" for a developmental delay

Current information (if not older than three months) sent from the child's previous early intervention program may be used to determine if the child is still not functioning at age level in all five areas of development. If this information is not available, the program will need to conduct an evaluation to determine eligibility based on whether the child is currently on age level in all areas or whether he is still demonstrating a delay. If eligible, the child will need to have a multidisciplinary assessment completed for program planning purposes and initial IFSP development.

The Connecticut Birth to Three System is not required to provide Part C early intervention services to a child who is also receiving Part C early intervention services in another state if that child and their family are only temporarily visiting in Connecticut. This does not apply to children who are homeless or whose family is highly mobile (e.g. migrant workers) or displaced by a catastrophic event such as a hurricane or flood, who are wards of the state, or who reside on an Indian reservation.

Initial Child and Family Assessment

Once a child is determined eligible, an initial assessment of a child's unique strengths and needs in all five developmental domains must be completed by a multidisciplinary team prior to the initial IFSP. This assessment must be based, in part, on an objective assessment tool. Initial Assessment of the child is informed through use of a SNR tool or an authentic curriculum-based tool in combination with information provided by the family. If administration of standardized, norm-referenced tool is not necessary for eligibility determination (i.e. when using medical records or diagnosed condition) an authentic curriculum-based tool can be used. See the *Evaluation and Assessment Procedure* for more information.

With parental permission Initial assessment must also include a family-directed assessment. Family assessment should be conducted through interview in addition to use of a published tool. Suggested family assessment tools are found in the Connecticut Birth to Three IFSP Guidance.

Evaluation Process

All timelines and regulations from the *Evaluation & Assessment Procedure* must be followed.

Parent's active participation in the evaluation/assessment is crucial. Your explanations will help them to feel less anxious during a potentially very stressful time for them. Their participation right from the start helps them to see their critical role in supporting their child's development and sets up the practice of the family's active involvement during visits. The family's participation during the evaluation may take many forms (demonstrating, validating, interpreting, informing, observing) based on the family's perceptions, cultural backgrounds, economic status, and value system as well as the assessor's attitude and communication skills. This information is explained to parents in the *Family Handbook: Guide I*.

If the parent has limited English proficiency or if they are not comfortable using English, the program must arrange for an interpreter during the evaluation/assessment. Family members or neighbors should not be used for interpretation, unless the family specifically requests them to be used.

Additional clarification:

- Information on the child's health, vision and hearing should be gathered as part of the evaluation. Parent report can provide information on medical screenings that have been completed. If the child has not had a vision exam, the assessor should use Birth to Three Vision Screening (Form 3-17). If "red flags" are identified on the screening, the results should be sent, with parent consent, to the child's physician for follow-up. Newborn hearing screening is valid for one year. If the status of the child's hearing or vision is in question, then providers must assure that this is addressed in the IFSP.-Additional screening can be completed as necessary (Nutrition screen – Form 3-16, etc.)
- Screening for Autism must be offered to the parent when the child is 16 months or older. If concerns are identified on the screening, the family is offered an assessment by one of the Connecticut Birth to Three programs that specialize in autism. (See "Information Specific to Autism Spectrum Disorders" later in this procedure).
- Information is also gathered using Authorization For programs to Obtain Information (Form 3-2), for written diagnostic information and/or to speak with medical professionals.
- After determining that a child is eligible, the family must be given information and choice regarding other available programs serving their town. The family may continue with services from the evaluating program or choose another program. If the family chooses not to accept services from the evaluating program, that program should assist the family to select another program that is accepting referrals. The program that completed the initial evaluation/assessment should contact the new program and complete the electronic transfer in the Birth to Three data system. When a child transfers to another program the sending program keeps the original record and sends a copy of the file to the receiving program.

Children who are eligible and exit before the IFSP

If a family of an eligible child who exited prior to receiving any Birth to Three services decides they would like to receive Birth to Three supports, the program or parent should contact Child Development Infoline for re-referral.

Dispute Resolution Regarding Eligibility

If a parent disagrees with the eligibility determination, they are encouraged to:

1. Discuss with the evaluator(s) how their child's abilities and needs compare with Connecticut's eligibility criteria.
2. Offer new information to the evaluator(s), such as a recent medical diagnosis that might affect eligibility.
3. Contact the Birth to Three Family Liaison and request that the eligibility decision be reviewed
4. Send a written complaint or a request for a hearing to the Birth to Three Director if they feel there were problems with the evaluation process.

When a parent calls the Family Liaison or files a written complaint, the following process will be followed:

1. The Family Liaison will request a copy of the evaluation and any other available information from the program.
2. The Family Liaison and the Birth to Three medical advisor may review the evaluation report and supporting documentation.
3. If, during the course of the review, it is discovered that information was overlooked or the evaluation process was flawed, the program will be asked to re-consider the eligibility determination in light of the new information or to re-evaluate the child.

Information Specific to Autism Spectrum Disorders

Initial Eligibility Process - Screening Children for Autism Spectrum Disorders (ASD)

The American Academy of Pediatrics recommends that children be screened for an ASD twice before their second birthday. Connecticut Birth to Three System requirements include:

- With parental permission, screening for ASD during the initial evaluation and assessment process if child is 16 months of age or older (adjusting for prematurity up to two years of age) at time of referral and child does not have a prior positive screen or a diagnosis of autism.
- The screening tool must be listed on the Permission to Evaluate (Form 1-4).
- If the parent declines to have their child screened, the evaluation team must document parental refusal in their evaluation report.
- A published, validated screening tool for ASD must be used such as the Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F), the Brief Infant Toddler Social-Emotional Assessment (BITSEA).

Children Found Not Eligible Due to Developmental Delay with a Positive Screen for ASD

When the autism screen indicates the presence of critical behaviors that may indicate an autism spectrum disorder, the family will be given the opportunity to have a program that specializes in

autism conduct further assessment to determine if the child meets the diagnosis of autism as determined by the latest version of the Diagnostic and Statistical Manual. In this case until the determination about an autism spectrum disorder is made, the child's eligibility status remains "pending". The child remains with their original program during the autism assessment. The parent and the program receive a brief written summary of the process and result of the assessment on the day it is completed. A full report will be sent when completed.

Determination Process for Diagnosing Autism Spectrum Disorder

Per the CT state insurance statute, ASD can be diagnosed by a licensed physician, licensed psychologist or licensed clinical social worker. Any Birth to Three program diagnosing an ASD must ensure:

- Use of autism-specific diagnostic instruments such as the Autism Diagnostic Observation Schedule 2nd Edition (ADOS-2) for children 12 months and older; the Autism Diagnostic Interview-Revised (ADI-R) or the Childhood Autism Rating Scale 2nd Edition (CARS 2) for children 24 months and older.
- Development of a differential diagnosis that meets the criteria for a diagnosis of ASD through the Current DSM
- Assessment reports (from Birth to Three or outside providers) including information on three core deficit areas of ASD (communication, social interaction, and a restricted range of interests/activities) and general developmental information that led to diagnosis of ASD

This determination process will consist of:

1. An in-depth review of the autism screening that was completed to confirm the "red flags" identified as part of the screening. This may be done as part of the original screening completed by the Birth to Three program.
2. A review of the child's health information to determine if the child's hearing has recently been screened or evaluated to rule out a possible hearing loss. It is critical that a child has a hearing test to rule out hearing loss prior to having an Autism assessment. In the rare instances that this is not possible, programs may proceed with the Autism assessment provided that a hearing test is completed within 3 months of a child receiving a diagnosis of Autism. This will be subject to monitoring.
3. A review of assessments previously completed on the child to assure that the child demonstrates a delay greater than 1 standard deviation below the mean in receptive language, expressive language, social-emotional or adaptive behavior skills. If needed, additional developmental assessments such as a Vineland Adaptive Behavior Scales or the Preschool Language Scales (latest editions) should be completed to give a full picture of the child.
4. If it is determined that there is a need for further assessment, the administration of a validated assessment measure such as the most recent version of the Autism Diagnostic Observation Schedule (ADOS-2), for children 12 months and older, the Autism Diagnostic Interview-Revised (ADI-R), for children 24 months and older, or the Childhood Autism Rating Scale (CARS 2) (2+ years) by a licensed physician, licensed psychologist, or licensed clinical social worker.

5. If the child is determined to have ASD, it will be documented on a summary form that the parents are offered the choice of:

- transferring to the program that completed the ASD assessment,
- choosing a different program that specializes in autism that serves their town,
- remaining with or choosing another Birth to Three program that serves their town, as long as the program they choose is accepting new referrals.

The parent's decision will also be documented on the summary form.

Eligibility Determination for a Child Referred for Possible ASD

If a child has been screened or determined by a doctor to have a high risk of having an autism spectrum disorder, the child will be referred directly to a program that specializes in autism at intake. The program must determine 1) whether the child is eligible for Birth to Three based on developmental delay and/or 2) whether the child has a DSM-5 diagnosis of ASD. If a child is determined to have the DSM-5 diagnosis of ASD, the parent will be offered the choice of remaining with their program or choosing a different program that specialize in autism that serves their town.

If the child is eligible due to developmental delay but is not determined to have a diagnosis of ASD, the family should be offered a choice of one of the Birth to Three programs that serves their town. If the child is neither eligible due to a developmental delay nor determined to have a diagnosis of an autism spectrum disorder, refer to "Children Determined Not Eligible".

Eligibility Determination for a Child Referred with an existing Diagnosis of ASD

For children who have already received a diagnosis of ASD based on the DSM-5 or the Birth to Three Autism Diagnostic Checklist prior to referral, Child Development Infoline will offer the family a choice of one of the programs that specialize in autism serving their town of residence. The program that receives the referral will first confirm that sufficient information on the diagnosis is available (see Documentation of a Diagnosed Condition section of this document). Since the child is already known to be eligible due to a diagnosed condition, the receiving program will complete an initial multi-disciplinary assessment in all five developmental domains and a family assessment prior to developing the initial IFSP.

Ongoing Assessment

Ongoing assessment includes all child and family assessments, both formal and informal, following the initial assessment. Ongoing child assessment must include use of an authentic curriculum-based assessment tool. Curriculum-based tools may be used in several ways during a child/family's participation in Birth to Three: during the initial evaluation/assessment process for children who are already known to be eligible; in an ongoing manner on home visits; to inform the team in preparation for an Annual IFSP meeting; during the transition process; and at exit.

Ongoing Curriculum-based Assessment

The Birth to Three System requires the use of appropriate curriculum-based assessment tools by all programs for planning and tracking of child progress, providing a framework for the child's

family and caregivers to understand the overall development, supporting completion of the Child Outcome Summary (COS) Form 3-18, informing IFSP development and the transition process. During the child's enrollment in Birth to Three, it is expected that providers will engage in ongoing, informal assessment each time they see the child, as well as regularly update the curriculum-based tool using one of the following approved authentic curriculum-based assessments:

1. The Hawaii Early Learning Profile (HELP)
2. The Carolina Curriculum for Infants and Toddlers with Special Needs (The Carolina)
3. The Assessment, Evaluation, and Programming System for Infants and Toddlers (AEPS)
4. Early Start Denver Model (ESDM)

Assessment for the Annual Review of the IFSP

According to IDEA Part C regulations, a meeting must be conducted on at least an annual basis to evaluate the IFSP and revise its provisions as appropriate. The assessment must address all five domains of development but does not need to be the result of a multidisciplinary assessment. The child's primary interventionist, if qualified under the Birth to Three Personnel Standards to complete evaluations and assessments, can provide all of the assessment information, in collaboration with the family and other team members. The results of current outside evaluations, information from the curriculum assessment, and the family assessment should be used in determining the status of the outcomes and service needs.

A child does not have to continue to meet the Birth to Three eligibility criteria when reassessed and can remain in Birth to Three until functioning at an age-appropriate level in all 5 areas of development or if the IFSP team has concerns about development. Any review or Annual IFSP meeting does require a multi-disciplinary team and Prior Written Notice to parent/caregiver.

Additional Use of Screening Tools

The Birth to Three System recommends the use of screening tools as appropriate. At times these screening tools may be used during the initial and annual assessment of the child. At other times they will be used as ongoing assessment of the child as part of their regular home visits. Examples include screenings for autism, mental health, vision (Birth to Three Form 3-17) and nutrition (Birth to Three Form 3-16).

Ongoing Family Assessment

Family assessment, similar to child assessment, is an ongoing process. Although a family assessment is required prior to writing the initial IFSP, additional and revised information pertaining to the family should be obtained during the course of the child's enrollment in the Birth to Three System, especially when family situations have changed. Suggestions of family assessment tools available to assist with gathering this information are listed in the Connecticut Birth to Three IFSP Handbook.

Title: Evaluation & Assessment Procedure

Definitions: “Evaluation means the procedures used by qualified personnel to determine a child’s initial and continuing eligibility” for Part C services. “Assessment means the ongoing procedures used by qualified personnel to identify the child’s unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child’s eligibility”. It includes “the assessment of the child and the assessment of the child’s family”. (*IDEA Part C 303.321 Regulations*)

Initial Eligibility Evaluation: Children are initially eligible if they are under the age of three, live in Connecticut, and have:

1. A significant developmental delay (-2 SD in one developmental domain, or -1.5 SD in two or more domains)
- OR
2. A diagnosed physical or mental condition with a high probability of resulting in a developmental delay

Each child referred for evaluation or services must receive an eligibility evaluation unless eligibility is determined through use of medical records that substantiate 1 or 2 above.

Procedures for evaluation must include:

- Administering an evaluation instrument
- Taking child’s history including interviewing the parent
- Identifying the child’s level of functioning in all five areas of development (cognitive; physical including vision and hearing; communication; social or emotional; adaptive)
- Gathering information from a variety of sources (family, other caregivers, medical or social providers, educators, etc.) to understand the full scope of the child’s unique strengths and needs
- Reviewing medical, educational, or other records

No single procedure may be used as the sole criteria for determining a child’s eligibility.

- Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of a child. Infrequently, standardized norm-referenced (SNR) instruments cannot be administered due to an infant’s age or significant illness or would require significant adaptation for a child to perform the items, thereby invalidating the results. When this occurs, informed clinical opinion of an appropriately composed evaluation team may be used to substantiate the equivalent delay of 2 SD below the mean in one area of development or 1.5 SD below the mean in two areas of development. When clinical opinion is used to substantiate eligibility, the child must be re-evaluated within 6 months using a SNR tool and exhibit delay meeting initial eligibility criteria. Information by clinical opinion of qualified personnel may be used on an independent basis to determine eligibility but cannot be used to negate the results of a standardized evaluation tool.

Initial Assessment: Once eligibility has been determined, further assessment is required that includes:

1. Child assessment - the unique strengths and needs of the child including participation in daily activities, and identification of supports appropriate to meet those needs. It includes review of the evaluation results, observation of the child, and identification of child's needs in each area of development.
2. Family-directed assessment – including the resources, priorities, and concerns of the family and identification of the supports and services needed to enhance the family's capacity to meet the developmental needs of the child. The family assessment must be voluntary, based on use of an assessment tool and family interview, and include the family's description of the above information.

Initial assessment must be completed prior to the first IFSP meeting. This assessment must be based, in part, on an objective assessment tool. Initial Assessment of the child is informed through use of a SNR tool or an authentic curriculum-based tool in combination with information provided by the family. If administration of standardized, norm-referenced tool is not necessary for eligibility determination (i.e. when using medical records or diagnosed condition) an authentic curriculum-based tool can be used. If a SNR tool is used for eligibility determination and for informing the initial assessment, a curriculum-based tool should be completed within the first three months and used in an ongoing manner with the family. *Refer to Evaluation Guidance Document for more information.*

Requirements for Initial Evaluations and Assessments:

Federal Requirements stipulate that initial evaluations and assessments must be:

- Performed with prior notification of parents. Prior written notice must be provided to parents a reasonable time before the lead agency or a provider proposes, or refuses, to initiate or change: the identification, evaluation, placement of their infant or toddler, or the provision of early intervention services to the infant or toddler with a disability and that infant's or toddler's family. Prior Written Notice (Form 1-6) is required to meet this requirement.
- Performed with parental consent. Written Consent to Conduct an Evaluation/Assessment (Form 1-4) must be signed by the parent, surrogate parent, or legal guardian prior to beginning the evaluation/assessment
- Timely – within 45 days of referral to Child Development Infoline (CDI)
- Comprehensive - including all five areas of development (cognitive; physical including health, vision, hearing; communication; social or emotional; adaptive)
- Multidisciplinary – including two professionals from different disciplines or one professional who is qualified in more than one discipline/profession. An exception exists in the federal regulations (§303.321(a)(3)(i)) that only one professional is necessary for the Eligibility Evaluation when using existing medical records that meet the requirements for determining developmental delay or, when a diagnosed condition is used to determine eligibility. Every Initial Assessment requires a multi-disciplinary team, regardless of this exception.
- Conducted by qualified personnel that meet Connecticut Birth to Three Personnel Standards

- Culturally and racially non-discriminatory
- In the native language(s) of the child and the family, unless clearly not feasible to do so

Additionally:

- The Birth to Three program must contact the family within one working day of receiving a referral
- Parents must receive Prior Written Notice (Form 1-6) and a written explanation of the eligibility decision including a clear statement of why the child was determined eligible or not (this can be in the form of written report, a one-page summary or visit note) within four days.
- After determining that a child is eligible, the family must be given information and choice regarding other available programs serving their town.
- Information, including whether the child is eligible, may NOT be shared with anyone, including the referral source, without the parent's written consent

Initial Eligibility Decisions

- A child with a confirmed, documented physical or mental condition that has a high probability of resulting in developmental delay may be automatically eligible for the Birth to Three System. A list of approved diagnoses that confer automatic eligibility is in the data system and on the Birth to Three Website. Refer to Evaluation/Assessment Guidance document for additional information on supporting evidence required when confirming eligibility due to diagnosed condition.
- For children who are NOT eligible based on a multi-domain SNR instrument, the evaluation team must assure that a domain specific tool was completed for the primary areas of concern, by someone with professional expertise in that area
- Section 303.321(a)(3)(i) of IDEA Part C regulations state that "a child's medical and other records may be used to establish eligibility (without conducting an evaluation of the child)". Therefore, if a program obtains written results of an existing evaluation(s), this may be used to determine eligibility when these three conditions are all met: completed within the past three months; provides information from a standardized, norm referenced instrument that confirms scores meeting Connecticut eligibility criteria; the determination is made by an appropriately composed team that meets Birth to Three personnel standards
- Screening for Autism must be offered when the child is 16 months or older.
- Information on the child's health, vision and hearing should be gathered as part of the evaluation. Parent report can provide information on medical screenings that have been completed. If the child has not had a vision exam, the evaluator should use Birth to Three Vision Screening (Form 3-17). Newborn hearing screening is valid for one year. Additional screening can be completed as necessary (Nutrition screen – Form 3-16, etc.)
- For specific guidance on eligibility decisions for children with autism, expressive communication delays only, motor delays or prematurity, social emotional concerns, or those who move to Connecticut, refer to *Evaluation & Assessment Guidance Document*
- Refer to attached *Chart for Initial Eligibility Determination*

All reports should include:

- All evaluators' input typed or legibly written in one report. This should be sent to the parent within two weeks and should not be considered finalized until the parents have been able to read it and suggest changes.
- Program name, address; parent's names, address; child name, DOB, and age at the time of the evaluation; date and location of the evaluation
- A description of the process and instruments used to complete the evaluation/assessment and standard scores, if used to determine eligibility, with explanations in plain language so parents understand the meaning of scores (Refer to attached chart for description of type of tool necessary)
- Descriptions written in a way that is useful to the parents, avoiding use of jargon
- A description of the family's input and how they participated in the evaluation/assessment process. This includes evidence throughout the body of the report referencing unique information about the child, shared by the family.
- Documentation if the parent declines to have their child screened for Autism, if the child is at least 16 months of age
- Signature with date (*original or electronic as per Department of Social Services requirements for electronic signature*) by all providers who participated in the evaluation or assessment, including a licensed practitioner. The evaluation must be signed within 45 days of the date that the evaluation was performed. If no licensed practitioner participated in the evaluation, documentation must be in the record from a licensed practitioner recommending the evaluation.
- With parental written consent (Form 3-3), the finalized report should be shared with the child's primary health care provider. It can be shared with others of the parent's choosing after receiving the parent's written consent.

Additionally, Eligibility reports must include:

- A clear statement of reason(s) why the child was determined eligible or not eligible
- Current levels of functioning across all five areas of development (cognitive; physical including vision, hearing, motor and health; communication; social or emotional; and adaptive skills) unless the child is determined eligible through use of medical records or due to a diagnosed condition, in which case comprehensive information in all areas of development will be addressed during the initial assessment.
- If a child is found not eligible but shows some degree of developmental delay, this information should be conveyed to the parents and included in the evaluation report, along with information about other appropriate community resources and programs

In addition to requirements for all reports, Initial Assessment reports must include:

- Identification of the child's unique strengths and needs
- Descriptions, throughout the body of the report, of family's daily activities and the child's functioning and participation during those activities and routines

- Identification of the child's strengths and needs in each of the developmental areas including next steps in development
- Information gathered during the family assessment, as appropriate

If submitting for reimbursement for both evaluation and assessment services, the eligibility evaluation and assessment reports must be separate reports, each following the requirements above and signed by the appropriate professionals. However, for best practice in providing comprehensive information to the family, if the eligibility evaluation and assessment information is contained in separate reports, this should be presented as one complete packet to the family.

Families that Programs are not Able to Locate before the Evaluation

Once a program marks the determination as Cannot Locate in the data system, the lead agency will assure that referral sources other than the parent will be notified.

Children Found Not Eligible for Birth to Three

- If the child is found not eligible for Birth to Three but mental health concerns are identified, the program, with parental permission, must refer the child to a licensed mental health care provider for evaluation and treatment, as noted per Connecticut Public Act 13-178.
- If a child is found not eligible but shows some degree of developmental delay, this information should be conveyed to the parents and included in the evaluation report, along with information about other appropriate community resources and programs.
- The parent should be encouraged to enroll in developmental monitoring through the Ages and Stages Questionnaires (online through Child Development Infoline at cdi.211ct.org or 800-505-7000)
- When appropriate parents should be informed that they may request a new eligibility evaluation one month after the last evaluation by contacting Child Development Infoline. Re-evaluation may be sooner if there is a significant change in the child's development or new medical information received that could affect eligibility. See *Payment Procedure* for information on when prior authorization may be necessary.
- Refer to *Records Procedure* for requirement for sharing record destruction information with the family when a child is found not eligible

In all cases programs should provide families with Form 3-3 to secure consent to release the results of the evaluation to the referral source and/or PHCP.

Dispute Resolution Regarding Eligibility

Parents have the right to dispute the results of the eligibility determination on their evaluation. Refer to *Evaluation and Assessment Guidance*.

Evaluation for Continuing Eligibility

“Evaluation means the procedures used by qualified personnel to determine a child’s initial and continuing eligibility” for Part C services. (*IDEA Part C 303.321 Regulations*)

In Connecticut, continuing eligibility requirements differ from initial eligibility requirements.

After initially being found eligible for Birth to Three supports, a child continues to be eligible if the IFSP team has a concern about development or until functioning at age level in all areas of development. Determination of continuing eligibility may be made through use of a Standardized Norm Referenced (SNR) or Curriculum Based tool. A SNR tool should be used when necessary to support a child’s transition from Birth to Three or if requested by the parent. All procedural requirements for evaluations noted previously apply. Refer to *Payment Procedure* for information on prior authorizations that may be necessary for these evaluations.

Reports for continuing eligibility should include all information required on initial eligibility reports.

Ongoing Assessment

Ongoing assessment includes all child and family assessments, both formal and informal, following the initial assessment.

During the child’s enrollment in Birth to Three, it is expected that providers will engage in ongoing, informal assessment each time they see the child, as well as regularly update an authentic curriculum-based tool. For all children who will be enrolled in the Birth to Three System for at least 6 months an approved curriculum-based assessment must be completed within the initial three months of services, used in an ongoing manner, and reviewed within one month of a child’s exit. The curriculum-based assessment will assist in informing completion of the entry and exit *Child Outcome Summary Form*. Please see the *Child Outcome Summary (COS) Procedure*.

Curriculum-based or other assessment tools that are used in an ongoing manner and updated regularly as part of the home visit only require Prior Written Notice (Form 1-6) and Consent to Conduct an Evaluation/Assessment (Form 1-4) the first time the tool is used. A paraprofessional, if functioning as the family’s primary interventionist, is able to assist the family in updating the curriculum as a regular part of the home visit.

Tools that are used as part of a more formal assessment that results in the generation of a report require Prior Written Notice (Form 1-6) and Consent to Conduct an Evaluation/Assessment (Form 1-4). Formal assessments may include discipline-specific areas, for instance, to assess sensory systems or articulation, or may involve a more extensive assessment to determine if a child meets the criteria for autism spectrum disorder. This formal assessment may include a curriculum-based

assessment, a standardized norm-referenced tool, or a discipline-specific tool and must be administered by staff authorized to conduct evaluations and assessments, as noted in *Personnel Standards*. The report that is a result of this assessment will be documented separately from the visit note and include information as appropriate based on the scope of the assessment.

Providers should consult available autism specialty programs based on the rotation schedule in the data system. In order to avoid multiple transitions, providers in rotation for the autism assessment should be able to accept the transfer. Families referred to a program that specializes in autism for assessment should be contacted within 48 business hours for scheduling. All autism assessments must be completed within 45 days of a request or family reasons for the delay must be documented. The assessment results must be entered into the Birth to Three data system within 10 days and shared with the family and sending program in a timely manner. With parent consent, the report shall also be shared with the PCHP. It is recommended that an IFSP review take place to include information about the assessment, update goals and revisit the transition plan to include any possible transfer. The family should be made aware that they may invite an autism specialty program to participate in this process.

Refer to *Payment Procedure* for information on prior authorization that may be necessary for these assessments.

Assessment and Possible Evaluation for Continuing Eligibility Prior to the Annual Meeting to Evaluate the IFSP (Annual IFSP Review)

Per IDEA regulations, an IFSP meeting must be held to “evaluate” the IFSP (commonly referred to as the Annual IFSP Meeting) no more than 12 months after the Initial IFSP or the previous Annual IFSP. In rare instances if this meeting is not held within the required timeframe, the reason for this delay must be documented in the record. Prior to this meeting, an assessment must be completed of the child and the child’s family. This does not need to be a multidisciplinary assessment. The child’s primary interventionist, if qualified under the Birth to Three Personnel Standards to complete evaluations and assessments, can provide all of the assessment information, in collaboration with the family and other team members.

Additionally, in preparation for the Annual IFSP meeting, determination of continuing eligibility for the child may be made. If an evaluation to determine continuing eligibility is being performed, it must include participation of a multi-disciplinary team.

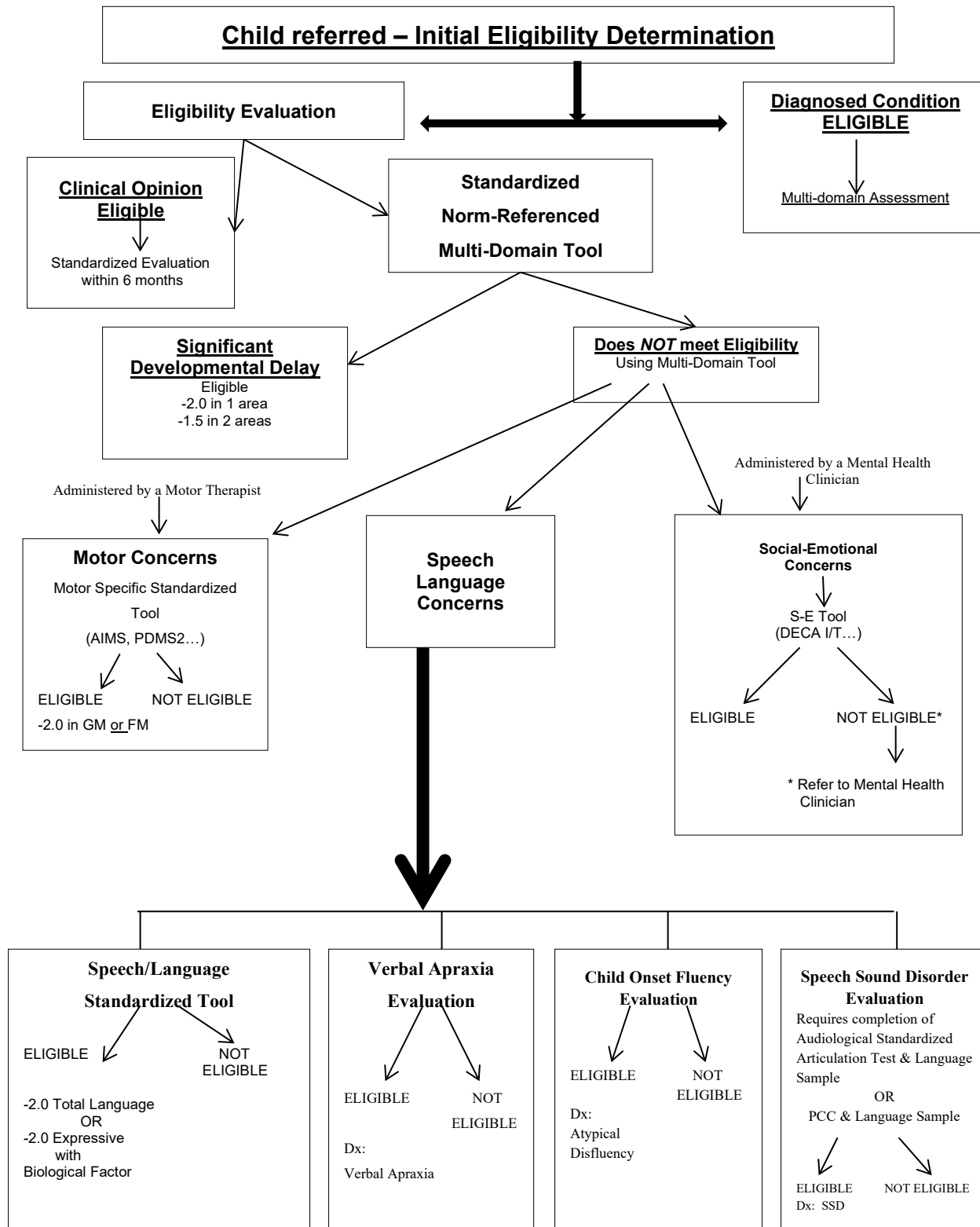
All continuing eligibility evaluations and/or assessments in preparation for the Annual IFSP meeting will follow the requirements for initial evaluations and assessment with the exceptions noted in this section for eligibility criteria, timelines, and multidisciplinary team requirements for assessments.

Refer to attached *Evaluation and Assessment Cycle Chart*.

Evaluation and Assessment Cycle

	<u>Initial Eligibility Evaluation</u>	<u>Initial Assessment</u>	<u>Continuing Eligibility Evaluation</u>	<u>Ongoing Assessment</u>	<u>Assessment for Annual IFSP, Transition, or Exit</u>
Purpose	Documents eligibility status and reasons for eligibility decision. Includes 5 areas of development: cognitive; physical including vision, hearing, motor and health; communication; social or emotional; adaptive	Documents child's unique strengths and needs within family routines in 5 areas of development and early intervention services appropriate to meet needs Informs COS**	Documents continuing eligibility status and reasons for eligibility decision. Includes 5 areas of development	Informs team and family of progress, strengths, and next areas of development. Informs COS	Informs assessment report prior to Annual IFSP, report for school transition/exit and/or COS Includes 5 areas of development
Who	Multi-disciplinary May be a single discipline if: confirming a diagnosed condition, or using medical records to substantiate significant delay	Multi-disciplinary	Multi-disciplinary	1. Updating curriculum can be done as part of home visit by paraprofessional 2. Assessment by a specific discipline	Primary Interventionist (if qualified to complete assessments) with input from other team members
Tools	Standardized, norm-referenced (SNR) tool if determining developmental delay meeting initial eligibility criteria	SNR if used during eligibility evaluation OR curriculum-based tool if child has been determined eligible through use of medical records or diagnosed condition	SNR or authentic curriculum-based tool	1. Authentic curriculum-based tool (ongoing). 2. Additional tools based on needs (i.e. sensory profile, articulation)	Authentic curriculum-based tool SNR tool may be used (supports transition)
Family Assessment		Documents family's resources, priorities, concerns and supports necessary to enhance family's capacity to meet developmental needs of child. Use of published tool in addition to interview.		Family assessment should be ongoing, especially when changes are noted	Family assessment should be ongoing, especially when changes are noted
Forms Needed	Prior Written Notice (Form 1-6) Consent to Conduct Evaluation/ Assessment (Form 1-4) Consent to Release (Form 3-3)	Prior Written Notice (1-6) Consent to Conduct Evaluation/ Assessment (Form 1-4)	Form 1-6 Form 1-4	Ongoing curriculum: 1-4 or 1-6 needed only initially. Additional tools: 1-4 and 1-6 needed	Prior Written Notice (1-6) Consent to Conduct an Evaluation/ Assessment (1-4)

**Child Outcome Summary Process (COS). See *Child Outcome Summary Procedure*



EXITING AND TRANSITIONING FROM BIRTH TO THREE

Overview

Families with children who are determined to be eligible for Birth to Three can remain enrolled until their child is functioning at age-level in all areas of development, their child reaches age 3, or when participation in the child's preschool special education program begins (start of the school year or implementation date on the IEP for late referrals) if "EIS Over 3" is chosen by the family. Most families will exit when their child turns age 3 and all will require transition planning. IDEA requires that the Birth to Three System has procedures in place to ensure a smooth transition to early childhood special education or other appropriate services.

In Connecticut, Local Education Agencies (LEAs or school districts) are responsible for offering early childhood special education and related services to children determined to be eligible for Part B of the IDEA no later than their third birthday. While some school districts may opt to provide services to an eligible child prior to age three, enrolled children and families continue to be eligible for Birth to Three services until age 3 or over 3 if they qualify for "EIS Over 3". Some families will exit before reaching age 3 for reasons noted below.

Informing Families about Transition

Families are introduced to the idea of transition upon entering the Birth to Three System. Transition should be discussed with families in a general manner at every IFSP meeting and during home visits as appropriate.

The service coordinator has an important role to ensure that each family is knowledgeable about the transition process. In addition to frequent conversations with their service coordinator, a family considering including their LEA in transition planning can access Birth23.org which has information for families about the transition process.

The service coordinator is also responsible for ensuring that Form 3-8, *Approval to Include My Local School District in Transition Planning*, is completed by the family prior to the child's age of 2 years 6 months. Parents can approve or decline having the LEA involved in the transition planning and conference. Families should be made aware that when their child reaches 2 years 6 month, directory information is automatically released from the data system to the State Education Agency (SEA) and LEA, regardless of their decision on Form 3-8. (see Notification after Age 2 ½ further in this procedure)

Transition Plans for all Children

According to IDEA Part C regulations, the IFSP must include the steps to be taken to support the smooth transition of the child from Part C supports to early childhood special education under Part B of the IDEA or other appropriate services. This section must include:

- Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition
- Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting
- Confirmation that child find information about the child has been transmitted to the LEA or other relevant agency, including information needed by the LEA to ensure continuity of services from the Part C program to the Part B program, such as a copy of the most

recent evaluation and assessments of the child and the family and the most recent IFSP developed (with written parent permission)

- Identification of transition supports and other activities that the IFSP Team determines are necessary to support the transition of the child.

In Connecticut, the statewide IFSP form includes a section to record a transition plan. This section explores the many possible outcomes that could be important for a family, including the family's transition out of Birth to Three. Every initial and annual IFSP must contain at least one family outcome that addresses a plan for transitioning when Birth to Three supports end. Family outcomes can include a variety of experiences or concerns that affect the whole family. For instance, learning how to explain their child's abilities and challenges, exploring food or housing assistance, finding childcare, moving to another town or state.

Programs will be prompted to indicate in the data system whether each IFSP contains an appropriate transition plan by checking the box that says: "Transition plan meets IDEA requirements".

Early Intervention Supports and Services Over 3 (EIS Over 3)

A family who is receiving Early Intervention Services (EIS) whose child meets all three criteria below will be able to choose to continue Part C Birth to Three EIS beyond the child's third birthday until the participation in the child's preschool special education program (start of the school year or implementation date on the IEP for late referrals).

This extension of Part C to children over age 3 applies only if the child is;

- reaching age three on or after May 1 of each year and before the first day of the school year for the LEA responsible for implementing the IEP after the child's third birthday.
- determined eligible prior to age 3 for Connecticut Birth to Three and receiving early intervention services, and
- eligible for preschool services under Section 619 of the IDEA (see below for EIS Over 3 and Late Referrals).

Programs must provide families with a copy of the Parent Rights brochure and "CT EIS Over 3 Notification" no later than the timely transition conference or as soon as possible if the timeline before the transition conference has passed. All the requirements for transition planning are the same for Part C and Part B. Once the child has been determined to be eligible for Part B and the IEP has been developed, the family will be able to choose how they would like to proceed.

Families cannot re-enter the Birth to Three System once they exit after the child has reached age 3. It is important to review the CT EIS Over 3 Notification Form with families including the information about Extended School Year (ESY). If the child is not eligible for ESY, services from the school will not start until the implementation date on the child's IEP. This means that if a parent does not elect to continue in Birth to Three, they will not receive supports from Birth to Three or services from their school over the summer. For all families with children who qualify for EIS Over 3, regardless of the choice made, the program must have the parent review and sign Form 5-5, CT EIS Over 3 Consent before the child reaches age 3.

EIS Over 3 and Late Referrals

Through a Memorandum of Understanding between the lead agency and the State Department of Education, children who

- a) qualify for EIS Over 3 based on their birth date,
- b) are referred to Part C between 97 and 46 days before their third birthday, and
- c) are determined to be eligible for Part C,

will be considered to be eligible for Part B on an interim basis until the LEA completes its eligibility determination. If the child is determined to be eligible for Part B, the family must be given Form 5-5. If the child is not eligible for Part B, the family will exit Part C the day after the family receives written prior notice from the LEA that the child is not eligible for Part B. For families with children who are not eligible for Part B, if the family exercises their rights as identified in *Procedural Safeguards in Special Education* regarding the eligibility determination, Part C services will continue during the pendency of proceedings for that determination of the results.

LEAs are still required to offer FAPE at 3 or for late referrals to the LEA they must develop the IEP for eligible children within a 45-school day timeline. In rare circumstances, regardless of whether the referral to Part C was late, if the eligibility determination by the LEA is delayed and the child is “pending determination” when the child turns age 3, the family may continue in Part C until the Part B determination is completed. In these circumstances the family must be actively engaged in the eligibility determination process with their LEA, or they will need to exit Part C.

Children who are found not eligible for Part B and whose parent has filed for due process, mediation or a complaint as a result of being not found eligible for Part B may stay in Part C until whatever comes first, the start of the school year or until a decision has been made regarding the complaint, request for mediation or due process. The parent must provide written documentation of the assigned case number (e.g., copy of letter/email) that includes the name of the person assigned to the issue by the Department of Education.

Exit Reasons and Dates

Programs must enter a child's exit information into the Birth to Three data system within ten business days. The table at the end of this procedure is an overview for the options described in more detail on the pages that follow.

FOR CHILDREN EXITING AT OR AFTER AGE 3

Sharing Information with School Districts before age 2 ½

Just as families develop a partnership with their Birth to Three program, families should see the future potential transition to their public school special education program as a partnership that begins while their child is receiving Birth to Three supports. Whenever a parent is interested in learning more about their town's early childhood special education and related services, they may choose to contact their school district directly or they may choose to have their service coordinator release information to give their district a heads up. Early notice helps districts with budgeting and planning and should be encouraged when it is clear that the child will be eligible for early childhood special education. If the parent wishes to share information with their school district before signing Form 3-8, the service coordinator should have the parent sign the Authorization to Release Information (Form 3-3) and send it to the school district along with the documents identified on the

form by title and date. Any information received by a Birth to Three program, using the Authorization to Obtain Information Form 3-2, becomes part of a child's early intervention record regardless of whether it originated from Birth to Three or a provider outside of Birth to Three and may be released with the parent's written permission (see Records Procedure). Future written updates of the child's progress or IFSP should be sent to the school district with parent permission (using Form 3-3) to keep the school district's preschool team current with the child's developmental status. The school district may contact the family when they receive this information but there is no requirement that the school district contact or act on the information received about the child.

As soon as a release of information form is signed the information should be entered in the Birth to Three data system to ensure that the child's information will be listed correctly in the data reports sent to the State Education Agency (SEA) and the Local Education Agency (LEA).

Notification after age 2 ½

Children who are enrolled or continuing to receive supports in Birth to Three after age 2½ are considered to be potentially eligible for early childhood special education. As required by Section 303.209(b) of IDEA, directory information about each child who is potentially eligible will be transmitted nightly to the SEA and the LEA where the child resides or the NEXUS LEA (responsible school district) so that this notification can be completed prior to 90 days before age 3 (when applicable). Directory information includes the child's name, date of birth, parent(s) name(s), address, telephone number, the name and contact information for the family's service coordinator, town of residence, whether the child resides with a parent or foster family, and the language spoken by the family. The report will also indicate whether the parent approved of including their LEA in transition planning (Form 3-8 as Yes or No.).

The data is available to LEAs in four separate reports in the CT SDE data system. The reports are called "Birth to Three Notifications" If the early childhood contact person is not familiar with the system, their pupil personnel or special education director will be.

This is how the reports are described in the SDE data system.

1. *Children with Signed B23 Approval to Include LEA (Form 3-8) - Children enrolled in Birth to Three whose parents agreed to include the school district in the child's transition planning conference. *IMPORTANT: This is an Official Referral. Start referral process immediately.*
2. *Notification of Children Over Age 2 ½ with No Release (Form 3-3) Or Approval to Include LEA (Form 3-8) - Children enrolled in Birth to Three who are over the age of 2½ whose parents had not yet referred or signed a release of information as of the date of export from the Birth to Three system. This list also includes data for children whose parents had revoked a referral for an evaluation. *NOTE: The LEA has immediate Child Find responsibility for students on this list.*
3. *Children with Release of Information to LEA (Form 3-3) - Children enrolled in Birth to Three whose parents had signed a release of information form but had not referred the child to the LEA for evaluation as of the date of export from the Birth to Three system. *NOTE: This is NOT a referral. However, the LEA has Child Find responsibility for students on this list.*
4. *Children Under Age 2 ½ with No Release (Form 3-3) or Approval to Include LEA (Form 3-8) - Children under the age of 2½ whose parents had not yet referred nor signed a release of information as of the date of export from the Birth to Three system. *NOTE: This is NOT a referral. The LEA does NOT have Child Find responsibility for students on this list.*

Including Local School Districts in the Transition Planning

Even if information has been shared with a local school district through a release of documents (using Form 3-3) or by the notification process explained above, a parent still must approve of including their LEA in transition planning. When a child is within 9 months of their third birthday and prior to the age of 2 years 6 months, Form 3-8 (Approval to Include my Local School District in Transition Planning) should be completed. This form must be signed by a parent and sent to the LEA to indicate that the parent wants their school district to begin the process to determine whether their child will be eligible for early childhood special education when they turn three. A Birth to Three surrogate or foster parent may sign Form 3-8. See Children in DCF Procedure for more information.

If necessary, the State Department of Education (SDE) will also assign a surrogate for the child. The surrogate parent appointed by SDE has statutory authority to receive all records related to the child and may request them from the Birth to Three program. This may be in addition to records that may have already been sent to the Local Education Agency or school district. The Birth to Three parent should sign a release (Form 3-3) for all requested documents.

The date that the Form 3-8 is sent to the school district should be entered into the Birth to Three data system. A copy of the form and any attachments should be sent to the school district within a week of it being signed. Any updated documents can be sent later with a separate permission to release (Form 3-3) signed by the parent. When the school district receives Form 3-8 they will acknowledge receipt of the form by contacting the family. As long as Form 3-8 is received in a timely manner and a transition conference is held on time (more than 90 days before age 3) the school district must ensure that the eligibility determination and the Individual Education Plan (IEP), if the child is eligible, is complete by the child's third birthday. A school district may request scheduling a planning and placement team prior to the end of the school year for children with summer birthdays.

Revoking Approval to Include the Local School District in Transition Planning

If after completing Form 3-8 a parent chooses not to include the school district in transition planning, exits Birth to Three or moves from to another school district, whenever possible, Form 3-8 indicating that the approval is being revoked should be signed and sent to the school district that received the initial Form 3-8, and the updated information entered in the data system. This informs the school district that they can close the record they began for this child.

In the case of a family who has moved to a new town in Connecticut, a new Form 3-8 should be completed and sent to the new school district. The new address and responsible LEA should be updated in SPIDER so that the child's name will display on the correct LEA data report.

Revoking approval without moving or exiting will not remove a child's name from the electronic reports to the school district but the district will see that Form 3-8 now reads as No instead of Yes.

Transition Conferences with LEAs

If a parent has signed Form 3-8 or has contacted the school district directly (and wants information from the child's record shared), then the service coordinator is responsible for arranging a transition conference with the LEA no fewer than 90 days prior to the child's third birthday and, at the discretion of all parties, not more than 9 months before the toddler's third birthday. The appropriate people to have present include: (1) the parent(s), (2) the service

coordinator, (3) an LEA representative, and (4) anyone else the parent, LEA or service coordinator feel would be helpful. If it is not possible for the LEA representative to be physically present at a meeting they may participate by another mode (e.g., telephone or other HIPPA compliant synchronous audio-visual communication).

The transition conference is the responsibility of Birth to Three with the main purpose being to help the family and school start to develop a relationship, along with determining the next steps in the process. Best practice would be to hold the transition conference in the child's home, if the family is in agreement. Some school districts may want to hold Planning and Placement Team (PPT) 1 at the same time. The PPT meeting is the school district's responsibility, and it must be a distinct meeting that is separate from the transition conference, but it may be held consecutively after the transition conference. Some school districts, upon receiving Form 3-8, may prefer to contact the family and schedule a meeting time themselves. This might happen if the school prefers to hold the PPT meeting right after the transition conference. However, it still the responsibility of the service coordinator to ensure that the transition conference is facilitated by Birth to Three, is held on time, and that the school district is invited with enough notice to facilitate their participation.

It is important that the service coordinator has developed a working relationship with the receiving LEA. Teams in Birth to Three and the LEA should be as flexible as possible in order to support the family during this process. Service coordinators, after a signed release from the parents, may contact the LEA to arrange a mutually agreeable time and place to hold the transition conference, with preference given to the family's wishes. Service coordinators may use the sample invitation letter included in this procedure or the program may develop its own that can also be used to schedule these meetings with school districts. However, a letter should not be the only contact with the school as considerable coordination may have to happen for scheduling purposes. Arranging the transition conference well in advance allows sufficient time for school district staff, Birth to Three staff, and the family to plan for the conference. There must be documentation in the child's record to show when contact was initiated with the school district to schedule the transition conference.

If, after attempting to accommodate both the LEA and the family's schedules, the LEA cannot participate in the transition conference, the conference must be held anyway in order to be timely and in compliance with IDEA Part C. The service coordinator is responsible for documenting the date the conference was held and this must be entered in the data system along with an indication about whether it was delayed due to documented extraordinary family circumstances and whether the LEA was not present.

If a family chooses to contact the school district directly and does not want any information shared with the district from the child's record or by the Birth to Three program, then the service coordinator cannot invite the school district to the transition conference. The service coordinator will still hold the transition conference without the district representative as they would for any child whose family did not approve of including their school district in transition planning.

Although not ideal, since the transition conference is a way to prepare parents for a Planning and Placement Team (PPT) meeting, the school district may hold a PPT meeting as a separate meeting immediately following the transition conference provided that the district adheres to all procedural requirements of the IDEA, Part B.

All of the decisions reached, and activities identified, including potential dates when the PPT will convene to determine eligibility or develop an IEP, should be recorded. This can be written on a

contact note or as part of the transition plan if the IFSP was reviewed as part of the meeting (and prior written notice provided).

For all children and especially for children with late spring or summer birthdays, it is helpful for the service coordinator to notify and work with the school district as early as possible within the school calendar year. This will allow ample time for the scheduling of the child's transition conference and planning and placement meeting(s) and allows the PPT to determine if a child is eligible for EIS Over age 3 and/or extended school year services (ESY).

The service coordinator should be sure to inform parents about the documentation that will be required before their child can enter school, including the birth certificate, proof that the family resides within the school district boundaries, and a completed health form.

If the family is experiencing insecure housing, the school district must assist them in registering their child, in accordance with the McKinney-Vento Act. For more information, see the Birth to Three Procedure on Children who are Homeless.

Eligibility Determination for Special Education and Related Services

The school district must complete a comprehensive evaluation of the child in the developmental area(s) of concern. To do this a school district may choose to use current information from the Birth to Three program to determine a child's eligibility, or they may choose to have their own personnel evaluate and assess the child to determine eligibility, or they may do some of each.

Ultimately, it is the responsibility of the public school staff to gather the necessary information, as it is the child's Planning and Placement Team that will make the determination of the child's eligibility.

Service Coordinators must document the sharing and review of Form 5-3 (Referral for Registering for Developmental Monitoring) for children found not eligible for Part B Services. This form gives the family the information they need to register for developmental screening which will be used by the LEA.

Role of the Service Coordinator or Provider at the PPT Meeting

Per IDEA with parent permission the Birth to Three Service Coordinator or staff member must be invited to attend the PPT and may participate in all portions of the meeting. The eligibility decision and the development and implementation of the IEP belong to the PPT with participation of the child's parents. IDEA requires the PPT to consider the child's IFSP when developing the IEP but it does not require that the IFSP be mirrored in the IEP.

The role of the service coordinator as well as other Birth to Three practitioners who may be in attendance, prior to and during the meeting, should be to support the competence in the parent's ability to describe their child abilities and challenges, as well as potential strategies to support their learning. By supporting the parent's ability to describe their child's strengths, interests, needs, and useful strategies, we are building the competency for the parent to act as an advocate for their own child. At times, the school district may request the opinion of the Birth to Three provider for ideas regarding effective strategies or recommendations. After coaching the parent to respond, the Birth to Three provider may also share information that will help the PPT make decisions. Unless specifically requested at the PPT, it is not the role of the Birth to Three

personnel to make recommendations on issues such as proposed special education goals, personnel, placement or services, including the location, type, frequency, or intensity of Part B services.

Transition for Children Enrolled in Birth to Three after 33 Months of Age

When a child enters the Connecticut Birth to Three System fewer than 97 but at least 46 calendar days before his third birthday, the Birth to Three System is still responsible for determining whether the child is eligible for Part C. If the child is eligible, an IFSP must be developed those addresses transitioning from the Birth to Three System to the local school district or other appropriate services. The service coordinator will explain the transition process and timelines for transition to the parent and the importance of contacting the LEA as soon as possible to begin the special education referral process to determine whether a child may be eligible for special education. With written consent (Form 3-3) from the family to contact the LEA the service coordinator could contact the school district to coordinate the child's initial evaluation with the local school district thus avoiding duplication of efforts.

Per Section 303.209(b)(iii) of the Part C regulations of IDEA, referrals to Child Development Infoline for children who are within 45 calendar days of their third birthday shall be re-directed to the responsible local school district for child find activities including potentially an evaluation and services if found eligible for preschool special education. This will not be considered a Birth to Three referral.

Transition Planning for Families Not Seeking Special Education

When families do not approve of including their school district in transition planning, they still must have a transition planning meeting before exiting. The meeting may occur as part of the development or review of the child's IFSP or during a regular visit. When it is part of an IFSP meeting, the transition meeting is documented on the IFSP form, otherwise a contact note or service coordination page may be used to document the meeting in the child's record. Timing for holding this conference can occur up to 9 months prior to the child's exit but no later than 90 days before the child's third birthday (for children exiting at age three). The service coordinator is responsible for arranging the meeting and ensuring that it is held within the required timelines and that it includes the parent(s), the service coordinator, and anyone else the parent feels would be helpful in developing the plan.

The transition plan as documented in the IFSP should include activities to prepare for the transition and a reasonable timeframe for completing them. It should also include connecting the family with community resources outside of the Birth to Three System and an offer to connect the family with the Ages and Stages Questionnaire (ASQ) process available through the Child Development Infoline (CDI) for children up to age five. If the parents are interested in participating in the ASQ, the service coordinator can assist the family with enrolling online at <https://cdi.211ct.org/program/ages-and-stages> or give the family the Ages and Stages brochure that contains the consent form which should be mailed back to CDI.

Even if a child is exiting from Birth to Three services because he or she is functioning within the normal age range in all areas of development, the service coordinator must still, with parent approval, convene a transition conference and should offer enrollment in the ASQ process, and discuss community resources and options.

FOR CHILDREN EXITING BEFORE AGE 3

Prior written notice must be given to parents of all eligible children before a provider proposes or refuses to change the identification, evaluation, or placement of the child or early intervention services. The service coordinator should schedule an IFSP review to discuss the updated assessment results and determine the need for continued early intervention supports and services. As always, prior written notice must be given to the family to notify them that the child's IFSP is going to be reviewed unless it is a parent-initiated review of the plan (refer to Procedural Safeguards).

The signed IFSP will be the documentation that the family is aware of their rights and is in agreement with their child's exiting. If a child exits without an IFSP review because the family has requested to have child exited or cannot be located (see section below on exiting child when family consistently misses visits) the service coordinator should put the decision in writing clearly stating what the action is and the reason for the action and send this to the parent with Prior Written Notice Form 1-6 and a copy of the CT Birth to Three Parent's Rights Brochure and Form 5-1 (Notice of Record Retention and Destruction).

Depending on the circumstances of the child's exit from Birth to Three services, the service coordinator should offer to hold a transition meeting with the family to discuss the discontinuation of the Birth to Three services. During this meeting the IFSP may be reviewed, especially the transition plan. The plan should include activities to prepare for the transition and a reasonable timeframe for completing them. It should also include connecting the family with community resources outside of the Birth to Three System and an offer to track the child's development through the Help Me Grow program which tracks development using developmental monitoring questionnaires up to the age of five. If the parents are interested in participating, the service coordinator should call Child Development Infoline (CDI) with the family so the family can speak with the staff at CDI. Families should also be given the CDI website <https://cdi.211ct.org/program/help-me-grow/>

Dispute Resolution Regarding Exit

If a parent disagrees with the decision to exit, they should be informed by their service coordinator of their right to request a review of their evaluation with the Birth to Three System by contacting the Birth to Three Family Liaison. The following process will be used to address the complaint:

1. The lead agency will request and review a copy of the report summarizing the most recent assessments used to make the determination and any other available information from the program.
2. The Birth to Three Medical Advisor may be asked to review the evaluation report and supporting documentation.
3. If, during the course of the review, it is discovered that information was overlooked or the assessment process was flawed, the program will be asked to reconsider the exit decision in light of the new information or to re-evaluate the child.
4. If the assessment was appropriate and all relevant information was considered, the lead agency will inform the family that the Birth to Three System supports the decision of the program and that the family may request a mediation or hearing.

Exiting Children Whose Families Consistently Miss Scheduled Visits

There are instances in which families are not home when the early interventionist arrives and they have not cancelled the visit ahead of time. In this case, the provider should leave a note explaining that she or he will contact the family to reschedule and remind them of the need to cancel appointments 24 hours prior to the visit whenever possible. Although it is certainly possible for a family to forget that they have scheduled a visit, repeated unplanned cancellations may be an indication that something is wrong with the IFSP. The family may be communicating that they do not wish to have services as specified (frequency, duration, location, or specific service provider). It may be an issue with a particular interventionist. At the point when a family is not home for a second consecutive scheduled visit without any advanced cancellation, the program should send the family prior written notice of an IFSP review and indicate that services may be suspended until the plan can be reviewed. At the review meeting, the service coordinator must try to determine how EI services can best be configured to meet the family's needs. If the family expresses a desire to transfer to another program, the service coordinator should facilitate that transfer (see Transfer procedure). If the family states at the meeting that they no longer want to receive early intervention services, the service coordinator should document their intent to withdraw their child from the Birth to Three System, and, at a minimum, hold an immediate transition conference with the family to discuss other available community resources. The program then exits the child from the Birth to Three System, using "parent withdrew" as the exit status for the data system. The service coordinator should remind the family that if they change their mind later, they may call 211 Child Development Infoline and re-refer their child. Depending on how long it has been since the child was last seen by a Birth to Three provider, when they decide to re-refer, the child may need to meet the criteria for Birth to Three again to be found eligible

Re-entering the Birth to Three System

Only families of eligible children "exit" Birth to Three. If a family exits for any reason the program may delete the exit data up to one month from the original exit date. After one month the family must contact 211 CD and make a new referral. Children over age three cannot re-enter Part C.

Disposition of Records at Exit

Form 5-1 (Notice of Record Retention and Destruction) must be completed with all families prior to exit. A copy should be given to the family and the original maintained by the program. This assures that the family has been informed that their record will be maintained for at least six years from the date of exit and how to request copies during the six-year period if needed. This form also serves as notification that the record will be destroyed after six years. Refer to the Records procedure for more information.

Children who are Deceased

In the unfortunate event that a child enrolled in the Birth to Three System dies:

1. As soon as possible, update the Birth to Three data system to indicate that the child is deceased. This will ensure that the family does not continue to receive mailings from Birth to Three (such as surveys) that are sent to families of eligible children.
2. Report to CTBirth23@ct.gov so the lead agency can update lists to make sure families are not contacted for family surveys or other reasons.

Exit Reasons and related Data Element

	Exit Reason	Data System Entry	
		Select	Exit Date
Exit Prior to Age 3	The whole IFSP team agrees that the child no longer needs early intervention services	Completion of IFSP	The date of the last visit.
	The family has withdrawn the child regardless of still being eligible for Part C <i>Additional information needed</i>	Withdrawn by parent/guardian	The date the family informs the program.
	<i>The family chose to pursue private services without expressing dissatisfaction with EIS</i>	<i>Parent chose private services</i>	
	<i>The family communicated dissatisfaction with EIS as the reason for exiting</i>	<i>Parent dissatisfied</i>	
	<i>The child is still eligible and the whole IFSP team didn't agree with the decision to end EIS.</i>	<i>Parent satisfied with development</i>	
	<i>Any other reason or the reason is not specified</i>	<i>Other</i>	
	The family moved out of Connecticut	Moved from state	The date after the date the family moved.
	The child died	Deceased	The date after t child's death
	Attempts to contact the family have been unsuccessful	Attempts to Contact unsuccessful	No more than 2 months after the last contact.
Exit Due to Age - Exiting Before Age 3	The LEA determined that the child was eligible	Part B eligible	Day before the child's third birthday
	The LEA determined that the child was not eligible AND the Birth to Three program has referred the family to another preschool program or service	Not eligible for Part B, exit to other programs	
	The LEA determined that the child was not eligible AND the Birth to Three program has not formally referred the family to any other preschool program or service	Not eligible for Part B, exit with no referral	
	The child reached age 3 without the LEA determining eligibility for any reason including those times when the family elected not to include the LEA in transition planning	Part B eligibility not determined	
Exit Due to Age - Only for those eligible for EIS Over 3	The child is determined to be not eligible for Part B after the child's third birthday (late referrals or delayed LEA evaluation)	Part B Eligible, Continued in Part C	The date the family receives WPN from the LEA.
	The family exits before the start of their child's preschool special education program.		The date the family informs the program.
	The family exits to start their child's preschool special education program		The date before Part B services begin.
	The family provided proof of Part B due process paperwork	Part B eligibility not determined	The date before Part B services begin or a decision is made.

Sample invitation that can be printed on your program's letterhead

Invitation to Transition Conference

Dear _____:

As discussed previously, this is to confirm that a transition conference is being

scheduled for _____, (DOB) _____. As noted in IDEA Part B regulations, a representative of the school district is required to participate. The date, time and location of the conference has been scheduled as follows:

_____	_____	_____
(day/date)	(time)	(location)

In order to meet the requirements of the IDEA as stated below, to ensure a smooth transition, Birth to Three must convene a transition planning conference at least 90 days prior to the child's third birthday. Therefore, the Birth to Three Transition

conference must be held no later than _____.

IDEA, Part C, Section 637 (a)(9)(A) requires that the Birth to Three System "ensure a smooth transition for toddlers receiving early intervention under this part to preschool or other appropriate services".

Additionally, IDEA, Part C, Section 637 (9)(A) (II) further specifies that "in the case of a child who may be eligible for such preschool services, with the approval of the family of the child, convene a conference among the lead agency, the family and the local educational agency at least 90 days (and at the discretion of all such parties, up to nine months) before the child is eligible for preschool services . . .".

IDEA, Part B, Section 612 (a) (9) specifies that "The local educational agency will participate in the transition planning conferences arranged by the designated lead agency . . .". In accordance with the IDEA, a representative of the school district is required to attend the transition planning conference convened by personnel from the child's birth to three program.

If someone from your school district cannot participate in this meeting, please notify me at the telephone number below as soon as possible in order for me to work with the family to coordinate all of our schedules.

Sincerely,
Service Coordinator

Program: _____

Address: _____

Telephone: _____

Sent: _____

cc: Parent _____

IFSP PROCEDURE/GUIDANCE

This document is a guide to working with the Individualized Family Service Plan (IFSP) Form 3-1. It includes Connecticut Birth to Three procedural requirements as well as page by page form guidance.

IFSP PROCEDURE:

Introduction and Overview (p.2)

Timelines and Requirements (p.3)

Meeting Participants/ Involvement of the Primary Health Care Provider in the IFSP (p.4)

Types of IFSP Meetings –Initial, Periodic Review, Annual, Interim (p.4 - 6)

Service Coordination Only/Implementation of IFSP/Types of Service (p.6 - 7)

PAGE BY PAGE IFSP FORM GUIDANCE:

General Information (p. 8)

Section 1: Child and Family Information (p.9)

Section 2: Family Resources (p.10)

Section 3: Family Priorities (p.11)

Section 4: Everyday Activities (p.12)

Section 5A: What We Will Work On/ Child Outcomes (p.13 - 14)

Section 5B: Progress/Review of Child Outcomes (p.15)

Section 5C: Family Outcomes and Transition Planning (p.15 - 17)

Section 6: Early Intervention Supports and Services (p.18 - 23)

Section 7: Who is Part of Our Team (p. 24)

Additional Page (p. 25)

Justification for Early Intervention Service that cannot be Achieved in a Natural Environment (p.25)

Frequently Asked Questions (p. 26)

Appendix:

Language & Communication Plan (p.28)

Family Assessment Tools (p.29-32)

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

Purpose: To insure that each eligible child and family has an Individualized Family Service Plan that is high quality and meets state and federal requirements.

Introduction and Overview

The Connecticut IFSP document is many things:

- a document for the family that describes their desired outcomes for their child and family and the supports they will receive to achieve those outcomes
- a flexible and individualized plan for each child and family
- a legal document with parent signature
- a clear description of services and supports for the child's health care providers

Additionally:

- Its contents must comply with Part C of the IDEA and State of Connecticut laws and regulations.
- It provides information to school districts and other community programs during the process of transition.
- The information in the IFSP supports billing of private insurance and Medicaid.
- The information from the IFSP is entered into the Birth to Three data system and is used in part to determine a Birth to Three program's compliance with state and federal requirements, and the system's quality assurance measures.

The individualized family service planning process is designed to develop a plan for appropriate early intervention supports for an infant or toddler with disabilities and his or her family. The mission of the Connecticut Birth to Three System is to strengthen the capacity of Connecticut's families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities. Based on best practices in Early Intervention, the system will ensure that all families have equal access to a coordinated program that:

- Supports the family and other caregivers to increase their confidence and competence in meeting their child's goals
- Fosters collaborative partnerships
- Is family centered and culturally aware
- Occurs in natural environments and during the everyday activities and routines of the family
- Utilizes coaching as a style of interaction to support the adults in the child's life
- Encourages use of a Primary Service Provider approach to teaming to best support the family

Professionals and parents work together as a team to identify the family's concerns and priorities. This is facilitated by reviewing the results of current assessments, identifying the family's resources and supports including the important people in their lives, reviewing the family's priorities, and exploring which of the family's everyday activities will best support working on those priorities. Outcomes reflect what the family members see as important for their child and themselves. The team determines the activities, strategies and supports that will best result in achievement of the outcomes. Only the IFSP team members, which include the family, can determine the supports that are listed on the IFSP.

IFSP Timelines and Requirements

Part C Regulations (34 CFR sec. 303.342) specify that for eligible children, the IFSP meeting must be:

- Held within 45 days of the referral to the Birth to Three System (i.e. the initial contact with Child Development Infoline).
- Conducted in settings and at times that are convenient to the family.
- Held in the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so. This may involve use of an interpreter.
- Include prior written notice: When both parents are involved, both must be given prior written notice a reasonable time before the program proposes, or refuses, to initiate or change the identification, evaluation or provision of early intervention services. Therefore, Prior Written Notice, (Form 1-6) must be given to the family prior to all IFSP meetings, early enough before the meeting date to ensure that they will be able to attend. Parents must be provided with Prior Written Notice before services begin. This is accomplished through their signature on the IFSP.
- Held at least annually to evaluate and revise the IFSP for the child and family. The results of any current evaluations or assessments (completed within the past three months and include all five areas of development) conducted under § 303.321 and other information available from the ongoing assessment of the child's development in all five domains and the resources, concerns, and priorities of the family should be used as the basis of the meeting to evaluate the IFSP. This can be completed anytime within the 12 months after the initial or previous annual evaluation of the IFSP. Once the due date for an annual evaluation of the IFSP has been reached, no further early intervention treatment services can be provided to the family and child unless the reason for the delay are documented in the file. The first visit with a family after expiration of the IFSP would need to an annual IFSP or an evaluation or assessment if that is not current. The developmental assessment does not need to be completed by a multidisciplinary team.

The IFSP:

- Must be reviewed at least every six months or more frequently if changes are needed or if the family requests a review. The purpose of this periodic review is to determine the degree of progress made toward achieving the outcomes and whether modifications or revision of the outcomes or supports is necessary.
- Must include a transition plan with the steps and services to be taken to support the smooth transition of the child and family, from Part C services. This transition plan must be developed or reviewed as part of an IFSP meeting (initial, periodic, or annual review of the IFSP) and can be updated whenever needed during an IFSP meeting to reflect the different stages of the transition planning process.
- May be reviewed as part of a Transition Conference, which must be convened at least 90 days, and with the approval of the family, up to 9 months prior to the child's third birthday.
- Must be signed and dated by a parent before supports and services can begin.
- Every IFSP must be signed by a licensed practitioner who is licensed by the Department of Public Health, is authorized to practice without supervision, and meets the criteria of the Connecticut Birth to Three System as qualified to conduct evaluations and assessments.

In order to ensure that the IFSP is recommended by at least one licensed practitioner in accordance with 42 CFR 440.103(c) the IFSP team shall include at least one licensed practitioner as listed in the State Plan Amendment and DSS Regulations. See DSS Regulations §17b-262-1114 (d) (3). Any early intervention treatment services performed for a period not covered by the IFSP must have the reasons for the variances from the IFSP documented and signed by a qualified practitioner. An electronic signature from the licensed practitioner on the IFSP is acceptable.

Each early intervention service is provided as soon as possible after the parent gives consent for that service and the IFSP has been signed by the licensed practitioner. Part C of IDEA requires that eligible children and their families receive timely services. Connecticut has defined "timely" as services starting within 45 days of a parent's signature on the IFSP.

IFSP Meeting Participants

Per Section 303.343(a)(1) of the Part C Regulations under IDEA, the IFSP team must include the involvement of the parent and two or more individuals from separate disciplines or professions (multi-disciplinary team) and one of these individuals must be the service coordinator.

Specifically at the initial meeting and each annual IFSP meeting to evaluate the IFSP, the team must include:

- (i) The parent or parents of the child,
- (ii) Other family members, as requested by the parent, if feasible to do so,
- (iii) An advocate or person outside of the family, if the parent requests that the person participate.
- (iv) The service coordinator (who has completed applicable training specified by the lead agency) designated by the public agency to be responsible for implementing the IFSP,
- (v) A person or persons directly involved in conducting the evaluations and assessments.
- (vi) As appropriate, persons who will be providing early intervention services under this part to the child or family.

For periodic reviews, the multidisciplinary IFSP team must include persons listed in (i) through (iv) above and if conditions warrant, provisions must be made for the participation of other representatives identified in (v) and (vi) above.

According to Part C Regulations under IDEA, if a person listed in (v) above is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including one of the following:

- (i) Participating in a phone or video call.
- (ii) Having a knowledgeable authorized representative attend the meeting.
- (iii) Making pertinent records available at the meeting (i.e. a current report, within 3 months)

Involvement of the Child's Primary Health Care Provider with the IFSP

Connecticut General Statute 17a-248e(c) currently requires that the IFSP be developed in consultation with the child's pediatrician or primary care physician. The lead agency interprets pediatrician or primary care physician to include APRNs and PAs as the scope of their practice has changed since the law was written. The name of the clinic may be used in the case where no primary health care provider (PCHP) can be identified.

The lead agency interprets consultation to mean that with parent consent (Form 3-3) the EIS program will share the evaluation and assessment reports, and initial and annual IFSPs with the PCHP for review. Based on input from the PCHP the IFSP team will consider whether modifications to the implementation of the IFSP or the plan are needed.

The following are approved methods for documenting the consultation of a Primary Health Care Provider (PHCP) in the development of an IFSP.

- a copy of a fax cover sheet used when sending documents to the PHCP
- a note in the record documenting a conversation with the PHCP
- listing the PHCP as a team member on the IFSP which allows for conversation without a release (Form 3-1)

Types of IFSPs and IFSP Meetings

Interim IFSP

Early intervention services may begin for *a child who is eligible* for Birth to Three services prior to the completion of the multidisciplinary assessment if the following conditions apply:

- Parental consent to develop an interim IFSP is obtained and the parent has been given written prior notice of the development of an interim IFSP using Form 1-6.
- An interim IFSP is developed that includes:

1. The name of the service coordinator who will be responsible for the implementation of the interim IFSP and coordination with other agencies and persons, and
 2. The early intervention services that have been determined to be needed immediately by the child and the child's family.
 3. The family signs the IFSP
 4. A licensed practitioner on the child's team reviews and signs the IFSP.
- The multidisciplinary assessment and the Initial IFSP must be completed within 45 calendar days from the child's date of referral to Child Development Infoline.
 - An interim IFSP document contains all the IFSP pages and sections. Sections relating to the multidisciplinary assessment of the child, which has not yet been completed, may be brief.

Initial IFSP

The majority of this document gives information related to the initial IFSP, which must be written within 45 days of the child's referral. This is the beginning of the family's relationship with Birth to Three and their understanding of how Birth to Three supports will help them achieve their outcomes. All timelines and requirements outlined in this document must be followed. All sections of the IFSP must be completed for the Initial IFSP except Section 5B: Progress/Review of Child Outcomes.

Periodic Review of the IFSP

The IFSP is reviewed at least every six months; (more frequently if conditions warrant or the family requests such a review) and evaluated at least annually. Each time an IFSP is reviewed the timeline starts again on the requirement that the IFSP be reviewed at least every six months but does not change the date for evaluating the complete IFSP on at least an annual basis.

The purpose of a periodic review is to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revision of the outcomes supports and services or other information (such as modification of the plan for transition) is necessary.

The service coordinator is responsible for making sure there is a multidisciplinary team to review the IFSP and that written prior notice (Form 1-6) is given before all reviews of the IFSP unless the parent has initiated the request to review the plan. The review may be carried out at a meeting or by another means, such as a phone call, that is acceptable to the parents and other participants. However, even if the review is by telephone, it does not eliminate the need for prior written notice or the team membership as specified in section 303.343 (b). The following sections of the IFSP must be included in a review:

- Section 1 Child and Family Information
- Section 5B and 5C: Can be photocopied with new information added during the review
- Section 6 Early Intervention Supports and Services
- Section 7 Who is Part of Our Team
- Section 5A can be added if there are new outcomes that are developed as a result of the review
- Any other pages of the IFSP form may be added as needed

If the sole purpose of the periodic review of the IFSP is to review or revise a transition plan during a transition conference with school district personnel present, the service coordinator and family may choose to update the progress on the child's and family's outcomes in advance of the conference and complete those sections of the page prior to the transition conference. This will allow more time to focus on the next steps in transitioning from the Birth to Three System. It is still a periodic IFSP review with all the requirements described above including Prior Written Notice and multidisciplinary participation.

Annual Meeting to Evaluate the IFSP

According to IDEA Part C regulations, a meeting to evaluate the IFSP that includes a multi-disciplinary team (See *IFSP Meeting Participants*) must be conducted at least annually to evaluate the IFSP for a child and family, and revise its provisions as appropriate. This meeting to evaluate the IFSP must be based on a current assessment, which does not have to be multi-disciplinary but does address all five domains of development for

the child. If conducted prior to the assessment, an evaluation to determine continuing eligibility would need to be multi-disciplinary.

The child's primary interventionist, if qualified under the Birth to Three Personnel Standards to complete evaluations and assessments, can provide all of the assessment information, in collaboration with the family and other team members. The results of progress made toward achieving the child and family's outcomes, information from the curriculum-based or other assessments, progress in the child's participation in daily activities and routines, the family assessment, and current outside evaluations should be used in determining the status of the outcomes and service needs.

To document the evaluation of the Annual IFSP:

- Service Coordinator completes all sections of the IFSP form
- Sections 1, 2, 3, 4 need new pages since many things may have changed over the year
- Section 5A will be added for any new outcomes as appropriate
- Sections 5B and 5C can be photocopied and new information added during the IFSP meeting
- Section 6: the start dates for all services should reflect the new date of this meeting.
- Section 7: lists all team members

Once the due date for an annual evaluation of the IFSP has been reached, no further early intervention treatment services can be provided to the family and child unless the reasons for the delay are documented in the record and signed by a qualified professional. The first visit with a family after expiration of the IFSP would need to be an annual IFSP or an evaluation or assessment if that is not current.

Completing the IFSP Form for Those Families Requesting Service Coordination Only

The entire IFSP should be completed as it would be for any IFSP (including a multi-disciplinary team), reflecting information about the child and the family concerns as well as child outcomes, family outcomes and transition plans, and the team members who participated in the development of the plan.

The service grid on Section 6 must list appropriate services to address what will be happening in the upcoming months for which the IFSP is in effect. For instance, "annual assessment" or a certain number of visits to prepare the family for transition. The transition meeting could take place within the context of a home visit, or as part of an IFSP review. To help the family understand what will be happening as a result of this plan, it is recommended that the service coordinator attach the additional page to the IFSP or use the meeting notes section to write a brief description of what will be happening.

The parent signs the IFSP indicating they have received their rights and are in agreement with the plan. If they give written permission to send a copy of the plan to the primary health care provider, the completed IFSP is sent. The IFSP is signed by a licensed practitioner. All timelines related to the IFSP remain in effect.

Implementation of the IFSP

As soon as possible following any IFSP meeting, the service coordinator should send a full copy of the IFSP (with all referenced reports attached) to the parent and copies to anyone else the parent has listed on a signed release (Form 3-3).

Every IFSP must be signed by a parent and a licensed practitioner on the child's team. The service coordinator should ensure uninterrupted implementation of an IFSP, with any variance from the IFSP documented in the record. A signed release (Form 3-3) from the parent is necessary when sending the IFSP to the child's primary health care provider.

Each early intervention service is provided as soon as possible after the parent provides consent for that service and the IFSP has been signed by the licensed practitioner. Part C of IDEA requires that eligible children and their families receive timely services. Connecticut has defined "timely" as within 45 days of the

parent(s)' signature(s) on the IFSP. (See *Supports and Services Procedure* for the definition of Timely Services). Programs cannot provide or arrange for a service for which the parent has not given consent or for which consent has been withdrawn in writing.

The reason(s) for ANY variances from the IFSP must be clearly documented in the visit note.

Types of Service

"Early Intervention services and supports those that are designed to meet the developmental needs of an infant or toddler with a disability and the needs to the family to assist appropriately in the infant's or toddler's development..." (§ 303.13)

Early intervention services include but are not limited to: assistive technology; audiology; family training, counseling; medical services for the purpose of determining the child's developmental status and need for early intervention; nutrition; occupational therapy; physical therapy; psychological services; service coordination; sign language; social work; special instruction; speech-language pathology; transportation; vision services; and other services as appropriate as recommended in the IFSP.

As a required Part C service, Assistive technology device(s) need to be included on the IFSP as indicated (see *Assistive Technology Procedure*). "Assistive Technology Device" should be listed in Supports and Services Section and the assistive technology must be listed in an Outcome, with general information about the device (i.e. hearing aid vs. the specific type, mobility device rather than the specific type of gait trainer and accessories). More specific information about the type of device can be listed if known. The specific device information will be required as part of the Durable Medical Equipment reimbursement process (see *Payment Procedure*).

Guidance about how to fill out the various sections of the IFSP can be found in the following *IFSP Page by Page Guidance*

IFSP PAGE BY PAGE GUIDANCE DOCUMENT

General Information Related to the IFSP Form:

- If an error is made, the information should not be covered with corrective fluid but should be crossed out, initialed and dated by the parent.
- If a laptop computer is used on-site to produce the IFSP or information is entered into a typed version at the office, the parent must review and sign the printed version.
- Throughout the IFSP form, an asterisk (*) next to an item denotes that the information for that item is part of the electronic record maintained in the Birth to Three Data System.

Information follows related to guidance on filling out the individual sections of the IFSP.

IFSP Section 1: Child and Family Information

Overview: This section provides contact information for the child and family, the service coordinator and program, the primary healthcare provider, and the school system. It also serves as a summary of information that has been gathered regarding the child's present level in physical development (including vision, hearing, and health status), cognitive development, communication, social and emotional development, and adaptive development.

Meeting Type: One of the following should be checked to indicate the type of meeting:

Interim - If there are immediate needs for a child who has been determined eligible to receive services prior to the completion of the multidisciplinary assessment

Initial - If this is the first complete IFSP written for the child and family

Annual - If this is the meeting scheduled at least annually to evaluate the IFSP

Review - If this is a review of the IFSP

Parent/Foster Parent/Guardian/Family Member: There are two boxes allowing for parents, foster parents or guardians with separate addresses and contact information. The box on the left should be used for the person with whom the child lives. The relationship of the person(s) to the child should be checked in the space above their name.

Program Contact Information: The name of the service coordinator assigned to the child and family, their contact number, the Birth to Three program they work for including the program director's name and contact number, the program address and email address are written here. The service coordinator should be from the profession most relevant to the family's or child's needs and be the team member who can serve as the Primary Service Provider for the family. This person must hold a certificate indicating successful completion of service coordination training in Connecticut.

Primary Health Care Provider: Confirm and enter contact information for the child's primary health care provider (physician, physician assistant, advanced practice registered nurse, or primary care clinic)

School District Contact: Enter the name and phone number for the contact person of the school district that will be responsible if the child requires early childhood special education services after exiting from Birth to Three. Families should be made aware that at age 2 ½ basic contact (directory) information is automatically uploaded to their school district or Local Education Agency (LEA) via the Birth to Three Data System.

List any evaluations or assessments completed since the last IFSP: List evaluations or assessments with the dates of completion.

General Health and Development Information: How is my child doing in these areas of development?

This section summarizes information that has been gathered regarding the child's present abilities in all areas of development. The information must be based on current (no more than 3 months old) evaluation and assessment results, observations and parent report. This section must include a statement of the child's present level of physical development, (including vision, hearing, and health status), cognitive development, communication, social and emotional development, and adaptive development. You may refer to a current report and enter the date of that report.

IFSP Section 2: Family Resources

Overview: To assist families in identifying the important people and places in their family's life and to begin discussion about who might be participating in early intervention visits and how best to work with them to support the child.

Family Map (ECO Map): An ECO-map allows the service coordinator and family an opportunity to identify the important people and supports a family uses during the week.

Be sure the family understands the purpose before beginning the eco-map. An eco-map can be changed throughout a family's time in Birth to Three. People can be added or removed as life circumstances change or families become more comfortable sharing information. Most families enjoy talking about the people who are important in their lives. Others will need a few prompts such as "Do you have any family members who you regularly rely on for support or who you call on a regular basis to talk about your child?" You might ask specifically about grandparents, aunts, uncles, friends, coworkers or clergy if the family is slow to identify people.

Family Assessment Tool: As required by federal law, a family assessment tool must be used but is voluntary on the part of each family member participating in the assessment. List the family assessment tool that was used. See Appendix for suggested tools.

The adults in my child's life learn best by: This information will help the provider design their session using the appropriate methodology for the caregiver. Because the plan and intervention will be geared toward the adults who are with the child daily, this section asks specific information about a learning style. This will allow the Birth to Three service providers to tailor how they explain and coach families on the techniques and strategies families will use.

IFSP Section 3: Family Priorities

Overview: This section helps parents to determine their priorities for their child based on thinking about their child's abilities, interests and challenges. Increasing the parent's ability to describe their child's abilities and strengths is a goal of the Connecticut Birth to Three System. This information supports the parent in moving forward in identifying outcomes as well as advocating for their child when they transition out of Birth to Three.

What are your child's abilities/strengths: This question ensures that the parent/caregiver is able to describe their child in a way that others will understand. Prompt the parent to describe their child's abilities and strengths that they observe during their everyday activities. It is important for parents to be able to adequately describe their child to doctors, school district personnel, family friends and others.

Child's interests: Young children are interested in many different things. Studies have shown children's participation in activities that make them happy and that are interesting to them are full of learning opportunities across domains. Early intervention supports should be built upon the child's interests.

Child's challenges: After discussing the child's abilities and strengths, prompt the parent to describe their child's challenges. It is important for parents to be able to adequately describe their child to doctors, school district personnel, family friends and others.

What are your priorities for your child: After thinking about their child's abilities, challenges, and interests, discuss what the parent's priorities are for their child. Some typical priorities for parents often include walking, talking, eating, and getting along with others. (Priorities related to the whole family will be probed in the Family Outcome Section).

IFSP Section 4: Everyday Activities

Overview: This section explores what a family's daily life looks like, what is working well and what they identify as areas of concern. This helps identify everyday activities in the home and community that may serve as settings where the parent's priorities for their child can be addressed.

What everyday activities might allow you to work on your priorities with your child? The function of this section is to connect the family's priorities with their everyday activities in their home and community. Research shows that babies and toddlers learn best through everyday experiences with familiar people, when they are interested and participating in the activity. This section helps the family to decide which activity/s they would like to focus on to start addressing their identified priorities. These will not be the only activities that the team works together on, but they will be the ones that are measured when the IFSP is reviewed. Additional activities that address outcomes and will be the focus of future visits with the family will be documented on visit notes through *Joint Plans* developed with the family.

Activity: For those activities or routines discussed, place a checkmark to indicate if this is an area that is going well, is an area of concern, or an area with a lot of concern for the family. Given the families priorities, check the box if this is an activity that the family would like to explore in Section 5A: What we will work on/Child Outcome. There can be one or several areas identified. Sometimes a family might identify another area such going grocery shopping or to doctor's appointments, etc. These can be listed under other.

The "Comment" box is available for use if desired. Activities that are a priority will be explored in depth in Section 5A, so there is no requirement for comments in this section.

IFSP Section 5A: What We Will Work On/Child Outcome

Overview: In this section, you will help the family explore an activity they chose to focus on to address their priorities for their child. These will not be the only activities you work on with the family, but these are the ones you will measure during periodic IFSP reviews.

What activity will we explore? As determined by the family in the previous section, list the activity they would like to further explore. You will be assisting the family to determine how their priorities can be addressed within the identified activity and what other areas of development can be addressed in this activity as well.

What does your child do well or find interesting during the activity? This pertains to the child's abilities and interests during the identified activity. The goal is to build on the child's strengths and interests to increase the child's participation in the activity in order for learning to occur.

Where does he/she need support? Explore where the parent feels the child needs support during the activity. This likely will include areas that were identified by the parent as a priority and may include Assistive Technology that would increase participation.

What have you and others tried (strategies)? This question helps families realize how much they already do that supports and helps their child's learning, as well as possibly identifying something that one caregiver has tried that is successful that might be able to be used by all caregivers. It helps inform the early interventionist of what has already been tried. Additional strategies from the early intervention team will also be listed here but will be found, in detail, on *Joint Plans* documented on visit notes.

What do you want your child to learn during this activity? Every activity has a wealth of learning opportunities. Although the family may be focusing on a specific priority, it is desirable to expand their awareness to include a variety of opportunities their child has for learning during that activity. This broadens the focus to look at learning in a variety of domains. Additionally, as required by federal regulations, thought should be given to pre-literacy and language areas as developmentally appropriate for the child. These areas can be supported in many ways even with very young infants.

The question "What do you want your child to learn during this activity?" may need some prompting from the provider. You may want to ask additional questions that will help the parents identify some other things that their child can learn during the activity. *(For instance, a family identified talking as a priority for their child. One activity that they identify for working on that priority is during "swimming" at the town pool. The priority focus is on talking during this activity. In exploring the activity more, "What else might he/she learn during swim time at the pool?" the parents note opportunities for learning other things such as interacting with other children and motor skill development.)*

Outcome: what would you like this activity to look like? Exploration of the activity through the previous questions naturally leads to what the parent would like their child to be able to do during this activity. *(For instance, Outcome: "For Jose to join in with his friends at the town pool, using words and jumping in the water".)*

Criteria: How will you know when we are done working on this? This includes more specific measures that will help the family know if the outcome has been achieved. *(For instance, "When Jose approaches other kids at the pool and says "Hi", stays alongside of them and imitates jumping in the water for a few minutes").* Assistive Technology may be included in the outcome, criteria, or strategies in order to increase the child's functional participation.

What other resources or supports do you have or need that can help you: Birth to Three is not the only support that a family has. There may be other supports they can identify that will help them achieve their outcomes. These supports or services are not required early intervention services under Part C of IDEA, yet they will be considered as part of the overall plan. The service coordinator is responsible for assisting the family to obtain and coordinate these services with the Birth to Three supports.

Who will pay for services: List funding sources here

Additional Examples

Parent Priority	Identified Activity To work on priority	Additional Areas for Learning During identified activity	Outcome Child's Participation in Activity	Criteria – How will we know it's done? More specific measures
Play with other kids	Church Playgroup	Sharing Talking	Joey will join with his friends playing at church playgroup and use words instead of hitting.	When teacher says, Joey played for a few minutes with a friend and used words instead of hitting, 3 playgroups
Eating	Mealtime with family	Positioning in highchair Using spoon/fork	Allyse will have supper with our family and eat what we eat.	When she sits in chair at table for 15 minutes, uses spoon/fork for half of meal, and eats 2 of the foods we are eating.
To talk	Visit to Grandpa's house	Motor: strength, climbing, balance	During playtime in the backyard with Grandpa, Tyrone will use his words and be safe using the slide.	When Tyrone uses a few words to let Grandpa know what he wants (Ball, bubbles, up), & climbs slide on his own
Play by himself	Hang out time while mom cooks	Motor: sitting Attention Two hand on toys	Jose will participate in hanging out time while his mother fixes supper by playing with things by himself.	When he plays alone, supporting himself in a sitting position, for at least 10 minutes in the kitchen near Mom, for 5 days in a row.
Do things on her own	Getting dressed in the morning	Get stronger, balance	Keisha will get dressed by putting on all of her clothes by herself	When she can balance while she puts on clothes that she picked out with her mom and it takes only 5 minutes.
Sleep through the night	Nighttime	Self-soothing Using books before bed (bedtime routine)	Maria will go to sleep on her own and sleep through the night.	When she goes to sleep within 30 minutes after bedtime routine and sleeps 6 hours in a row, at least 5 nights a week.
Walking	Brother's Soccer games	Looking at other kids Making friends	Nicholas will go to his brother's soccer games and walk in the grass to go over to other kids to "make friends".	When mom doesn't need stroller at the soccer game, and Nicholas is able to walk over to the neighbor's little boy to look & smile at him.
Follow Directions Not get upset	Song time at childcare	Sitting with other children and teacher	Kaiden will join his friends at childcare during circle/song time using musical instruments.	When Kaiden finds his "mat" for circle, sit for two songs and use musical instruments alongside his friends.
Grow and develop as she should (infant)	Diaper change	Motor: head control, midline Looking at dad Responding to sound	During diaper change, Sophia will look at dad, reach for his face, and listen to his voice.	When Sophia looks at dad, reaches to the middle to touch his face with both hands, and reacts to his silly sounds by opening eyes wide or smiling.

IFSP Section 5B: Progress/Review of Child Outcomes

Overview: This section is to be used for a review of the Child outcomes that the family has identified.

Reviews of the IFSP must happen at least every six months and can happen more frequently if changes are needed or if the family requests a review or change.

Outcome: Copy outcome from Section 5A

To Be Achieved By: Copy from 5A

Criteria from Section 5A of the Outcome does not have to be copied but needs to be reviewed and documented in the Progress Update section (see below).

Progress Update as of _____: Note the date of the review that you are currently doing.

Check if the Outcome is Met, or will be Continued or Discontinued. Documentation in the progress update should explain this further, focusing on the child's progress in functional participation in the everyday activity addressed in the outcome.

Criteria Review: Discuss the progress the child has made towards meeting the Outcome, based on the identified Criteria that were previously developed in Section 5A. Although the previous criteria does not have to be copied onto this page, the team must address the measurements of progress as determined in the criteria. All information on progress is documented.

It is possible to have an Outcome remain as "Continued", but have the criteria change, as noted by checking the box for "New Criteria (if applicable)". The new criteria would be written at the bottom of the Progress Update, as indicated. When the IFSP is reviewed in the future, this new criteria will be used as a basis for measurement of outcome attainment.

As a required Part C service, Assistive technology device(s) need to be included on the IFSP if it has been determined necessary for the child's attainment of an outcome. "Assistive Technology Device" will be listed in Supports and Services Section and the assistive technology must be listed in an Outcome in Section 5A, with general information about the device (i.e. hearing aid vs. the specific type, mobility device rather than the specific type of gait trainer and accessories). More specific information about the type of device can be listed if known. The specific device information will be required as part of the Durable Medical Equipment reimbursement process (see *Payment Procedure*).

IFSP Section 5C: Family Outcomes and Transition Planning

Overview: This section explores the many possible outcomes that could be important for a family, including the family's transition out of Birth to Three. Family outcomes can include a variety of experiences or concerns that affect the whole family. (For instance, learning how to explain their child's diagnosis, exploring food or housing assistance, finding childcare, moving to another town or state, leaving Birth to Three...)

Every initial and annual IFSP must contain at least one family outcome that addresses a plan for transitioning when Birth to Three supports end. This transition plan includes supports for the child as well supports for the family for the benefit of the child in order to prepare for transition out of Birth to Three.

In addition to outcomes for your child, is there something that concerns you or was identified during the family assessment that you would like to discuss?

Information for family outcomes is gathered in many ways: during first calls to the family, during child evaluation and assessment, through use of a family assessment tool, and during the IFSP (ecomap, concerns, priorities, resources). This information helps you move naturally to exploring possible family outcomes.

Family Outcome: What do you want to have happen? Assist the family to formulate a family outcome that they would like to address.

What are your family's/child's strengths in addressing this outcome? Discuss what the family feels will be their strengths and resources in achieving this outcome or during this transition.

What will be the challenges? Discuss what the family feels will be their challenges in achieving this outcome or during this transition. This may include resources or supports they need (e.g. someone to watch children while they attend classes for a degree)

Steps That Will Help Your Family and Child

Using the table in the IFSP form, help the parent think about what will help the family and child reach this outcome or adjust to a new setting. Keep in mind that there are other supports for the family besides Birth to Three. They should be listed in the table.

Would you like to talk to a family that has been through a similar situation or whose child has gone through Birth to Three?

Research shows that families often receive their greatest source of support from other parents whose children have similar disabilities but who are older. It is important to ask families if they would like to be contacted by another parent whose child has gone through Birth to Three rather than simply giving them a brochure on a parent organization or telephone number to call. Often family members are too overwhelmed to initiate a call or they lose the number or brochure under the avalanche of initial paperwork. If a parent is interested in being contacted by another parent or an organization, have them sign a CT Birth to Three release of information (Form 3-3) or one provided by the parent organization. You can then notify the parent or the organization of the contact information of the interested family. If the parent is initially not interested in being contacted, there is a space to indicate when the parent may be interested in being asked again. The service coordinator should continue to ask this question not just at each IFSP meeting, but also throughout the family's time in the Birth to Three System.

Family Outcome Progress Update: At the bottom of the page, there is room for the outcome to be reviewed two times.

Additional Information on Family Outcomes That Contain Transition Plans:

A family outcome that includes information or steps to plan for a transition meets the criteria for having a transition plan in the IFSP and provides the opportunity to record the discussion of the family's concerns. This may include plans for the changes that may be coming up for the whole family (e.g. plans for the child to be cared for while parent goes back to work) or specifically related to the child's eventual transition out of the Birth to Three System..

A transition plan for leaving Birth to Three must be completed during the initial and annual IFSP and revised as needed during periodic IFSP reviews. The transition plan should include concerns related to the whole family but must also include the steps to be taken to support the transition of the child including discussion with, and training of, parents regarding future placements and other matters related to the child's moving on to other services; procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting.

Even if families of very young infants are not thinking about transition out of Birth to Three as they begin receiving supports, the service coordinator should use this opportunity to explain why this is part of the planning process. This may prompt the family to share any questions or concerns they have for the future. If the family does not express any issues, they should be told that the transition plan would be revisited at each IFSP review with a more detailed plan developed, as the child gets older. If a child will be exiting Birth to Three prior to the next review and currently has family outcome with little detail in the transition plan, you would need to revise the IFSP to include a more detailed transition plan since Federal law requires this for any child exiting Birth to Three. It is important to inform the family that they can always discuss questions or concerns if something changes and they want to discuss this as part of the IFSP.

An Example: Family Outcome

3 Months

Section 5C: Family Outcome

Family outcomes can include transitions and experiences with childcare, learning about your child's diagnosis, expectations, and how the family can have a smooth transition out of Birth to Three.

In addition to outcomes for your child, is there a family assessment that you would like to discuss?

Family Outcome: What do you want to have happen?

We know what to do when we leave Birth to Three

What are your family's/child's strengths in addressing this outcome?

What will be the challenges?

Steps That Will Help Your Family and Child

Think about what will help you reach this outcome or help you and your child adjust to a new setting. Birth to Three is only one of the supports that can help you with this.

What are some next steps?	How or where will this happen?	Resources or supports you have or need that can help you?	By When?
Re-visit transition plan in 6 months			12/2016
Let us know if anything changes before then			

It is required by federal law to have a detailed transition plan for any child exiting Birth to Three

Families of very young infants often are not thinking about transition out of Birth to Three.

If there are no concerns and no plans for the child to exit within the next 6 months, then the plan can be revisited.

Children and their families exit the Birth to Three system for several reasons: the child is approaching his third birthday and does not qualify for Early Intervention over 3, the child is progressing to demonstrate skills on age level or the family no longer feels they need the supports. Whatever the reason, the family outcome regarding transition out of Birth to Three should include steps and information to help the child and family have a smooth transition. Transition plans when a child is getting closer to exiting Birth to Three will need to be much more detailed as described above.

IFSP Section 6. Early Intervention Supports and Services

Overview: This section identifies the early intervention supports and services necessary to meet the unique needs of the child and family. Supports are provided for the family and other caregivers to help them work towards achieving their identified outcomes for their child and family.

Decisions regarding supports and services including type, frequency, location, method, intensity, and duration, can only be made after the development of outcomes. The decision on the type and intensity of the supports should come from an open discussion about what the family needs to help them achieve their outcomes.

Services (including assistive technology devices) that support achievement of functional outcomes or strategies are determined through discussion with the family and must be delivered as indicated on the IFSP. The decision to provide a service or support cannot be based solely upon factors such as: nature or severity of disability, age of child, availability of services, administrative convenience, family preference, payment methodology, or service provider preference but must be tied to supports necessary for the family to achieve their desired outcomes for their child and family.

Services provided under Part C of IDEA (see the Services Procedure for more information) should be listed on the grid on Section 6. However, services and supports provided under IDEA Part C and listed on Section 6 are only part of what will help a family achieve their outcomes. Additional resources and supports that are identified by the family can help them attain their outcomes and should be listed at the bottom of Section 5A as a support to achieve a child outcome or in Section 5C, *Steps That Will Help Your Family and Child*.

Any variance from the services or dates listed on the IFSP (settings, type, frequency, length) must be documented in the visit note. See *Planning and Documenting Services Procedure* for more information.

What is Going to Happen: This indicates clearly to the parent which early intervention supports or services will be provided to their family. These are the supports considered clinically necessary by the IFSP team and will be the responsibility of the program to provide.

Transportation should be listed on the IFSP service section as a required service whenever travel is necessary to enable an enrolled child and family to receive a Part C service.

Using a Primary Service Provider (PSP) approach to teaming ensures that the family has one professional who serves as the main liaison with the family and the rest of the team.

Secondary service providers support the family and the Primary Service Provider through joint visits during an activity with the child where specific expertise from that discipline is necessary. Joint visits occur as often as necessary based on the needs of the PSP and family. These service providers should be listed on the IFSP. Occasionally a need arises for consultation with a person who is not listed on the IFSP. This visit can happen without it being listed on the current IFSP and the reason for the consult must be documented in a visit contact note. If there will be future visits as a result of that joint visit, then a meeting to review the IFSP should be scheduled and the plan updated to reflect the change.

Special Considerations:

Remote Visits – The intent is that the vast majority of a family's supports in Birth to Three will be provided in-person. However, there will be times when supports may be provided remotely (Refer to *Remote Early Intervention Procedure*). "Remote" would be the method of delivery and should be written next to the appropriate service, as appropriate. See the following example:

What is Going to Happen	Delivered by: (Discipline responsible)	Location	How often	How Long	Start Date	End Date
Early intervention visit	Occupational Therapist	Home	1 time a week	1 hour	5/28/21	5/27/22
Early intervention visit REMOTE	Nutritionist	Home	1 time a month	1 hour	5/28/21	5/27/22

If the OT intends on regularly completing a Remote EI visit in addition to the in-person visits, a second line should be added to align what is signed by the parent with how the data is collected and entered as follows. As the new data system is developed the paper IFSP will be revised to match.

What is Going to Happen	Delivered by: (Discipline responsible)	Location	How often	How Long	Start Date	End Date
Early intervention visit	Occupational Therapist	Home	3 x per month	1 hour	5/28/21	5/27/22
Early intervention visit REMOTE	Occupational Therapist	Home	Once a month	1 hour	5/28/21	5/27/22

Outside Agency: It is possible to list a service considered by the IFSP team to be a necessary Part C service, which might be provided or funded by another agency (e.g. Board of Education and Services for the Blind). If it is listed here and the other agency is not able to deliver the service or discontinues it, the Birth to Three program is still responsible to provide this service. The delivery of the service by the outside agency does not need to be reflected in the data system but should be tracked by the service coordinator and reflected in the contact or service coordination notes.

Intensive Services: When a family is receiving intensive services, a regularly scheduled team meeting in the form of an IFSP review with the family is important to ensure that everyone is providing coordinated services. Joint visits are also an important function for ensuring coordination of efforts.

Assistive Technology: If assistive technology devices or services are to be part of the IFSP, they must be listed separately in Section 6. As a required Part C service, Assistive technology device(s) need to be included on the IFSP as indicated (see *Assistive Technology Procedure*). "Assistive Technology Device" should be listed in Supports and Services Section and the assistive technology must be listed in an Outcome, with general information about the device (i.e. hearing aid vs. the specific type, mobility device rather than the specific type of gait trainer and accessories). More specific information about the type of device can be listed if known. The specific device information will be required as part of the Durable Medical Equipment reimbursement process (see *Payment Procedure*). For an assistive technology device, the boxes for "Location", "How Often" and "How Long" may not apply and can be left blank. In the box for "Start Date", write the expected date of delivery of the service or device, allowing for processing of insurance claims and ordering time.

Transportation: Transportation and related costs, according to IDEA, include 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). Therefore, transportation should be listed on the IFSP service section as a required service whenever travel is necessary to enable an enrolled child and family to receive a Part C service. Parents must be reimbursed for transporting their own child unless they decline. A reasonable reimbursement rate would be the same rate at which staff is reimbursed for use of their car or some other standard rate used by the program.

Children Who Are Deaf or Hard of Hearing: The Language and Communication Plan (LCP) for children in the Connecticut Birth to Three System, Form 3-19, should be completed with the family by the IFSP team prior to or as part of the initial, annual or any periodic review of the IFSP. The plan was developed to prompt a discussion about the family's understanding of their child's needs and the possible outcomes, strategies or services that the IFSP should address (see the *Birth to Three Service Guideline #5 Young Children Who are Hard of Hearing or Deaf*). It may also be helpful for the parent to review in preparation for transitioning out of the Birth to Three System. The Connecticut IDEA Part B also has a Communication and Language plan as part of the Individual Education Plan (IEP) form.

For Children Who Are Visually Impaired or Blind: If the service being provided by BESB is a required service under IDEA Part C, it must be listed in Section 6 under "What is Going to Happen". Enter supports in a way that are meaningful for the family (1 x per month vs. 10 hours per year) and if the services will not happen in

the summer, the service should be listed twice with stop and end dates to reflect the summer break. BESB should then be listed in the box entitled "Services are paid for by the Birth to Three System unless otherwise indicated". In the event BESB discontinues delivering the service; the program is still responsible to provide the service as written on the IFSP. *(For instance, these would include any services that would involve a home or community visit with the family and BESB staff)*. If BESB or another agency is providing a service or support to a family that the team wants to be reflected on the plan but the service is not one required under IDEA Part C then this service or support should be written in Section 5A under *What other resources or supports do you have or need that can help you? (For instance, this might be a small grant from BESB for the child)*.

Delivered by (discipline responsible): The discipline of the person who will be delivering the early intervention service or support is indicated here. (See Birth to Three System Procedures Manual – *Personnel Standards* for disciplines approved to deliver early intervention services)

Each individual delivering a service should be represented on a different line. It is important that the family clearly understands what services they can expect to be delivered, by whom, where, how (in-person, remote), and for what length of time.

Joint Visits: For visits that will be joint visits there must be somewhere else in the IFSP such as the additional page or meeting notes to indicate that the parents understand that visits will be made at the same time. (For instance, when a visit will occur with an audiologist and another team member). Joint visits that occur in order to support the Primary Service Provider and the family are possible as supported by the "bullet" under the grid in Section 6: "Supports are provided to assist families in helping their child learn and develop. These may be provided by a primary service provider (PSP). A full team is available to support your PSP and family through joint visits".

If not specifically recommended on the IFSP, the visit note must document the reason why two practitioners of the same or different discipline(s) provide services at the same time and what each practitioner did during the visit with the family (i.e. joint visit needing expertise from two practitioners). This may be more easily documented on two separate visit notes.

Location/Setting: Indicate where the service will be delivered using only one location per box. If the Primary Service Provider will be regularly making an early intervention visit at home and also at the child's Early Head Start classroom, they must each be listed on separate lines with separate frequency and intensity. It is reasonable and allowable to vary the location of a service listed for the home by providing it in a community setting such as the neighborhood playground or the local grocery store. This change must be noted in visit notes on the Joint Plan but does not affect the IFSP as written.

How Often: Indicate how often (frequency) the service will be delivered. Specific frequencies should be stated so that the parents know what to expect. As noted on this page as a bullet under the grid, the supports listed may vary in order to best meet the family's needs in addressing the joint plan developed together with the family on early intervention visits. This allows flexibility over a three month period to vary supports based on the family's need. For example, supports could be written for 12x/3 months by a Physical Therapist (who is the PSP). The physical therapist may do 4 visits one month, 2 visits the next month, and 6 visits the following month based on the family's needs as identified on joint plans, with clear explanation of any variance from the IFSP documented in the visit notes.

(See image on next page)

[illegible]

Ongoing supports should be listed as # times/week or per month. There can be flexibility in how these visits are delivered over a 3 month period.

- Based on the joint plan, the family may need more or less support in implementing the plan.
- For example, supports are written for 12x/3 months by PT (who is PSP). The PT may do 4 visits one month, 2 visits the next month and 6 visits the following month based on the family's needs identified on the joint plans.

Additionally, there may occasionally be instances when service delivery will exceed or be less than the amount indicated on the IFSP. Any variation in service must be documented in the joint plans in home visit notes. If the changes are more than occasional and not related to the family's needs as noted on joint plans, the IFSP will need to be revised.

Often the team will identify an assessment that needs to occur prior to the next scheduled IFSP review and wish to document it as a listed service. The type of assessment should be written in the “What is Going to Happen” box. “How Often” should state the number of anticipated sessions, for example 2 visits. “How Long” should state the anticipated length of each session, for example 1 hour. If the exact number of visits or time required to complete the assessment is uncertain, the maximum amount of time or visits that might be needed should be listed here. If there is no documentation in the IFSP that an agreement with the family has been reached about program schedules, such as vacations, meetings, etc., the program is legally obligated to deliver the number of hours as specified. The meeting notes in Section 7 or an additional page can be used to document this agreement and discussion.

As noted in the IFSP, with parental agreement, any discipline listed in Section 7 may provide coverage for another team member to address the outcomes on the plan due to circumstances that will be documented on the visit notes. The covering interventionist must be from one of the disciplines listed in Section 7, be able to address Outcomes on the IFSP, and be working within their scope of practice.

How long: The length of time (intensity) the service will be delivered each time is written here. For example: "1 hr."

Start Date: The date services will begin should be written here. For an initial IFSP or for an IFSP review with new services, this date should allow enough time to obtain a licensed practitioner's signature. For Annual IFSP meetings the start dates for all services should reflect a new start date after the annual meeting.

When services are scheduled to increase or decrease during the course of an IFSP, multiple lines should be

used on the service grid to record the projected changes. Using the start and end dates, the plan can reflect a phase-in of the frequency/intensity of services or addition of service types on the service grid using staggered start and end dates. This example reflects a phased decrease of supports from the Physical Therapist. The process would be reversed to reflect a phased increase in supports.

What is Going to Happen	Delivered by: (Discipline responsible)	Location	How often	How Long	Start Date	End Date
Early intervention visit	Physical Therapist	Home	1 time a week	1 hour	3/3/17	6/3/17
Early intervention visit	Physical Therapist	Home	2 times a month	1 hour	6/4/17	3/2/18

End Date: The projected date that the services listed on this line will end is indicated here. The IFSP is written for up to one year. Unless the plan is to adjust the services at an earlier date, the service end date should be listed as the date of the projected annual meeting to evaluate the IFSP or the day before the child's third birthday if that date comes first. For children turning age 3 between May 1 and the start of the school year after age 3, and who are likely to be eligible for Part B Pre-school Special Education Services, the *projected* end date may be after the child's third birthday and up until the day before the start of the school year, as the family may choose to receive early intervention services after age three. (Refer to *EIS Over Three Procedure*) It is important to make it clear to the parent that if the child is not eligible for Part B, the end date will be the day before age 3.

Once the due date for an annual evaluation of the IFSP has been reached, no further early intervention treatment services can be provided to the family and child unless the reason for the delay are documented in the file. The first visit with a family after expiration of the IFSP would need to be an annual IFSP or an evaluation or assessment if that is not current.

The reason for ANY variances from the IFSP must be clearly documented in the visit note.

Part C Services are paid for by the Birth to Three System unless otherwise indicated here: Federal regulations are clear that IDEA Part C (the Birth to Three System) is the payer of last resort. If there is some alternative payment arrangement for an early intervention service listed in the service grid it should be listed here. (e.g. Insurance payment for AT devices)

Check if any early intervention service cannot be achieved satisfactorily in a natural environment and attach a justification for each service: If any service listed is not delivered in a natural environment, the *Justification for Early Intervention Service that Cannot be Achieved Satisfactorily in a Natural Environment* page of the IFSP must be completed for each applicable service. Audiological testing, parent groups and counseling for parents do not require justification (for additional information regarding natural environments see Birth to Three System *Service Guideline #2: Natural Environments*).

Informed Consent by Parents: There are several important acknowledgements that a parent makes in this section:

- A Parent must give permission for services to be delivered by initialing line A. If they do not agree with the complete plan, they can indicate this by initialing line B and listing those services that they do agree to start in the space below. If an IFSP is already in place and is not expiring and the parent does not agree with a revision of an IFSP that has been developed, then the existing IFSP continues to be carried out until the team can develop a plan to which the parent gives consent. Any variance from the IFSP, including start and end dates and services provided, must be documented in the visit notes. When a parent does not accept an IFSP fully, the provider must take steps to resolve the issue and in the meantime, the services that are agreed upon must be delivered. By initialing line B, the parent is acknowledging that if the team cannot come to an agreement within one month, they will request mediation, file a written complaint, and / or request a hearing.

- Under Federal law, parents must indicate that they understand and have received a written copy of their rights. The service coordinator gives them the Connecticut Birth to Three System booklet entitled *Parent's Rights Under IDEA, Part C* initially, at least annually, and at exit, and takes the time to review these rights with the parents.
- The parent also acknowledges that their signature serves as Prior Written Notice for starting the supports listed in Section 6 of the IFSP

Parent Signature: The parent, the appointed surrogate parent, or someone who is acting in the parental role must sign here. Department of Children and Families staff members or contractors such as safe home staff may not sign the IFSP because they do not meet the IDEA definition of parent.

Licensed Practitioner Signature: A licensed practitioner must recommend the supports and services outlined on the IFSP by signing and dating. To expedite the return of the signed service page, a faxed signature is acceptable.

Date: The licensed practitioner writes the date he or she signed the IFSP here.

Print name: The service coordinator prints the name of the licensed practitioner here.

ICD-10 Code(s): The service coordinator lists suggested ICD-10 code(s) (International Classification of Diseases-10th revision)

IFSP Section 7: Who is Part of Our Team

Overview: This section identifies who is part of the family's team. It includes individuals who participated in the development of the IFSP and/or who will assist in its implementation. It includes the family, Birth to Three team members, and others that the parents feel are part of their team (for instance, the primary health care provider or childcare provider).

Name: List each parent's and other team members' names. Occasionally, especially for an initial IFSP, a Birth to Three team member who will be supporting the Primary Service Provider may not be identified by the time of the IFSP. In this case, the discipline of the team member should be written down and efforts should be made to inform the family of who that team member will be (by name) as soon as possible. On the next IFSP review, that team member should be listed by name.

Relationship: Spaces are noted for the parents, primary service provider/service coordinator, and primary health care provider. Disciplines for other members of the Birth to Three team should be listed.

How they participated in this meeting: Place a check in the appropriate column, i.e. if they participated by being present, by video/audio conference, or through a current report (within 3 months). There is also a column to check for additional Birth to Three team members who will support the family directly and those who will be supporting the Primary Service Provider and family through regular team meetings and/or through joint visits. The last column refers to people the parents feel are part of their team in addition to Birth to Three. This should minimally include the primary health care provider.

Connecticut General Statute 17a-248e(c) currently requires that the IFSP be developed in consultation with the child's pediatrician or primary care physician (and includes APRNs and PAs). The lead agency interprets consultation to mean that with parent consent (Form 3-3) the EIS program will share the initial evaluation report and initial IFSP with the PCHP for review. Based on input from the PCHP the IFSP team will consider whether modifications to the implementation of the IFSP or the plan are needed. The following are approved methods for documenting the consultation of a Primary Health Care Provider (PHCP) in the development of an IFSP.

- a copy of a fax cover sheet used when sending documents to the PHCP
- a note in the record documenting a conversation with the PHCP
- listing the PHCP as a team member on the IFSP which allows for conversation without a release (Form 3-1)

Additional Information: Any discipline listed in Section 7 can provide a 1x consult (joint visit) as clinically appropriate without being listed on Section 6 of the IFSP. A discipline not listed in Section 7 may provide a 1x consultation as clinically appropriate for the purpose of an assessment that results in a written report. The reason for this variance from the IFSP must be documented on the visit note.

Meeting Notes: This area can include notes about what occurred at the IFSP meeting. For example, this may include decisions by a parent to not have services provided at the childcare setting, plans to have some visits at a relative's house, or information on joint visits, makeup visits, or coverage. Additionally, discussion about remote visits could be listed here, although this also has to be listed clearly in the Supports and Services grid. It should also include information about when team meetings with the family will occur.

Missed visits: The parent must initial this box to indicate that the information has been discussed. This statement gives the language regarding the policy on cancelations and rescheduling visits, including information that make-up visits will not be provided for regularly scheduled visits that occur on days that the state will be closed (i.e. holidays, governmental closures).

The service coordinator should clarify with the family if there are known days that will be a problem for the family or Birth to Three staff and how these missed visits will be handled including whether someone will substitute. The specifics of this discussion must be documented in Meeting Notes or on an additional page that becomes part of the IFSP. Blanket statements issued by agencies on holidays and cancellations will not cover the legal obligation of the program to provide the services that are listed on the IFSP. If there is no documentation in the IFSP that agreement with the family has been reached about program schedules, such

as vacations, meetings, etc., the program is legally obligated to deliver the number of hours as specified.

Additional Page

Overview: Serves as extra space to be used, if needed, for reporting information or discussion under any section of the IFSP. When used, this page becomes a part of the IFSP document.

Justification for Early Intervention Service that cannot be Achieved Satisfactorily in a Natural Environment.

Overview: This page serves as a place to write a justification of the extent to which services will not be provided in a natural environment. Per regulations, all early intervention services must be delivered in the child's natural environments as described in Section 303.26. If a service cannot be achieved satisfactorily in a natural environment, the box on Section 6 Early Intervention Services and Supports is checked and a justification page must be completed for each service not provided in a natural environment as well as plans to move the service to the natural setting.

Because audiological evaluation and supports as well as counseling or support groups for parents do not usually occur in the child's natural environment they do not require justification. (For additional information regarding natural environments, see CT Birth to Three System *Service Guideline #2: Natural Environments*).

Child's Name / DOB / Meeting Start Date: The first and last name of the child, the child's month/day/year of birth, and the date or dates that the meeting was held to develop the IFSP are written in these spaces.

Service: Indicate the service that will not be provided in a natural environment.

Location/Setting: Indicate the location of each service that will not be provided in a natural environment.

Complete the following questions for the service:

- Explain how and why the child's outcome(s) could not be met if the service were provided in the child's natural environment with supplementary supports. If the child has not made satisfactory progress towards an outcome in a natural environment, include a description of why alternative natural environments have not been selected or outcome not modified.
- Explain how services provided in this location will be generalized to support the child's ability to function in his or her natural environment.
- Describe a plan with timelines and supports necessary to allow the child's outcome(s) to be satisfactorily achieved in his or her natural environment.

Frequently Asked Questions

Q. What if the family I am working with is very reluctant to fill out the ECO-map or talk about their daily routines?

A. It is important to explain to families why you are asking questions about their families and their daily life before the IFSP begins. For some families an explanation may be all it takes to overcome their reluctance. For others gentle prompts such as “Who do you call when you are worried about something?” Or “Tell me about your morning routine, how do you get all three children out the door and to childcare before 7:00 AM?” If a family gives brief or incomplete answers, assure them that you can always return to this section and add to it at a future IFSP meeting.

For the very rare family who refuses to talk about family or routines this might be a good opportunity to talk about what Birth to Three looks like, based on best practice in Early Intervention. A family expecting services to be delivered in a more traditional outpatient rehabilitation or medical model may see no need to share personal information. Staff need to be comfortable discussing that the focus of Birth to Three is to work with parents and other important people in the child’s life in order to support them in attaining their outcomes for their child. Often parents are not thinking of other resources they have, besides Birth to Three, to help them achieve their outcomes. Ultimately, a family can share as much or as little as they want to and still receive Birth to Three services.

Q. Some of the questions I ask during the IFSP have already been covered in the assessment. Do I have to ask the family to repeat their answer?

A. Rather than asking repetitive questions, you can use the information from the assessment as a way to enhance their previous answers and learn more about the family during the IFSP. For example, “I know you mentioned your mother and grandmother were a huge source of support to you when your baby was in the hospital. Now that he is home, who are the other people in your life that you know you can count on for support?”

Q. How can we document that we have encouraged a family to consider a service or a different frequency of a service that was not accepted?

A. This discussion could be reflected in the meeting notes of Section 7, along with the parent’s refusal or reluctance to accept the service or service frequency. The additional blank page can be used if more space is needed.

Q. What if the family wants an “alternative” approach like cranio sacral or mega vitamin therapy?

A. The Birth to Three System does not provide alternative treatments but can support a parent’s effort to pursue that treatment on their own. If appropriate this should be listed in Section 5A under Other Services that are related to this Outcome that are in Place or Needed and coordinated with the child’s Birth to Three services as much as possible.

Q. If I need the occupational therapist for a one-time consult, do I need to revise the IFSP to indicate this as a service?

A. No. One-time consults that are needed to address specific concerns of the family or primary service provider (PSP) that did not come up at the previous IFSP meeting do not have to be listed on the IFSP but must be justified in the visit note. Any discipline listed in Section 7 can provide a 1x consult (joint visit) as clinically appropriate without being listed on Section 6 of the IFSP. A discipline not listed in Section 7 may provide a 1x consultation as clinically appropriate for the purpose of an assessment that results in a written report. The reason for this variance from the IFSP must be documented on the visit note. However, if at an IFSP meeting the team knows that a consult by the occupational therapist to the PSP and family will be needed in the next six months, it should be listed on the IFSP with an anticipated start date several months from the

date of the IFSP.

Q. If the parents want to add or change an outcome that does not change the supports and services being delivered, do I have to do a review?

A. Yes. The purpose of reviewing the IFSP is to review changes for the child and family, family concerns, and new priorities, as well as the supports they need to achieve their outcomes. All changes to outcomes or early intervention supports and services have to occur in the context of an IFSP meeting.

Q. Do I have to make-up all missed visits listed on the IFSP?

A. Yes, unless the family cancels or the State of Connecticut is closed on the day of the regularly scheduled visit. Providers may use the Meeting Notes section of the IFSP to document conversations regarding when and how make up visits will be delivered and by whom. Documentation of the make-up visit must be provided on the visit note.

Q. Why do I have to ask parents more than once if they would like to talk to a family who has been in a similar situation or whose child has gone through Birth to Three?

A. Parents may be overwhelmed or reluctant to agree to this support at first. Research shows that families often receive their greatest source of support from other parents whose children have similar disabilities but who are older. See Section 5C for more information.

APPENDIX
Language & Communication Plan
For Children in the Connecticut Birth to Three System

This tool is designed to assist the IFSP team in identifying the ongoing unique communication considerations of children who are deaf or hard of hearing that should be reflected in the IFSP.

Child's Name: _____
Service Coordinator's Name: _____

Date: _____
Program: _____

The service coordinator and the IFSP team have considered and discussed:

1. Issues related to making a decision about a communication approach.

How does the child's family communicate?

What communication approaches has the family been informed about for their child?

What are the family's wishes with regards to child's communication mode at this time?

2. Opportunities for direct communication with children and, or adults who are deaf or hard of hearing and who are using the chosen communication approach:

3. The child and family will be supported by the following professionals who are knowledgeable and experienced in working with children with hearing loss and the chosen communication approach:

4. Assistive technology devices that will be used with the child while enrolled in the Birth to Three System:

5. Additional comments or concerns:

For more information, please see the CT Birth to Three Service Guideline #5 Young Children Who are Hard of Hearing or Deaf.

Family Assessment Tools

Links to Some Family Assessment Tools (click on tool to access link):

Family Needs Survey

Parent Caregiver Involvement Scale

Family - [http://www.wbpress.com/shop/family-resource-scale-reliability-and-validity/Resource Scale](http://www.wbpress.com/shop/family-resource-scale-reliability-and-validity/Resource%20Scale)

Family Needs Scale

<http://www.wbpress.com/shop/family-needs-scale-reliability-and-validity-3/>

Family Functioning Style Scale (FACES IV) Family Support Scale

<http://www.wbpress.com/shop/family-functioning-style-scale-a-research-instrument-for-measuring-strengths-and-resources/>

AEPS Family Interest Survey

<http://www.worldcat.org/title/aeps-family-interest-survey/oclc/224608538>

Assessment, Evaluation and Programming System (AEPS) for Infants and Children By Juliann Cripe, Ph.D., and Diane Bricker, Ph.D.

<http://www.worldcat.org/title/aeps-family-interest-survey/oclc/224608538>

Brooks Publishing Co., P O Box 10624, Baltimore, MD 21285

Family Assessment Tool Samples included in Appendix:

Family Needs Scale

C.J. Dunst, C. M. Trivette, and A.G. Deal (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books.

Family Resource Needs, A Screening Tool

Adapted with permission from Project Dakota Outreach, 680 O'Neill Drive, Eagan, MN 55121

Family Resource Scale

Healthy Families America, 1996

Family Needs Scale

Carl J. Dunst, Carolyn S. Cooper, Janet C. Weeldreyer, Kathy D. Snyder, & Joyce H. Chase

Name _____ Date _____

This scale asks you to indicate if you have a need for any type of help or assistance in 41 different areas. Please *circle* the response that best describes how you feel about needing help in those areas.

To what extent do you feel the need for any of the following types of help or assistance:	Not Applicable	Almost Never	Seldom	Sometimes	Often	Almost Always
1. Having money to buy necessities and pay bills	NA	1	2	3	4	5
2. Budgeting money	NA	1	2	3	4	5
3. Paying for special needs of my child	NA	1	2	3	4	5
4. Saving money for the future	NA	1	2	3	4	5
5. Having clean water to drink	NA	1	2	3	4	5
6. Having food for two meals for my family	NA	1	2	3	4	5
7. Having time to cook healthy meals for my family	NA	1	2	3	4	5
8. Feeding my child	NA	1	2	3	4	5
9. Getting a place to live	NA	1	2	3	4	5
10. Having plumbing, lighting, heat	NA	1	2	3	4	5
11. Getting furniture, clothes, toys	NA	1	2	3	4	5
12. Completing chores, repairs, home improvements	NA	1	2	3	4	5
13. Adapting my house for my child	NA	1	2	3	4	5
14. Getting a job	NA	1	2	3	4	5
15. Having a satisfying job	NA	1	2	3	4	5
16. Planning for future job of my child	NA	1	2	3	4	5
17. Getting where I need to go	NA	1	2	3	4	5
18. Getting in touch with people I need to talk to	NA	1	2	3	4	5
19. Transporting my child	NA	1	2	3	4	5
20. Having special travel equipment for my child	NA	1	2	3	4	5
21. Finding someone to talk to about my child	NA	1	2	3	4	5
22. Having someone to talk to	NA	1	2	3	4	5
23. Having medical and dental care for my family	NA	1	2	3	4	5
24. Having time to take care of myself	NA	1	2	3	4	5
25. Having emergency health care	NA	1	2	3	4	5
26. Finding special dental and medical care for my child	NA	1	2	3	4	5
27. Planning for future health needs	NA	1	2	3	4	5
28. Managing the daily needs of my child at home	NA	1	2	3	4	5
29. Caring for my child during work hours	NA	1	2	3	4	5
30. Having emergency child care	NA	1	2	3	4	5
31. Getting respite care for my child	NA	1	2	3	4	5
32. Finding care for my child in the future	NA	1	2	3	4	5
33. Finding a school placement for my child	NA	1	2	3	4	5
34. Getting equipment or therapy for my child	NA	1	2	3	4	5
35. Having time to take my child to appointments	NA	1	2	3	4	5
36. Exploring future educational options for my child	NA	1	2	3	4	5
37. Expanding my education, skills, and interests	NA	1	2	3	4	5
38. Doing things that I enjoy	NA	1	2	3	4	5
39. Doing things with my family	NA	1	2	3	4	5
40. Participation in parent groups or clubs	NA	1	2	3	4	5
41. Traveling/vacationing with my child	NA	1	2	3	4	5

Source: C.J. Dunst, C.M. Trivette, and A.G. Deal (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books. May be reproduced.

Family Resource Needs A Screening Tool

1. What concerns you most about your child or caring for your child?
2. Do you need information or assistance for weekday, weekend, and overnight childcare or respite?
3. We know of parents who would be willing to visit with you by phone or in person to offer support and a listening ear. Does this interest you?
4. Would you like more information or assistance regarding medical/health services?
5. Do you want more information or assistance with early intervention services or adaptive equipment?
6. Would you find it helpful to hear about different types of financial assistance for medical costs or other expenses that you have?
7. Would you like (more) assistance in finding resources, working out problems with agencies, and getting more appropriate services, transportation, or communications with agencies?
8. Is there other information you are looking for now?

Family Resource Scale

This scale is designed to assess what resources you need for your family. For each item please check the response that best describes how well each need is met on a regular basis (that is month to month).

To what extent are the following resources adequate for your family:	Does Not Apply	Not at all adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost always adequate
1. Food for two meals a day						
2. House or apartment						
3. Money to buy necessities						
4. Enough clothes for your family						
5. Heat for your house or apartment						
6. Indoor plumbing/water						
7. Money to pay monthly bills						
8. Good job for yourself or spouse/partner						
9. Medical care for your family						
10. Public Assistance (SSI, TANF, Medicaid, SNAP etc)						
11. Dependable transportation						
12. Time to get enough sleep/rest						
13. Furniture for your home or apartment						
14. Time to be by yourself						
15. Time for family to be together						
16. Time to be with your child/children						
17. Time to be with spouse/partner or close friend						
18. Telephone or access to a phone						
19. Babysitting for your child/children						
20. Child care for your child/children						
21. Money to buy supplies for your child/children						
22. Dental care for your family						

Title: INSURANCE

Purpose: *Birth to Three programs must work with the CT Birth to Three System to maximize the revenue from insurance coverage to support Part C services.*

Overview

The Birth to Three State Statute 17a-248g requires that programs assist in the billing of private insurance for Birth to Three Services. The Affordable Care Act (ACA) restricts the use of financial limits so insurance companies may equate these dollar limits to another unit of measure.

The CT Birth to Three System has a contractor to process all direct service billing for children who are covered by Medicaid and commercial insurance coverage. In order to be paid, all EIS Programs are required to work with the billing contractor to maximize the revenue from Medicaid and commercial insurance. The state will only pay for unpaid claims when service data has been entered within 10 business days of the event and the insurance data is correct. Claims denied due to untimely filing will not be paid by the lead agency.

Insurance Billing Requirements

State statutes and regulations combined with this procedure ensure that the state meets the following requirements of the IDEA Part C Regulations: (1) the Connecticut Birth to Three System will not disclose any personally identifiable information for the purpose of billing commercial insurance or Medicaid without parental consent, (2) coverage for Birth to Three services will not decrease the available annual or lifetime limits for the child or family, (3) the state will not collect insurance plan co-pays or deductibles, (4) in order to receive early intervention services, parents are not required to sign up for, or enroll in Medicaid or commercial health insurance programs and can withdraw consent to bill health insurance at any time, (5) enrollment in Birth to Three will not adversely affect the availability of health insurance to the child, the child's parent or child's family members, and (6) will not result in any increase in premiums or discontinuation of Medicaid or insurance benefits for the child or the child's family. The parent is responsible for paying their insurance premiums.

Insurance Pre/Prior Authorization (PA)

Because Birth to Three is covered by a state insurance statute and the Affordable Care Act, the number of Pre/Prior Authorizations (PA) that will be needed is expected to be small. PCG will be able to determine quickly if a claim is rejected because PA is needed. That information will show up in EI Billing and then programs will need to contact the carriers to find out what the carrier needs and send it to them. This shouldn't stop services from being delivered. Escrow payments will pay for claims that are denied until PA process is complete. Programs are expected to work PA requests

once it is identified and this will be monitored. As programs learn which carriers need PA they can do the work up front to save time and increase the revenue to the system. Once some time has passed and we have data to analyze, we can work with programs and PCG to determine the best course for handling PAs that will be the most efficient and result in the most claims being paid quickly. The Lead Agency will monitor use of escrow funds and the PA process.

Form 1-3: Insurance Data Collection and Consent to Release Information

Prior to completing an evaluation, EI programs must accurately collect the required information on the Insurance Data Collection Form 1-3. The insurance data must be entered in a timely manner, and whenever possible before the evaluation is billed, and the original form is placed in the child's record. This will be monitored by the lead agency. Based on the protections in the Affordable Care Act and state statute, Form 1-3 is not completed to secure the family's consent to bill insurance but secures their consent to share personally identifiable information with the billing contractors, CMS and/or the family's insurance carrier(s).

The billing contractor will validate insurance policies based on the data entered into the Birth to Three data system. There will be notification in the billing contractor's web portal if more information is needed to validate the policy.

Some plans may require prior authorization and the Birth to Three billing contractor will assist with notifying programs when this is true after a claim has been denied.

If the carrier requests additional information such as a copy of the evaluation, a copy of IFSP, or a contact note the EI Program will work with the carrier directly.

Informed Consent to Bill Health Insurance Plans Exempt from State Insurance Mandates

Insurance plans that are not required to follow state mandates (plans that are self-funded by an employer, also called ERISA, non-mandated / non-regulated plans, or plans written by companies that do not sell health insurance in Connecticut) may not pay or, if they do, may not offer the protections required by state statute.

EI Programs must explore with families whether their insurance falls into this category and when it is determined to be so, offer the family Form 1-3a, Informed Consent to Bill Health Insurance Plans Exempt from State Insurance Mandates.

The policy validation process completed by the billing contractor will confirm whether the family's insurance plan is non-mandated / non-regulated. Form 1-3a ensures that families understand that their annual and lifetime caps may not be protected.

Because it is not always apparent which plans are mandated, if a parent signs only Form 1-3 and the billing contractor later discovers that the plan is non-mandated, the program should ask the family to complete Form 1-3a before the next visit and update

Form 1-3 if needed. If they sign that they do not grant permission on 1-3a, the program must then indicate that the consent on Form 1-3 has been revoked and change the information in the data system.

Informed Consent to Use a Health Reimbursement Agreement (HRA) or a Health Savings Account (HSA)

Many families may not know whether they have a Health Reimbursement Agreement (HRA) or a Health Savings Accounts (HSA), the Birth to Three System will not bill HRAs/HSAs without a family's informed consent.

HRAs are a special account funded by an employer to pay for current and future medical expenses and are used in conjunction with a High Deductible Health Plan.

HSAs are a special account owned by an individual used to pay for current and future medical expenses and are used in conjunction with a High Deductible Health Plan (HDHP). The HSAs are a means by which a family or individual with a specific HDHP is allowed to set aside pre-tax money to cover the high deductible. When a claim is processed, the owner of the HSA is allowed to make the determination whether he or she wants the claim to be paid out of the HSA or their own pocket. Some HRAs and HSAs have automatic options that will pay the deductible portion of the claim which is not in line with the Birth to Three policy of not collecting the deductible from the family. This creates a problem in that the program would be required to return the money if it were, in fact, paying the deductible.

As soon as it becomes clear that a family has an HRA/HSA, the program should explain Form 1-3HSA. If the family knows that their deductible has already been met, signing Form 1-3HSA for a limited time will allow programs to bill for Birth to Three services.

Flexible Spending Accounts

Flexible Spending Accounts are sponsored by the parent's employer. It allows the parent to set aside "pre-tax" dollars for medical expenses. The account is managed by the parent and can include an automatic withdrawal option. If the automatic withdrawal option is activated, any portion of the insurance claim not covered by the insurance carrier can then be withdrawn and either mailed to the provider processing the claim or directly to the family. The potential could be to totally deplete the flexible spending account prematurely or to accidentally charge the family for co-pays, deductibles or unreimbursed claims. Programs would be responsible for reimbursing families if this happens. The automatic withdrawal option should be discussed with the parent who could inquire about deactivating the option or at least be aware of the potential possibilities.

Insurance Payments Received by Families

State law requires Connecticut insurance companies to reimburse for early intervention services provided by EI programs. If the reimbursement by the insurance company is received by the family, the family is obligated to reimburse the program as stated on

Form 1-3. The Explanation of Benefits (EOB) will alert either the billing contractor or the program that a family has received an insurance check and has not reimbursed the program.

Discounts Requested by Insurance Companies through Claims Processing Companies

Any forms received from claims processing companies (e.g. MultiPlan or OmniClaim) requesting the Birth to Three program to accept a discounted payment for Birth to Three claims, should be forwarded to the billing contractor immediately upon receipt.

Use of Diagnosis Codes (ICD10) By Programs

ICD refers to the International Classification of Disease and 10 is the most current update of codes by the National Center for Health Statistics. ICD codes are specific codes that tell insurance companies the condition or diagnosis of the child for whom you are providing services. ICD Codes are necessary to bill for services and are sometimes referred to as “diagnosis codes”. It is important for insurance reimbursement that the code is up to date and accurate. If the ICD 10 code is not listed in the drop down list for IFSP ICDs, email CTBirth23@ct.gov and request that it be added.

Limited Time Diagnosis Codes (ICD10)

For insurance purposes, some children who enter Birth to Three may have an ICD Code that is only valid for a specific time frame. In these cases, the program needs to add a new additional ICD code for the child into the data system. The following auto-eligible conditions have ICD codes that are time sensitive:

- P07 (Gestational Age).

Title: INTAKE

Purpose: *Describes the single point of intake for Birth to Three referrals under Part C of IDEA and the capacity to track non-eligible children's development.*

Overview

Child Development Infoline (CDI) is the single point of entry into the Connecticut Birth to Three System via a toll free telephone number, or fax or website referral form. Within the United Way of CT 2-1-1 organization, CDI handles all calls coming into the 1-800-505-7000 line, including calls for Birth to Three, and a variety of other supports. Only CDI can enroll children in the Birth to Three System and assign a case number

Availability of CDI Staff

CDI staff accept referrals and other calls Monday through Friday from 8 a.m. to 6 p.m. The CDI voicemail system is available 24 hours a day, every day. The outgoing message indicates when the office is closed, e.g., holiday or extreme weather conditions. Callers may leave their name and number to receive a return call. Their outgoing message names Birth to Three and the other programs and services accessed via CDI.

Processing a Contact

To best match the caller's needs and the child's age, CDI staff begin the intake process by triaging calls across all of the programs, services and supports for which they are the access point. This includes Help Me Grow, In-Home Supports, Birth to Three, Early Childhood Special Education, and Children and Youth with Special Health Care Needs. Every contact to Child Development Infoline (CDI) about a child younger than 34.5 months is considered a Birth to Three referral only when a developmental concern is identified.

Birth to Three Referrals

For referrals triaged into to the Birth to Three System, CDI staff gather, confirm, record and share information.

Confirm:

1. the parent's or legal guardian's interest in proceeding with the referral when it was made by anyone other than the child's parent or legal guardian.
 - a. If a family has no telephone or does not respond to messages left by CDI staff, a "request for contact" letter is sent to the family asking them to call CDI to complete the intake for Birth to Three, if interested. If CDI is unable to reach the family or if the family declines the Birth to Three referral, a disposition letter is sent to the referral source indicating the outcome.
2. that the child lives in the state of CT. The Connecticut Birth to Three System is not required to provide Part C early intervention services to a child who is also receiving Part C early intervention services in another state if that child and their family are only

temporarily visiting Connecticut. If the family is in the process of moving, CDI informs them to call back when they do live in Connecticut. This does not apply to children who:

- a. are homeless or whose family is highly mobile (e.g. migrant workers) or
- b. are displaced by a catastrophic event such as a hurricane or flood, or
- c. are wards of the state, or who
- d. reside on an Indian reservation.

Gather and Record Information about:

1. the child's current abilities from the referral source and/or parent.
2. the child's birth history and relevant medical information
 - a. whether an audiological exam has been completed,
 - b. developmental, social-emotional or autism screening plus results when available.
 - c. If the child has a diagnosed condition that affects eligibility, CDI staff will record that diagnosis prominently in the Notes section of the Referral concerns in the Birth to Three data system
3. the child's primary health care provider and other medical providers.
4. language(s) spoken and read in the home.
5. If questions arise related to eligibility, staff indicate that eligibility is determined at the program level.

CDI informs Families that:

1. the evaluation is provided at no cost to their family
2. if families do not indicate a choice of program from among those serving their town, CDI uses a rotation process to identify the program that will complete the initial evaluation or assessment,
3. all of the programs are comparable in terms of quality of services, types of staff employed, and ability to schedule the evaluation and services in the home or other natural environment.
4. the assigned program will contact them within a few days to schedule the initial appointment, and offer a brief description of the visit
5. provide the website address to Family Handbook Guide I which describes the evaluation process and their parent rights under Part C of IDEA
6. provide the website address to the Home Visiting video at youtu.be/8fOJGmldj0c
7. If a family has additional questions, CDI addresses them.
8. they can call CDI back if they have any questions or concerns, have not heard from a program as expected, or are unhappy with the selected program

Steps taken once referral has been assigned to a program:

1. CDI sends the family a parent Welcome packet that includes:
 - a. the name and contact information for the Birth to Three program that will schedule their evaluation visit
 - b. a list of all the programs serving families living in their town

- c. a “Welcome to the Birth to Three System” letter that includes a Family Handbook Guide I website link
 - d. additional resources
2. CDI sends the referral source a confirmation letter if the referral was made by someone other than the parent or guardian that includes:
- a. the name, address, contact person and phone number of the program that will determine the child’s eligibility.

Note: If a child is referred who is already in process with Birth to Three, a letter indicating that the child has already been referred will be sent to that referral source.

Parent Requests for Specific Programs

If a parent requests a specific program that serves their town and is open to new referrals or transfers, CDI will note this in the database and assign the referral to that program. When a parent makes a special request listed below, CDI takes these actions before assigning the referral to any program.

Parent requests services...	CDI action step(s)
from a program that does not serve their town	Contact the Birth to Three administration for approval for special circumstances.
in both the town of residence and at the child’s early care setting in another town outside of the program’s catchment area	Offer the parent a choice from among all program(s) that serve both towns. If there are none, CDI will identify a program that can accommodate the request. CDI tells the parent that they must actively participate and be present during the eligibility determination and at least some service visits regardless of the location.
be provided by a program that serves their town but is not currently accepting referrals via rotation	Contact the program director to learn if a new referral can be accepted. If the program is not able to accept the referral within five calendar days, the referral will be sent to the next available program in the rotation cycle.

Family or Child Special Circumstances

1. If CDI learns that the family is homeless, they will enter that information in the data system. This will alert the receiving program that the family needs to be contacted as soon as possible before there may be a change in their address, and to take extra measures to ensure completion of the evaluation, assessment and IFSP process if the child is found to be eligible. For more information see the procedure entitled, "Children who are Homeless".
2. If the child is hospitalized and not available, CDI staff records "Referral on Hold" in the notes section of the referral concerns screen. (Only CDI staff may use this option.)
3. If the child being referred has a diagnosed hearing loss that meets Birth to Three eligibility criteria CDI will work with the family to identify a program that serves the town where the family lives. If the family has a preferred approach to learning language CDI may discuss the different programs that specialize in hearing. CDI will send families a handout created by Connecticut's Early Hearing Detection and Intervention (EHDI) workgroup and give the family information on "Guide By Your Side".
4. If the parent or referral source indicates that the child has been diagnosed with an Autism Spectrum Disorder, failed a screen for Autism, or if there are any concerns regarding autism and the child is 12 months or older, CDI offers information about the programs that specialize in autism, in addition to the general programs that serve their town.
 - For children 12 months and older, if there is a concern about autism the family can be referred to a program that specializes in autism, regardless of whether the MCHAT- RF has been administered.
 - CDI will ask if the child has a sibling who has been diagnosed with autism as there is more risk if a sibling has already been diagnosed
 - The autism concern box on the referral should be checked regardless of age or who expressed concern
 - Parent readiness and choice are still strong values for selecting a program

CDI also directs the parent to the online location of the Birth to Three Service Guideline #1, Autism Spectrum Disorder for more information. CDI forwards the referral to the parent's chosen program.

5. CDI redirects callers whose intention is to refer children within 45 days of their third birthdays by offering the following:
 - A. information about the responsible local school district to seek an evaluation for early childhood special education, including the LEA address and phone number.
 - B. the web site location for the State Department of Education's Form ED621, "Referral for Special Education" or mail a copy
 - C. information about supports available from the CT Parent Advocacy Center (CPAC) including their website address.

Re-entering the Birth to Three System

Families re-enter Birth to Three for a variety of reasons. Most will be treated as new referrals. Sample scenarios are listed below. In most cases CDI will refer the family back to the program that did the previous evaluation or provided services unless the parent requests a different one.

For children who were never evaluated

If the family contacts the EI program within one month of the date when it was determined that the family declined the evaluation or the program was unable to contact the family, the determination data can be changed to Pending by the program.

If the family or another referral source contacts CDI, after the one month return period, a new referral will be created.

For children who were not eligible

If it has been less than one month since the determination was made, the referral source should be told that they need to wait a month and call CDI to make a new referral.

If there is a new diagnosis or information that warrants a re-determination, families do not need to wait and referral sources should contact CDI to make a new referral. In this case programs must email CTBirth23@ct.gov for prior authorization to complete an evaluation within one month of a previous evaluation.

If during the tracking and monitoring process (Help Me Grow) it appears that the child may be demonstrating a significant developmental delay, Child Development Infoline will treat that as a new referral.

For children who were eligible

If the family exited and enrolled in the tracking and monitoring process (Help Me Grow) and it appears that the child is again demonstrating a significant developmental delay, Child Development Infoline will treat that as a new referral. In most cases CDI will refer the family back to the program that was supporting them before they lost contact unless the parent requests a different one.

If the family of an eligible child was exited due to the program not being able to locate them, Child Development Infoline will treat the contact as a new referral. In most cases CDI will refer the family back to the program that was supporting them before they lost contact unless the parent requests a different one.

If the family requests a new program, CDI or staff at Birth to Three can help the new program identify the date of the previous evaluation.

When a child re-enters with a new record, timelines begin anew as if the child had no prior enrollment. Prior authorization may be needed if annual maximums may be reached by completing a new evaluation.

Birth to Three Program Responsibilities

Birth to Three programs agree to the following:

1. have personnel available to accept referrals on all business days, fifty-two weeks per year
2. accept referrals only from CDI and redirect referral sources to CDI when needed
3. indicate whether they can accept new referrals and transfers via rotation in the Birth to Three data system, or when they are temporarily closed to new referrals.
4. accept all referrals and provide an evaluation or initial assessment to any child without regard to the referral concerns while the program is accepting referrals via rotation.
5. accept the transfer of any child without regard to the reason for eligibility or services listed on the current IFSP while the program is accepting referrals via rotation.
 - a. When accepting a referral or transfer of a child living outside their catchment area with approval of the Birth to Three administration, the program agrees to provide all services identified on the IFSP including transition activities without any additional compensation from the CT Birth to Three System or the family.
 - b. When no contracted Birth to Three programs serving a particular town are accepting new referrals or transfers, CDI will send new referrals to each contractor serving that town on a rotation basis and the contractor agrees to accept those referrals.
6. contact assigned families within one business day by telephone or by mail to:
 - a. introduce themselves
 - b. confirm the SPELLING OF THE NAME, complete home address, name and birthdate of the child, GENDER and other referral information
 - c. update any new or changed information in the data system
 - d. schedule the first visit
7. retain evaluation information for six years (see Records procedure). If a child will be evaluated by another provider, the program that completed the first evaluation may be asked to send the information, or a copy of it, to the second program.

For a child found **ineligible** for the Birth to Three System, offer the family the option of enrolling their child in the Ages and Stages (ASQ) Developmental Monitoring Program available through CDI/Help Me Grow. ASQ will help to monitor a child's development over time and can trigger a re-referral if concerns are identified. The service coordinator should explain the process and support the parent's enrollment:

- online at <http://cdi.211ct.org/program/ages-and-stages/> or
- obtain the parent's written consent to participate using the Help Me Grow/ASQ brochure or enrollment form.

After the consent form is completed, the service coordinator can mail or fax it to CDI. Questionnaires are available in English and Spanish. ASQ enrollment should be done within one week of determining the child not eligible.

The following Addendum includes the letters that CDI sends out to families and referral sources.

Addendum 1: Intake Letter

1-800-505-7000
<http://www.birth23.org>



Dear Parent,

Thank you for talking with us about _____. The program listed below will call you to schedule a visit for an evaluation.

Name of Program
Address
Phone Number
Contact Person

Please take a moment to read, "Welcome to The Connecticut Birth to Three System!". It contains information about Birth to Three and what to expect at your evaluation. We have also included a list of programs that serve your town and resources for your family. If you have any questions, please feel free to call us at 1-800-505-7000.

Sincerely,

Birth to Three Intake Staff

Child Development Infoline
United Way of Connecticut
1344 Silas Deane Highway Rocky Hill, CT 06067

Addendum 2: Intake Referral Source Letter

1-800-505-7000
<http://www.birth23.org>



Dear _____:

Thank you for your recent referral to the Birth to Three System for
_____. DOB _____. This referral was
forwarded to the following program on _____ for determination of
eligibility and / or service needs:

Name of Program
Address
Phone Number
Contact Name

If you have questions or would like general information regarding the Birth to Three System, please feel free to call us at 1-800-505-7000.

Sincerely,

Birth to Three Intake Staff

Child Development Infoline
United Way of Connecticut
1344 Silas Deane Highway Rocky Hill, CT 06067

Addendum 3: Referral No Contact Letter

1-800-505-7000
<http://www.birthe23.org>



Dear _____:

Your child, _____, was referred to the Birth to Three System by _____ for an evaluation of his/her growth and development.

We have been trying to reach you to explain in more detail the Birth to Three system, so you can decide if you would like your child to be evaluated. Please call us at 1-800-505-7000.

Until we hear from you, no further action will be taken on this referral. We will notify _____ that we have been unable to reach you to complete the referral process.

We hope to hear from you soon. Your call to Child Development Infoline is free and completely confidential.

Thank you.

Sincerely ,

Child Development InfoLine Staff

Child Development Infoline
United Way of Connecticut
1344 Silas Deane Highway Rocky Hill, CT 06067

Addendum 4: No contact Referral Letter

1-800-505-7000
<http://www.birthe23.org>



Dear _____,

Thank you for your recent referral to the Birth to Three System for:

Child: _____ DOB: _____

_____ We do not have sufficient information to process this referral. Please call us with complete information.

_____ The family never responded to our multiple attempts to contact them. Unless we hear from the family, the case will be closed.

_____ When the family was contacted, they indicated they were moving out of state

_____ The family was contacted and indicated they were not interested in our services at this time

_____ The family was contacted and indicated they were not interested in a Birth to Three evaluation at this time. However, they expressed interest in participating in the Ages and Stages Child Monitoring Program (ASQ) and a consent form to enroll in ASQ was mailed to the family.

_____ When we spoke to the family, it appeared that the child was doing well. Since Birth to Three is for children with significant delays, other information/services were offered that better match the child's needs and abilities.

_____ The child's third birthday is within 45 calendar days of this referral, therefore the parent was given information on how to refer their child for preschool special education from their local school district

_____ Other _____

Sincerely,

Child Development Infoline Staff

Child Development Infoline
United Way of Connecticut
1344 Silas Deane Highway Rocky Hill, CT 06067

Addendum 5: Ages and Stages letter

Date

Parent Name

Address

Re: Child's Name

Dear

Welcome to the Ages & Stages (ASQ) Child Monitoring Program, a free service provided by Help Me Grow through Child Development Infoline. Your child's first 5 years are important and we want to help you provide the best start for your child's future development. To assist with this, we offer the Ages & Stages Questionnaire, Third Edition (ASQ-3) to help you keep track of your child's development by asking questions about some things your child can and cannot do.

Your child's age (or developmental age, if born prematurely, up until 24 months) will determine when you will receive the first questionnaire.

ASQ questionnaires are available at 2, 4, 8, 12, 16, 20, 24, 27, 30, 33, 36, 42, 48, 54 and 60 months of age. You will receive questionnaires until your child's fifth birthday.

Thank you for enrolling your child in the Ages & Stages Child Monitoring Program. If you have any questions, contact Help Me Grow / Child Development Infoline at 1-800-505-7000 or email us at CDI.ASQ.INFO@ctunitedway.org.

We look forward to your participation.

Sincerely,

Child Development Infoline Staff United Way of CT 1344 Silas Deane Highway Rocky Hill, CT 06067
<https://cdi.211ct.org/>

The Ages & Stages Child Monitoring Program is a service of Help Me Grow, a program of the Connecticut Office of Early Childhood

Title: CHILDREN SUPPORTED BY THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)

Purpose: *Some children enrolled in the Birth to Three System are living in DCF foster homes and require the service coordinator to have knowledge of their legal status.*

The mission of DCF is to protect children, strengthen families, and help young people reach their fullest potential. When family relationships become abusive and/or neglectful and children are no longer safe, DCF steps in. While DCF strives to strengthen and support the family relationships, if the safety of the child cannot be guaranteed in the family, DCF removes the child. DCF will make efforts to find a relative known to the child who could serve as a temporary caretaker. In many situations, however, no relative is immediately available or none are appropriate. At this point, arrangements are made for the child to be placed with an unrelated foster family.

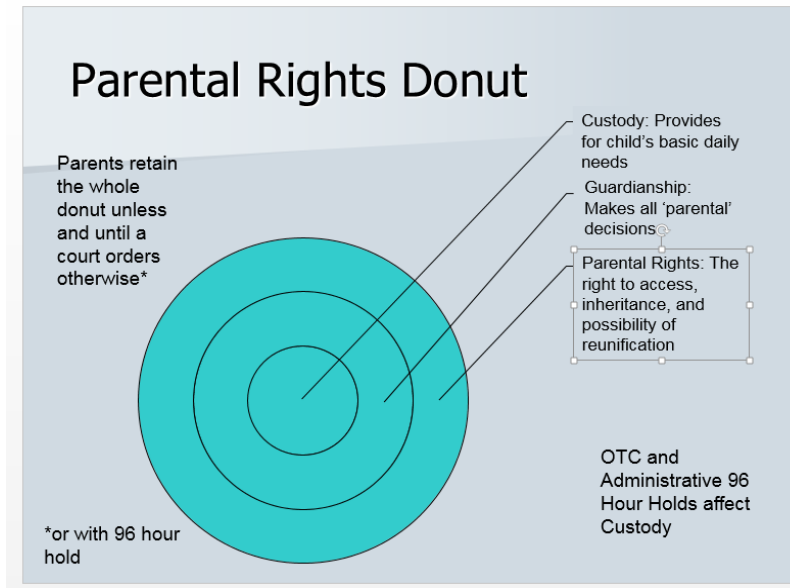
IDEA Definition of Parent

When a child is referred to the Birth to Three System, the service coordinator is responsible for ensuring that there is a person who meets the definition of parent to represent the child's interest. Section 602.23 of the IDEA defines parent as (A) a natural, adoptive, or foster parent of a child (unless a foster parent is prohibited by State law from serving as a parent); (B) a guardian (but not the State if the child is a ward of the State); (C) an individual acting in the place of a natural 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 (D) an individual assigned under either of those sections to be a surrogate parent. Under this definition if a child is placed in a foster home the foster parent acts in the role of the parent to sign for developmental evaluations and assessment and the IFSP.

The service coordinator as part of an evaluation team or IFSP team must determine who meets the IDEA definition of parent above using all information available at the time of the EIS being provided. This determination may change as new information becomes available and should be documented in the record. All children in foster care are under the guardianship of DCF. There are occasional exceptions for example when children are placed in foster care under an order of temporary care (OTC), or there is a 96 hour hold. Service Coordinators with questions about the guardianship of a child should reach out to DCF for clarification. DCF, as guardian of children in foster care, signs for release of medical records. An individual that meets the IDEA definition of parent may sign the *Insurance Information Collection and Consent to Release Information Form* (1-3) as part of completing it. However, a signature of consent is not officially required as consent is part of enrollment into Medicaid. Confirmation about guardianship status is the responsibility of the Birth to Three program. For initial evaluations the person who meets the IDEA definition of "parent" is able to consent to the evaluation. In the extremely rare exception that a child is not living with someone

who fits the definition of parent (or a foster parent is unwilling to serve in the role of parent) the Birth to Three System will appoint a surrogate parent.

**Parental Rights (Outside of IDEA)
within CT Department of Children and Families (DCF)**



Source: CT DCF

DCF is responsible for the legal paperwork that outlines the type of custodianship/guardianship of a child they are involved with.

Types of Legal Status of Children Placed in DCF Licensed Homes:

a. 96-Hour Hold

A 96-hour occurs when DCF or a hospital exercises the responsibility and authority, without court involvement, to take immediate temporary custody of the child. The parent remains the legal guardian. Therefore, the parents have the right to make medical and other types of decisions for the child. However, during a 96 hour hold, DCF shall provide the child with all necessary care, including medical care, which may include an examination by a physician or mental health professional with or without the consent of the child's parents, guardian or other person responsible for the child's care, provided reasonable attempts have been made to obtain consent of the child's parents or guardian or other person responsible for the care of such child. If it is determined that the child should remain in care beyond 96 hours, DCF must file a motion for an Order of Temporary Custody with Juvenile Court.

b. Order of Temporary Custody (OTC)

An Order of Temporary Custody (OTC) occurs when the juvenile court makes a decision to assign immediate care and custody of the child to the Commissioner of the Department of Children and Families. DCF or

another suitable agency or person has custody of the child. However, the parent remains the legal guardian.

c. Commitment

This occurs after the juvenile court has determined that a child has been abused, neglected or is uncared for. The court places the child under the guardianship of the Commissioner of DCF until commitment is revoked by the court. DCF has authority to make all decisions for the child, although parents are consulted when appropriate. The commitment is reviewed at least annually.

d. Termination of Parental Rights

This occurs when the parental rights of the child's parents have been terminated. Juvenile court generally appoints DCF as the statutory parent. The parents whose rights have been terminated have 20 days to appeal the decision. The child is legally free for adoption after the appeal period or until the appeal has been concluded by the court, and may be considered for adoption. DCF has authority over all decisions and parents have no rights nor are they consulted about decisions.

e. Voluntary Placement

DCF does not have guardianship. This occurs when the birth parent/guardian gives permission for the out-of-home placement of the child and they are given the name and address of the person with whom the child is living. During the 90-day maximum voluntary placement, the parent(s) retain rights and responsibilities to and for the child, including authorization of medical care, educational placements, consent to marriage, enlistment in armed forces, baptism, and other legal decisions. DCF may authorize necessary medical care if the parent(s) cannot be reached but may not authorize any procedures requiring anesthesia. At any time during the 90 days, the parent(s) have the right to the return of the child. If returning home places, the child in immediate physical danger, DCF will take appropriate legal action.

(From DCF/CT Foster Adoption Manual Chapter 5-
<https://portal.ct.gov/DCF/CTFosterAdopt/Manual/Chapter5#96-HourHold>)

Sharing Information with DCF

In 2013, the Uninterrupted Scholars Act (USA) (Public Law 112-278), was signed into law which amends Section 444 of the General Education Provisions Act (20 U.S.C. § 1232g) (commonly known as the Family Educational Rights and Privacy Act (FERPA). FERPA to permit educational agencies and institutions to disclose a student's education records, without parental consent, to a caseworker or other representative of a State or local child welfare agency or tribal organization authorized to access a student's case

plan "when such agency or organization is legally responsible, in accordance with State or tribal law, for the care and protection of the student.

The table below shows the requirements for sharing information with DCF and the role of the foster parent or surrogate parent.

Status of Child	DCF Roles and Responsibilities	B23 Roles and Responsibilities	Bio Parent Roles and Responsibilities	Foster Parent Roles and Responsibilities
Order of Temporary Custody- Child is in foster care	Responsible for the care of the child including the provision of routine and necessary health care. No consent is required as based on the MOU between the OEC and DCF, DCF is a participating agency (34 CFR § 303.414(a)(1) and (b))	Release records requested by DCF. Form 1-3 needs to be completed but no signature is required	The biological parents retain rights to be involved, receive PWN and participate in EIS	Foster parents typically meet the definition of Parent and can sign all Part C documents If as "a" parent under IDEA they consent to EIS, then EIS may be provided even if the bio parent does not consent.
Committed- Child is in foster care	Responsible for decisions regarding medical and mental health treatment. DCF will request records directly from EIS programs.	Release records requested by DCF. Form 1-3 needs to be completed but no signature is required	May not sign releases	Signs all releases but does not need to give consent to release information requested by DCF

Sharing information with Biological Parents/Foster Family

It is the goal of DCF to move children out of foster care quickly. In many cases this means reuniting children with their biological parents. For this reason, with the consent of the DCF case worker, the biological parent should be informed of the child's program and receive copies of reports. Again, with DCF consent, biological parents should be offered an opportunity to participate in Birth to Three visits. This can take place during a supervised visitation, regular visitation or at the foster home, with the consent of the foster parent. Occasionally a foster parent will be reluctant to have their identifying information shared with the biological parent. If this is the case, programs must redact

all identifying information of the foster parent from the file (name, address,) when sharing information with the biological parent.

Early intervention professionals should use information from multiple sources for an evaluation. This includes information from the biological parents (if possible), DCF, medical reports and the foster parents. It can be challenging evaluating a child when there are multiple viewpoints regarding a child's abilities. Early intervention professionals should carefully weigh all information and use their best clinical judgement in evaluating a child in foster care. Early intervention professionals must respect the confidential nature of information regarding children and their biological parents.

Types of Foster Placement

There are two types of foster placements: Core and Therapeutic Foster Care. It is important for service coordinators to know the difference so that they know if they are working with a DCF or DCF contracted social worker. If a child is placed in a therapeutic foster home, they may be working more with the agency social worker.

- Core - these are foster families that are identified and licensed by the department of children and families and are probably the ones providers will come across most frequently.
- Therapeutic Foster Care - these are foster homes that have been identified by other licensed child placing agencies. Therapeutic Foster placements are for youth with significant behavioral health needs, or complex medical needs. There is extensive training that goes into being a therapeutic foster home and the placing agency licenses the foster home in addition to them having to meet all DCF Core criteria. There is typically an agency worker that is attached in addition to the DCF social worker who carries the case.

Relocation or Exit of Children under the Guardianship of DCF

As written in the MOU between DCF and the OEC, a child's DCF social worker should notify a child's Birth to Three service coordinator or program director within one week when a child engaged in the referral, evaluation or service process is being relocated (DCF Policy 36-55-15) Because of the MOU, DCF is an IDEA participating agency and EI Programs may share PII without consent particularly for pending referrals.

For children involved with DCF, the Birth to Three program shall ensure:

1. That the DCF social worker is notified within one week when there is a change in the child's Birth to Three service coordinator and
2. That the DCF social worker is notified at least one week before a determination has been made to exit a child, including the reason for the exit.

For all other children being served by DCF, the Birth to Three program shall ensure that with parent permission, information is released to the child's DCF Social Worker when a

determination has been made by either the parent or the Birth to Three System to exit a child, including the reason for exit.

DCF and Transition to Public School

When a child approaches 24 months of age the service coordinator should obtain written consent from the foster parent or Birth to Three surrogate parent, if one was assigned, to make a referral to the local public school district by completing Form 3-8, Approval to Include my Local School District in Transition Planning. At the latest, Form 3-8 must be completed by the child's age of 2 years, 6 months.

When referring a child for preschool special education, the service coordinator must be sure that the school district for the correct nexus town is notified and receives the referral. If there are questions about a child's nexus, programs should contact the child's DCF case worker or the Educational Liaison at the DCF office for that child. Best practice is to obtain a release to notify school district personnel in both the town of nexus and the town where the child resides when referring a child for preschool special education.

If during the process of evaluation for special education, DCF relocates the child, the service coordinator should notify the DCF worker that DCF needs to make arrangements with the LEA conducting the evaluation to transport the child in order to complete the evaluation.

The CT State Dept. of Education (SDE) will appoint a surrogate parent to represent the child in the special education system under Part B of the IDEA. The service coordinator should notify the responsible LEA upon referral to the school district that the child is followed by DCF by checking the appropriate area on Form 3-8. The school district should request a current copy of DCF Form 603, *Notification to LEA of a DCF Placement* from the DCF case worker.

Until the State Department of Education appoints a surrogate parent to represent the child in the special education system, a child's foster parent or Birth to Three surrogate parent, if assigned, is authorized to grant consent for evaluations necessary to determine eligibility for preschool special education. A Birth to Three surrogate parent may be invited to the Planning and Placement Team (PPT) meeting to determine eligibility as someone who knows the child however, the SDE appointed surrogate parent is the only one acting in a parental role for the child at this meeting.

After the child is three years of age, the person appointed by the Birth to Three System will no longer function as the child's surrogate parent unless the State Department of Education (SDE) has officially appointed them. If the child is found eligible for preschool special education, an SDE surrogate (requested by the school district) must sign consent for initial placement and the IEP services.

Once Form 3-8 has been signed or the child has reached the age of three, the surrogate parent appointed by SDE has statutory authority to receive all records related to the child and may request them from the Birth to Three program. This may be in addition to records that may have already been sent to the Local Education Agency or school district. The SDE surrogate should sign a release (Form 3-3) for all requested documents. The Birth to Three Service Coordinator or program must also request proof from the SDE Surrogate that they have been officially appointed by SDE, this would be in the form of written notice of appointment of the surrogate from SDE.

Determining the Responsible LEA for a Child in Placement

An infant or toddler living in a foster home who requires preschool special education at age three remains the educational responsibility of the town in which the child's biological parent(s) live, unless parental rights have been terminated. That town is often referred to as the child's "nexus LEA." If the parents live in separate towns, it is the town in which the child would most likely live, if he or she were not living in a foster home. Usually, this is the parent that is most actively involved with the child.

If the child's parents are deceased, or if the whereabouts of the child's parents are unknown or not within the State of Connecticut or if both parents are incarcerated or parental rights have been terminated and the child has no legal guardian other than DCF, then the child is considered to have "no nexus" and it is the town in which the child lives that is responsible for his or her education at age three.

Birth to Three Surrogate Parents

A child requires a surrogate parent if he does not live with anyone who meets the IDEA definition of "parent" and the child is under the guardianship of the Commissioner of the Department of Children and Families or the whereabouts of the parent(s) is unknown. This is a very rare occurrence. Programs should contact Birth to Three lead agency if they have questions about appointing a surrogate parent

Child Development Infoline staff begins the conversation of guardianship with the DCF staff person or foster parent who makes the referral.

Role of Birth to Three Surrogate

In the rare circumstances when a Birth to Three Surrogate is appointed, the role of that surrogate parent is to serve in place of the child's parent as the child's advocate for early intervention decisions affecting the child. Early intervention decisions include identification, evaluation, placement, development and periodic reviews of the Individualized Family Service Plan (IFSP) and due process procedures. A surrogate parent has access to all early intervention records concerning the child and due process rights. Surrogate parents do not have the authority to request or release medical information or insurance related forms.

A surrogate parent will be asked to be present at and participate in the IFSP meeting. They will be asked for their input into the development of the IFSP. They will also be asked to sign the IFSP, consent forms for evaluations, releases of information, referral to the local public school, and consent for initial evaluation by the school district. They may not sign permission for release nor have access to a child's medical records. The DCF case worker signs for release of medical records.

Appointing a Birth to Three Surrogate Parent

When the appointment of a surrogate is necessary, the service coordinator will request from the DCF case worker a copy of DCF Form 603, *Notification to LEA of a DCF Placement* and send this along with a completed Form 3-10, Request for Surrogate Parent, to the Family Liaison. If the request is because the parent's whereabouts are unknown, the DCF case worker may write a letter or supply other documentation in lieu of a Form 603. The Family Liaison will review the request and DCF Form 603 or other documentation sent and appoint a person to act as the surrogate parent. The Family Liaison or a Birth to Three administrator in her absence will sign Form 3-10 and send the form to the Birth to Three program along with the contact information for the appointed surrogate parent. The Birth to Three Program will send a copy to the child's DCF staff person.

Since no child may be evaluated until there is a parent, legal guardian, person in a parental relationship, or surrogate parent to consent for the evaluation, a surrogate parent must be appointed prior to initial evaluation.

Title: LOBBYING

Purpose: *To clarify for programs the restrictions on lobbying at both the Federal and State levels.*

Overview

Births to Three programs are not permitted to use federal funding to influence employees of federal agencies or members of Congress or their employees. At the state level, Birth to Three program staff may participate in committees or task forces convened by the Lead Agency or on statutorily mandated committees or councils without such participation being viewed as lobbying. However, if program staff engage in any form of attempted influence of a state agency or a member of the General Assembly that person must register with Connecticut's Office of State Ethics as a lobbyist.

Lobbying at the Federal Level

The Birth to Three System and Birth to Three programs may not use federal Birth to Three funds to pay any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any federal action. As an example, this would include funding (with Part C dollars) the travel of a provider, parent, or ICC member to a national conference in Washington D.C., during which the individual takes the opportunity to look up a member of their state delegation to argue for increased funding for Part C.

A program is subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for lobbying with federal funds.

Lobbying at the State Level

If a provider is appointed to a statutorily mandated council, committee, or task force (e.g. State ICC or Local ICCs), the provider's staff participation is not considered lobbying. In addition, the Lead Agency may invite a provider to participate in any informal policy-making committee, task force, work group, or other ad hoc committee established by the department and such participation would not be considered to be lobbying.

However, an individual provider or organization who either expends or agrees to expend, or receives or agrees to receive, \$2,000 or more in a calendar year, including the pro-rated value of a salary, to communicate directly or to solicit others to communicate with any public official or their staff in the legislative or executive branch, or in a quasi-public agency, in an effort to influence legislative or administrative action is a lobbyist and must register with the Office of State Ethics.

Normal interactions between a Birth to Three program and the Lead Agency regarding a contract are not considered lobbying. If, however, a program seeks to circumvent the usual process by asking a member of the Connecticut General Assembly or the Governor's office to intervene, or if the program seeks intervention from an employee of the Lead Agency outside of the normal contract process, then that activity is considered administrative lobbying and the \$2000 threshold would apply. For example, this would include having service coordinators distributing flyers urging parents to contact members of the Appropriations Committee to increase funding for the Birth to Three System. If the aggregate cost of the service coordinator's time and the cost of the flyers exceeded \$2000, then the program staff would need to register as lobbyists.

The Office of State Ethics investigates alleged violations of Connecticut's lobbying requirements. Any person who intentionally violates any provision of the Code of Ethics for Lobbyists in Chapter 10, Part II of the Connecticut General Statutes "shall be imprisoned for a term not to exceed one year or shall be fined an amount not to exceed two thousand dollars, or both."

References:

Federal Part C Application: "Certification Regarding Lobbying"

U.S. Department of Education General Administrative Regulations §82.100
1-91 of the C.G.S.

1-101aa(a) and (b) of the C.G.S.

State Ethics Commission Advisory Opinion No. 99-16

Title: Representing and Marketing of the CT Birth to Three System

Purpose: *Describes the standards required for all presentations, promotional activities, Child Find, products and events produced by a Birth to Three program or representing the Birth to Three system.*

Overview

Most presentations, promotional activities, and events are related to “Child Find”. Child Find is a required component for the lead agency of an early intervention system under the Individuals with Disabilities Education Act, Part C. Regulations state that system must include, “a comprehensive child find system” with the purpose of identifying, locating, and evaluating all infants and toddlers with disabilities birth to age three as early as possible. The Connecticut Birth to Three System under the Office of Early Childhood is supportive of constructive activities to promote the availability of early intervention according to these principles. Because no single message or advertiser could possibly reach all potential referral sources, the Birth to Three System relies upon a comprehensive network of Child Find marketing partners. This specifically includes our Birth to Three programs, other state and federal agencies, community programs, medical providers, and others.

Contracted Birth to Three programs must adhere to a goal of enhancing the overall reputation of the Birth to Three System and this set of criteria when developing and implementing any presentation, advertisement or promotional activity across all events, products and media.

Adherence to these criteria below when sharing any information about a provider or the Birth to Three System as a whole will help ensure adherence to “Child Find”, positive community understanding of referral practices, and early intervention supports.

Presentations

Formal presentations are considered a formal speech or talk to an audience that is planned such as a conference, or medical office visit. The Lead Agency may request or a program may be requested to engage in a presentation to support the identification of infants and toddlers who may be eligible for early intervention. Informal presentations are spontaneous conversations that do not follow a planned format. Both formal and informal presentations for Child Find purposes and other reasons that share information about the Birth to Three system must comply with all Birth to Three laws, regulations, policies and procedures.

For Child Find activity counts, the Lead Agency must be made aware of all formal presentations using ctbirth23@ct.gov and sharing the following: name of program, staff name and discipline presenting, topics discussed, date of presentation, length of presentation, and who the presentation was made to and the audience. Providers are

responsible for retaining all formal presentations as they may be requested and reviewed by the Lead Agency at any time.

Forms, Documents & Electronic Media

All Birth to Three forms, documents and electronic media that are designed, shared, distributed, or published items generated by the Lead Agency are official documents. These cannot be altered, edited or added to without the written permission of the Lead Agency with the exception of completing the required fields. For example, filling in your program's name.

Forms, documents and electronic media that are created by the provider or other entity outside of the Lead Agency may be used to supplement the Birth to Three's Systems materials. These items must meet the content standards listed below in this procedure, and not in any way conflict with the Lead Agency's official items, procedures or regulations. They also need state clearly, who generated the document.

Marketing Materials: Brochures, Handouts & Promotional Items

Marketing for Child Find

The Lead Agency has a limited supply of marketing materials such as slides, brochures and handouts representing the Birth to Three System and the Office of Early Childhood. These can be requested using ctbirth23@ct.gov. Child Development Infoline and the Connecticut Parent Advocacy Center (CPAC) also have materials that may be requested by contacting them directly.

Upon request, many child development and related agencies supply brochures and promotional information. For example, the Center for Disease Control (CDC), Help Me Grow network, and the US Department of Education often provide materials at low or no cost.

Other Marketing

Providers may need to provide information about their program or agency for a purpose other than child find such as fundraising or promotional events. When marketing for a reason other than child find a provider must follow the content guidance below.

Surveys

The Birth to Three System is required by the US Dept. of Education (OSEP) to complete an annual family survey. This is initiated and produced by the Lead Agency. Programs are responsible for supporting the agency in the sharing, distribution and collecting of the survey and responses. This survey is typically distributed in March through June.

Programs are able to have families complete agency surveys as long as the information collected and the timing of collection do not interfere with the Lead Agency's Family

Survey. These surveys must also state clearly who is requesting the information, for what purpose, and how it is going to be used.

Content

Must be Included in a Child Find Message

1. The toll-free intake phone number at Child Development Infoline (1-800-505-7000)
2. The Birth to Three System web address (www.birth23.org)
3. Any on-line promotion that mentions Birth to Three or early intervention must include a link to the Birth to Three website (www.birth23.org).
4. An agency web address is allowed if it includes a link to the Birth to Three-website page for early intervention referrals.
5. Some information about what supports in Birth to Three look like including basic information on best practices of Natural Learning Environment Practices, Coaching, and Primary Provider/Teaming.

Not to be included in in a Child Find Message

6. No instruction to “call and ask for our program”. Telling a referral source to choose a specific program both undermines the integrity of parent choice and omits the information that other choices are available. No overt or implied disparaging remarks about another Birth to Three program. This is unprofessional and reflects negatively on the entire system.
 - a. No statement or implication that one program is the best
 - b. No statement or implication that one program is the only high quality provider agency
7. No portrayal of Birth to Three as a “place”. Including an agency address that may suggest that supports are provided in a specific location, (i.e., the office).
8. No portrayal of Birth to Three as a way to “get therapy”.
9. No statement that a program provides any particular amount or type of service.
10. No names of State of Connecticut officials or the State of Connecticut Seal may be used unless written authorization from the Secretary of the Office of Policy and Management has been obtained.

May be Included in the Message

1. The CT Birth to Three System logo may be used to indicate that the agency is an approved provider. If so, it must be the complete logo, i.e. three babies plus the System name (not the babies alone) in the correct proportions.
2. An agency logo may be used alongside, or to the exclusion of, the CT Birth to Three System logo.
3. A description of staff qualifications is allowed, but should not be portrayed as a promise that a certain type of professional will work with a child. Staffing decisions and choices of service type and intensity are only made during IFSP development by the IFSP team-
4. A description of Birth to Three (e.g., “Helping families and their infants and toddlers who have significant developmental delays or disabilities”),
5. A description of the referral process, (e.g., “You will be asked for information about the child and family and the specific nature of your developmental

concerns about the child”). Any of the official Birth to Three publications (e.g., the family handbooks) can be checked for suggested wording of information to include.

A review of the advertisement, promotional message, broadcast, form, or presentation may be requested via e-mail ctbirth23@ct.org to the Lead Agency before use.

References:

[34 CFR Section 303.301 and 303.302](#)

[Section 17a-248-2 of the Regulations of the State of CT](#)

Title: PAYMENTS TO PROGRAMS

Purpose: *To provide financial support to programs providing Birth to Three services within available appropriations and in accordance with CMS SPA 17-0019.*

Overview: Agencies that contract with the Office of Early Childhood (OEC) to provide Early Intervention Services (EIS) will enter child and service information into the Birth to Three Data System. This information will be transmitted to a third party billing contractor, herein known as the central billing office (CBO), who will create claims on behalf of EIS Programs and will submit the claims electronically to payers including Medicaid and commercial insurance plans. Payments from these claims will be made to EIS Programs directly from Medicaid and commercial insurance plans. The lead agency will pay EIS programs monthly for the unpaid balances of non-workable insurance claims and certain additional EI services and activities, these authorized services are defined below. Providers are prohibited from seeking payment for EI services from the parent. Providers are also prohibited from billing Medicaid and commercial insurance directly for services the OEC has required to be submitted by the CBO.

A glossary and acronym list is located at the end of this procedure.

ENROLLMENT

As billing providers, EIS programs are required to bill third party insurance through the CBO, including commercial insurance and Medicaid prior to seeking funds from the lead agency. All agencies must enroll with the commercial insurance clearinghouse used by the CBO and with the Connecticut Medical Assistance Program (CMAP) to receive payment for services.

National Provider Identifier (NPI) numbers

A separate and distinct NPI is required for agencies with lines of business other than EI. These are obtained at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. The EI NPI must match the NPI used to enroll in Medicaid and is associated with the billing contractor's records.

Commercial Insurance

Commercial Insurance Electronic Data Interchange (EDI) transactions require EIS programs to enroll with the clearinghouse used by the CBO, so that the CBO may submit claims by electronic means through the clearinghouse on behalf of the EIS programs. Additionally, EIS programs must enroll with each commercial payer to allow payers to accept electronic claims, known as 837s, from the CBO's clearinghouse and send insurance remittance data electronically in a HIPAA-compliant 835 format to the CBO.

Once a provider is enrolled, claims submitted by the CBO will be paid directly to the EIS Program. The CBO will track the payments and claims decisions through receipt of the Electronic Remittance Advice (ERA) file called an 835. 835s are received by the CBO only and are visible via the CBO's billing portal. Programs will be able to determine the

decision on claims through reports and queues available as the data is updated in real time. The CBO only receives the 835s for the EI line of business for those that have multiple lines of business.

Medicaid

Providers must enroll with CMAP to receive payment for services to allow the CBO to submit 837 and receive 835s. Once a provider is enrolled, claims submitted by the CBO will be paid directly to the EIS Program. The CBO will track the payments and claims decisions through receipt of the 835. 835s are received by the CBO only and are visible via the CBO's billing portal. Programs will be able to determine the decision on claims through reports and queues available as the data is updated in real time. The CBO only receives the 835s for the EI line of business for those that have multiple lines of business.

GENERAL PROCESS FLOW

The timing of this process depends on the payer. Medicaid pays clean claims every two weeks. Commercial plans vary. The lead agency will issue payments monthly. The faster accurate insurance and service data is entered in the Birth to Three data system and the faster workable claims are managed, the faster payments will be paid or adjudicated to non-workable status and paid by the lead agency.

ORDER OF PAYMENT

Commercial Insurance

It is very important for EIS programs to obtain and maintain the most recent and accurate insurance information for each family. The lead agency will not bill self-funded plans or plans linked to a Health Spending/Savings Account (HSA) without parent consent. EIS programs must confirm with families regarding the type of insurance plan they have. As needed the CBO will contact families when the program no longer is in contact with them.

The CBO will submit an eligibility request file (a.k.a. 270) to the commercial payer prior to submitting a claim. If the eligibility response (a.k.a. 271) file is received with an adverse response and the response is workable, meaning additional or corrected information is needed, the EIS Program will be required to contact the family to obtain corrected insurance or HRA/ HSA information. The HRA/HSA billing consent form has an end date so families who want to spend down their accounts until 12/31 of a year can do so.

All claims data is available on the CBO EI Billing portal. Once eligibility is determined, a claim is submitted and a response is received, EIS Programs are required to utilize data provided in the CBO Early Intervention billing and claiming system to address workable denials or rejections. Claims will not move to the next payer when issues are workable per the Adjudication Matrix (Appendix 1) and remain unresolved. Data for claims must be correct and within required timelines for timely filing. Timeliness can be a program requirement (e.g., lead agency requires EIS Programs to get their attendance in the Birth to Three data system for monthly FCP fees within 15 calendar days of the event)

or an insurer's specific requirement. The CBO will work with EI programs to assure they are taking action on claims which must be resubmitted to insurers. If the claim has an issue that will lead to CBO assistance such as, correcting CPT/HCPCS, then the CBO will work the claim within a couple of days and resubmit it to the insurer.

If it is determined that a program has not put services in the Birth to Three data system or the correct insurance information wasn't obtained and the claim is not timely with a commercial insurer, then it will not get paid and it will NOT move to the next payer. The CBO has internal controls to determine if programs do not seem to be working their queues and will reach out to determine if more training is required.

The CBO will bill the Usual and Customary rates, as received by SPIDER, on behalf of EIS programs. In the event providers do not have usual and customary rates established, they will submit the provider rate at 200% of the State EI service rate. If it is determined to be advantageous to the system, EIS programs will be required to enroll with commercial payers and secure in-network status.

For any mandated private insurance coverage, the plan will be billed for early intervention services and only consent to share personally identifiable information (PII) with the CBO and plan is needed from the parent (Form 1-3). Actual consent to bill insurance and share PII is required for non-mandated plans and to bill Health Savings Accounts (HSA). (Form 1-3a and Form 1-3_HSA)

Medicaid

As with Commercial Insurance plans, it is important for EIS Programs to obtain and maintain the most recent and accurate Medicaid eligibility information for each child on their caseload.

The CBO will submit a 270 eligibility request file to Medicaid prior to submitting a claim. If the 271 eligibility response file is received with an adverse response and the response is workable, the EIS Program will be required to obtain corrected Medicaid eligibility information.

The CMAP requires contracted Birth to Three Providers to enroll as a Medicaid "Special Services" (provider type 12) and "Birth to Three Billing Provider" (Specialty 583). Enrollment with Medicaid can be completed through the DSS website, www.ctdssmap.com and select "Provider Enrollment." After completing enrollment, a provider will receive an Application Tracking Number (ATN) to track the status of their enrollment. Once successfully enrolled the Provider will receive a Provider Enrollment Approval Notice, AVRS ID and initial password.

When a child is enrolled in the Medicaid Program, parent consent has already been provided to bill. If the family has both private insurance and Medicaid coverage for the child, claims for payment of early intervention services will first be billed to private insurance and only the remaining balance will be billed to Medicaid for payment. Medicaid pays claims up to the fee schedule amount.

If the Medicaid response is received and it is determined to be a workable denial or rejection, the EIS program is required to use the information available in the CBO Early Intervention billing and claiming system and on the ctdssmap.com secure site to address the claims. However changes should NOT be made on the ctdssmap.com site for claims submitted by the CBO. Claims will not move to the next payer when issues are workable per the Adjudication Matrix (Appendix 1) and remain unresolved. In some cases, workable denials or rejections will be addressed by the CBO but in other cases only the EI Program can resolve the issue.

Lead Agency Funds (a.k.a. Escrow Payments)

EIS programs will receive payment from lead agency funds (escrow) using the state Birth to Three rates for services that are partially reimbursed or denied by the insurer (subject to workable denials or rejections per the attached Adjudication Matrix (Appendix 1)).

QUALITY ASSURANCE/AUDIT PROCESS

EIS Programs will receive timely feedback and opportunity to correct deficiencies. If continued errors occur, resulting plans of action may include desk audits and on site fiscal audits.

The lead agency shall complete standard methodology and process for completing regular *post-payment* reviews of each program's claims. The post payment review process assists the lead agency to monitor and improve quality over time, and provides staff confidence in the application of Birth to Three regulations and policies.

- The goal of the lead agency, or its contractor, is to complete monthly qualitative reviews of a sample of adjudicated and paid claims. Claims will be reviewed using a standardized quality assurance review tool.
- The lead agency's review will include random sampling, focused sampling based upon service area and focused sampling based upon billing practices. As a practical matter, the sampling plan will also consider the amount of time that the accountability team has to dedicate to this activity – the purpose is not simply to add work but to identify and address strengths, risks and weaknesses in a systematic way.
- The results of this quality review will be provided in a written report by the lead agency, or its contractor. Deficiencies in the application of regulations or policies will be documented and voided claims and earned take-back provisions will be employed to ensure all claims activities are sound and true.

The lead agency's system of general supervision will include onsite fiscal audits and desk audits as related to track changes in behavior and to assure that programs are prepared for possible CMS audits. The lead agency will work with the QA division at DSS and programs to develop tools and the processes as described in the Accountability procedure.

BIRTH TO THREE SERVICES PAYMENT AND CRITERIA

The Birth to Three System works closely with CMAP to coordinate the billing and payment for services. Service maximums are per child not per program and will not reset if a child is transferred to another program. If the program notices in the available data systems that they are approaching the approved service limits as identified, authorization from the lead agency to exceed the limits must be approved prior to the service being delivered (See Prior Authorization below). In addition, any discovery of a misuse of units should be reported to the lead agency. Evaluations, Assessments, an IFSP meeting and EI services can occur on the same day if necessary.

Payment for Initial and Continuing Eligibility Evaluations

For the determination of specific activities which meet the criteria for an evaluation please refer to the draft State Plan Amendment 17-0019 and DSS regulations.

One unit equals one person regardless of length of the evaluation visit. Evaluations are required by IDEA to be multidisciplinary so billing for two professionals with the same discipline for an initial evaluation is not permitted. At times, it may be beneficial to the child to include a third practitioner on the evaluation team. The reason that this third person is required must be documented in the record and may be billed as a unit using the evaluation code. Programs can bill up to 4 units per year without prior authorization (PA). If four people completed the initial evaluation, that would use up all evaluation units for the year. Any additional units would need PA. Prior Authorization for more than 4 units per year is only for OEC Escrow payments as Medicaid will not cover any units over the annual limit.

If the evaluation cannot be completed by 2 practitioners in the same day, treat this as 2 separate service delivery items.

If the initial evaluation is completed more than 45 days from referral the program will not be reimbursed unless it is delayed based on documented family circumstances and the indicator in the Birth to Three data system attesting to this is marked.

After the initial evaluation, evaluations may be completed annually to determine a child's continuing eligibility without the use of a standardized test. Children continue to be eligible until they are age appropriate in all areas. Please refer to the Evaluation and Assessment procedures for more guidance about evaluation vs. assessment.

Payment for Assessments

For the determination of specific activities which meet the criteria for an assessment please refer to the draft State Plan Amendment 17-0019.

One (1) unit is equal to 15 minutes therefore an assessment greater than 7 minutes rounds up to 15 minutes (1 unit) and an assessment greater than 22 minutes rounds up to 30 minutes (2 units). Programs may bill up to 32 units per calendar year per child without prior authorization. Prior Authorization for more than 32 units per year is only for OEC Escrow payments as Medicaid will not cover any units over the annual

limit. When it is determined that there is a need to exceed the limit of 16 units per day, a prior authorization request must be submitted (see Prior Authorization section below). Assessments should not be scheduled without first determining whether prior authorization is needed. Billable assessments are those that result in a written report. A completed Child Outcome Summary (COS) form is not considered a report and may not be billed as an assessment.

Initial assessments are required by IDEA to be multidisciplinary so billing for two professionals with the same discipline for an initial assessment is not permitted.

Payment for IFSP Meetings (develop, review and revise forms as needed)

For the determination of specific activities which meet the criteria for an IFSP meeting please refer to the draft State Plan Amendment 17-0019.

There must be written prior notice to the family documented for every IFSP meeting. IFSP meetings include interim/initial meetings, periodic reviews and re-writing the IFSP annually. There must be evidence on the IFSP that the team reviewed the plan. A licensed practitioner (see Birth to Three Personnel Standards) must sign the IFSP but is not required to deliver IFSP services or be at the meeting. The child is not required to be present since the IFSP is developed in collaboration with the child's caregivers.

One (1) unit is equal to 15 minutes therefore an IFSP meeting greater than 7 minutes rounds up to 15 minutes (1 unit) and an IFSP meeting greater than 22 minutes rounds up to 30 minutes (2 units). Programs may bill up to 40 units per calendar year per child without prior authorization. Prior Authorization for more than 40 units per year is only for OEC Escrow payments as Medicaid will not cover any units over the annual limit.

If the IFSP meeting cannot be completed in the same day, treat this as 2 separate service delivery items.

If the initial IFSP is completed more than 45 days from referral the program will not be reimbursed unless it is delayed based on documented family circumstances and the indicator in the Birth to Three data system attesting to this is marked.

IFSP meetings are required by IDEA to be multidisciplinary. To assist with transition from one interventionist to another, billing for two professionals with the same discipline for a periodic review may be permitted unless with prior approval to provide Remote Early Intervention. No IFSP planning may occur without the service coordinator and parent present. The Lead agency interprets applicable training for IFSP planning to mean that the person is licensed, certified or has completed Service Coordination training. See Remote EI Procedure for more details.

Visits to support the caregiver for the benefit of the child in planning for transition out of Birth to Three in any setting are considered an EI Treatment Service unless the

IFSP is modified. In that case, prior written notice must be provided and the program could bill for an IFSP meeting.

Payment for Early Intervention Treatment Services (EITS)

EI Treatment Services will be billed to commercial payers, Medicaid and the Birth to Three System as appropriate using HCPCS and CPT codes as assigned to the “What Will Happen” and “Delivered by” fields in the lead agency data system, as long as an identified caregiver is present. Modifiers will be used as appropriate for Commercial payers and Medicaid.

State EITS rates fall into two categories; professional and paraprofessional. How these billing categories are applied is included in the Birth to Three System Personnel Standards procedure.

The rates are further grouped based on the total amount of time EITS are provided in the day per practitioner. The total services per practitioner per day up to 1.5 hours (6 units) will be billed without a modifier at a higher rate. If more than six units are billed per practitioner per day, all the units in the day are paid using a modifier (TF) that results in a lower rate. The rates are not per discipline and only apply to EITS not Evaluations, Assessments or IFSP meetings.

One (1) unit is equal to 15 minutes therefore an EITS greater than 7 minutes rounds up to 15 minutes (1 unit) and an EITS greater than 22 minutes rounds up to 30 minutes (2 units). Programs can only bill for up to 32 units per day. There is no prior authorization or payment for more than 32 units of EITS per day. Joint visits, co-treats or team meetings with the family and up to two EI Practitioners may be billed as EI Visits unless the IFSP is reviewed in accordance with IDEA in which case it may be billed as an IFSP meeting (see above). Prior Authorization is required for any visits with more than two practitioners present at the same time. For more information about what is required, see the prior authorization section below.

A one-time consultation by a professional not listed on the IFSP may be reimbursed by the Birth to Three System as an EITS or as an assessment if written report is generated as a result of the visit. If the consultation is billed as an EITS, the visit note must clearly document the reason for the consultation. The start and end time for each practitioner must be recorded on the note. Two practitioners with the same or different disciplines may provide EITS together as long as the documentation of the reason for the joint visit is clear as well as how the two practitioners are bringing different skills or addressing different aspects of an activity.

Practitioners with disciplines listed on the IFSP team may cover for one another to address the outcomes on the IFSP as long as the services being provided are within the practitioner’s professional scope of practice. The rates used for billing are based on the discipline of the person providing the service and signing the visit note.

The state rates include travel related costs for EIS practitioners. The program that is billing for the Part C service that requires transportation is the one that is expected to

provide the transportation or reimbursement for transportation as defined in the Services Procedure.

OEC Prior Authorization (PA) Requirements

The Birth to Three data system in sync with the CBO will track the number of units billed per day and per year. Daily and annual maximums cannot be overridden with prior authorization (PA) for Medicaid reimbursement. Visits exceeding the maximums listed above must have PA for each claim that is over the maximum limit (per child per calendar year regardless of which EIS program provides the service). The information about total units used is available in the Birth to Three Data System.

Before providing any units of service over an annual or daily limit, programs must enter the following information using the Birth to Three data system:

- the child's Birth to Three number,
- the service (evaluation, assessment, IFSP) that needs PA
- the reason that the annual or daily maximum must be exceeded.

Prior Authorization for supporting families in towns not on the program's list of towns, for special circumstances regarding interpreter services, completing an evaluation within one month of a previous evaluation, or for visits with more than two practitioners at the same time is requested by emailing CTBirth23@ct.gov. The email must include the child's Birth to Three number and a detailed explanation of the reasons the PA is being requested.

The lead agency will respond within 3 business days. Appeals can be made by emailing the Part C Coordinator or her designee additional information for consideration who will respond within 2 days via email. The date that PA is approved is recorded and will be compared to the date the service is provided. The OEC will not pay for any services that require PA that occur before the PA approval date. All PA approvals must be included in a child's record. See Records Procedure for more information.

General Administrative Payments (GAP)

A GAP will be paid to programs for services such as team meetings without the family present that are not billable but are needed for high quality EI. The GAP will be paid for each child whose IFSP on the 1st of the billing month plans for fewer than 9 hours of service per month and as long as at least one billable service was provided and approved during the billing month. The lead agency will pay the GAPs monthly in arrears. The rate to be paid will be posted on the lead agency website. The count will be generated by the Birth to Three data system when the monthly invoice is processed. GAPs will not be paid retroactively based on data entry errors. Programs should correct the data before signing off their monthly invoice. Regular desk audits will be completed to assure that IFSP data is entered correctly. If it is identified that IFSPs or services were entered into the Birth to Three data system incorrectly and a payment was made in error, the associated GAP payments will be deducted from future payments. GAPs for children who transfer to another program are paid to the program with the IFSP on the 1st of the month if a service was provided and approved by the sending program before the transfer. Receiving programs will be paid the GAP

in the following month if a new IFSP was written on or before the 1st of the billing month. The GAP will also be paid when the only service on the IFSP is provided by BESB as long as there is at least EI visit from the service coordinator in the month.

Entering Billing Data

The Birth to Three data system is the system of record for any child, family, insurance, services data. Therefore, it is important that for program reporting, billing and claiming that the data entered is timely and accurate. The accuracy of data input results in greater amounts of paid claims and less time spent by program in researching and correcting incorrect data. Clean unpaid claims will move to the next payer 90 days after date the service was approved in the Birth to Three data system. Services approved in the Birth to Three data system after the monthly invoice is signed will not move to escrow. Acceptable reasons for missing this timely filing requirement include

- major illness lasting more than 5 days of a key staff person
- major weather event or power outage lasting more than 5 days
- the Birth to Three Data System is down for more than 5 days
- other major event resulting in a disruption of travel for more than 5 days

Requests for overriding the timely filing requirement should be sent to the Part C Coordinator or designee at CTBirth23@CT.gov with Timely Filing Override Request in the subject and should include the B23#, dates, specific services and a clear description of the override reason.

OTHER BILLABLE SERVICES AND ACTIVITIES

Reimbursement for Assistive Technology Devices

Seeking third party payment for assistive technology devices is required per attached Appendix 2 chart if the child is covered by commercial health insurance or Medicaid. It is not required if the child has no health insurance coverage.

Prior authorization (PA) for Medicaid AT devices and DME will be obtained by the DME vendor or by the program submitting for PA through CHNCT (see Appendix 2). For commercial insurance or no insurance, prior authorization, when required in accordance with requirements outlined on Appendix 2, is submitted to the lead agency using Form 3-11 which is emailed securely to CTBirth23@ct.gov. Once a request for AT is approved by the lead agency, the program works with a Durable Medical Equipment (DME) vendor to purchase the item and submit for third party reimbursement.

DME vendors will submit prior authorization for devices to Medicaid or insurances. Birth to Three providers are encouraged to use DME Medicaid enrolled providers when submitting for DME items. When accessing Medicaid funding, DME vendors must accept Medicaid state rates (Provider Fee Schedule as posted on ctdssmap.com) as full payment. For commercial or no insurance, DME vendors may invoice Birth to Three programs for costs not covered by insurance, up to the Medicaid state rate. The lead agency will reimburse providers for costs up to the Medicaid state rate for approved AT devices. Families should never be billed for approved AT devices.

For Medicaid and commercial insurance, reimbursement for certain devices not billed through a DME vendor such as hearing aids and inexpensive, small AT devices will require prior approval in accordance with the Department of Social Services Provider fee schedule and prior authorization requirements. The Medicaid Program's medical administrative services organization (ASO), currently Community Health Network of Connecticut, Inc. (CHNCT) will review prior authorizations submitted by Birth to Three programs. Birth to Three providers can contact CHNCT member services number for a list of participating Medicaid enrolled DME providers at 1-800-859-9889. The Prior authorization process is delineated on the CHNCT website. (See appendix 2)

Reimbursement up to the Medicaid state rates, for partial or full costs of AT devices when there is commercial or no insurance will require prior approval from the lead agency in accordance with PA requirements for Medicaid, using Form 3-11 emailed securely to CTBirth23@ct.gov.

The lead agency will accept requests for approval for reimbursement of modifications to previously-approved devices. In this instance, the program must submit the previously approved Form 3-11 clearly marked with a "REVISED" date that reflects the nature, purpose and costs of the proposed modifications.

Using Form 3-11 (if PA was needed) or Form 3-12 (if PA was not needed), programs can bill the lead agency for costs not covered by insurance up to the Medicaid state rate or actual acquisition cost if the AT device is not available on the fee schedule. Programs must submit documentation as listed on Appendix 2 with their request for reimbursement for items purchased.

In order to meet timely filing requirements for reimbursement of AT Forms 3-11 and Form 3-12 must be submitted to the lead agency no later than 6 months from the date the device was dispensed. Otherwise, reimbursement will be denied.

Refer to AT Reimbursement Chart (Appendix 2) at end of this procedure for details on submitting for reimbursement for AT.

Interpretation

Programs will be reimbursed for the actual cost of interpreting services (phone interpretation is allowed) up to \$85 per hour for all languages other than Spanish using approved state vendors listed at https://www.biznet.ct.gov/SCP_Search/Default.aspx.

Programs will be reimbursed for the actual cost of Spanish interpreting services (phone interpretation is allowed) up to \$75 per hour for any evaluation or assessment using approved state vendors listed at https://www.biznet.ct.gov/SCP_Search/Default.aspx.

If a language is not available in a timely or consistent manner from an approved state vendor the program should document this in the child's record. Except for rare exceptions for which prior authorization has been obtained, interpreting services should not be performed by an individual who is a staff member or a sub-contractor of the EIS

Program unless the individual is a sub-contractor specifically qualified and paid for interpretation services. When authorizing such service, consideration will be given to the prevailing rates in the current state contracts for interpretation and per those contracts, charges related to travel, parking, mileage and/or any other miscellaneous expenses are not allowed. For visits shorter than 2 hours and last minute cancellations, if the interpreter service bills the EIS program, the lead agency will reimburse EIS programs for the amount billed up to 2 hours however programs should make every attempt to negotiate waiving minimums as part of providing services remotely. Those cancellations must be entered into the Birth to Three Data System. Any visits longer than 2 hours will only be reimbursed up to the length of the visit as entered in the Birth to Three Data System. Invoices are reconciled using the Birth to Three Data System. Therefore, requests for reimbursement of interpretations of evaluations for more than 2 hours must show the actual amount of hours and match the data system.

Prior approval requests for extraordinary interpretation circumstances with details about the reasons and the period of time for the approval must be submitted to the Part C Coordinator.

To receive payments, the program must submit documentation no later than 6 months from the date of service for the interpreting service along with proof of payment to the vendor. Which consists of:

- A copy of the canceled check or a zero balance bill from vendor
- A vendor invoice with the child's name, language, date, rate and duration
- A copy of the prior approval email (only required for rare exceptions above)

When possible lead agency forms will be translated by the lead agency.

Distance Payments

For the purpose of enhancing program quality and to help offset unforeseen program costs beyond the control of statewide EIS programs that specialize in supporting families with children who are Deaf or Hard of Hearing (DHH), a payment equal to the rate of one hour of EITS by a professional will be available as a Distance Payment.

The payment will only be applied if the visit occurs in person at the child's home, childcare, or other community setting for children without disabilities and the town is outside of a local catchment area based on a list as established by the lead agency. Programs may also request the payment for visits when the family was not present for a confirmed appointment and the home visitor had already driven to the town. If the practitioner is traveling from his or her home, from visiting another child or from a satellite office to the setting where the EIS are being provided, the distance travelled must be greater than 20 miles.

To receive this payment, programs will bill the OEC on the monthly invoice using the "Other" section and fax or securely email a report supplied by the Lead Agency to BirthtoThreeFiscal@ct.gov. If a family is not present for a previously confirmed visit or if the visit is not in the child's home, the program must provide a list to BirthtoThreeFiscal@ct.gov and include the billable amount under the "Other" section of

the invoice. The list must include the child's B23# number, name, town traveled to, proof of travel (i.e. mileage reimbursement or travel time submitted to the program) and a copy of the note left for the family.

Reimbursement for Transportation to Audiological Visits

Programs may be reimbursed for the actual cost of transportation services to audiological visits provided under Part C as part of an IFSP. Transportation services are defined as necessary to enable an eligible child and a member of the child's family to travel to and from audiologists office where an audiological service is to be provided. Transportation services reimbursement for families is approved only for audiological assessments or a visit to an audiologist's office where specialized equipment is needed using a Birth to Three contracted provider. All services must be completed by at least one licensed audiologist. Only one reimbursement per family per day is permitted. Additional charges related to travel, parking, mileage and/or any other miscellaneous expenses are not allowed. Regardless if reimbursement is being requested, programs must document that a parent was offered reimbursement for transporting their own child to Birth to Three audiological visits even if they decline.

Children who are Medicaid eligible have access to the non-emergency medical transportation covered by Medicaid. Veyo is the contracted provider in Connecticut to arrange transportation for HUSKY Health members. It may be necessary for service coordinators to complete a medical necessity form on Veyo to request a specific Birth to Three Provider. The form can be found on the Veyo website. There is no reimbursement for transportation for children who are eligible for HUSKY.

Transportation services include transportation by public common carriers, provider transportation service vehicles, taxicabs, car service or private automobile. All transportation services must meet federal and state regulations including using a child's car seat, insured and registered vehicle, and licensed driver.

Transportation services must be by most economical means appropriate for the child. Rental car reimbursement will not be approved.

Mileage for transportation services may be reimbursed to a provider up to the most currently issued IRS optional standard mileage rate. Mileage reimbursement is for the most direct route from the home or starting point to the destination. If the most direct route is unavailable (e.g., road closed due to construction), then the provider must note the reason for additional mileage. Copies of maps showing the mileage must accompany PA requests.

Documentation of mileage or transportation is maintained by the Provider in a record that details the visit, including the child's B23 case number, date the service was delivered, the type of EI service provided, the name of the practitioner and discipline, the start and destination address, and the total number of miles.

The Lead Agency may audit mileage logs in order to substantiate mileage was delivered in accordance with the amount paid to providers.

To receive payments, the program must submit documentation no later than 6 months from the date of service along with proof of payment to the vendor or family. Which consists of:

- documentation that includes the child's B23 case number, date of service, type of service, name of practitioner and discipline, start and end destination addresses and total number of miles.
- the vendor invoice
- a copy of the canceled check to the family/vendor or a zero balance bill from vendor
- a copy of map showing the mileage

The amount will be included on the monthly Birth to Three invoice using the "Other" section with supporting documentation transmitted securely to the Lead Agency at OEC.AP@ct.gov and copied to BirthtoThreeFiscal@ct.gov.

MONTHLY SERVICE INVOICE SUBMISSION


Programs will bill the lead agency monthly for escrow payments (the amount reimbursed by third party payers subtracted from the posted state rates), GAPs and other payments identified on the monthly invoice. After confirming that all the data related to services provided in the billing month has been correctly entered and approved, programs must click the invoice signoff button. Signoff must occur by the close of business on 15th of each month or the close of business on the first Monday if the 15th falls on a weekend.

Programs should save copies of the invoice (using the Print Invoice button) and related reports before signoff and anytime changes are made during reconciliation.


After signoff, programs must send an email to OEC.AP@ct.gov with the subject line reading, "Birth to Three (insert month) invoice signed off and attached". The program's monthly invoice must be attached to the email. If the program is requesting reimbursement for "Adjustments" then supporting documentation must also be attached. Any PII must be redacted from attached documents and replaced with the child's Birth to Three number. Supporting documentation for "Adjustments" may include bills for interpretation and assistive technology forms. Supporting documentation for "Other" may include documentation for distance payments and GAP issues. NOTE: If the invoice is revised, all required documentation must be resent to OEC.AP@ct.gov.

Payments to programs will be processed through the state's CORE-CT system. Once an invoice has been entered into CORE for payment, an email from "Osc.Apd@ct.gov" is automatically sent to programs. This may not be to the Birth to Three program office if there is another email address in the CORE system.

The lead agency fiscal office will reconcile the invoice with available reports and documentation. If any discrepancies are found during their review, the program will be notified via email. Birthtothreefiscal@ct.gov is used for communication to reconcile any concerns or questions with the invoice.



Connecticut Office of
Early Childhood



DDS Home
Logout

Service Delivery Monthly Invoice for Sample

Invoice Month: 05/2018 ▼
Invoice Not Saved!

Escrow payments for fully adjudicated claims for invoiced month:

	Children	Claims	Escrow
Evaluation Claims:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="\$0.00"/>
Assessment Claims:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="\$0.00"/>
IFSP Meetings:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="\$0.00"/>
EI Service Claims:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="\$0.00"/>
Subtotal:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="\$0.00"/>

General Administration Payment (GAP):

	Children	Rate	GAP
Qualifying IFSPs:	<input type="text" value="0"/>	<input type="text" value="100.00"/>	<input type="text" value="\$0.00"/>

Adjustments:

	Adjustments
AT Devices:	<input type="text" value="\$0.00"/>
Interpretation:	<input type="text" value="\$0.00"/>
OEC Cash Advance Repayment:	<input type="text" value="\$0.00"/>
Other:	<input type="text" value="\$0.00"/>
Subtotal:	<input type="text" value="\$0.00"/>

Total Due Agency:	\$0.00
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Save Invoice
Program Signoff/Lock GAP/Send FCP
Print Invoice

Unlock Invoice
View GAP Report

Escrow payments for claims approved on time and fully adjudicated during invoiced month will be populated by the CBO. These values should be compared to reports available from the third party billing contractor.

GAPs will be calculated by the lead agency using available data in the Birth to Three data system as described above in the GAP section of this procedure.

Adjustments require supporting documentation except the cash advance repayment which the lead agency holds.

Issues with the Birth to Three Data System

In some cases, a discrepancy may be related to an issue with the Birth to Three Data System. Questions about the data system related to payment should be submitted to BirthtoThreeFiscal@ct.gov with "data system" in the subject line.

Appendix 1: Adjudication Matrix Summary

In EI Billing the CBO posts guidance regarding the Adjudication Matrix and directs Programs regarding actions to take on claims. Both the CBO and EIS programs will work on claims that are workable. In some cases, the CBO will be able to work the claim and resubmit quickly, in other cases the EIS program will need to collect or submit or correct information as identified under each category. For more information regarding the adjudication matrix search the EI Billing Portal.

Payment terms and Acronyms

270 - Eligibility request

271 - Eligibility response

835 - Electronic remittance advice

837 - Electronic claims

Adjudication Matrix – a list of how claim errors will be processed

ATN - Application Tracking Number

AVRS ID

CHNCT – Community Health Network of CT, Inc.

CMAAP - Connecticut Medical Assistance Program

CMS – Centers for Medicaid and Medicare Services

CBO - Central Billing Office

CMS – Centers for Medicare and Medicaid Services

CPT - Current Procedural Terminology

DXC – This doesn't stand for anything; they manage the billing data for DSS

EDI - Electronic Data Interchange

EFT – Electronic Funds Transfer

EI Billing – the CBOs web-based portal for EIS programs to use

EIS - Early Intervention Services

ERA - Electronic Remittance Advice

Escrow – funds held by the lead agency (state, federal part C and Part B, parent fees)

FCP – Family Cost Participation

GAP - General Administrative Payments

HCPCS – Healthcare Common Procedure Coding System

HSA - Health Spending/Savings Account

NPI - National Provider Identifier numbers

OEC - Office of Early Childhood (OEC)

PA - Prior Authorization

PII - Personally Identifiable Information

SPA - State Plan Amendment

SPIDER - Birth to Three Data System

Usual and Customary rates -

Workable - items in a program's "Needs Attention Queue" are those which can be 'fixed' and resubmitted to insurers. (Non-workable claims move to escrow.)

Example 1 - Cause: A claim is submitted to insurer X, the claim is denied

Resolution: It is determined that the claim is denied due to there being another commercial insurer that should have been billed as the primary insurance. The family had forgotten to provide that insurance information upon intake. Once the insurance

information is obtained and the claim is submitted to the primary insurance company, the claim is then reimbursed appropriately.

Example 2 - Cause: When checking eligibility through an electronic transaction the return decision states the child is not eligible.

Resolution: The program would check the insurance number with the family, and it turns out numbers were transposed. The correct data is put into the Birth to Three data system and the claim is resubmitted by the CBO and paid.

In some cases, the CBO will 'work' and resubmit claims.

Example 3 - Cause: A claim is submitted and rejected due to the wrong procedure code being sent to an insurer

Resolution: PCG checks the procedure code, determines the appropriate HCPCS or CPT code, then resubmits the claim and the claim is reimbursed appropriately.

As needed (see below), prior to purchasing, submit Form 3-11 to lead agency or secure prior authorization (PA) from:

<http://www.huskyhealthct.org/providers/prior-authorization.html#> PA is NOT necessary for all AT devices. Rules/rates for AT reimbursement are the same for all children and mirror the DSS process for DME. (www.ctdssmap.com. Go to "Information", select "Publications". Scroll to Chapter 8, select "Birth to Three" provider type. Click "View Chapter 8"). Medicaid Rates available on Provider Fee Schedule ([ctdssmap.com](http://www.ctdssmap.com))

	<i>DME: Large Equipment</i>	<i>DME: Small AT Devices</i>	<i>Hearing Aids, Assistive Listening Devices, etc.</i>
Medicaid	<ul style="list-style-type: none"> -Work with Medicaid enrolled DME vendor to purchase AT device -DME vendor submits PA and all claim info to Medicaid and accepts Medicaid state rate as payment in full 	<ul style="list-style-type: none"> -E1399 code (misc. DME) -Work with Medicaid DME vendor (if DME vendor is willing to submit PA for approval for low cost devices) OR -Program submits PA to CHNCT using E1399 code as required. (See fee schedule) http://www.huskyhealthct.org/providers/prior-authorization.html# Actual Acquisition Cost (AAC) + shipping required. -Program bills DXC Technology directly for AAC + shipping approved on PA - Medicaid state rate is considered payment in full. 	<ul style="list-style-type: none"> -As needed, Birth to Three Provider submits PA to CHNCT using appropriate code found on the Birth to Three fee schedule. PA form found at: http://www.huskyhealthct.org/providers/prior-authorization.html# AAC + shipping required. - Program bills DXC Technology directly for Actual Acquisition Cost (AAC) + shipping approved on PA - Medicaid state rate is considered payment in full.
Commercial Insurance OR No Insurance	<ul style="list-style-type: none"> - Submit PA to lead agency (LA) using 3-11 -Work with DME vendor to purchase approved AT -Re-submit 3-11 after insurance payment is known -DME vendor bills program for balance <u>up to state rate</u> (after insurance) -Program bills lead agency for balance (No later than 6 months from the date of service) 	<ul style="list-style-type: none"> -Program works with DME vendor (Vendor may not want to submit for low cost devices) OR -For AT devices that cost less than the set Medicaid threshold for PA, program orders AT device and bills LA on Form 3-12 (AAC + shipping) -For AT devices costing more than the set Medicaid threshold, Form 3-11 is submitted for prior approval, program orders AT device and billing the LA using Form 3-11 (AAC +shipping) (No later than 6 months from the date of service) 	<ul style="list-style-type: none"> - PA requested from lead agency (Form 3-11) only when needed, mirroring requirements in DSS Birth to Three fee schedule: -Program bills insurance directly -Program bills lead agency using Form 3-11- or 3-12 for expenditures not reimbursed by insurance up to the Medicaid state rate or as prior authorized on Form 3-11 (in alignment with Medicaid) (No later than 6 months from the date of service)
Documents Needed For all insurances	Medical vendor responsible for documents required by Medicaid & other insurance. If submitting 3-11 or 3-12 to LA for balance after Commercial or no insurance see next column for documentation	Prescription, medical necessity documentation, pricing invoices (done in PA process for Medicaid) Delivery receipt. When submitting 3-12 or 3-11 to lead agency include above AND proof of payment (cancelled check or 0 vendor balance), proof of insurance acceptance/denial if above the Medicaid threshold for PA. Use Form 3-11 when PA required.	Prescription, medical necessity documentation, pricing invoices (done in PA process for Medicaid). Delivery receipt. When submitting 3-11- or 3-12 to lead agency include above AND proof of payment (cancelled check or 0 vendor balance), proof of insurance acceptance/denial if above the Medicaid threshold for PA. Use Form 3-11 when PA required
Signed Delivery Receipt must include: Provider name, client name, Itemization of DME delivered including product description, brand name, model name and number, serial number (if applicable), quantity delivered, amount billed per item, and date of delivery. All prescriptions must include: client's name, address, date of birth, diagnosis related to DME need, detailed description of medical need of item including quantities and directions for use (as appropriate), length of need of item, name and address of prescribing practitioner, prescribing practitioner's signature and date. During Medicaid audit if program billed Medicaid for item and is missing prescription or delivery receipt, then money is recouped.			
IPADs are not considered DME and not reimbursable through Medicaid or commercial insurance. IPADs are LOANED through NEAT.			

Title: PERSONNEL STANDARDS

Purpose: *Defines the suitable qualifications and supervision required for personnel providing early intervention services based on entry level and credentialing requirements.*

Overview

A quality program begins with employing or contracting with personnel who meet the highest entry-level requirements for their discipline. Those requirements are listed on the CT Birth to Three System Personnel Standards grid in this procedure. The grid includes all of the professions listed as Qualified Personnel in the Federal Part C Regulations.

Most employees are required to hold a valid Connecticut licensure or certification in order to conduct the activities of their profession. All staff must follow the requirements in the personal standards as well as follow the state licensing or certification requirements and standards of practice for their individual professions. State licensing and certification standards including scope of practice and supervision requirements supersede personnel standards. It is the responsibility of each professional to know and follow their specific discipline requirements. Programs must verify the credentials indicated for personnel employed or contracted. The program must maintain copies of current certifications and licenses and make them available for review upon request by the Birth to Three System.

Required Training and Supervision

It is recommended that programs prioritize hiring people in all disciplines who have a demonstrated knowledge through coursework and preferably through work experience, with very young children. All new staff who work one or more hours per week with families, regardless of experience, will have to complete required training within 90 days of their start date in order to successfully complete the Birth to Three Initial Certificate. Additional training requirements will need to be completed in order to receive the Service Coordinator Certificate. When qualified staff are hired who have limited experience in the Connecticut Birth to Three System, it is the responsibility of the program to ensure that the proper training and supervision of these staff has been provided.

Programs are required to train staff on use of evidence-based practices for Activity-Based Teaming. Annually staff will be required to complete a Quality Practices Self-Assessment related to this area. (Refer to *Training and Supervision Procedure* for more information).

Use of Students Completing Internships/Practicums

Students who are completing coursework for any related discipline may complete their internships or practicums in the Birth to Three System in either paid or unpaid positions for up to 6 months. They may not go out on visits alone.

Standards for Developmental Therapists

A developmental therapist must possess a valid initial, provisional or professional teaching certificate from the Connecticut State Department of Education (SDE) in endorsements #112, #113, #065, #165, #265, #055, #059, #057. If certification is lapsed, the individual cannot be employed as a developmental therapist.

Effective July 1, 2021 EIS program directors may request a waiver (Public Act 21-172) from the Commissioner of Education, to allow any individual who holds an endorsement in the areas of 1) comprehensive special education #165 or #065 or #265, 2) partially sighted #055, 3) blind #059, 4) deaf and hard of hearing #057, 5) integrated early childhood and special education #113, to teach infants and toddlers beginning at birth in the CT Birth to Three System. (SDE Regulations Amend Sec. 10-145d). Individuals with the #112 endorsement are not affected by this waiver as their endorsement already allows work with children down to birth.

The waiver allows the above mentioned endorsements to consider their employment in Birth to Three as counting towards teaching experience for certification purposes. Any teacher with these endorsements should have a waiver in place, regardless of which Birth to Three program they are employed by.

After receipt of a waiver from the CT State Department of Education (CSDE), a developmental therapist (#112, #113, #065, #165, #265, #055, #059, #057) working in Birth to Three at a school district, a Regional Education Service Center (RESC), or an approved private school would typically be considered working towards retirement for Teacher's Retirement Board (TRB) purposes. All Developmental therapists should contact the State Department of Education directly to explore the specifics of their situation.

Developmental therapists with the following certifications (#112, #113, #065, #165, #265, #055, #059, #057) who are employed by private Birth to Three programs are considered to be professionals in the Birth to Three System. Through receipt of the waiver, they are considered by the State Department of Education to be working in an "approved nonpublic school" for purposes for teaching experience and certification, however do not earn credit towards retirement through TRB, as they are not employed by local or regional boards of education.

Teachers with a waiver to work in Birth to Three, as all Birth to Three staff, receive additional training through Birth to Three and must minimally complete the Initial Birth to Three Certificate requirements.

Process for Applying for CSDE Waiver

The program director/executive director of the Birth to Three program must submit an online form to the Commissioner of the CSDE requesting the Birth to Three Authorization Found on the *CSDE Certification District Resources* web page, <https://portal.ct.gov/SDE/Certification/Certification-Resources-for-Districts#forms>). Access the Form by clicking on: *Submit Online Kindergarten/B – 3 Authorization Request*. Once approved by the Commissioner, a formal letter will be sent to the program, with a copy going to the educator. CSDE will also maintain a copy of the authorization in the educator's CSDE records. This waiver will only authorize service from the time the authorization is granted as CSDE does not have the authority to backdate an authorization to any time prior to July 1, 2021. The authorization aligns with the educator's certificate; therefore, a new request must be made when the educator renews or advances their certificate. Additionally, if the educator changes programs, a different waiver must be submitted, as the waiver is only approved for work in a specific Birth to Three program.

To Maintain or Advance Developmental Therapist (Teacher) Certification through CSDE and Change Status

All matters regarding teacher certification should follow specific information provided by the CSDE. This information is accessible here: <https://portal.ct.gov/sde/certification/bureau-of-certification>

Temporary 90-Day Certificates

Developmental therapists who are finishing an Alternate Route to Certification (ARC) must work as fully certified developmental therapists in Birth to Three during the 90-day temporary certificate period. The 90 days includes school days only.

When a Birth to Three provider completes an ARC at Charter Oak State College there is a specific process they must follow including submitting form ED172 and ED 172A. For information refer to CSDE website: <https://portal.ct.gov/SDE/Certification/General-Certification-Application-Information-and-Forms>

Developmental Therapy Specialist

Referred to previously and in the Infant, Toddler, Family Specialist Credential as Early Intervention Specialist. This position is considered a Birth to Three professional delivering special instruction under IDEA. A staff member who has attained the Infant, Toddler, Family Specialist Credential from the Connecticut Birth to Three System with endorsement # 123 may use the title Developmental Therapy Specialist (DSP) and may:

- Perform evaluations and assessments.
- Be listed as a professional on the IFSP without having another professional listed for supervisory purposes.
- Not require sign off on contact notes.
- Be reimbursed at professional rate. (See Payment Procedure)

For more information on DSP (formerly Early Intervention Specialist) see Credentialing and Certification Guidance on the Birth to Three website.

CT Birth to Three System Infant Toddler Family Specialist Credential (Voluntary)

The Infant Toddler Family Specialist (ITFS) credential was developed to assure the quality of personnel providing supports and services to families. The practice of early intervention requires very specific knowledge and skills that change and develop over time and are not adequately presented in most pre-service training programs. Anyone who provides direct services to children and families in their home or community may obtain an Infant Toddler Family Specialist credential with the proper endorsement for their role. For more information <http://www.birth23.org/providers/cert/>

Standards for Licensed Personnel

All personnel noted in the following grid of this procedure for which a license is issued by the Department of Public Health must have a current license in order to be employed or contracted with a Birth to Three program. Renewal of each appropriate staff's license must be verified and a copy maintained by the program. All staff must follow the requirements in the personal standards as well as follow the state licensing requirements and state standards of practice for their individual professions. State licensing standards including scope of practice and supervision requirements supersede personnel standards. It is the responsibility of each professional to know and follow their specific discipline requirements.

Guidelines for the Use of Paraprofessionals

Physical Therapy Assistants (PTAs), Certified Occupational Therapy Assistants (COTAs) Developmental Therapy Associates (DTA), and Board Certified Associate Behavior Analysts (BCaBAs)

These positions have the following restrictions:

- Paraprofessionals must receive at least one hour per month of direct supervision by professionally licensed or certified early intervention personnel. Direct supervision should be documented with, at a minimum a log of supervision occurrences.
- They must participate as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes. They may function independently, providing direct services to children and families in home, or community-based settings, however all progress notes must be countersigned by their supervisor.
- They cannot be the only service provider listed on the IFSP.
- They may not conduct initial evaluations or formal assessments; however, they may provide information that contributes to those evaluations or assessments, and may update curriculum assessments with families as part of providing Early Intervention Treatment Services.

Early Intervention Assistants

Staff members who are in the personnel category of EI Assistant as of July 1, 2013 may continue to function in that role. After July 1, 2013 the category of EI Assistant will no longer be available.

Dually Certified/Licensed Staff

Dually certified staff (for instance, SW & BCBA) should write both degrees on the paper IFSP and sign with both degree initials on the visit notes (for audit purposes these the IFSP and visit note have to match). In alignment with what was provided on the visit and as dictated by scope of practice for the specific license, as appropriate the degree/license with the highest likelihood of being covered by insurance should be entered into SPIDER (in this case it may be SW). The IFSP that the parent signs will be considered the official IFSP, not the data extracts in SPIDER.

Service Coordinators

Certain Birth to Three personnel may function as Service Coordinators, as delineated in the grid that follows. In order to function as a Service Coordinator, the appropriate staff member must have completed applicable training as required and specified by the lead agency. Proof of completion of required training should be maintained by the individual and available upon request by the EIS program.

Connecticut Birth to Three System Personnel Standards

Required Training: ALL personnel working 1 or more hours/week with families must complete the Birth to Three Initial Certificate within 90 days of their start date. Personnel authorized to act as Service Coordinators must also complete the Service Coordinator Certificate prior to functioning in that role.

Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Assistive Technology Provider	Associates or Bachelor's degree with AT coursework and experience	RESNA (Rehabilitation Engineering Society of North America) Certification as: ATP Assistive Technology Practitioner or ATS Assistive Technology Supplier or RET Rehabilitation Engineering Technologist.		Completes assistive technology evaluations and assists the IFSP team to analyze needs of child with disabilities; assist in selection or service of assistive technology devices and may provide training in the use of the selected device(s). (Audiologists, Physical Therapists, Occupational Therapists, Speech Pathologists and Developmental therapist s may also possess the skills to perform these functions.)	Yes
Audiologist	Masters or AuD	Licensed by the Department of Public Health Under §2-411 C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides Early Intervention (EI) supports to families for the benefit of the child.	Yes
Audiologist CFY		Clinical Fellowship Year (CFY) Status Permissive.	Must be supervised by a licensed audiologist as required under § 20-411 C.G.S At least one hour of supervision per month. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes. All notes must be countersigned by a licensed audiologist.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Licensed Behavioral Analyst (LBA)	MA or Doctorate	Licensed by the Department of Public Health as a behavior analyst (section 1905(a)(6) which includes certification as a Board Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board (BACB) (section 1905(a)(13)(C)		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Board Certified Associate Behavior Analyst (BCA) Or Board Certified Behavioral Analyst (not licensed)	BA in behavior analysis or in psychology, spec education or another human service discipline with an emphasis in behavior analysis	Certification from the Behavior Analyst Certification Board, Inc. or the states of Pennsylvania or Florida.	Periodic consultation from Board Certified Behavior Analyst or licensed Psychologist. At least one hour of supervision per month. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes All progress notes must be countersigned by a supervisor who is a certified Behavior Analyst or licensed Psychologist.	Participates in IFSP development and implementation, monitors outcomes as part of a transdisciplinary team, and provides EI supports to families for the benefit of the child. Under supervision by licensed/certified personnel, may function independently. Does not perform evaluations or assessments but provides data and input. May update Curriculum-based tool with family as part of Early Intervention Treatment Services.	Yes

Connecticut Birth to Three System Personnel Standards

Required Training: ALL personnel working 1 or more hours/week with families must complete the Birth to Three Initial Certificate within 90 days of their start date. Personnel authorized to act as Service Coordinators must also complete the Service Coordinator Certificate prior to functioning in that role.

Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Developmental Therapy Assistant <i>This category is not available for hiring purposes after 7/1/13</i>	High School Diploma or GED	Documentation of training specific to child, the child's disability or delays and the specific techniques being used with the child.	At least one hour per week of supervision and at least one team meeting per month. All notes must be countersigned by a supervisor who is licensed or certified.	Provides direct supports to children and families by performing routine tasks assigned by professionally licensed or certified personnel. Takes no independent action. Carries out written programs and service plans designed by licensed or certified personnel. Does not perform evaluations or assessments but provides data and input.	No
Developmental Therapy Associate (DTA) (Previously Early Intervention Associate – EIA)	BA degree in a human service field Or Bachelor's degree in unrelated field with Registered Behavioral Technician Credential (RBT)	None Or RBT Credential from Behavior Analyst Certification Board	At least one hour of supervision per month. Participates as a member of a team that that meets at least monthly to receive support as needed to address child and family outcomes All progress notes must be countersigned by a supervisor All progress notes countersigned by a supervisor who is licensed or certified	Participates in IFSP development and implementation, monitors outcomes as part of a transdisciplinary team, and provides early intervention supports to families for the benefit of the child. Under regular supervision by professionally licensed or certified personnel, may function independently. Does not perform evaluations or assessments but provides data and input. May update Curriculum-based tool with family as part Early Intervention Treatment Services.	Yes
Developmental Therapy Specialist (DSP) (Previously Early Intervention Specialist – ESP)	BA or MA in education, special education, psychology, early intervention, child and family studies, or closely related field. Requires college level courses in each: infant/toddler; evaluation and assessment; working with families or early language and literacy; 300 hrs of experience working with infants /toddlers and completion of other requirements of the credential process.	Infant, Toddler, Family Specialist Credential from the Connecticut Birth to Three System with endorsement # 123.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child. Supervises EI assistants or associates as appropriate Provides special instruction. Cannot be paired with a developmental therapist for a multidisciplinary evaluation.	Yes

Connecticut Birth to Three System Personnel Standards

Required Training: ALL personnel working 1 or more hours/week with families must complete the Birth to Three Initial Certificate within 90 days of their start date. Personnel authorized to act as Service Coordinators must also complete the Service Coordinator Certificate prior to functioning in that role.

Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Developmental Therapist a. Early Childhood Special Education b. Hearing Impaired c. Visually Impaired	Bachelor's Degree	Department of Education a. Certificate endorsements: #112 Birth-Kindergarten #113 Nursery-Third grade #065 Comprehensive Special Education Pre-K to 12 #165 Comprehensive Special Education K-12 #265 Comprehensive Special Ed b. Certificate endorsement #057 Pre-K to 12 c. Certificate endorsements: #059 Blind Pre-12 #055 Partially sighted 1-12	Refer to chart on page 3 for Developmental Therapists. For all except the #112 endorsement, the teacher should have the waiver for Birth to Three in place from CSDE. See information on p. 1-2 of this procedure for Developmental Therapists.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child. Supervises EI assistants or associates as appropriate. Provides special instruction. Cannot be paired with a developmental therapist for a multidisciplinary evaluation.	Yes.
Marital and Family Therapist	Masters Degree in Marital and Family Therapy	Department of Public Health license under §20-195c C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Marital and Family Therapist Intern	Masters Degree in Marital and Family Therapy	Working toward Department of Public Health license under professional supervision. Valid up to two years from date of hire into the Birth to Three System	All progress notes, evaluations and assessments must be countersigned by a supervisor who is licensed.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Nurse a. APRN b. R.N.	a. Masters (MSN) b. Bachelors (BSN) or Associates Degree or Diploma	a. Licensed by the Department of Public Health under §20-94a C.G.S. b. Licensed by the Department of Public Health under § 20-87 to 102 C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Nurse, Practical (LPN)	Diploma/Certificate	Licensed by the Department of Public Health under § 20-87 to 102 C.G.S.	Supervision conducted by a registered nurse. Takes no independent action. Carries out written programs and service plans designed by licensed or certified personnel.	Under the supervision of the BSN/MSN assists in the provision of early intervention services Provides direct supports to children and families by performing routine tasks assigned by professionally licensed or certified personnel. Does not perform initial evaluations, ongoing assessments or service coordination duties but provides data and input	No.

Connecticut Birth to Three System Personnel Standards

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Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Dietician-Nutritionist	Registered Dietician MA or PhD.	Registered with the Commission of Dietetic Registration or certified by the Department of Public Health under §20-206n		Conducts nutrition evaluations and assessments, participates in IFSP development and implementation, monitors outcomes a member of the team, and provides EI supports to families for the benefit of the child. The Birth to Three Infant Toddler Family Specialist Credential with endorsement 120 or 123 is required before these personnel may conduct developmental evaluations or assessments.	Yes
Occupational Therapist	Bachelors or Master's degree in Occupational Therapy, depending on year of graduation	Licensed by the Department of Public Health under § 20-74b C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Certified Occupational Therapy Assistant (COTA)	Associate Degree from accredited AOTA program	Department of Public Health license under § 20-74b C.G.S.	Supervised by a licensed occupational therapist. At least one hour of supervision per month. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes All progress notes must be countersigned by a supervisor who is a licensed OT.	Participates in IFSP development and implementation, monitors outcomes as member of team, and provides EI supports to families for the benefit of the child. Under regular supervision by professionally licensed or certified personnel, may function independently. Does not perform evaluations or assessments but provides data and input. May update Curriculum-based tool with family as part of Early Intervention Treatment Services.	Yes
Optometrist	Doctor of Optometry	Licensed by the Department of Public Health under § 20-130 C.G.S.		Conducts vision evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child. The Birth to Three Credential with endorsement 120 or 123 is required before these personnel may conduct developmental evaluations or on-going assessments.	Yes
Orientation & Mobility Specialist	Bachelor's Degree	Department of Education Certificate with endorsement #059		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes

Connecticut Birth to Three System Personnel Standards

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Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Physical Therapist	Doctorate, Masters or Bachelors depending on year of graduation	Licensed by the Department of Public Health under § 20 -70 C.G.S.	Per CT PT practice Act, consultation may be required with a physician. *	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Physical Therapy Assistant	Associate degree from an approved PTA program	Graduation from an accredited PTA program Licensed by the Department of Public Health under § 20-73(b) C.G.S.	Supervised by a licensed physical therapist. At least one hour of supervision per month. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes All progress notes must be countersigned by a supervisor who is a licensed PT.	Participates in IFSP development and implementation, monitors outcomes as member of team, and provides direct supports to children and families. Under regular supervision by professionally licensed Physical Therapist, may function independently. Does not perform evaluations or assessments but provides data and input. May update Curriculum-based tool with family as part of Early Intervention Treatment Services.	Yes
Physician (Pediatrician or other Physician)	Doctor of Medicine (MD) or Doctor of Osteopathy (OD)	Licensed by the Department of Public Health under § 20-10 (MD) or § 20-17 (OD) C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Professional Counselor Licensed	Doctorate, Masters	Licensed by the Department of Public Health under § 20-195(b) C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Psychologist Licensed	Doctorate	Licensed by the Department of Public Health under §187a C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Psychologist School	Graduate level (masters or higher)	Department of Education certificate endorsement #070		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as member of team, and provides EI supports to families for the benefit of the child.	Yes
Licensed Clinical Social Worker (LCSW)	Masters or doctorate of Social Work	Licensed by the Department of Public Health under §20-195n C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes

Connecticut Birth to Three System Personnel Standards

Required Training: ALL personnel working 1 or more hours/week with families must complete the Birth to Three Initial Certificate within 90 days of their start date. Personnel authorized to act as Service Coordinators must also complete the Service Coordinator Certificate prior to functioning in that role.

Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Licensed Master Social Worker (LMSW)	Masters or doctorate of Social Work	Licensed by Department of Public Health under 20-195n C.G.S. Complies with requirements in section 20-195s C.G.S. concerning professional supervision and consultation under a licensed practitioner	Requires professional supervision, under a licensed practitioner and consultation regarding mental health diagnoses with a licensed practitioner such as physician, APRN, psychologist, licensed marital and family therapist, professional counselor, LCSW. At least one hour per month of supervision.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Social Worker School	Masters or doctorate of Social Work	Department of Education certificate endorsement #071		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Social Worker Intern	Masters of Social Work	Temporary permit to an applicant for licensure as in C.G.S. 20-195n authorizing the holder to practice as a master social worker as provided for in section 20-195s. Permit valid for up to one hundred twenty calendar days after the date of attaining such master's degree	By a licensed social worker. At least one hour per month of supervision. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes All progress notes, evaluation and assessment reports must be countersigned by a supervisor who is a licensed Social Worker.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team and provides EI supports to families for the benefit of the child.	Yes
Speech/ Language Pathologist (CFY)	Masters	Clinical Fellowship Year (CFY) status permissive.	Must be supervised by a licensed speech/language pathologist as required under § 20-411 C.G.S. At least one hour per month of supervision. Participates as a member of a team that meets at least monthly to receive support as needed to address child and family outcomes Under regular supervision by professionally licensed or certified SLP, personnel may function independently. All progress notes, evaluations and assessments must be countersigned by a supervisor who is a licensed SLP.	Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes

Connecticut Birth to Three System Personnel Standards

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Licensed personnel, as listed in the Centers for Medicare and Medicaid Services State Plan Amendment 17-0019, may sign IFSPs.

Personnel Category	Entry Degree	Licensure/Certification	Additional Supervision Required	Job Responsibilities	Act as Service Coordinator?
Speech/ Language Pathologist	Masters	Licensed by the Department of Public Health under §20-411 C.G.S.		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes
Speech/ Language Pathologist School	Masters	Licensed by the Department of Public Health under §20-411 C.G.S. Department of Education Special Services Endorsement #061		Conducts evaluations and assessments, participates in IFSP development and implementation, monitors outcomes as a member of the team, and provides EI supports to families for the benefit of the child.	Yes

* For billing purposes, it is not required to have a physician signature in addition to another licensed professional, including Physical Therapist (PT). For PT license purposes, the CT. state PT practice act states that PT's need to consult or refer to a physician when the medical condition is prolonged or does not show "objective, measurable, functional improvement in a period of thirty consecutive days or at the end of six visits, whichever is earlier." To meet PT licensing requirements, it is recommended that IFSPs that include PT are sent for physician signature. Ultimately it is up to the PT and agency to assure alignment with the practice act, including when to consult with and obtain signature from a physician. This will be influenced, on a case by case basis, by the child's progress and documentation of this progress.

Title: PLANNING AND DOCUMENTING INTERVENTION SERVICES

Purpose: *Service providers need to ensure that early intervention visits or other forms of service are well-planned, the child's progress is noted, and the information is developed in conjunction with families. In addition, documentation is needed in order to seek third party reimbursement.*

Overview

The lead agency interprets the phrase "clinical progress note" as the visit note. The visit note documents the joint plan and additionally documents the family's progress in use of strategies that support their child as well as the child's progress. Providers are required to develop a joint plan with the family for each instance of early intervention treatment service and document this plan along with the activities and strategies used during the visit that address child and family outcomes.

All documentation must be maintained in its original form or in a secured electronic format (See *Records Procedure* for retention schedule). Documentation includes but is not limited to services provided and provider qualifications. All documentation is subject to review by the lead agency and appropriate agencies for audit purposes. When a child transfers to another program the sending program keeps the original record and sends a copy of the file to the receiving program.

Intervention Visit / Joint Plan

The [joint plan](#) has two parts and describes: 1) the activities and strategies the family will focus on between visits ("Between Visit Plan") and 2) the activity that will be the focus of the "Next Visit".

At the start of each visit the service provider reviews the joint plan that was developed at the previous visit. This should include the review of the "Between Visit" plan for the activity (including strategies) that the family or caregiver was going to focus on between the last visit and the current one. It also includes a review of the previously developed plan for the current visit (i.e., what activity was going to be the focus of the current visit). A new joint plan including a "Between Visit" plan and a "Next Visit" plan should be developed at the end of each visit.

For families receiving intensive supports the joint plan would not necessarily change at each visit (i.e., if the family is receiving supports every day there would not be enough time for them to work on a joint plan if it was changed at each visit). A reasonable amount of time for the plan to change is approximately on a weekly basis, or at each visit, if the frequency is less than weekly.

Some ideas to keep in mind when developing joint plans include:

- The plan should be developed with the the parent or caregiver actively involved in deciding what activity and strategies they would like to focus on between the current visit and the next. The activity that the family or caregiver will focus on should have been addressed during a home visit so that strategies to increase their child's learning could be developed and practiced. The activity should be one that is or is desired to be a part of the family's everyday life when the interventionist is not there.
- Strategies developed for use by the family during the activity should address a variety of learning opportunities and domains.
- The joint plan developed at the end of a visit is the launching point for the next visit. The home visitor should always begin the next visit reviewing the "between visit" plan to reflect with the family on what worked, what was challenging, and other ideas or thoughts they may have. The home visitor can problem-solve from there, adjusting strategies or trying new ones as needed. The home visitor then would progress into the visit based on reviewing and beginning the previously developed plan for the activity that will be the focus of the current visit.
- Joint plans are specific to activities and strategies but are also flexible based on what the family wants to address.
- The activities listed in the functional outcomes on the IFSP are not the only activities in which families will receive support from their team. The activities addressed in IFSP outcomes are what will be measured. However, there are a wide variety of activities at home and in the community that families participate in that would support attainment of outcomes and it would be important to explore to increase the child's opportunities for learning.
- Child interest is critical to learning and should be considered when developing plans.
- More information on Joint Planning can be found at:
<http://www.birthe23.org/files/Training/factSheetJointPlan2-.pdf>

Documenting Consultation by Primary Health Care Provider

The following are approved methods for documenting the consultation of a Primary Health Care Provider (PHCP) in the development of an IFSP. (See *IFSP Procedure for more details about how the OEC interprets CGS 17a-248e(c).*)

- a copy of a fax cover sheet used when sending documents to the PHCP
- a note in the record documenting a conversation with the PHCP
- listing the PHCP as a team member on the IFSP which allows for conversation without a release (Form 3-1)

Documentation on Visit Note

For each instance of service there must be a corresponding visit note in the record. Parents must be given a copy of the visit note at the end of the visit. Programs may develop their own format for the visit note which must include the following information:

- Child's name, address, date of birth, and Medicaid number if applicable (address, DOB and Insurance information may be contained elsewhere in the permanent record and not recorded on every visit note)
- The type of early intervention treatment service provided (links to IFSP disciplines)
- Date of visit, with start and end times for each person that provided services
- The location or site where services were rendered
- The names or role of each individual who primarily participated in the visit
- A description of what happened during the session including modification of strategies in accordance with the IFSP
- The reason for ANY variance between the IFSP and the early intervention services provided including, as applicable:
 - Information about who and why another early interventionist is substituting for a regular team member in providing services (i.e., make-up visits, coverage for vacation...)
 - If not specifically recommended on the IFSP, the reason why two practitioners of the same or different discipline(s) provide services at the same time(i.e. joint visit needing expertise from two practitioners must clearly document what each person did during the visit with the family). This may be more easily documented on two separate visit notes. The reason can NOT be for staff training. This includes reasons why an Early Intervention Treatment Service occurs at a clinic with a non-Birth to Three provider of the same discipline.
 - The reason for a one-time consultation if it is not recommended on the IFSP.
 - The reason that the setting, frequency, or length of visit varied from what was recommended on the IFSP, including what additional service was provided that required additional time (i.e., consultation with parent due to family concerns, family emergency, additional time for make-up hours owed to family, parent requested additional consultation to review carry-over activities...) The setting variation will likely be explained through documentation of the joint plan (i.e., IFSP reads that visits are at "home" but a visit occurs at the grocery store to support family and child).
 - The reason(s) why the early intervention visits were not performed within six months of a documented IFSP review or within twelve months of an evaluation of the IFSP
 - The reason why the early intervention visit was performed for a period not covered by an IFSP or was not performed within six months of a documented review of the IFSP with the family or within twelve months of an evaluation of the IFSP
 - It is acceptable for reasons for variance from the IFSP to be provided in a checklist or by using check boxes
- The reason why an early intervention service was provided that would duplicate services being received through an outside practitioner or clinic justifying that the concurrent service was medically necessary
- Information related to service coordination that happens during the visit.

- The signature by a qualified provider with a signature date for each person who provided any services with clear indication of the discipline of the provider. If the program would like to use the date of the visit as the date of the signature the following line must be added to the visit template: “Unless otherwise indicated, this note was signed on the date of service” If not, the note must be signed within 10 days after the visit was completed.
- A co-signature by supervising staff if this is required (see the Personnel Standards Procedure).
- In the case where a practitioner is dually certified, for example, a social worker who is also a BCBA, all documentation must include notation of both certifications. This allows flexibility for billing of insurance.
- A Joint Plan that includes a “between visit” plan and a “next visit” plan. (See Joint Planning section above)
- A review/progress on the previous “between visit” plan including the activities and strategies that were attempted and the results related to increasing the child’s participation during everyday activities, as well as the child’s progress during these activities
- The planned activity and learning opportunities for the current visit: the activity that is the focus of the visit must support attainment of an IFSP outcome but does NOT have to be only limited to a specific activity listed in an IFSP outcome.
- Documentation should support that the learning opportunities and strategies used during everyday activities on the visit note are clinically necessary and address outcomes (from IFSP).

Additionally:

- Since parents and caregivers are taking the lead in determining what they want to work on for their joint plan, they may sign the visit note. This supports that they are partners in working on strategies that address their desired outcomes.
- Cancellations of visits by either the family or the provider should be noted in the record, with indication of whether the visit will be rescheduled.
- All notes should be written legibly and should be dark enough to be copied if necessary. White-out should not be used to make corrections.

Service Coordination Notes Including Voice Only Contact

Service coordinators are expected to document service coordination activities that take place during and outside of the early intervention visit in the child’s early intervention record. These could include phone contacts, visits with the family to the physician or other professionals, and notes from face-to-face meetings with the family or with other providers. Service coordination documentation requirements are the same for children receiving services at no cost. Phone calls as the only service in the month should include the length of the call. Service coordination notes should be included on the visit note, particularly around issues discussed during the visit. Check boxes used as reminders alone do not suffice as documentation of what was discussed. Information on community resources, if discussed, should be included so that the family can easily reference it. For

activities that occur outside of a visit, the service coordinator may use a contact sheet such as Form 3-5a or 3-5b or a form customized by the program. Service coordination notes should be dated and signed. Families have access to everything contained in their record.

Parent Reason (also known as Family Reason)

Parent Reason is a term used to describe an extraordinary family circumstance in which a service coordinator or provider documents that a client-based outcome and measures (see below) cannot be met in a timely manner. These should be rare occurrences, based on the child's and family's needs, and must be specific to the individual client-based outcome. For example, a parent hospitalization, a parent is away for a long length of time, multiple parent cancellations, or multiple attempts to contact. These instances need to be clearly documented in the child's record. "Parent Reason" cannot be used for delays based upon the program's needs.

OUTCOMES AND MEASURES (State Performance Plan (SPP) and Annual Performance Report (APR))

Outcome	Measure
a. Eligible Children will be identified as early as possible.	All evaluations are completed within 45 days from referral to Birth to Three unless documented "Parent Reason".
b. Eligible Children will be enrolled and receive services as early as possible.	All Families and Children will have an initial IFSP meeting within 45 days of referral date unless documented "Parent Reason".
c. New services will be delivered in a timely manner.	All Families and Children will receive all new services scheduled to be provided at least monthly, within 45 days of the parent's signature on the IFSP unless documented "Parent Reason".
d. Transitions for families and Children leaving the Program at age three are smooth.	All Families and Children will receive transition conferences at least 90 days but no more than 9 months prior to the Child's third birthday unless documented by "Parent Reason"

Title: PROCEDURAL SAFEGUARDS

Purpose: *Describes the rights and safeguards guaranteed to families under Part C of the IDEA and its regulations and the Connecticut Birth to Three law and its regulations.*

Overview

The federal and state laws and their regulations attempt to ensure that families understand their rights in all early intervention processes. Service coordinators and providers must embed the explanation of each right in the context of the early intervention process. Families must be notified in writing prior to actions being taken that affect their child; they must understand and consent to all activities and written records about their child; they must be assured that information about their child and family is kept confidential and that they have access to that information; they must have the ability to accept or decline services without jeopardy; and they must be aware of procedures for resolving complaints. While in the Connecticut Birth to Three System, families must be given a copy of the “Connecticut Birth to Three System Parent Rights under IDEA Part C” booklet that summarizes their rights prior to the initial evaluation/assessment and then at least annually, and prior to exit if the child is found to be eligible and has an IFSP.

Explaining Parents Rights and Safeguards

Even though written materials are given to families at least annually, a simple listing of rights and safeguards does not adequately convey the meaning of these protections. Each right and safeguard has implications for a family’s experience with the Birth to Three System. Further, because Birth to Three is family-oriented, the rights and safeguards convey the IDEA’s central principles of respect for families’ privacy, diversity, and role as informed members of the IFSP team. The diagram on page five of this procedure lists some of the central rights and safeguards under IDEA Part C that must be addressed during the process of processing paperwork, planning, and providing services. It outlines the information that families need to understand at each step in the process, from referral through IFSP development and service implementation. At each step, important decisions must be made. Only to the extent that families understand their options can they fully exercise their decision-making authority as part of the IFSP team. In fact, going over and explaining a family’s rights under Part B of IDEA could be included as a step on a transition plan.

Prior Written Notice

Section 303.421 of the IDEA Part C regulations states that, prior written notice must be provided to parents a reasonable time before the lead agency or an EIS provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of their infant or toddler, or the provision of early intervention services to the infant or toddler with a disability and that infant’s or toddler’s family.

With this in mind, IDEA Part C requires that parents be given prior written notice on several occasions. Written notice must be provided to the family early enough before the initial eligibility evaluation to ensure that they will be able to attend. If the child is NOT eligible for Birth to Three, the family must be given Form 1-6 (§ 303.322). For

families with children who are eligible prior written notice must be given to the family a reasonable amount of time before the IFSP meeting and after the IFSP meeting when the family and their team has determined which services are being proposed and that the start dates that are a reasonable amount of time before they begin.

Form 1-6 is the Prior Written Notice form to be given to families for all actions except for those proposed or refused during an IFSP meeting including if a program cancels an IFSP meeting. If a program is refusing to initiate services because they do not have the required paperwork back from the family, Form 1-6 can be used for this purpose. Programs check all the actions that apply for the date, time and location listed on the form. The reason, if not self-evident by the choice selected should be noted in the applicable section. Documentation of how and when Form 1-6 was given to the family must be included in a child's record.

On the IFSP signature page is an additional statement about prior written notice when the program proposes, or refuses, to initiate or change early intervention services. Service Coordinators must explain this procedural safeguard to families as they establish start dates that are a reasonable amount of time before any service begins or ends.

Proposing to exit a child from the system, for whatever reason, would be another example of such a change for which parents need prior written notice. Typically, this change would be proposed in the context of an IFSP meeting, but there are occasions when a program is unable to contact the family and must notify them of this proposed change. Form 1-6 is the Prior Written Notice form to be sent to families in this case. The notice must be in the parents' native language or preferred mode of communication.

Prior written notice is not required before an IFSP meeting if it is initiated by the parent. When this occurs, this situation should be documented in the record. If possible the form can be faxed or emailed to the family.

Native Language or Preferred Mode of Communication

Families must be able to understand all activities and written records about their child. If the family prefers another language or way of communicating (such as Braille or American Sign Language), the program must provide an interpreter if at all possible. For families who do not read, the written information should be provided orally. This is the only way that the family can become an informed team member and decision-maker.

Written Consent

A program must obtain written consent (Consent to Conduct an Evaluation/Assessment Form 1-4) from a parent before conducting the initial evaluation or assessment. If consent is not given, the service coordinator must be sure that the parent:

1. is fully aware of the nature of the evaluation and assessment; and
2. understands that by not consenting to a developmental evaluation of the child, the child will not be able to receive the evaluation and assessment or services; and

3. family assessments are voluntary. An IFSP will be developed when a family declines a family assessment and the family will receive all services agreed to by the IFSP team.

A program must obtain written consent (IFSP Form 3-1 Section 8, including initials in box A or B) from a parent before initiating services. If consent is not given, the service coordinator must be sure that the parent understands that by not consenting to the IFSP, the child will not be able to receive services. Written consent is required for evaluations and assessments subsequent to the initial evaluation/assessment.

Confidentiality and Release of Information

Laws at both the federal and state levels address the confidentiality, content, review, destruction, and accessibility of a child's early intervention record. Each program must assure compliance with these laws. At their request, parents are to be notified who, by title, will have access to their child's record. A program's employees and subcontractors who need access to the record to perform a task related to his or her job description or to provide a service to the child or family, can access the record at any time. An Early Intervention Record Access Log (Form 3-4) is kept in the front of each early intervention record, but the aforementioned employees and subcontractors do not need to sign the access log. The log must be signed by any other person seeking access to the record such as the LEA (with parent consent), authorized representatives of the U.S. Dept. of Education, Dept. of Social Services, Department of Developmental Services, Center for Medicare Medicaid Services (CMS), accrediting organizations, or persons investigating allegations of abuse or neglect. For more formation, see the *Records procedure*.

All persons will respect the confidentiality of infants/toddlers and their families in the daily operation of the Birth to Three program by:

1. obtaining parental permission before sharing personally identifiable information concerning children or families with any outside agency or person (Form 3-3). However, as part of our agreement with the State Department of Education related to their Child Find responsibilities, directory information for each child enrolled in Birth to Three IS automatically shared through the data system when the child reaches the age of 2 years, 6 months old.
2. obtaining parental permission before requesting personally identifiable information concerning children or families from any outside agency or person (Form 3-2) including verbal communication with anyone not listed as a team member in Section VII of the IFSP.
3. obtaining parental permission before using a child as a subject of a study or paper for an education course
4. obtaining parental permission before taking a photo for a media presentation
5. refraining from using names of children and families in conversations outside the workplace
6. reflecting positive values and language in statements concerning children and families in professional context and daily interactions.

Electronic communication shall never include child or parent full names in the subject, body or in an unencrypted attachment. For more detailed information, see the Records procedure.

Examination of Records

Parents may review their child's record at any time by written request and they may request a copy of anything in that record. Records kept by early intervention professionals such as intervention visit plans, daily data, anecdotal notes, or test scores are those persons' personal records *only until the information is shared with someone else*. At that point, they become part of the child's early intervention record and are subject to all rules of confidentiality and access. When a family leaves Birth to Three, programs may offer them a copy of their child's record. Programs are required to give parents that are exiting the "Connecticut Birth to Three System Parent Rights under IDEA Part C" brochure. For more detailed information, see the Records procedure.

Accepting or Declining Services without Jeopardy

Parents have the right to accept or decline any early intervention service and may decline a service after first accepting it without jeopardizing other early intervention services. If parents decide differently at a later date, they can give their consent then.

Parents indicate using option A on their IFSP that they accept the services as written. Option B on the IFSP is used to decline some or all services and to indicate which if any services may begin. In a statement above the Parent Signature the IFSP also indicates that the family will take action if the team cannot come to a decision within one month. If the family requests mediation or a hearing, services from the previous IFSP must continue to be provided while the dispute is in the process of being resolved. If a parent refuses to sign their IFSP giving consent for any service to begin, Form 1-6 should be used to give the parent's prior written notice that explains the reason why the program cannot initiate services.

Procedures for Resolving Complaints

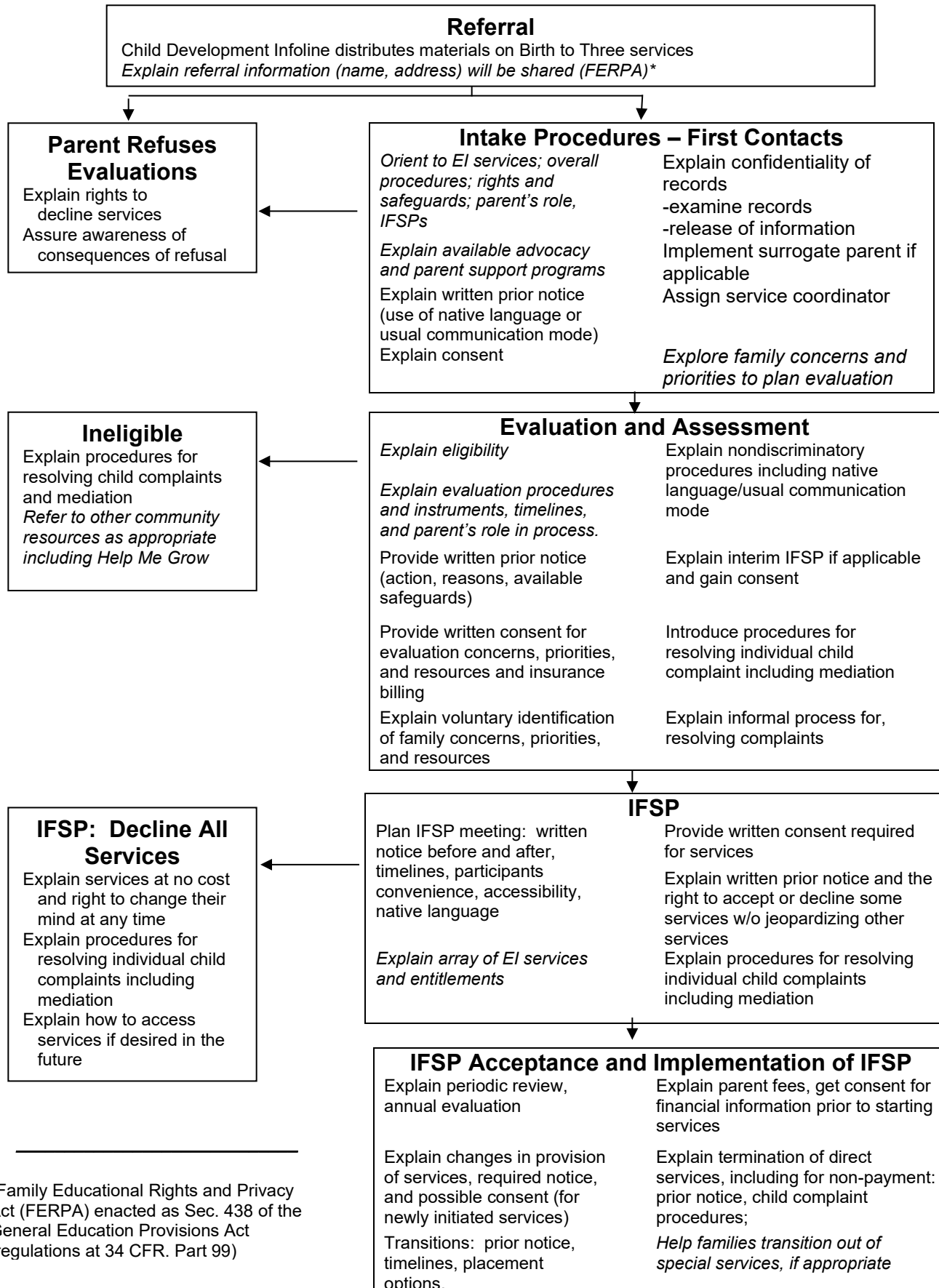
If the family and the early intervention team do not agree on eligibility or plans or services, or if the family has other complaints about their experience with the program or the Birth to Three System, there are procedures for resolving their concerns. (See Complaint and Dispute Resolution: Mediations and Hearings procedures) There are many informal ways for families to share their concerns with their team, however if informal steps do not work to satisfy their concern, there are other more formal steps that include a written complaint, mediation, and/or a hearing. In order to be considered by the lead agency, a formal written complaint must be received within one year of the date the last incident in the complaint took place. For more detailed information, see Complaints and/or Dispute Resolution Procedure.

Annual Notice of Rights

Each service coordinator must annually notify families of their rights, using the brochure "Parent Rights under IDEA Part CEI Programs must document on the IFSP that parents have received a copy and it is preferable that they have a discussion about it with the family rather than just handing them the document. This English/Spanish document is available in several other languages on the Birth to Three website: www.birthe23.org under "Especially for Families/ Parent Rights".

A Step-by-Step Process for Explaining Rights to Parents

Text in italics indicates practices that are recommended but are not required by law



*Family Educational Rights and Privacy Act (FERPA) enacted as Sec. 438 of the General Education Provisions Act (regulations at 34 CFR. Part 99)

Title: RECORDING

Purpose: *Provides clarification to programs about issues around Recording of children or providers of service.*

Overview

A recording (audio and/or visual) is a well-recognized technology for the purpose of evaluating learning and the effectiveness of intervention strategies. The Birth to Three System allows the use of recording as long as the confidentiality and rights of children and staff are protected. Parents, viewers approved by the parents, and Birth to Three staff only will review the recordings. The recordings can be left with the parents or stored at a program and destroyed when no longer needed unless a specific release, signed by the parents, states otherwise. Recordings stored at the program become part of a child's record, and all provisions of the recording procedure apply. Remote EI visits must not be recorded by the EIS Program without written consent by the parent.

Recording Early Intervention Services (EIS)

No recording will be taken of any child or parent without the written permission of the parent or guardian. The permission form must specify the use of the recording. With signed consent by a parent as defined in IDEA, children under the guardianship of the Department of Children and Families (DCF) may be recorded as long as their identity is not revealed, and they are not identified as a child in foster care. EIS practitioner consent is not required to be recorded however, their knowledge of the recording is. In addition, written consent of EIS practitioners is required to produce or use the recording for training, public awareness, or dissemination.

Acceptable uses of recording are to:

- Evaluate intervention strategies
- Provide a picture of a child's progress by recording over time
- Evaluate the function and skill level of a child
- Train parents and EIS practitioners working directly with an individual child
- Demonstrate a child's level of ability or needs to an outside consultant hired by the provider program
- Evaluate the consistency of service delivery by multiple persons in specifically designed behavior programs
- Self-observation and reflection for the purpose of professional development
- Documentation for credentialing
- Allow the lead agency to use the recording for training, educational purposes, promotions, publicity, etc.,

Copies of Recordings

Occasionally, a parent will request a recording of their child and EIS practitioner to share. A parent may also request a recording of their child and teacher or therapist without explaining their reason for wanting it Birth to Three programs should provide the recording to the family.

The Birth to Three program should retain a copy of the recording they produced for their records. In the event that the parents did the recording, the provider program may request a copy of the it for their records as long as the family is informed in writing that the recording will be part of the child's permanent service record. Unsolicited recordings are not part of the record.

Title: RECORDS

Purpose: *To assist Birth to Three Programs in addressing families' privacy and confidentiality through IDEA and FERPA provisions*

Overview

In accordance with the IDEA and the Family Educational Rights and Privacy Act (FERPA 20 U.S.C. § 1232g; 34 C.F.R. Part 99; 34 C.F.R. §303.460), the confidentiality of early intervention records must be safeguarded. Any and all personally identifiable information regarding children and families receiving services from Birth to Three programs is protected from unauthorized disclosure by FERPA. Personally identifiable information protected by FERPA is specifically *exempted* from the definition of "protected health information" that is subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) privacy standards (Source: 45 C.F.R. § 164.501).

Definition of Records

The IDEA Part C regulations define "early intervention records" as all records regarding a child that are required to be collected, maintained, or used under IDEA Part C, 34 CFR § 303.403(b). "Record" means any information recorded in any way, including, but not limited to, hand writing, print, computer media, video or audio tape, film, microfilm, and microfiche. (Source: 20 U.S.C. 1232g. An electronic record system (ERS) can be used as a child's early intervention record (source 34 C.F.R. § 99.3). Any information in a child's record, including health information, becomes part of the educational record and is protected under FERPA. Once a document has been stored electronically in an electronic record system the original document no longer needs to be kept on file.

Personally Identifiable Information or PII is protected under the IDEA confidentiality provisions.

The IDEA Part C regulations in 34 CFR §303.29 references the FERPA definition for PII and refers to "student" as "child" and "school" as Early Intervention Service Provider." Thus under IDEA Part C, PII is defined as information that includes, but is not limited to:

- The child's name;
- The name of the child's parents or other family members;
- The address of the child or child's family;
- A personal identifier, such as the child's social security number, program identification number, or biometric record;
- Other indirect identifiers, such as the child's date of birth, place of birth, and mother's maiden name; other information that, alone or in combination is linked or linkable to a specific child that would allow a reasonable person in the program or school community, who does not have personal knowledge of the relevant circumstances, to identify the child with reasonable certainty; or

- Information requested by a person who the educational agency reasonably believes knows the identity of the child to whom the education record relates (Source: 34 CFR § 99.3).

Electronic Communication and the Child's Birth to Three Record

All communication between team members about a family or direct communication with families is part of a child's record. This includes text messages, emails, and communication via sites such as Facebook. A program can either print the electronic communication and add it to the record or identify a way to archive the information where it can be retrieved.

Electronic Signatures and the Child's Birth to Three Record

Electronic signatures may be used as long as appropriate safeguards for parental consent have been followed (34 C.F.R. § 303.7. T). The electronic signature must:

- Be signed and dated;
- Identify and authenticate a particular person as the source of the electronic consent;
- Indicate such person's approval of the information contained in the electronic consent; and
- be accompanied by a statement that the person understands and agrees.

Electronic Communication between Parents and Providers

Discussion of the preferred manner of communication between provider and parents should be discussed and agreed upon during the initial visits with the family. Some families may choose not to use electronic communication, or limit its use due to financial or equipment constraints. It is recommended that documentation of this discussion be in the child's record.

The discussion of the use of social network sites should also occur during the initial visits with the family. Families should be informed that while their child is receiving services through Birth to Three the provider will be unable to communicate with them via personal social network sites. Families should be encouraged to follow all Birth to Three social media.

Caution should always be taken whenever using any form of electronic communication for the following reasons: use of personal email, cell phone numbers or personal social network sites can be accessed by others not working with the family; if a complaint leads to an investigation all electronic communication records (including personal email accounts) could be requested through the Freedom of Information Act. Finally, the use of electronic communication may make maintaining professional boundaries more difficult by allowing both families and providers access to personal cell phones, emails and texts at all hours of the day and night.

Exempted from Definition of Records

Exempted from the definition of education records are those records which are kept in the sole possession of the maker of the records and are not accessible or revealed to any other person except a temporary substitute for the maker of the records. Once the contents or information recorded in sole possession records is disclosed to any party other than a temporary substitute for the maker of the records, those records become education records subject to FERPA. Generally sole possession records are of the nature to serve as a “memory jogger” for the creator of the record. For example, if a therapist has taken notes regarding telephone or face to face conversations, such notes could be sole possession records depending on the nature and content of the notes. (Source: studentprivacy.ed.gov/ferpa)

Test protocols would be exempted from a child’s record if the child’s name was encoded on the test protocol in such a way that the examiner was the only person who could decode it.

Name Changes while in Birth to Three

A legal name must be used when providing documentation in a child’s record. There may be instances where a child’s name is changed while enrolled in Birth to Three. If this occurs, service coordinators shall request a copy of a legal document such as a court order as proof from the parent and include it in the child’s record. Service coordinators are encouraged to support parents in alerting their insurance or Department of Social Services regarding the change so that new medical cards may be issued.

Documentation of Requests to Access Records

Each program will maintain documentation of requests for and disclosure of PII, from the early intervention record in each child’s record for all persons using the Early Intervention Record Access Log, Form 3-4. Exception to this log is by parents and authorized representatives and employees of the participating agency. (Source: (§303.406) (§ 99.31(a)(9)(ii)(A)-(C). § 99.32(d)). Parents who request to see their child’s record should be included on the log which may take the form of an email when a child is no longer eligible for services. The record of requests will be maintained as long as the child’s record is maintained and the parent may inspect it.

Programs must use reasonable methods to identify and authenticate the identity of parents, students, officials, and other parties before disclosing or permitting access to PII (Source: 34 CFR §99.31[c]). These requirements help to ensure that educational agencies and institutions protect the privacy of education records and do not violate FERPA by disclosing education records to the wrong party.

Under Parts C of the IDEA, programs may use electronic or digital signatures, provided they take the necessary steps to ensure that there are appropriate safeguards to protect the integrity of the process (Source: OSEP Policy Letter dated March 21, 2014). FERPA specifies that “signed and dated written consent” may include a record and

signature in electronic form that 1) identifies and authenticates a particular person as the source of the electronic consent; and 2) indicates such person's approval of the information contained in the electronic consent. (Source: 34 CFR § 99.30(d)).

Parents Access to Records

At their request, parents are to be notified who, by title, will have access to their child's record. Regardless of how records are stored, electronically or paper files, programs must permit parents to inspect and review any early intervention records relating to their child without unnecessary delay and before an IFSP meeting or any hearing and in no case more than 10 days after the parents have made the request.

(§303.401) Parents' rights to access are restricted to the records of their own child. Information about children who are not part of the family should never appear in an early intervention record.

Either parents shall have full rights under FERPA, unless the program has been provided with evidence that there is a court order or legally binding document relating to such matters as divorce, separation, or custody that specifically revokes these rights. (Authority: 20 U.S.C. 1232g)

The program must provide at no cost to the parent, a copy of each evaluation, assessment of the child, family assessment, and IFSP as soon as possible after each IFSP meeting. Parents may be charged a fee to obtain a copy of their child's early intervention record if the fee does not effectively prevent the parents from exercising their rights. The fee cannot exceed the cost of the copies.

Regardless of the information being provided and how it is accessed (e.g., in person or electronically) from a child's record, the same degree of certainty in the requester's identity is required. Whether access to education records is by computer or telephone, programs must have procedures in place to be able to establish the same level of identity authentication assurance regardless of whether the data are accessed via electronic systems, mail, fax, telephone, or in person (Source: studentprivacy.ed Path: Identify Authentication Best Practices).

While FERPA does not specifically prohibit personally identifiable information from a child's education records over the telephone, it does require that the programs use reasonable methods to identify and authenticate the identity of parents and any other parties to whom the program discloses personally identifiable information from education records (Source: 34 CFR § 99.31(c)).

DCF Access to Records

If a child is under the guardianship (in foster care placement) of the Department of Children and Families, the child's DCF worker may have access to the child's early intervention record without the consent of the child's parent or surrogate parent. If the child is not under DCF guardianship, however, then only the surrogate parent or parent, may consent to releasing information from the early intervention record to DCF. (Source: studentprivacy.ed Path: Frequently Asked Questions). Programs are

encouraged to disclose information from education records to DCF to effectively implement a child's case plan and to ensure the child's education needs are met.

In the instances where DCF is conducting an active investigation of abuse or neglect and a request is made in writing on DCF letterhead, DCF investigators will be granted access to any information in the early intervention record. There is no need for consent or for a subpoena. (Source: 20 U.S.C. § 1232g(b)(1)(L), FERPA)).

When Consent is NOT Needed for Access PII

Parental consent is not required to release PII to:

1. A program's employees and contractors such as teachers, therapists, supervisors, administrators, secretaries, or paraprofessionals who have been determined to have legitimate interests. Legitimate interest is performing a task related to his or her job description or a service to the child or family.
2. LEAs or school systems where the child resides, in accordance with §303.209(b)(1)(i) and (b)(1)(ii), the following personally identifiable information under the Act: (i) A child's name, (ii) A child's date of birth., (iii) Parent contact information (including parents' names, addresses, and telephone numbers). This information is needed to enable the lead agency, as well as LEAs and SEAs under part B of the Act, to identify all children potentially eligible for services under §303.211 and part B of the Act. (Authority: 20 U.S.C. 1412(a)(8), 1412(a)(9), 1417(c), 1435(a)(5), 1437(a)(9), 1439(a)(2), 1439(a)(4), 1439(a)(6), 1442)
3. Participating agencies as defined in IDEA as an agency including the lead agency and EIS providers and any individual or entity that provides any part C services (including service coordination, evaluations and assessments, and other part C services), but does not include primary referral sources, or public agencies (such as the State Medicaid, CHIP program, or Bureau of Education Services for the Blind (BESB) or private entities (such as private insurance companies) that act solely as funding sources for part C services. (Sec. 303.403)
4. Authorized representatives of: United States Department of Education, Connecticut Office of Early Childhood and Department of Social Services, or Health Care Financing Administration (HCFA) in connection with the audit, evaluation, or enforcement of state and federally supported programs. These representatives are not permitted to collect (take away) PII unless specifically authorized to do so by state or federal law.
5. Accrediting organizations in order to carry out their accrediting functions.
6. Appropriate persons, if the knowledge of such information is necessary to protect the health or safety of a child in case of neglect or abuse. The factors to be taken into account in determining whether personally identifiable information from the early intervention record of a child may be disclosed under this section shall include the following:
 - a. the seriousness of the threat to the health or safety of the child or other individuals
 - b. the need for the information to meet the emergency

- c. whether the parties to whom the information is disclosed are in a position to deal with the emergency
 - d. the extent to which time is essential in dealing with the emergency
- When a program makes a disclosure under the health or safety exception, it must record in the child's education records the articulable and significant threat that formed the basis for the disclosure, and the parties to whom the information was disclosed. (Authority: § 99.32(a)(5).
- 7. To comply with a judicial order or lawfully issued subpoena. (§ 99.31(a)(9)(i) and (ii))
 - 8. If an educational agency or institution initiates legal action against a parent or student, the educational agency or institution may disclose to the court, without a court order or subpoena, the education records of the student that are relevant for the educational agency or institution to proceed with the legal action as plaintiff. (Authority: 20 U.S.C. 1232g(a)(5)(A), (b), (h), (i), and (j)). A program may disclose to the court the education records of the student that are relevant for the educational agency or institution to proceed with or defend against the legal action. 34 CFR § 99.31(a)(9)(iii).
 - 9. If a parent or eligible student initiates legal action against an educational agency or institution, the educational agency or institution may disclose to the court, without a court order or subpoena, the student's education records that are relevant for the educational agency or institution to defend itself. (Authority: 20 U.S.C. 1232g(a)(5)(A), (b), (h), (i), and (j))
 - 10. An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. (Authority: 20 U.S.C. 1232g (b)(1)(I) and (h))

Amendment of Records

Parents have the right to request that information collected on their child or family, which they believe inaccurate, misleading or in violation of their child's rights or privacy be amended. Programs are not required to make the change but must consider the requested change. Requests will be acted upon by the program within thirty (30) days.

If the program decides to refuse to amend the information in accordance with the request, it shall inform the parent of the refusal, and advise the parent of the right to have a hearing by an independent third party. The program will notify the Birth to Three Family Liaison. If the program agrees to the request the document is revised. If denied, the parent or eligible student has the right to include a statement in the record stating why he or she believes that the information contained in the education record is incorrect, misleading, or violates his or her right of privacy, why he or she disagrees with the hearing decision, or both. (Source: 2.ed.gov Path: Questions and Answers about Education Records).

A hearing is held within a reasonable period of time after the Birth to Three Family Liaison receives the request. The parent is given notice of the date, place, and time in

advance of the hearing. The hearing will be conducted by an impartial hearing officer who will make a recommendation to the Commissioner of the Office of Early Childhood. The parent is afforded a full and fair opportunity to present evidence relevant to the issues raised, and is assisted or represented by individuals of his or her choice at his or her own expense, including an attorney. The hearing officer makes his decision in writing within thirty (30) days after the conclusion of the hearing.

If, as a result of the hearing, it is determined that the information is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the infant, toddler or family, the program shall amend the information accordingly and so inform the parent in writing.

If, as a result of due process, it is determined that the records do not need amending, the parents may enclose a statement indicating that they disagree with the contested information. Their statement will then become a formal part of the child's record and be kept as such for the life of the record. Copies of the statement will be released, whenever copies of the contested part of the record are released (always with parental permission).

Parents also have the right to file a complaint with the U.S. Dept. of Education concerning alleged failures of compliance with FERPA.

No record or part of a record may be altered in any way after anyone requests to inspect, review or copy a record. (Authority: 20 U.S.C. 1232g(a)(1)(A) and (B))

Electronic Record System

When utilizing an electronic record system programs must adhere to all procedures including parent rights and confidentiality as directed on Birth23.org. A Business Associate Agreement (BAA) is required for HIPAA ensuring compliance between the provider and the electronic record company. All providers utilizing an electronic record system must notify the Lead Agency via ctbirth23@ct.gov of the name of the system and the contact information of the system they are using..

Retention and Destruction of Records

Programs must maintain all required documentation in its original form or a secured electronic format for six years. Documentation includes but is not limited to services provided and provider qualifications. All documentation is subject to review by the lead agency and appropriate agencies for audit purposes. When a child transfers to or receives a service from another program such as an autism or hearing assessment, sending program keeps the original record and sends a copy of the file to the receiving program. When documentation has been translated for the family, a copy in English must be maintained in the record.

Each program protects the confidentiality of PII at the collection, storage, disclosure, and destruction stage. One official at each program should assume this responsibility which includes:

1. making certain the confidentiality of the records is safeguarded and preserved;
2. denying or granting access to records;
3. reviewing all records to delete information that is not accurate, no longer valid or pertinent, or may be an infringement of the rights of the child or family;
4. maintaining in each record a current log of persons requesting access to that record;
5. annually notify parents of their rights regarding their child's record using the "Parents Rights Under the IDEA Part C" booklet.

Under §303.416(a) of the IDEA a participating agency needs to inform parents when "personally identifiable information collected, maintained, or used under this part is no longer needed to provide services to the child under Part C of IDEA, the General Education Provisions Act (GEPA) provisions in 20 U.S.C. 1232f, and Education Department General Administrative Regulations (EDGAR), 34 CFR Parts 76 and 80.". The parent notice should be provided when a family exits from Part C using Form 5-1 *Notification of Retention and Destruction of Records* (See Exit procedure effective date) along with Parent's Rights Brochure. Informing parents may mean mailing notification if Form 5-1 was not provided to them.

Programs should remind parents that these records may be needed by the child or parent for school, medical records, social security benefits or other reasons. Under section 303.403 of the IDEA Part C regulations, "destruction means to physically destroy the record or ensure that personal identifiers are removed from a record so that the record is no longer personally identifiable." However, a permanent record of certain information or PII about the student (or child) can be maintained under IDEA without limitation. The information in the Birth to Three data system is maintained indefinitely. A program may not destroy any education records if there is an outstanding request to inspect or review them. (Authority: 20 U.S.C. 1232g(a)(1)(A) and (B))

Data Destruction Guidance

No matter which method of destruction you choose, consider following these general best practices for data destruction:

1. When drafting written agreements with third parties, include provisions that specify that all PII that was provided to the third party must be destroyed when no longer needed for the specific purpose for which it was provided, including any copies of the PII that may reside in system backups, temporary files, or other storage media.
2. Ensure accountability for destruction of PII by using certification forms which are signed by the individual responsible for performing the destruction and contain detailed information about the destruction.
3. Remember that PII may also be present in non-electronic media. Organizations should manage non-electronic records in a similar fashion to their electronic data. When data are no longer required, destroy non-electronic media using secure

means to render it safe for disposal or recycling. Commonly used methods include cross-cut shredders, pulverizers, and incinerators.

4. Depending on the sensitivity of the data being shared, be specific in the written agreement as to the type of destruction to be carried out.
5. When destroying electronic data, use appropriate data deletion methods to ensure the data cannot be recovered. Please note that simple deletion of the data is not effective. Often, when a data file is deleted, only the reference to that file is removed from the media. The actual file data remain on the disk and are available for recovery until overwritten. Talk to your IT professional to ensure proper deletion of records consistent with technology best practice standards.
6. Avoid using file deletion, disk formatting, and “one way” encryption to dispose of sensitive data—these methods are not effective because they leave the majority of the data intact and vulnerable to being retrieved by a determined person with the right tools.
7. Destroy CDs, DVDs, and any magneto-optical disks by pulverizing, cross-cut shredding, or burning.
8. Address in a timely manner sanitization of storage media which might have failed and need to be replaced under warranty or service contract. Many data breaches result from storage media containing sensitive information being returned to the manufacturer for service or replacement.
9. Create formal, documented processes for data destruction within your organization and require that partner organizations do the same.

(Source: US Dept. of Education Best Practices for Data Destruction)

ata Breach

In the case of a data breach of physical or electronic records, specific steps must be taken as required and outlined in the program’s current Birth to Three purchase of services contract.

Programs may refer to the Privacy Technical Assistance Center’s Data Security Checklist for assistance in developing and maintaining a successful data security program. *(Source: studentprivacy.ed.gov Data Security Checklist)*

Highly Confidential Records

Highly confidential records contain information that if disclosed would likely constitute an invasion of personal privacy.

To Obtain Highly Confidential Information

In order to obtain highly confidential information, the written consent by the parent or guardian, specific to the information, is needed. The general release of information for individual records is not sufficient in this case. See Authorization for Programs to Obtain Confidential Information, Form 3-15.

Authorized records containing highly confidential information shall be maintained separately from the early intervention records, unless the parent specifies that each person who has access to the early intervention record has access to this confidential information. Upon a child’s exit from Birth to Three services, confidential records kept

separate from the child's early intervention record will be destroyed with parental notification or the contents returned to the parent.

To Release Highly Confidential Information

In order to release highly confidential information, written consent by the parent or guardian is needed. The consent must indicate that highly confidential information will be shared and must indicate to whom. The highly confidential information shall be released only to those providers who have a need to know.

If a child with a condition is to participate in a community group setting, the family must be advised to consult with the physician who is documented to know the child's status to determine the risk to that child. Written permission by the parent or guardian is needed before the highly confidential information can be shared with the director of a community agency.

Unauthorized Information

If verbal or written information regarding highly confidential information is received by any provider without the proper releases on file, it shall remain confidential.

Once a provider has knowledge of highly confidential information, regardless of its source, providers may not disclose or be compelled to disclose the information. Unauthorized written information shall be returned to the source.

Whenever a party, other than the parent or legal guardian, discloses highly confidential information without written permission, providers should interrupt the disclosure. Remind the party of the related Statutes and that willful violation of the statute that protects highly confidential information may subject a person to damages to compensate the injured party.

Sharing Information from a Record

All information received by a provider using the authorization to obtain information will become part of a child's early intervention record and will be kept confidential in accordance with the Individuals with Disabilities Education Act and the Family Educational Rights and Privacy Act (FERPA). With a signed Authorization to Release Information Form 3-3, any information within the child's early intervention record may be released. Form 3-3 is a one-time release of the information listed. The "date" listed is meant to cover the time between when the form is signed and when you expect the information to be released. It gives the parent a timeframe during which they may change their mind about releasing the information and can revoke their consent by filling out the bottom of the form. A typical date might be a week after the parent has signed.

When a child exits the Birth to Three System to attend a program under the jurisdiction of their LEA, the minimum information shared from their early intervention record with parental permission is the current IFSP and most recent evaluation of progress. With parental permission, any information from point of referral on may be shared. Upon a child's exit from Birth to Three services, confidential records kept separate from the

child's early intervention record will be destroyed with parental notification or the contents returned to the parent.

At the request of the parent and upon a signed Authorization to Release Information Form 3-3, any specified information may be shared with other community agencies or service providers. *Note: the parent(s) must have had an opportunity to review the document(s) being released before signing Form 3-3 or Form 3-15.* (Source: Understanding the Confidentiality Requirements Applicable to IDEA Early Childhood Programs Frequently Asked Questions Oct. 2016")

Email Guidance

The following guidelines are offered as suggestions for staff that choose to use emails to communicate with families:

- Joint personal emails and unprofessional sounding personal email addresses should never be used by providers.
- Careful attention should be paid to the address the email is being sent to in order to avoid sending the email to an unintended recipient.
- Read the email carefully before you send it checking that all personal information about the family is de-identified and the intent of the message is clear.
- Keep messages short and concise and encourage families to do the same.
- The signature at the end of the email should include your full name, email address, work address, phone number and job description (i.e. Occupational therapist, BCBA)
- Never use all capital letters. This is the online equivalent of shouting.
- Avoid using URGENT and IMPORTANT
- The use of a confidentiality disclaimer at the bottom of emails sent to or about families is encouraged. The following is an example of a confidentiality warning.

Confidentiality Warning: This e-mail contains information intended only for the use of the individual or entity named above. If the reader of this e-mail is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, any dissemination, publication or copying of this e-mail is strictly prohibited. The sender does not accept any responsibility for any loss, disruption or damage to your data or computer system that may occur while using data contained in, or transmitted with, this e-mail. If you have received this e-mail in error, please immediately notify us by return e-mail. Thank you.

Text Message Guidance

The following guidelines are offered as suggestions for staff that choose to use text messages to communicate with families:

- Always ask permission from a family before you begin texting them. Some phone plans may not cover texting or may charge for each text sent. Or the family may prefer voice messages left on their phone.
- Use text messages sparingly, for example, to update families on a change in appointment time.
- Always end your text with your first and last name. Do not assume the family has your name as a contact in their phone or will recognize your telephone number.

- Make sure all information in the text is de-identified and does not contain any personal information about the family.
- Keep the text strictly professional. Do not use texting shorthand assuming the family will understand. Do not use slang or all capital letters.
- Do not respond to a telephone call with a text message.
- Do not send text messages late in the evening or early in the morning.
- Careful attention should be paid to the telephone number the text is being sent to in order to avoid sending the text to an unintended recipient.
- Do not check your text messages or answer text messages while you are with a family. It is just as rude as talking on the telephone.
- Do not rely on text messaging with families as your sole form of communication.
- As with emails, text messages are considered part of the record and must be included in the file. If your phone does not allow you to email a text message where it can be printed out or archived where it can be retrieved, do not communicate with families via text.

Emails and texts are increasingly used as a means of communication between staff and families. If the information contained in either of those is pertinent to the child's services, then the information is considered to be part of the record.

The use of electronic communication should be discussed with parents and a communication plan agreed upon. This plan could be included in the IFSP. The preferred method for discussions and sharing sensitive information is in person or synchronous audio-visual.

Title: Remote Early Intervention

Purpose: To define the standards and requirements for providing Early Intervention (EI) Services remotely.

Overview

All Early Intervention Services (EIS) Programs must meet the qualifications of the Connecticut Office of Early Childhood (OEC) or designated successor state agency and CT Birth to Three Standards. Please refer to <https://www.birthe23.org/providers/provider-resources/procedures/> for OEC qualifications and Birth to Three Standards. When clinically appropriate for a child's circumstances and treatment, a practitioner may provide early intervention services (EIS) using Remote EI. Remote EI is defined as a practitioner providing supports to a family from a remote location, separate from the families' location, via the use of synchronous audio-visual communications.

In order to provide coordinated, interdisciplinary supports to families with children who are referred to or eligible for Birth to Three, the primary method of delivering EIS will remain as in-person services. Additionally, provision of Service Coordination by the Primary Service Provider is required to happen primarily in-person. In-person services ensure that families receive supports in the natural learning environments. Remote EI is not a mechanism to replace in-person visits and compliance with in-person services will periodically be monitored by the Lead Agency. The Remote EI method must demonstrate substantial compliance with providing timely evaluations, assessments, Individualized Family Service Plans (IFSPs), timely new services and timely transition planning.

Remote EI Guidelines

Reasons for using Remote EI may include, but are not limited to:

- When a family has requested to have supports provided remotely;
- Bringing in provider specialties that otherwise would not be readily available. For instance rather than transferring a family due to shortage of a specific needed discipline, the family may choose to receive support remotely from a discipline employed by the program in a different region. It must be documented in Service Coordination notes that the family has been given the option of transferring and prefers to receive that support remotely;
- Accessing practitioners who are licensed or certified to practice in Connecticut and who have specialized expertise but are located outside the state of Connecticut.
- Providing supports to a family who has a child or other family member with a compromised immune system;
- When a family member/child or provider is sick but well enough to complete a remote visit;
- If a family member/child or provider is in quarantine due to exposure to a communicable disease;
- Allowing multiple providers to participate in an IFSP; and
- Offer a way to bring other caregivers or parents into the visit from multiple sites;
- Offer a way for joint visits where one practitioner is in the natural learning environment and the other practitioner(s) joins the visit remotely;
- Provide a way to complete a visit during inclement weather and parking bans;

- Provide a way to support families in: (1) state closures of more than one week due to natural disasters, pandemics, or other emergencies or (2) other emergency conditions approved in advance by the OEC in writing on a case-by-case basis.

Providers are eligible to provide Remote EI services if the following criteria are met:

- Services that will regularly be delivered remotely must be noted as Remote EI services on the IFSP. If a planned in-person session is changed to a remote session rather than cancelling a visit due to reasons similar to those listed above, the reason for the variance from the IFSP must be documented on the visit note. (see *IFSP* procedure);
- A Remote EI Consent Form (5-2) is signed by the family, which may include electronic signatures and transmission in accordance with OEC guidelines.
- Technology and services comply with all appropriate information security and privacy requirements, including, but not limited to, Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules;
- Services are provided in accordance with all applicable OEC and Department of Social Services (DSS) policies and regulations;
- All other applicable requirements for an EI service are met, including, but not limited to: practitioner qualifications, duration of service and specific services provided; and
- Early Intervention Treatment Services (EITS): Synchronous audio-video communication is the required method for Remote EITS. In extenuating circumstances on a case-by-case basis when a family is unable to access synchronous audio-video communication, audio-only phone EITS may be used for one month with prior written approval from the OEC on Form 5-2 so the program can help the family access audio-video communication.

Privacy and Confidentiality Requirements

All Remote EI visits require the same processes and standards as for face-to-face (in-person) visits. All technology and software used for remote EI services must be listed on the lead agency's approved software list (Appendix A), which will be amended from time to time. The software listed must include FERPA and HIPAA compliant technology only; therefore, the appropriate safeguards must be in place. Additionally, software used must have the ability to maintain the coaching style of interaction, therefore, not all HIPAA and FERPA compliant software programs will be on the approved list. Software and technology which does not comply with FERPA and HIPAA are not permitted (for example, certain popular video chatting software programs, such as Skype, FaceTime, and WhatsApp). It is the provider's responsibility to ensure the family understands that remote EI visits are private and the technology used is confidential and secure. Providers must provide information to the family and other caregivers that Remote EI sessions will not be recorded without their written consent which can be revoked at any time and recordings will be maintained as described in the Records procedure. It is important that Remote EI visits ensure that the family's privacy and confidentiality are maintained at all times. Contact CTBirth23@ct.gov to request an application to be added to Appendix A.

Setting/ Equipment Requirements

A practitioner must provide the family technical assistance to utilize Remote EI successfully, as well as test the audiovisual quality before the start of Remote EI. Practitioners rendering services via Remote EI must use a setting that ensures confidentiality and prevents interruption such as external noise and disturbances. Families must also be in a setting so that all who are in the background consent to video conferencing.

At the time that the February 2022 update to this policy was issued, technology in the form of iPads may be available for loan to families to allow or enhance their participation in Remote EI. At the time that the February 2022 update is issued, these iPads are available through the Governor's Education Emergency Relief Fund (GEER) and are in a Birth to Three GEER inventory at New England Assistive Technology. Refer to Assistive Technology Procedure for requesting these devices, which is subject to availability at the time of each request.

IFSP Requirements

The plan to provide regular Remote EI visits must be documented in the IFSP. Unless in-person visits are not possible due to a declared state and/or federal public health emergency or other reason for which the provider has received Prior Authorization from the lead agency, the IFSP must include consistent in-person visits from the Service Coordinator/ primary service provider. The IFSP should clearly document the need for Remote EI and how remote EI will be provided. See the IFSP procedure for guidance about documenting Remote EI in the IFSP. Remote EI may be used for IFSP planning including meetings with the IFSP team to review or revise an IFSP via synchronous audio-visual communications as appropriate.

Parental Informed Consent

Prior Written Approval Form 5-2 for Remote EI requires family consent. However, this does not fulfill the requirement of Service Coordinators to ensure that a family is making an informed decision about Remote EI. It is the Service Coordinator's responsibility to ensure that the family fully understands their choices for provision of services, whether a service will be in-person or remote, including requesting to transfer to a different program if the current program cannot meet the families choice for how supports will be delivered. These conversations must be documented in the record.

Prior Authorization (PA)

Prior Authorization from the OEC on Form 5-2 is required:

- If the eligibility determination portion of an evaluation does not include at least one provider in-person during the evaluation. PA may be provided from OEC on a limited, case-by-case basis using synchronous audio communications only if synchronous audio-visual communications is not available;
- If assessments do not include at least one provider in-person during the visit;
- When the IFSP indicates that any discipline will complete all EI Services only using synchronous audio-video communication or audio-only;
- When the Service Coordinator/Primary Service Provider will provide less than 50% of visits listed on the IFSP in-person.
- To use remote EI to address a practitioner shortage;
 - PA requests need to include the following:

- Discipline of service area shortage staff
- Current staff available at your program with that discipline including employment statuses and hours worked a week,
- Towns impacted by the shortage
- Date range
- Description of what actions have been utilized to fill the discipline.
- Documentation supporting the description such as copies of employment ads
- A plan of action with timelines remedying the identified need

In order to obtain PA, Form 5-2 must be submitted to CTBirth23@ct.gov along with the relevant pages of the IFSP. To receive approval for Remote EI, the IFSP team must have identified a Primary Service Provider (PSP) who, when able, is primarily completing in-person visits. The lead agency may authorize Remote EI based on the training and qualifications of the practitioners such as being part of a team that includes a mentor coach who has demonstrated fidelity to the evidence based practices in Connecticut.

If EI services can only be provided remotely using audio-only communication, Form 5-2 must be submitted to CTBirth23@ct.gov for PA with an explanation about why in-person or synchronous audio-visual communication cannot occur.

Programs cannot require all parents sign Form 5-2 as a preventative measure when scheduling an in-person evaluation, assessment, or service.

In the event an in-person eligibility evaluation changes unexpectedly to a remote eligibility evaluation the PA should be submitted within 24 hours of the event.

Documentation of Visit

Remote EI visits cannot be recorded without the caregiver's written consent by the EIS Program.

Documentation requirements for a Remote EI visit are the same as for in-person visits with the exception that the note must identify that the visit was completed remotely, and document any variance from the IFSP for provision of Remote EI. In cases where practitioners are on both ends of the Remote EI visit, each practitioner must document how they individually addressed an IFSP outcome in their notes. The practitioner must have an informed consent (Form 5-2) signed and kept in the child's records. The practitioner shall maintain all documentation per the CT Birth to Three Procedures found at: <https://www.birthe23.org/providers/provider-resources/procedures/>.

Appendix A:

List of OEC Approved Applications for Remote EI (as of July 1, 2021)

It is essential to note that even though a platform has a HIPAA compliant option, all versions may not be HIPAA compliant (i.e., Zoom has a medical subscription, which is the only HIPAA compliant version).

A Business Associate Agreement (BAA) is required for HIPAA compliance.

HIPAA addresses the need for both encryption and the use of any data collected.

- Am Well - <https://business.amwell.com/>
- Blue Jeans - <https://www.bluejeans.com/>
- Clocktree - <https://www.clocktree.com/>
- Doxy.me - <https://doxy.me/>
- Google G Suite - <https://gsuite.google.com/>
- GoToMeeting - <https://www.gotomeeting.com/>
- Lifesize - <https://www.lifesize.com/>
- Mega Meeting - <https://www.megameeting.com>
- MS Team - <https://products.office.com/>
- Ring Central - <https://www.ringcentral.com>
- Simple Practice - <https://www.simplepractice.com/>
- VSee - <https://vsee.com/>
- Zoom for Healthcare - <https://zoom.us/healthcare>

Remote Early Intervention Guidance: Evaluation

Thank you to everyone from the programs that took time to discuss these suggestions for competing eligibility determinations remotely. We fully expect more guidance from the ECTA Center, ECPC and OSEP in the coming weeks. Evaluations and assessments are billable services during the PHE as describe in the Interim Remote EI procedure. Details about how to enter them into SPIDER will be available no later than March 30, 2020.

What's needed:	How:
Written Prior Notice, Parental Consent, FCP, Insurance forms, etc	<ul style="list-style-type: none"> • Emailed securely (without PII information) or Mailed to family • Family mails signed forms back to program
Family understanding process, family interview	<ul style="list-style-type: none"> • Phone call or video conference (HIPPA compliant) to explain what the remote evaluation process will look like, do family interview of concerns, priorities, and resources, possibly begin interview questions for evaluation tool that is being used. • Discuss some items that the family might want to have available (if they have them) for the testing session (pretend play items, doll, pretend food, crayons, paper...) • Help them to understand the importance of their right to privacy and the steps needed to assure it.
Determining Eligibility over the phone	<ul style="list-style-type: none"> • Please refer to the Interim Remote EI procedure for guidance drafted jointly with DSS.
Child Eligibility Testing	<ul style="list-style-type: none"> • HIPPA compliant video conferencing • Can have two evaluators on at same time or can use 1 evaluator to do one part of the evaluation and another do other parts • Help the family to administer items as possible • If family has a video that they would like to share with you that addresses some information needed for the evaluation, you can have them send it to you as long as they use a secure email service or file sharing app. If the family wants to send it to you anyway you must ensure that they know that it may be accessible publically and that you cannot ensure security. (How can we record their understanding without recording the conversation or creating another form?) • Start testing the primary area(s) of concern and determine eligibility in at least one area if you can. Other areas of development can be addressed as time allows as part of an Interim IFSP.
Meeting eligibility criteria	<ul style="list-style-type: none"> • Use standardized tools as in the past but adapt as needed. (This may be waived in the future but until then it is in statute.) • If a standardized tool cannot be completed to determine eligibility and it is apparent that the child meets our eligibility criteria, use clinical opinion. • Use of curriculums embedded assessments to inform clinical opinion would be beneficial • If clinical opinion is used, eligibility will have to be re-determined after the public health emergency is over • Some tools more appropriate for by parent interview – REEL, Vineland...
Results of Eval to Family	<ul style="list-style-type: none"> • If time is needed to score the tool, take a break and reconnect. Just as we want families to get results before we left the house, the same is true remotely. • Mail or securely email a statement of eligibility within 4 days • Written report stating how eligibility was determined, even if it does not include all areas of development initially
Report writing	<ul style="list-style-type: none"> • The report format should not be different but the dates of the evaluation will likely be extended until all areas of development are completed.

We will continue to update this with your suggestions and suggestions from other states and TA centers.

Title: RESEARCH

Purpose: *Defines requirements for conducting research involving the Birth to Three System.*

Overview

The Birth to Three System supports involvement in research designed to improve the field of early intervention. Any request made to an individual provider program or the Birth to Three System involving access to personally identifiable data, families, staff, or children in the Birth to Three System must adhere to this procedure. This applies to all researchers including CT Office of Early Childhood (OEC) employees or contractors, and non-OEC researchers, including but not limited to: faculty, staff, graduate students, undergraduate students, and others. The goal of this procedure is to safeguard the rights, welfare, and confidentiality of children, families, and staff, as well as their personal information.

How to Handle a Research Request

When a Birth to Three program director or staff person is approached by a researcher with a request for access to children, families, providers or their information they should:

1. Instruct the researcher to contact the Birth to Three System Part C Manager to discuss the proposed research study.
2. The Part C Manager will direct the researcher to the Office of Early Childhood webpage entitled, "[Research with OEC](#)". This page contains information about the researcher's responsibilities, guidance for conducting safe research, a data request form, and more. The Birth to Three System Part C Manager will also describe the required process to request a Letter of Support from the Family Support Division Director.
3. The Part C Manager will bring it to the attention of the Family Support Division Director or administrative designee who will agree or decline to provide a Letter of Support.

Role of the Birth to Three System in Research

When proposed research involves people or data associated with the Birth to Three System, a Letter of Support (LOS) must be requested from The Family Support Division Director by the person wishing to conduct the research study. The Family Support Division Director will consider the potential benefits to the field of early intervention that the study may produce and weigh the merit and feasibility of the request before choosing to provide, or declining, the request for a LOS.

If the Director agrees to provide a LOS, the principal investigator must still seek and obtain approval from their home institution (e.g., university or hospital of employment) Investigational Review Board (IRB). If an IRB has already granted approval for the proposed research, the Director may still agree or decline the invitation to provide a LOS.

Right of Refusal to Participate

Neither the LOS, nor approval by any IRB, obligates any Birth to Three program, staff person, parent, or child to participate in any research project. Individual provider programs and families always have the option of agreeing to participate, to agree then terminate their participation, or decline to participate - for any reason - without any repercussions or impact on their eligibility for, or receipt of, supports to which they would otherwise be entitled.

Distribution of Research Opportunities

Service Coordinators may share research opportunities in their community. Families' participation in research is voluntary and a decision that should not be influenced by involvement in Part C Birth to Three, nor should it take the place of services provided by Birth to Three. Service Coordinators should take care to not endorse or promote participation of any research that does not have a LOS.

Title: SERVICE COORDINATION

Purpose: *To ensure that all families receive appropriate service coordination from a qualified early intervention provider.*

Overview

Each eligible child and family will be provided with one service coordinator who is responsible for coordinating all services across agency lines and serving as a single point of contact in helping parents to obtain the services and assistance they need. Service coordination should occur and be documented in the child's record at least one time per month for each family. The service coordinator should also be supporting the family as the Primary Service Provider.

Qualifications/Training of Service Coordinators

Service coordinators must meet the personnel standards, must be one of the family's service providers and must have completed applicable training as required and specified by the lead agency. In order to function as a Service Coordinator, staff must first complete the Birth to Three Initial Certificate and then complete and receive the Service Coordinator Certificate. Proof of completion of required training through award of the Birth to Three Initial Certificate and the Service Coordinator Certificate should be maintained by the program and available upon request. See addendum for information on how programs verify staff completion of applicable service coordination training.

Required training for the Birth to Three Initial Certificate and the Service Coordinator Certificate are posted on the [Required Training page of the Birth to Three website](#).

Knowledge and Skills of Service Coordinators

According to the IDEA, the service coordinator should be knowledgeable about:

- infants and toddlers who are eligible under Connecticut's definition.
- the federal and state laws and regulations governing the Birth to Three System.
- the nature and scope of services available under the Connecticut Birth to Three System and the system of payments for services in Connecticut.
- Birth to Three System's procedures regarding evaluation and assessment, developing the IFSP, service guidelines, and transition from Birth to Three to community programs or preschool special education.
- Federal, state, and local resources that are available to families and young children.

Assignment of the Initial Service Coordinator

When the family contacts the Birth to Three System to refer their child, a program is chosen from among those available to complete an evaluation to determine eligibility. From this program, a person is identified as the family's initial service coordinator. This person is responsible for coordinating the child's eligibility evaluation and/or assessment. The service coordinator reviews the results with the family, and if the child is eligible, gives the family information about other Birth to Three programs available in their geographic area allowing the family to make a choice of programs. If the child is not eligible, the initial service coordinator informs the family about the Ages and Stages

Monitoring process and helps them refer the child, and discusses other community resources which may be of interest to the family.

Ongoing Service Coordination

If the program that completed the initial evaluation/assessment is chosen by the family to provide the services, the parent may keep the initial service coordinator if they will be a primary provider of direct services to the family. However, if that person is not going to be providing direct services to that family the program must assign a new service coordinator who will be the service coordinator and a provider. The service coordinator must be on the IFSP and seeing the family regularly as the primary provider. In a rare instance if this is not possible, clear documentation must be in the notes section of the IFSP.

If the family chooses to receive services from another program, then the family will be assigned a service coordinator from the new agency. The initial service coordinator is responsible for transferring all information to the new service coordinator.

Ongoing service coordination activities, according to the IDEA include:

- coordinating the performance of evaluations and assessments.
- Informing families of their rights and procedural safeguards
- facilitating and participating in the development, review, and evaluation of the individualized family service plan (IFSP).
- assisting families in identifying available service providers.
- coordinating and monitoring the delivery of services.
- informing families of the availability of advocacy services.
- coordinating with medical and health providers.
- facilitating the development of a transition plan to pre-school services, if appropriate.

In addition, Connecticut Birth to Three specific service coordination activities include:

- completing ongoing paperwork requirements of the Birth to Three System.
- ensuring proper information is collected as required by the lead agency for accessing third party reimbursement for early intervention services identified in the IFSP, including private insurance, Board of Education and Services for the Blind (BESB), and Medicaid.
- assisting the family in locating services outside of the Birth to Three System.
- facilitating the development of a transition plan to other community services
- assisting the family to contact other families if requested

Documenting Service Coordination

Service coordinators are expected to document service coordination activities that take place during and outside of the early intervention visit. These could include phone contacts, visits with the family to the physician or other professionals, notes from face-to-face meetings with the family or other providers, email or text.

Service coordination that occurs during an early intervention visit may be documented on the Early Intervention Visit Plan (see Planning and Documenting Intervention Services procedure). Information on community resources, if provided, should be included where the family can easily reference it. For activities that occur outside of a visit, the service

coordinator may use a contact sheet, which can be as simple as running notes on a blank page or a form such as contact sheet, Form 3-5a or 3-5b. Another form customized by the program for the same purpose is also acceptable. Service coordination notes must be dated and signed.

Families have full access to everything in their child's record.

Addendum

Service Coordination: Documentation of Applicable Training

Program verification of staff completion of applicable required training can be fulfilled by the following:

1. Service Coordination Certificate of Completion– Can be printed from Protraxx by the program staff member. This is available for 2005 and later dates.
2. Email verification from lead agency – For staff training from 1996 – 2004 that was not recorded in Protraxx, email CTBirth23@ct.gov requesting confirmation of attendance at Service Coordination. The staff member's name and date of attendance at Service Coordination training is necessary. Records will not be researched prior to 1996. As possible, the lead agency will verify attendance of the staff member at the training through email. This will involve research and lead agency staff time and may not be immediately available – plan ahead.
3. Staff Member previously functioning as approved Service Coordinator prior to September 1, 2018 – if staff member has previously been trained as a service coordinator and has been acting in that role with families, but is unable to show proof through 1. or 2. (above), they will need to complete the online IFSP module housed on [CT TRAIN](#). After completion of the module, the staff member will print the certificate of completion of the CT Birth to Three: IFSP module from the Initial Certificate. Follow instructions on the [Required Training page of the Birth to Three website](#) for information on accessing the module.

Staff member NEVER previously trained as Service Coordinator – A staff member can NOT act as a Service Coordinator until completion of applicable training. Service Coordination training is being revised and as of September 1, 2018 will include:

- a. Completion of the Birth to Three Initial Certificate and the Service Coordinator Certificate including online modules that must be completed and will be housed on [TRAIN CT](#)
- b. Successful completion of knowledge test at the end of each module
- c. Verified observation of an Evaluation, Initial IFSP and an IFSP review
- d. One day in-person training (online modules MUST be successfully completed prior to attending the in-person training)
- e. Staff member will be able to act as a Service Coordinator after completion of the in-person training and therefore completion of the Service Coordinator Certificate (printable from Protraxx)

For the period of April 1, 2018 through September 1, 2018 ONLY – a staff member who has not been previously trained will be allowed to function as a Service Coordinator as long as they are being actively supported by the program in that role, and have completed any required online modules, as of April 2018: the IFSP module.

During July and August 2018 online modules will be added and MUST be completed prior to staff functioning in a service coordinator role. Staff must also receive supervision and support in this role from the program. One day in-person trainings will be scheduled beginning September 2018. All staff who have been functioning as service coordinators awaiting the in-person training should complete online modules, required observations and register for the next available training.

All certificates of completion of modules should be printed by the program staff and maintained by the program.

After September 1, 2018 - All staff who have never functioned as service coordinators previously will need to complete and receive the Birth to Three Initial Certificate and the Service Coordinator Certificate. All information regarding these required trainings is found on the [Required Training page of the Birth to Three Website](#).

Staff trained as Service Coordinators prior to September 1, 2018 will not have completed the Birth to Three Initial Certificate and will show completion of applicable training as a Service Coordinator as described above in this addendum.

Title: SUPPORTS and SERVICES

Purpose: *Describes the early intervention supports and services in Section 303.13 of the Part C Regulations and recommended best practices in supporting families in Birth to Three*

Overview

Early intervention supports and services are developed to address the needs of the family in meeting their outcomes and the developmental needs their child. The goal of early intervention supports, achieved through coaching the family, is to foster the family's confidence and competence for use of strategies that support their child's learning during their everyday activities and routines. The supports must be provided by qualified personnel in programs under public supervision and must be delivered in accordance with the IFSP.

Identifying Services and Level of Supports and Services

Best practice (National Mission, Key Principles of Part C, 2008) indicates that families are supported best through natural learning environment practices, coaching, and primary service provider approach to teaming. Children learn through interactions with their environment (e.g., adults, peers, materials). Learning happens throughout the child's day and week during routine activities. Since children learn best during familiar activities, with familiar people, early intervention supports family members and other caregivers in order for families to address their outcomes and developmental priorities for their child. Coaching has been shown to be an adult-learning strategy that best supports developing competence in family members and other caregivers in using strategies that will support their child's learning.

When determining the type and frequency of Part C supports and services the IFSP team should look at family's abilities, interests, priorities, needs, concerns, and IFSP outcomes. The frequency of services is individualized to meet each child's and family's unique skills, interests, resources, and priorities including the family's need for support in order to address outcomes for their child.

The primary service provider approach to teaming relies on a primary provider who is the main liaison with the family and provides support on a consistent basis at a frequency determined by the IFSP team. Additionally, when using this approach every family has a full team available to them for support through regular team meetings and, as needed, on joint visits. The secondary service providers lend support to the family and PSP when additional expertise is necessary to increase child participation and develop strategies to be used during an everyday activity. In most instances, the secondary service provider will be seeing the family in conjunction with the PSP in order to develop supports and strategies with the family and PSP. Two practitioners with the same or different disciplines may provide EITS together as long as the documentation of the reason for the

joint visit is clear as well as how the two practitioners are bringing different skills or addressing different aspects of an activity.

When determining the intensity and type of supports the family may need, the team should consider:

- Is the family new to Birth to Three and what level of support do they require to meet the child's needs and their desired outcomes?
- Are the strategies used likely to change frequently or will they be in place for a longer period of time?
- Is there urgency to an outcome that requires immediate attention?
- Is the child progressing and is the family feeling more comfortable with the strategies? What does the progress data indicate about the current makeup of the team? Should there be a change in strategies or team membership?
- How much skill is required to address the identified outcomes? More specialized skill may require more frequent visits to ensure that the caregiver is comfortable in carrying out the strategy.
- Working with several caregivers may necessitate more frequent visits to ensure that all caregivers are comfortable implementing the strategies.
- Does the caregiver have cognitive or emotional issues that may require additional visits to heighten their ability to implement strategies?

Early Intervention Supports and Natural Environments

Section 303.26 of IDEA defines Natural Environments as, “settings that are natural or typical for a same-aged infant or toddler without a disability, may include the home or community setting...” The family, based on their typical activities, determines the most appropriate settings for Early Intervention supports within the definition of natural environment. See IFSP procedure If Early Intervention supports cannot be provided in natural environments.

Once the IFSP is developed, the intervention team implements the plan within the natural environments identified on the IFSP. Provision of Birth to Three supports in natural environments considers both the *content* of the intervention visit as well as the *process* of the visit. For both aspects, the focus of the intervention visit is on supporting the family and other caregivers in using the strategies to promote child learning and development in between intervention visits when the identified routines occur.

For this reason, it is essential that Birth to Three visits be carried out with the parent(s) or primary caregiver present and actively engaged. This is true whether the visit is in the home, or a community setting and includes children receiving intensive hours of service. The Birth to Three providers should be clear about the expectations of participation in the visits with the parent(s) and caregivers early in the IFSP process.

While the parent or primary caregiver should be actively involved with their child during every visit, at the very least, for liability reasons, they should always be nearby and in the line of sight of the child and staff person.

Services and supports should assist the family in supporting their child during their daily routines which often leads to working with the child outside of their home with other family members and childcare providers. The location should be discussed with the parents and other team members at the IFSP, and the plan should clearly document the decisions on location.

Missed or Cancelled Visits

When a family declines a scheduled service by calling to say that the child is ill, or that they will be away or if they are not home at the agreed upon day and time, or if they call to change days/times with less than 24hour notice, programs are not obligated to make up that time. Birth to Three providers is also not required to reschedule any visits that would fall on days when the state is closed. Programs should document the reason that the family did not receive services that day in the child's record.

Programs must apply a "reasonableness" test to decisions about whether they will make up visits. There may be some situations in which it would be reasonable and beneficial to try to reschedule a cancelled visit. If a visit is missed due to an early interventionist's cancellation and/or the program is proactively planning to provide services knowing that a team member will be absent due to illness or vacation, programs may:

1. Offer to have another early interventionist substitute for the team member who will be absent. The substitute interventionist must be from one of the disciplines listed on the page in the IFSP that lists the family's team members, be able to address outcomes on the IFSP, and be working within their scope of practice.
2. Offer supports on days, including weekends, or outside of normal business hours.

There are other creative ways that programs can use to make-up services.

In each case there must be documentation in the record that the substitution will be happening if known in advance, as well as the reason(s) why the substitution is happening and how the outcomes on the IFSP are being addressed.

Approved Service Areas

Each EI Program has an approved service area maintained by the lead agency as a list of all towns regardless of specialty designation. The service area is based on where families reside not where EIS are provided. If a child or family moves out of a program's approved service area and the program is willing to continue supporting the family in new town, the program must request prior authorization from the lead agency by submitting the request to CTBirth23@ct.gov. The email must contain the child's initials and Birth to Three number, the town for which temporary approval is being requested and the reason. Once approved the town will be considered part of this program's approved service area for the purpose of serving the one family and does not allow the

program to accept additional referrals for that town. 211 Child Development can assist with requesting prior authorization in situations when needed at referral.

Changing Service Areas

When concerns are raised about capacity or timelines for EIS provided in a given town by families, 211 Child Development, programs, data reports or other sources, the lead agency will follow the process detailed below.

1. The EIS programs with the town(s) in their service area will be contacted to determine whether they can accept new referrals and stay within IDEA and OEC agreed upon timelines.
 - a. If any program with the town in their service area indicates that they can handle the increase, no new programs will be added.
 - i. Timeline and complaint data will be closely monitored.
2. If all programs in (1) indicate that they cannot or if data continues to demonstrate that they cannot, EIS programs without that town on their list will be approached.
 - a. EIS programs that requested and were not awarded the town(s) in the 2019 RFP will be approached in rank order based on the RFP results. In the case of a tie lots will be drawn.
3. If none of the EIS programs that requested the town(s) in the 2019 RFP wish to add the town(s) to their service area, other EIS programs that support bordering towns will be approached based on the ranked order from the RFP results.
4. EIS programs with an open Corrective Action Plan (CAP) or Improvement Plan (IP) will be contacted last regardless of RFP result ranking.
5. If an EIS program that was approached agrees to add town(s), the towns will be added to the Birth to Three Data System and website (program pages and all town page).
6. If programs cannot complete evaluations, assessments, IFSP meetings and new services in a timely manner, the lead agency will explore posting an RFP for towns in need of more programs.

If an EIS program would like to add towns to their service area without there being a concern about capacity or meeting timelines, the program requesting the town should reach out to all the programs that have the town(s) in their service area and secure written support for the town(s) to be added. This written support should be sent to the Part C Coordinator. A town will not be added unless ALL EIS programs in the town support the addition of another EIS program.

A program that is closing may arrange with another to accept their transfers and hire their staff, but this is not a guarantee that the receiving program will have towns added to their list. This protects the programs that already serve the town. New programs will only be added if capacity cannot be managed by the 2019 RFP awarded contracts.

Types of Services

The following are types of services included under “early intervention services” and definitions of those services:

1. “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 the functional capabilities of an infant or toddler with a disability. Assistive technology service means a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include:
 - a. the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment.
 - b. purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by infants or toddlers with disabilities.
 - c. selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
 - d. coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs.
 - e. training or technical assistance for a child with disabilities or, if appropriate, that child's family; and
 - f. training or technical assistance for professionals (including individuals providing education or rehabilitation services), or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of infants and toddlers with disabilities.

2. “Audiology” includes:
 - a. identification of children with auditory impairment, using at-risk criteria and appropriate audiological screening techniques.
 - b. determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures.
 - c. referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment.
 - d. provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services.
 - e. provision of services for prevention of hearing loss.
 - f. 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.

3. “Family training, counseling and home visits” means services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development.

4. "Health services" as defined in § 303.16 means services necessary to enable an otherwise eligible child to benefit from the other early intervention services under this part during the time that the child is eligible to receive early intervention services. The term includes:
- (1) Such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and
 - (2) Consultation by physicians with other service providers concerning the special health care needs of infants and toddlers with disabilities that will need to be addressed in the course of providing other early intervention services.

The term does not include:

- (1) Services that are—(i) Surgical in nature (such as cleft palate surgery, surgery or club foot, or the shunting of hydrocephalus); (ii) Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or (iii) Related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.

Nothing in this part limits the right of an infant or toddler with a disability with a surgically implanted device (e.g., cochlear implant) to receive the early intervention services that are identified in the child's IFSP as being needed to meet the child's developmental outcomes.

Nothing in this part prevents the provider from routinely checking that either the hearing aid or the external components of a surgically implanted device (e.g., cochlear implant) of an infant or toddler with a disability are functioning properly.

Health services does not include devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; and Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

5. "Medical services only for diagnostic or evaluation purposes" means services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for early intervention services.
6. "Nursing services" includes:
- a. 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.
 - b. provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development.
 - c. administration of medication, treatments, and regimens prescribed by a licensed physician.

7. "Nutrition services" includes:
 - a. conducting individual assessments in:
 - 1) nutritional history and dietary intake
 - 2) anthropometric, biochemical and clinical variables
 - 3) feeding skills and feeding problems
 - 4) food habits and food preferences
 - b. developing and monitoring appropriate plans to address the nutritional needs of eligible children based on the assessment findings.
 - c. making referrals to appropriate community resources to carry out nutrition goals.
8. "Occupational therapy" includes services to address the functional needs of a child related to the performance of self-help skills, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:
 - a. identification, assessment, and intervention.
 - b. adaptation of the environment and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills.
 - c. prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.
9. "Physical therapy" includes 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:
 - a. screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction.
 - b. obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
 - c. providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.
10. "Psychological services" includes:
 - a. administering psychological and developmental tests, and other assessment procedures.
 - b. interpreting assessment results.
 - c. obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development.
 - d. planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

11. "Service coordination services" mean services provided by a service coordinator to assist and enable an infant or toddler with a disability and the child's family to receive the services and rights, including procedural safeguards, required under this part. (See Service Coordination procedure).
1. Sign language and cued language services include teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.
13. "Social work services" includes:
 - a. making home visits to evaluate a child's living conditions and patterns of parent-child interaction.
 - b. preparing a social or emotional developmental assessment of the child within the family context.
 - c. providing individual and family-group counseling with parents and other family members and appropriate social skill-building activities with the child and parents.
 - d. working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services.
 - e. identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.
14. "Special instruction" includes:
 - a. 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.
 - b. curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan.
 - c. providing families with information, skills, and support related to enhancing the skill development of the child.
 - d. working with the child to enhance the child's development.
15. "Speech-language pathology" includes:
 - a. identification of children with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.
 - b. referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills.

- c. provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.
16. "Transportation and related costs" Transportation and related costs, according to IDEA, include 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). Therefore, transportation should be listed on the IFSP service section as a required service whenever travel is necessary to enable an enrolled child and family to receive a Part C service. Parents must be reimbursed for transporting their own child unless they decline. A reasonable reimbursement rate would be the same rate at which staff is reimbursed for use of their car or some other standard rate used by the program. The program that is billing for the Part C service that requires transportation is the one that is expected to provide the transportation or reimbursement for transportation.
17. "Vision services" means:
- a. evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development:
 - b. referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both.
 - c. communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Vision Services

For families receiving "Vision Services" from the Department of Aging and Disability Services, Bureau of Education Services for the Blind (DADS-BESB), the service shall be listed in the IFSP under Early Intervention Services and Supports as Vision Services with the setting, frequency, duration, and intensity determined by the IFSP team with input from the BESB Teacher of the Visually Impaired (TVI). Under the grid the payment source for the vision services should be listed as "Vision Services by DADS-BESB."

Definition of Timely Services

Part C of IDEA requires that eligible children and their families receive timely services. Connecticut has defined "timely" as within 45 days of the parent(s)' signature(s) on the IFSP, therefore, in order to be in compliance with the law, all services that are scheduled to start within 45 days of the parent signature on the IFSP must be delivered on time. Services will not be considered "New" if it is an increase of an existing service nor are services considered new if they are continued on a new IFSP after a transfer. This data will be reviewed annually, and program level data will be displayed on the Birth to Three website (www.birth23.org).

Translation and Interpretation

IDEA requires that reasonable efforts are made for families to receive services and written materials in their native language. Thus, programs are required to use bilingual staff for oral interpretation and/or translators to produce written documents.

It may be difficult to assess a family's need for translation or interpretation prior to the initial assessment and as the initial IFSP is being developed. But it is important that a family understand their rights and procedural safeguards, the evaluation and eligibility process (including the role of the family in the initial evaluation), and the availability of translation and interpretation services. Families that may be comfortable using English in social situations may not understand technical terms, the intent of safeguards, and may not be comfortable describing nuances of child behavior that may be necessary for eligibility determination. Unless programs are certain that the family can fully participate in the initial evaluation meeting and the initial IFSP meeting when the child is eligible, bilingual staff or interpreters are required for these events. The evaluation report and the initial IFSP must be provided in the preferred language unless the family requests it in English only.

The Connecticut Birth to Three System does not encourage the use of family members as translators or interpreters and prohibits the use of minor children in these roles. If a family requests that a bilingual relative or friend be present during service delivery, such a person should be welcomed and encouraged, but should not be used to supplant more formal interpretation services.

The Birth to Three System provides required procedural safeguard forms in languages spoken by over 90% of the non-English speakers in Connecticut. Many materials are available in Spanish and some materials in the most frequently encountered languages. The program needs to determine the type and extent of written language support that is appropriate for each family in the following situations:

- IFSPs
- Ongoing Curriculum Assessments
- Specialty Assessments
- Home Visit Notes
- Meeting Notes
- And other situations where written communication is used

The program needs to determine the type and extent of oral language support that is appropriate for each family in the following situations:

- Assessments and meetings
- Home visits
- Community experiences.

See the Payment to Programs procedure for information on reimbursement for interpretation.

Title: Training and Supervision of Staff

Purpose: *To ensure that programs have staff who are highly trained and receive ongoing supervision*

Overview

Each program providing Birth to Three supports to families must have policies in place for hiring, training, and supervision of staff. Programs must address the requirements in this procedure to ensure staff working with families are highly qualified, participate in staff development activities and trainings, advance in their use of evidence-based practices in early intervention, and receive ongoing supervision. Programs are required to develop a comprehensive Training and Supervision plan with an associated tracking system. The Training and Supervision plan must be reviewed and updated as needed, annually at a minimum. This plan will be made available to the lead agency upon request.

For the purpose of this procedure “staff” means employees, per diem employees, as well as subcontractors working for the Birth to Three program, since the training and supervision requirements are the same.

Supervision Coordinator

Programs must have a person responsible for providing or overseeing provision of supervision to all staff. Programs must provide supervision and observation of all staff specifically for the purpose of evaluating the quality of their work including their level of fidelity with the evidence-based practices (EBP) in Early Intervention. While the lead agency provides some opportunities for training and technical assistance, programs are expected to supplement this based on identified needs.

All staff should have regularly scheduled supervision sessions that occur more frequently based on the length of time a staff member has been with the agency or on identified needs for supervision. There should be goals developed as part of ongoing supervision. Based on how to best support adults, supervision should include coaching practices and reflective supervision.

Training Coordinator

Each program must designate one person or organizational position who is responsible for overseeing the system for training of staff, ensuring that individual training plans for all staff are in place, as well as developing a training plan for their Birth to Three program as a whole. This can be the same person as the Supervision Coordinator, or a different person, depending on the needs of the program. There may be additional staff responsible for training in the program that report information to the training coordinator.

Program Training and Supervision Plan

Programs must have a training and supervision plan for the program as a whole. This plan should include the designated training and supervision coordinators or designated organizational position, the orientation and training process for new staff, supervision process including determination and monitoring of staff outcomes, system for staff specific trainings, agency-wide training and Activity-Based Teaming (ABT) focused implementation.

Data provided by the Lead Agency must be used to guide training needs for the programs. Data from the Quality Practices Self-Assessment (QPSA) will identify training needs related to fidelity with use of evidence-based practices in early intervention. Data from the IDEA Compliance Self-Assessment (ICSA) will identify training needs related to laws and regulations as well as procedures.

Basic Qualifications and Required Training

It is recommended that programs prioritize hiring people in all disciplines who have a demonstrated knowledge through coursework and preferably through work experience, with very young children. All staff hired by Birth to Three programs must meet the requirements found in the *Personnel Standards* procedure and the Birth to Three Contract including, as appropriate, educational requirements, CT licensure or certification, continuing education and training.

New staff who are working with families one or more hours per week must complete required trainings that are included in the Initial Birth to Three Certificate within 90 days of their start date. There are additional requirements for staff who will function as service coordinators. Required trainings are outlined in the *Personnel Standards and Service Coordination procedures*, and found on the Birth to Three website.

When qualified staff are hired who have limited experience in the Connecticut Birth to Three System, it is the responsibility of the program to ensure that the proper training and supervision of these staff is provided.

Staff Orientation

Programs must have a written orientation plan for all new staff that includes direct observations in the field and receives intense focus during the first 90 days of hire. Depending on prior CT Birth to Three experience, orientation should include, at minimum:

- Determination of designated supervisor and chain of command
- Determination of training supervisor, if different than personnel supervisor
- Introduction to and understanding of who is on their team
- Program-specific policies (i.e. Mandated reporter)
- Connecticut Birth to Three procedures

- Connecticut Birth to Three forms
- Parental rights and safeguards (Procedural Safeguards)
- Activity-based teaming basics
- Observations of home visits and IFSPs.
- Observation of an eligibility evaluation if they will be evaluating children and have not been doing evaluations specifically in Birth to Three

Staff Supervision and Training Plans

All staff must have a designated person(s) responsible for providing their supervision and overseeing their individualized supervision and training plans, which must include specific goals with measurable outcomes. These plans may be combined into one plan that distinctly addresses both supervision matters and training plans. They must be reviewed bi-annually, and all staff must be observed in the field for this purpose at least annually.

For new hires, after the initial orientation period of 90 days is complete, a training plan must be developed with the staff member and their supervisor or a designated person responsible for training of staff.

Individual training plans can be informed through a variety of sources including the person's education, previous work experience, experience in Birth to Three, and discipline-specific areas for improvement. Input is also gathered from the state's Quality Practices Self-Assessment which should only be used to address agency-wide needs rather than individual needs, previous continuing education, observations in the field, and tools used by the lead agency that measure fidelity with evidence-based practices in early intervention (i.e. coaching logs, fidelity checklists). Plans should also consider the need for education and oversight of the rights and safeguards guaranteed to families under Part C of IDEA and its regulations and the CT Birth to Three procedures, as well as related laws and regulations.

Evidence-Based Practices in Early Intervention

Programs are expected to know and use EBPs related to all aspects of early intervention, for instance, discipline-specific practices, autism-specific supports, and overall early intervention practices. Programs must provide training and technical assistance to staff in order to advance their fidelity in use of EBPs in early intervention, specifically known as Activity-Based Teaming (ABT) in Connecticut. These EBPs include Natural Learning Environment Practices, coaching as a style of interaction, and Primary Service Provider approach to teaming. It must be clear to staff that the expectation is that delivery of supports to families in early intervention follows these best practices.

The lead agency offers trainings and technical assistance in this area as funds allow. Emphasis is to support development and use of Master Coaches, also known as Mentor Coaches, within the program for program-wide implementation.

Programs are expected to have multi-disciplinary teams trained in Activity-Based Teaming and using these practices with all families, regardless of the child's diagnosis. Staff will vary in their level of fidelity to ABT and it is recommended that each team include staff who have higher levels of fidelity who can model and support other team members.

Programs are responsible for ensuring all staff have a basic understand Natural Learning Environment practices that is expected to be enhanced over time.

Programs are expected to support their staff in becoming family coaches through use of coaching logs, video review, or field/remote observations which are reviewed by Mentor Coaches or Fidelity coaches. The use of Electronic Coaching logs followed by coaching conversations is highly recommended as the measures of fidelity are built into the logs. If a program chooses to use another form of review such as video or observation, without use of logs, they would have to develop or determine a tool to measure fidelity. Discussion with lead agency staff will be necessary to determine appropriate measures and technical assistance plans. Technical assistance in the form of a coaching conversation reviewing the log, video, or home visit should happen more frequently (at least monthly is recommended) when working on achieving fidelity, and continue periodically after attainment of fidelity.

Mentor Coaches receive additional training and TA after first achieving fidelity as a family coach. Mentor Coaches who have achieved fidelity are used as mentors to other staff, and able to coach and determine the level of fidelity for staff in their use of ABT. Programs can use Mentor Coaches in training roles for increasing staff's knowledge base but also should use Mentor Coaches to develop fidelity in family coaches. A determination of fidelity of a staff person must be made in consultation with the lead agency, after submission of Electronic Coaching logs or other agreed upon measurement tools. The lead agency maintains a list of staff who have undergone training and TA and what their level of fidelity was at the completion of TA. It should be understood that fidelity will slip unless the practices are being used regularly and occasionally reviewed through submission of logs, video, or observation followed by a coaching conversation.

A Fidelity coach is one that has received additional training above the Mentor Coach level and is able to train other Mentor Coaches.

Quality Practices Self-Assessment

To assist programs in determining the level of fidelity to ABT in their program as a whole, the lead agency has developed a Quality Practices Self-Assessment (QPSA), which needs to be completed annually by all staff. The QPSA is completed online

through a link that is sent to programs annually by the lead agency. New employees also have to fill out the QPSA on a timeline determined by the lead agency.

The goal of the QPSA is to help programs identify trends where more training is necessary for the program. Results of the QPSA present program level data and does not provide staff specific data.

Technical Assistance

Technical assistance (TA) is defined as, "... a process within a dynamic context that enables a goal focused, strategy-oriented, accountable organization to transfer knowledge to clients for the purpose of their growth, change and improvement. (Pascal Trohanis, Foundations and Perspectives of TA)"

Programs are encouraged to provide TA support for their staff in areas for growth identified through supervision and, as necessary, to address goals and outcomes on their individualized training plan.

Lead Agency Contribution to Training and Technical Assistance

The lead agency provides training and technical assistance to the system and programs as funds allow. Online modules and videos are provided to assist programs in training of their staff.

Programs can request training or TA on a variety of topics in order to increase understanding of procedures, enhance supports provided to children and families, and keep current with best practices in early intervention. As feasible, the lead agency will address these requests.

Additionally, the CT Birth to Three System is responsible for the public supervision and monitoring of programs in the Connecticut Birth to Three System. In fulfillment of this requirement, programs will participate in a variety of integrated monitoring activities including, self-assessments, data verification, and focused monitoring. As a result of these monitoring activities, a program may request or be required to receive technical assistance. Depending on the nature of the non-compliance identified, TA may be provided at a cost to the program. For more information on monitoring, see the Accountability and Monitoring procedure.

Peer Supported Technical Assistance

Peer Supported technical assistance (TA) is defined as one provider providing technical assistance to another provider. The Lead Agency may request a provider receive peer supported technical assistance as a result of finding on the priority rubric, supervision or monitoring, or program identified need. The lead agency will approve the peer mentor

program and specific outcomes to be measured to support the identified need. Peer supported TA reimbursement (using Form 4-3) is provided based on pre-approval from lead agency and the availability of funds.

Accessing Technical Assistance

Programs may request TA by completing Form 4-1 “Technical Assistance Request Form” and submitting it to CTBirth23@ct.gov.

TA plans should be individualized to meet the needs of the program and the topic being addressed. For this reason, the TA may:

- be provided by a member of the Birth to Three staff, a peer mentor program, or an outside party with more specific knowledge on the topic,
- be delivered in person or through technology,
- involve file reviews or onsite activities,
- be addressed through articles and discussion,
- offered in a small group meeting or through an on-going study group
- offered for several programs at the same time or for the system as a whole

Following the completion of formal TA, programs will complete Form 4-2 “Technical Assistance Evaluation” and submit it via email to CTBirth23@ct.gov.

References:

Trohanis, Pascal, Foundations and Perspectives of TA. *Design Considerations for State TA Systems*. NECTAS, 2001

Title: TRANSFER OF CHILD FROM ONE PROGRAM TO ANOTHER

Purpose: *When parents choose another program or move to a new town transfers occur smoothly within the Birth to Three System.*

Overview

There are several scenarios that may result in a child transferring from one program to another, such as the family choosing a new program or moving to a different town in the state not served by their current program. Programs should not exit a child from the Birth to Three data system if he is continuing to receive services from another Birth to Three program. Before the transfer is made to the receiving program, all child and family information must be updated in the Birth to Three data system. For purposes of billing the lead agency the term “transfer” only refers to an attendance status after the first visit has been provided following the Initial IFSP. For this procedure, “transfer” is used more broadly. No program can decline a transfer if the program is in rotation. *When a family transfers from one Connecticut Birth to Three program to another, the family should be informed that the existing record is being sent to the new program however, a release of information form is not required before sending the record.*

When a child transfers programs, regardless of the reason for the transfer, it is strongly recommended that programs complete an IFSP periodic review on the first visit with the family. The receiving program must provide supports and services as listed on the previous program’s IFSP unless the IFSP has been revised.

When a family does not have a preference on the program, they want to transfer to the program next “in rotation” is chosen. If there are no programs “in rotation” then it goes to the next program in “accepting children”. If no programs are in “accepting children” then the transfer goes to “not accepting children”. Information about next program in rotation can be found in the data system. There should be minimal to no delay or disruption of services due to the transfer.

“Transferring” a Child Prior to the Initial Eligibility Evaluation

1. The referral has been processed at Child Development Infoline and a program has received the referral information electronically but due to parent choice or some other circumstance the referral must be sent to another program for the evaluation to be completed.
2. The sending program or a Birth to Three System administrator will contact the receiving program to notify them of the change.
3. The sending program will then electronically transfer the record to the receiving program.

“Transferring” A Child When a Family Requests a New Program after Initial Evaluation and Before Services Begin

1. After the initial evaluation, the evaluating program reminds the family of every eligible child that they have a choice of programs and reviews with them those program choices. The family is told that the ability of another program to accept new referrals must be determined.
2. If a program is not accepting referrals, the service coordinator tells the family which programs are available. If the family selects a different program, the initial service coordinator determines whether that program is able to accept a new child by directly contacting the new program.
3. Once the program selection has been made and the service coordinator has determined that the receiving program can accept the transfer, the service coordinator must send the evaluation and any other materials in the child's record to the receiving program. The sending program must send a copy of the entire early intervention record to the receiving program. The sending program should maintain all documentation in its original form. (See *Records* procedure for details of retention schedule) The service coordinator ensures that the transfer to the new program and new service coordinator is made in the data system. Until this electronic transfer is complete the family remains the responsibility of the sending program. The sending program will have access to the child's information in the data system only up to the point of electronic data transfer.
4. The receiving program must assign a new service coordinator and meet with the family to develop the initial IFSP and complete all new permission forms. If possible and agreeable to the parent, one of the initial evaluators should participate in the IFSP meeting (in person or by speakerphone). If not possible, the information must be available in a written report.

Transferring a Child when a Family Requests a New Program after Services have begun

1. The family requests a change either by telling their Birth to Three program, the Connecticut Birth to Three Family Liaison, 211 Child Development or a Connecticut Birth to Three System administrator. If the request is the result of a problem that the family is having, the program or Family Liaison should ask for the reason to determine whether the problem can be remedied without a transfer (such as a change in the person delivering services). If a transfer is the only remedy for a problem, the program assists the family in selecting a new program that is accepting referrals.
2. The sending program must send a copy of the entire early intervention record to the receiving program. The sending program should maintain all documentation in its original form. (See *Records* procedure for details of retention schedule)
3. The sending program ensures that the transfer is made to the receiving program in the data system. Until this electronic transfer is complete, the family remains the responsibility of the sending program. The sending program will continue to have

access to the child's data only up to the point of transfer. The sending program can still enter service delivery data after the electronic transfer.

4. Transfers may occur at any time during the month.

Lead Agency staff may follow-up with the family after the transfer has been completed.

Birth to Three Programs Continuation of Services When a Child Moves out of The Program's Approved Service Area

If a child or family moves out of a program's approved service area and the current program is willing to continue providing services in new town, they must request permission from the lead agency by contacting Part C Director or designee by submitting the request to CTBirth23@ct.gov. The email must contain the Birth to Three number, the town for which temporary approval is being requested and the reason. Once approved the town will be considered part of this program's approved service area for the purpose of serving the one family and does not allow the program to accept additional referrals for that town.

Transferring a Child in Foster Placement when the Child has been Moved

When a service coordinator learns that a child is moving or has already been moved to a new home by DCF the following options exist:

1. The program will update the Birth to Three data system to reflect the child's current residence, and update consent forms as appropriate with the new parent/guardian. When there is a change in foster placement, the IFSP should be reviewed with the new parent and revised as appropriate.
2. If the existing program cannot continue to provide services in the new location, the sending program should, with the assistance of DCF, determine which program (of those serving the town of residence and available to take new referrals) would be appropriate to serve the child in the new location.

The sending program must send a copy of the entire early intervention record to the receiving program. The sending program should maintain all documentation in its original form. (See *Records* procedure for details of retention schedule. The sending program ensures that the transfer is made in the data system. Until this electronic transfer is complete, the child remains the responsibility of the sending program. The sending program will continue to have access to the child's data only up to the point of transfer.

3. Transfers may occur at any time during the month.
4. The receiving program must ensure that the child has someone acting in a parental role in the new foster home. If a new surrogate parent appointment is needed requests for surrogate parent appointments are made to the Family Liaison using Form 3-10.

Transferring a Child Who is Homeless

As explained in the “Children Who are Homeless” procedure, it is likely that families that are homeless will need to transfer programs more than once. A service coordinator should discuss with the parent how important it is to inform her or him ahead of time of any anticipated change in address. If the parent and child’s address is expected to change to a town that the provider program does not serve, the service coordinator should facilitate the parent’s choice of a Birth to Three program that serves families in their new town. The sending program must send a copy of the entire early intervention record to the receiving program. The sending program should maintain all documentation in its original form. (See *Records* procedure for details of retention schedule) Children who are homeless do have a higher priority status than other children who are transferring programs or waiting for initial assignment to a program. Any questions regarding this should be directed to the Birth to Three Liaison.

Transferring a Child to a Program Specializing in Deaf/HoH

When it has been determined that a parent wants to transfer to one of the programs that specialize in working with children who are deaf or hard of hearing, the service coordinator should give them Service Guideline #5 “Young Children who are Hard of Hearing or Deaf”. The service coordinator should encourage and assist the parent to call each of the programs serving their town to ask questions before selecting one and then follow the transfer procedure.

Transferring a Child to a Program Specializing in Autism

If an eligible child is referred to a program specializing in autism by a Comprehensive Early Intervention Supports (EIS) program for an autism assessment due to red flags on an autism screening instrument and the child is determined to have a diagnosis of autism spectrum disorder, the family may wish to transfer to a program specializing in autism. The program specializing in autism can give the family general information about their preferred methodology and the general IFSP process used to determine types and frequencies of services. Specific information about what their IFSP will include for services and supports can only be discussed at the IFSP meeting. Families should be encouraged to also talk to other programs (EIS programs and those specializing in autism) that serve their town. The family should be aware that their EIS program is responsible for making any transfers in accordance with this procedure. In the event that no program specializing in autism is available in the family’s town of residence, refer to the Supports and Services procedure.

This process should also be followed when a child is determined *not eligible* by a general Birth to Three program (no significant delay), is referred for an autism assessment due to red flags on an autism screening tool, and is subsequently determined to have a diagnosis of autism spectrum disorder. If the child *does not* have a diagnosis of autism spectrum disorder, then the child is not eligible for Birth to Three

and the family may contact 211 Child Development within one month for another eligibility evaluation. Until the determination about an autism spectrum disorder is made, the child's eligibility status is "pending".