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

Child's Name: First: Middle: Last		Birth to Three #:
Date of Birth: *(please verify)*	Birth to Three Program Name:	Program Phone #:

The services provided by Connecticut Birth to Three System to eligible children are paid for by Medicaid, private health insurance, state and federal funds.

Connecticut laws 38a-516a and 38a-490a require health insurance plans to provide coverage for Birth to Three services. The laws also specify that:

- the CT Birth to Three System will not disclose any personally identifiable information for billing insurance without parental consent,
- the state will not collect co-pays or deductibles required by the insurance company,
- parents are not required to sign up for, or enroll in public or private health insurance in order to receive services,
- parents can withdraw consent to bill insurance at any time,
- enrollment in Birth to Three will not adversely affect the availability of health insurance to the child, child's parent or child's family members,
- billing will not result in increased premiums or discontinuation of public or private insurance benefits for the child
- reimbursement from insurance and parent fees will not exceed the state's cost for services,

It has been determined that your health insurance plan is one that is exempt from state insurance laws. Therefore, you may choose to authorize the Birth to Three System to file claims with your plan or not to authorize claims

If you choose to allow the Birth to Three System to bill your health insurance plan, you should also consider the following *(please initial each as reviewed):*

_____Your health insurance plan may or may not agree to cover Birth to Three services. This decision will not affect the supports you or your family receive in any way.

_____If your health insurance plan provides coverage, the Affordable Care Act may or may not prevent your plan from applying such payments against the maximum annual or lifetime limits of the policy.

_____The decision to allow or not allow billing is completely up to you as the named insured AND your decision may be changed at any time and for any reason.

_____Your child and family will continue to receive the services and supports specified on your Individualized Family Service Plan (IFSP) regardless of your decision about insurance billing.

Please discuss this decision with your service coordinator, employer, and family as needed to achieve full understanding before making your decision.

Non-Mandated Billing Authorization (to be completed with Form 1-3)

I grant permission to the Birth to Three Program listed above to submit information in order to bill my health insurance plan which is exempt from CT insurance mandates. If payment for Birth to Three services is sent to me directly, I must send that payment to my Birth to Three program. This permission remains in effect during the time in which my child is enrolled in the Connecticut Birth to Three System or until I revise this form to revoke permission. I will complete a new Form 1-3 if I secure new insurance.

Print Name _____ Signature _____ Date _____

OR

I do not grant permission or I revoke permission to the Birth to Three Program listed above to submit information for the purpose of billing my health insurance plan which is exempt from CT insurance mandates.

Print Name _____ Signature _____ Date _____

INFORMED CONSENT TO BILL
HEALTH REIMBURSEMENT AGREEMENTS or HEALTH SAVINGS ACCOUNT

Child's Name	Birth to Three Case #

Connecticut laws 38a-516a and 38a-490a require health insurance plans to provide coverage for Birth to Three services. Health Reimbursement Agreements (HRAs) and Health Savings Accounts (HSAs) however cannot be billed unless the annual deductible has been fully spent down or the family consents to allowing Birth to Three to bill the HRA or HSA.

It has been determined that you have a Health Reimbursement Agreements (HRAs) or Health Savings Account (HSA). Therefore, you may choose to authorize the Birth to Three System to file claims with your plan.

If you decide to allow the Birth to Three System to bill your HRA or HSA, you should also consider the following:

- The decision to allow or not allow billing is completely up to you as the named insured AND your decision may be changed at any time and for any reason.
- Your child and family will continue to receive the services and supports specified on your Individualized Family Service Plan (IFSP) regardless of your decision about insurance billing.
- Your decision will not change the types or amounts of service specified in your IFSP.

Please discuss this decision with your service coordinator, employer, and family as needed to achieve full understanding before making your decision.

HRA / HSA Billing Authorization: (to be completed only when a family agrees to use their HRA or HSA)

I _____ (print name) authorize the Birth to Three System Lead Agency and its agents as described in Form 1-3 to receive reimbursement for claims submitted to my insurance carrier on behalf of my child. **I understand that the funds in my HRA / HSA will be used**. This permission remains in effect until _____(date).

_____ _____
Parent Signature *Date*

For office use only. In Part C data system

HSA box checked on: _____ (date) by _____(name)

HSA box unchecked on: _____ (date) by _____(name)

HSA box checked on: _____ (date) by _____(name)

Form 1-3-HSA (Revised 7/1/18)

Insurance Information Collection and Consent to Release Information

Child's Name		Birth to Three #
Date of Birth:	Birth to Three Program Name	Program Phone #:

To support as many families as possible, the Connecticut Birth to Three System is funded by a combination of state and federal funds, Medicaid, and private health insurance. (See Form 1-3a as applicable.)

Federal and state statutes and regulations state: (1) the CT Birth to Three System will not disclose any personally identifiable information for billing public/private insurance without parental consent, (2) the state will not collect co-pays or deductibles required by the insurance company, (3) reimbursement from insurance will not exceed the state's cost for services, (4) parents are not required to sign up for, or enroll in public or private health insurance in order to receive services, (5) parents can withdraw consent to bill insurance at any time, (6) enrollment in Birth to Three will not adversely affect the availability of health insurance to the child, child's parent or child's family members, (7) billing will not result in increased premiums or discontinuation of public or private insurance benefits for the child or the child's family.
Exceptions to Above State Statute on Billing Private Health Insurance: Some private insurance plans are not required to follow CT state mandates as listed above (e.g. plans that are self-funded by an employer, also called ERISA plans, plans written by companies that do not sell health insurance in CT, or out of state policies). These non-mandated plans may or may not pay claims for Birth to Three services, or may affect other protections above (See Form 1-3a).

Child's Medicaid Number: Husky ☐ A ☐ B # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Primary Insurance Company Name:		Claim Address:	
Phone:		Effective Date:	
Member Number:		Group Number:	
Employer:		Employer's Address:	
Primary Policy Holder's Name:	DOB:	Relationship to Child:	Mailing Address:
Is Primary Policy Holder's address same as home address? ☐ Yes ☐ No			

Secondary Insurance Company Name:		Claim Address:	
Phone:		Effective Date:	
Member Number:		Group Number:	
Employer:		Employer's Address:	
Secondary Policy Holder's Name:	DOB:	Relationship to Child:	Mailing Address:
Is Secondary Policy Holder's address same as home address? ☐Yes ☐No			

- Is plan(s) non-mandated? ☐Yes ☐No If Yes, complete Form 1-3a
- Is there a health savings account? ☐Yes ☐No HSA will not be billed without a signed Form 1-3-HSA

____I authorize the release of medical or other information necessary to process claims to my insurance carrier or federal Centers for Medicare & Medicaid Services on behalf of my child, who is being evaluated and as a result may be enrolled in the Connecticut Birth to Three System. I understand that if payment for Birth to Three services is sent to me directly, I must send that payment to my Birth to Three program. I also understand that I can withdraw this consent at any time.

____I do not authorize the release.
____ I have no insurance.

Print Name	Signature	Date

_____ Consent Revoked on _____(date) _____(signature)

Information reviewed by:	Signature of Birth to Three representative/Date

CONSENT TO CONDUCT AN EVALUATION/ASSESSMENT

Dear _____,

In order for your child, _____, to participate in the Connecticut Birth to Three System, a complete evaluation, assessment or both is necessary. Federal and state regulations require that you give written permission before this can happen. In addition, you have the following rights:

1. Parents have the right to refuse consent and, if consent is given, it may be revoked at any time.
2. Parents have the right to review and obtain copies of anything in their child's record.
3. Parents have the right to be fully informed of all evaluation/assessment results in their native language.
4. Parents have the right to disagree with the results of this evaluation or assessment and may file a formal complaint or request mediation or a hearing.

The Evaluation/Assessment is scheduled for:

Date:_____Time: _____Location: _____

Along with observation and review of any previously completed assessments the following evaluation procedures/instruments will be used:

❒ I give my consent for the evaluations and assessments described above. I understand I may revoke my consent at any time.

❒ I do **not** give my consent for the following instruments:

_____
_, I understand that a refusal of child development evaluations or assessments could affect my child's eligibility for early intervention services.

_____ _____
Signature of parent, guardian or surrogate parent Date

Prior written notice was sent on _____
Date

Prior Written Notice

Parent Name_____

Address_____

_____

Dear _____, Date_____

The _____ is proposing the following for:_____
(Birth to Three program name) (Child's Name)

🡻 Check all the appropriate box(es)

	We will complete an evaluation / assessment with you as a team member.
	Your child is eligible for Birth to Three, and we need to meet with you to ☐ develop your child's initial Individual Family Service Plan (IFSP), ☐ review or revise your IFSP, or ☐ complete the annual meeting to evaluate your IFSP.(*check only one*)
	Your child is not eligible for Birth to Three.
	A transition planning conference is being convened with your approval where we will discuss the transition plan that is part of your IFSP and as a result we may revise the IFSP.
	The services as listed on your current IFSP will not begin until (see reason below)
	Your child does not need an assessment at this time. (see reason below)
	Your child is being exited from the Connecticut Birth to Three System. (see reason below)
	Other:

If applicable the **Location** for this is:_____

On this date: _____ **At this time**: _____

As required below, these are the reasons for the decision including a description of information used (such as evaluation/assessment results, reports, records, child progress, or informed clinical opinion):

_____

_____

_____

Federal law and regulations require that you receive this written notice early enough before an evaluation or meeting so that you can participate. Also if the state or a service provider proposes, or refuses, to start or change the eligibility of your child for the Connecticut Birth to Three System or the services your child and family receive you have the right to prior written notice. In addition, parents have the right to:

1. refuse consent and, if consent is given, it may be revoked at any time.
2. review and obtain copies of all records used.
3. be fully informed of all evaluation/assessment results in their native language.
4. disagree with the results of this evaluation or assessment or IFSP and may file a formal complaint or request mediation or a hearing.

If the time or place listed above is not convenient for you please call _____

Sincerely,

_____ _____
Name Title

Connecticut Birth to Three System Individualized Family Service Plan- IFSP

To support your family in helping your child learn and develop during your everyday activities

Meeting Type: ❑ Interim ❑ Initial ❑ Annual ❑ Review Meeting Start Date:_____
(*check*)

Section 1: Child and Family Information

*Child's Name:	*Date of Birth
Birth to Three #:	❑ *Male ❑ *Female

❑ **Parent** ❑ **Foster Parent** ❑ **Guardian**	❑ **Parent** ❑ **Foster Parent** ❑ **Guardian**
*Name	*Name
Street	Street
Town, State Zip code	Town, State, Zip code
Phone	Phone
Email	Email

Program Contact Information

Service Coordinator Name:	Contact #:
Program Name:	Program Director's Name and Phone #:
Program Address / Email	

Primary Health Care Provider:	Phone:
Address:	FAX:

School District Contact (*Name/Phone*):

Contact information is shared with school districts about all eligible children over age 2 ½ to help with planning for early childhood special education if needed. A "transition conference" is held for all children to help ensure that your exit from Birth to Three is smooth. With your approval, your school district may be invited.
Your transition conference will be held before:

List any evaluations/assessments completed since the last IFSP meeting.

General Health and Development Information: How is your child doing in these areas of development?
Address any changes to all areas including important health information like allergies, as well as vision, hearing, communication, movement, thinking, learning, behavior, and self-help. Also refer to the evaluation / assessment report dated _____.

Child's Name: _____DOB: _____Meeting Start Date:_____

Section 2: Family Resources

Family Map (ECO Map)**:** Who provides support to your family? This can include grandparents, aunts, uncles, friends, groups/organizations (childcare, WIC, parent groups, religious groups), babysitters, doctor, nurse, etc. This helps us understand who's important in your family life and who might be a resource to you in achieving your outcomes. Start with the child and family members in the middle.

Any comments?

Additional information about resources and concerns is gathered using a family assessment tool.
(*List tool used*)

Birth to Three supports the adults that regularly interact with your child. How do the adults in your child's life learn best (reading, doing, hearing, watching)?

Section 3: Family Priorities

One goal of the Connecticut Birth to Three System is that parents are able to describe their child's abilities and challenges more effectively as a result of their participation in the program.

Overall, what are your child's abilities/strengths: *(in parent's words)*

Child's interests: *What makes him/her laugh or smile? What's exciting? What are you proud of?*

Your child's challenges:

What are your priorities for your child:

Child's Name: _____DOB: _____Meeting Start Date:_____

Child's Name: _____ DOB: _____ Meeting Start Date: _____

Section 4: Everyday Activities

Where you can support your child's learning and development

We know from research that babies and toddlers learn best through every day experiences and activities with familiar people, when they are interested and participating in the activity.

What <u>everyday activities</u> might allow you to work on your priorities with your child?

Activities include anything that is part of your family and child's life. They can be things you do together, with other family members or friends, or things your child does in childcare or at other community functions. Some activities might include going to playgroups, grocery shopping, walking the dog, fishing with grandpa, going to the doctors or to sibling's activities, going to religious activities, getting ready to go out...

Activity *Please put an (X) in the appropriate boxes:*	**Going well**	**Some concern**	**A lot of concern**	**Activity to <u>focus on</u> related to priorities.** *Further explore in Section 5*	**Comment (as needed)**
Wake up/Bed time/Naps					
Dressing/Diapering					
Mealtimes					
Bath time					
Play					
Going Out					
Time with Friends/Family					
Time at Childcare					
Any other activities your child/family enjoys? (*Including things at home, in the community, with others…)*					
Other					
Other					
Other					

Child's Name: _____DOB: _____Meeting Start Date:_____

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

This information will help you support your child's participation in your everyday activities based on your priorities for his/her learning and development. The activities you focus on as outcomes serve as a measure of your child's progress but will not be the only activities worked on with your team. You will identify other activities that support your child's learning.

What activity will we explore?

What does your child do well or find interesting during the activity?

Where does he/she need support?

What have you and others tried (strategies) to support your child in this activity?

Additional strategies and activities related to this outcome will be developed jointly with you during your visits.

What do you want your child to learn during this activity? (*priorities **AND** other areas of development that might be addressed as part of the outcome*)

OUTCOME: *What would you like this activity to look like?*	To be achieved By: (date/event)
CRITERIA: *How will you know when you are done working on this?*	
Birth to Three is only one of many supports you may have to help you with this activity. **What other resources or supports do you have or need that can help you?** *(in addition to Birth to Three)*	Who will pay?

Copy page as needed for additional outcomes

Child's Name: _____DOB: _____Meeting Start Date:_____

Section 5B: Progress/Review Of Child Outcome

OUTCOME: (*Previously developed in Section 5 A*)	To be achieved By (event/date):

PROGRESS UPDATE as of_____ OUTCOME: ___Met ___Continue ___Discontinue
Criteria Review:

___New Criteria (if applicable):

PROGRESS UPDATE as of_____ OUTCOME: ___Met ___Continue ___Discontinue
Criteria Review:

___New Criteria (if applicable):

PROGRESS UPDATE as of_____ OUTCOME: ___Met ___Continue ___Discontinue
Criteria Review:

___New Criteria (if applicable):

Child's Name: _____DOB: _____Meeting Start Date:_____

Copy page as needed for review of outcomes

Child's Name: _____DOB: _____Meeting Start Date:_____

Section 5C: Family Outcomes and Transition Planning

Family outcomes can include transitions and experiences provided to the family and caregiver for the benefit of the child. These outcomes and transitions include things that affect your whole family like going back to work, finding childcare, learning about your child's diagnosis, exploring housing or food assistance and helping you and your child have a smooth 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?

Family Outcome: What do you want to have happen?

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?**

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

❑ yes ❑ no ❑ not right now ❑ ask me again in _____ ❑weeks ❑months.

FAMILY OUTCOME PROGRESS UPDATE as of_____

- Met
- Continue
- Discontinue

FAMILY OUTCOME PROGRESS UPDATE as of_____

- Met
- Continue
- Discontinue

Copy page as needed for additional outcomes or transitions for family

Child's Name: _____ DOB: _____ Meeting Start Date: _____

Meeting Type: ❑ Interim ❑ Initial ❑ Annual ❑ Review

Program Name: _____ Fax Number: _____

Section 6: Early Intervention Supports and Services

*What is going to happen	*Delivered by: (Discipline responsible)	*Location/ Settings	*How often	*How long	*Start date	*End date

❑ Check if ANY early intervention service listed above cannot be achieved satisfactorily in a natural environment and attach a justification page for each service*.

Part C supports are paid for by the Birth to Three System unless otherwise indicated here:

- 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.
- Service coordination is provided as part of your early intervention visit.
- Your supports (settings, type, frequency, and length of visit) as listed above may occasionally vary in order to best meet your family's needs in addressing the joint plan developed together at every visit with your team.
- With parental agreement, any discipline in Section 7 may provide coverage for another team member to address the outcomes on this plan due to circumstances documented on visit notes.

Informed Consent by Parents:
(initial A **OR** B **)**

A._____ (initial) I give permission to carry out this IFSP as written.

B._____ (initial) I disagree with this IFSP as written. I do give permission for the supports (listed below) to start. The supports that may start are as follows:

If I have initialed B above and if our team cannot come to an agreement within one month, I will request mediation, file a written complaint, and / or request a hearing.

Parental Rights/Signature: (initial and sign below)

_____ (initial) I have received a written copy of *Parent Rights under IDEA Part C*. I understand this serves as my written notice prior to starting the supports listed above and I agree that the start date(s) are a reasonable amount of time from this meeting so I may consider the plan. If I wish to have another IFSP meeting, I can request it at any time.

Parent Name:_____

Signature:_____ Date:_____

Parent Name:_____

Signature:_____ Date:_____

I reviewed this IFSP as a licensed practitioner and recommend the plan as written . *ICD10_____, _____

Child's Name: _____DOB: _____Meeting Start Date:_____
Signature:_____Name:_____*Date:_____

Optional Sig: _____
Name:_____*Date:_____

*Denotes part of the electronic record

Child's Name: _____DOB: _____Meeting Start Date:_____

Section 7: Who is Part of The Team

The following individuals have participated in the development of this IFSP and/or will assist in its implementation*.

Name (as soon as available)	**Relationship** (discipline as appropriate)	**How they participated in this meeting (X)**				
		Present	Phone/Video conference	Current Written Report	Additional Birth to Three Team Member**	Other agency Team Member
	Parent					
	Parent					
	Primary Provider Service Coordinator Discipline:					
	Primary Health Care Provider					

**Any practitioner with a discipline listed in Section 7 can provide a one-time consult (joint visit) as clinically appropriate without being listed on Section 6 of the IFSP. A practitioner with a discipline not listed in Section 7 may provide a one-time consultation as clinically appropriate for the purpose of an assessment that results in a written report.*

***Who supports you and your PSP at regular team meetings and/or joint visits.*

Meeting Notes: Additional things we talked about at the IFSP meeting:

Missed Visits: _____(initial) I understand my Birth to Three team is not required to reschedule any visits cancelled by our family or visits that would fall on days that the state is closed. If my family requests it, my program will provide for visits that were cancelled by my Birth to Three program (this may be provided by someone not currently on my team). All

missed and rescheduled visits will be clearly documented on our visit note.

Child's Name: _____ DOB: _____ Meeting Start Date: _____

Additional Page
Individualized Family Service Plan

Child's Name: _____ DOB: _____ Meeting Start Date: _____

Justification For Early Intervention Services That Cannot Be Achieved Satisfactorily in a Natural Environment

Service		**Location**	
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.			

AUTHORIZATION FOR PROGRAMS TO <u>OBTAIN</u> INFORMATION

Child's Name: _____ D.O.B.: _____

Address:_____

The following individual/agency has my authorization to release the information identified. *(Only one individual or agency per release form.)*

_____
Name or Agency/Individual

_____
Address

_____
Phone Number

Information to be released:
(Please do not release any information or records that have not been specifically authorized for release.)

_____

_____

Reason for information to be released:

_____

Information to be released to:

_____
Birth to Three Program

_____
Address

_____
Phone Number Fax Number

_____ _____
Signature of Parent/Guardian Signature Date

All information received will become part of this 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. With a written release from the parent, any information within the child's early intervention record may be released to the local school district or other providers.

The Parent/Guardian has a right to revoke this consent. Consent can be revoked by requesting this form from the program and indicating below that you are revoking consent. Consent cannot be revoked retroactively. The information listed above may have already been obtained with consent prior to the date of revocation.

☐ I wish to revoke my consent to obtain the information listed above.

_____ _____
Signature of Parent/Guardian Revocation Signature Date

AUTHORIZATION FOR PROGRAMS TO <u>RELEASE</u> INFORMATION

Child's Name: _____ D.O.B.: _____

The following Birth to Three Program has my authorization to release the information identified.

_____
Birth to Three Program

_____
Address

_____
Phone Number

Specific Information to be released:

Document	Date of Document

Reason for information to be released:

_____

Information to be released to:

_____
Name of Agency/Individual Address

_____
Name of Agency/Individual Address

_____
Name of Agency/Individual Address

_____ _____
Signature of Parent/Guardian Signature Date

Initials _____ The results of the evaluation have been shared with me. I understand that my child is NOT eligible and I have not yet seen the final written report. I consent to my program sharing it with the parties listed above before I read it.

_____

You have a right to revoke this consent. Consent can be revoked by requesting this form from the program and indicating below that you are revoking consent. Consent cannot be revoked retroactively. You have until the following date to revoke your consent

_____ after which the documents will be sent.
(date documents will be sent)

☐ I wish to revoke my consent to release the information listed above.

_____ _____

Signature of Parent/Guardian Revocation Signature Date

EARLY INTERVENTION RECORD ACCESS LOG

The following individuals have accessed the service record of_____
(child's name)

Date	Name of Person Seeking Access	Affiliation	Reason for Access

This form is to be signed by each individual who accesses this child's service record.

SERVICE COORDINATION CONTACT SHEET

Child's Name: _____ D.O.B. _____ SS #: _____
Service Coordinator: _____

Date	Note (description of contact or other service coordination activity)	Initial

Signature
X_____
_____ Discipline
x_____ (initials)

SERVICE COORDINATION CONTACT SHEET

Child's Name:_____ DOB:_____ Case #:_____

Service Coordinator: _____

Date	Notes (description of contact or other service coordination activity)	
		Signature:
		Signature:
		Signature:

Discipline

Original signature needed for <u>each</u> contact.

APPROVAL TO INCLUDE MY LOCAL SCHOOL DISTRICT IN TRANSITION PLANNING

I approve of including my school district listed below in planning for my child's transition out of Birth to Three at age 3. I also consent to the specific records listed below being sent to my school district in order to assist the with transition planning.

Parent/Guardian Signature _____ Date _____

*I do **NOT** approve of including my school district listed below in planning for my child's transition out of Birth to Three at age 3. I understand that after age 2 ½ years, notification about my child's name and how to reach me will be shared but my school district will not be invited to my transition conference. I also understand that delaying this approval and invitation to the transition conference may delay my school district's ability to determine eligibility for special education and to develop an IEP on or before my child's 3rd birthday.*

Parent/Guardian Signature _____ Date _____

*I **revoke the previous** approval and invitation. I no longer approve of including my school district in transition planning for my child at age 3. I understand that this revocation is not retroactive.*

Parent/Guardian Signature _____ Date _____

TO: _____ DATE SENT: _____

Responsible School District Contact Person

Responsible School District

FROM THE PARENT(S) OR GUARDIAN OF:

_____ CHECK IF CHILD IS IN FOSTER CARE

Child's Name _____ Date of Birth _____

Parent(s) or Guardian's Name(s) _____

Address _____ Phone: (circle) Home / Work / Cell _____

If no phone, other contact _____

I authorize release of each of the following document(s) to my school district:

Document (IFSP, Evaluation, Progress report): _____ *Date of Document:* _____

Document: _____ *Date of Document:* _____

Document: _____ *Date of Document:* _____

NOTE: Release of any additional documents after this requires parent consent on Form 3-3.

Service Coordinator	Birth to Three Program Name
Address	Birth to Three Program Telephone Number

Proposed Transition conference Date_____ Time_____

Location_____

Transition conference is responsibility of Birth to Three. All PPTs are school district's responsibility.

FOR SCHOOL DISTRICT USE

Date Received	Proposed Date/Time of PPT Meeting

REQUEST FOR SURROGATE PARENT

Child's Name: _____ D.O.B.: _____

Address: _____

Child Case # _____

This child does not live with anyone who meets the IDEA definition of "parent." Documentation (such as DCF Form #603) is attached and one or more of the following is true:

- ❑ Child is a ward of the Commissioner of Department of Children and Families
- ❑ Parents' whereabouts are unknown
- ❑ No parent can be identified.

_____

DCF Worker Name *Address* *Phone*

I certify that the information is true to the best of my knowledge.

_____ _____

Service Coordinator Name *Date of Request*

_____ _____

Program *Phone #*

_____

Fax #

For Birth to Three Use Only:

Based on documentation signed by_____ on _____

DCF Contact Person *Date*

The following person has been appointed by the Connecticut Birth to Three System to act on behalf of the child for educational purposes:

Surrogate Parent Name: _____

Address and Phone: _____

_____

This appointment supersedes any and all appointments made previously. This appointment ends when the child is no longer enrolled in the Birth to Three System, or is superceded by a subsequent appointment, whichever comes first.

_____ _____

Birth to Three Administrator *Date*

❑ Copy to Program sent on _____

Send to: Birth to Three Family Liaison: 460 Capitol Ave., Hartford, CT 06106 Fax: 860-418-6003

ASSISTIVE TECHNOLOGY PRIOR AUTHORIZATION/REIMBURSEMENT

STEP 1: Assistive Technology <u>Prior Authorization</u>

Child's Name_____ Date of Birth_____B23#_____

Program Name_____ AT Contact (name)_____

Do not send this to the OEC for children insured by Medicaid.
Email this securely with any attachments to CTBirth23@ct.gov

NOTE: Before you submit this form you must have confirmed that NEAT does not have a suitable AT device for loan.	
Enter the information below regarding commercial insurance (when determined).	☐ No insurance
Date sent to CI for estimate: -Estimated amount of insurance coverage:	
NOTE: Sections 5A & 6 from the IFSP (or Interim IFSP) must be faxed with this form demonstrating how the AT device(s) support the child's functional participation in activities.	

Complete for Step 1 – Prior Authorization				**Complete for Step 2 - Reimbursement**		
Product:	**Proc. Code**	**Quantity**	**Cost $**	**(Amt paid by CI)**	**Net Cost**	**Date to Family**
Audio Shoes						
BAHA						
Hearing Aid						
FM Transmitter						
FM Receiver						
Warranty						
Hearing Aid Insurance						
Ear Mold (one ear)	V5264					
Ear Molds (both ears)	V5264					
Batteries (Regular)	V5266					
Batteries (Rechgble AA)	V5266					
Adhesive Tape	V5267					
Air Blower	V5267					
BAHA Listener	V5267					
Battery Tester	V5267					
Dri Aid Kit	V5267					
Headband B/C	V5267					
Huggie Aids	V5267					
Otoslik	V5267					
Safe N Sound Clips	V5267					
Shipping Charges	V5267					
Soft Bands	V5267					
SS Refill Kit	V5267					
Super Seals	V5267					
Tamper Proof Doors	V5267					
Test Kit	V5267					
Wax Loop	V5267					
Other	V5267					
Describe Other						

ASSISTIVE TECHNOLOGY PRIOR AUTHORIZATION/REIMBURSEMENT

Complete for Step 1 – Prior Authorization				Complete for Step 2 - Reimbursement		
Product:	**Proc. Code**	**Quantity**	**Cost $**	**(Amt paid by CI)**	**Net Cost**	**Date Dispensed**
Other DME/List Device:						
Describe DME Device						
Total cost of all AT including supplies		$				
Total tax & shipping		$				
Dispensing Fee (one ear)	V5090	$				
Dispensing Fee (both ears)	V5090 -U1	$				
Grand Total Not To Exceed		$				

Lead Agency Administration Only:		
Date request received: Date returned to program:	_____Approved not to exceed amount above _____Denial Reason: _____Need Additional Information:	Authorized Signature and Date:

Step 2: ASSISTIVE TECHNOLOGY <u>REIMBURSEMENT</u> REQUEST

Complete this section for reimbursement after the devices approved above have been given to the family. Enter the date above on each row when each item was dispensed. Total the Net Costs for the reimbursement being requested and attach supporting documentation as required. Supplies not to exceed the monthly amount posted on the CTDSSMAP.com website, unless prior authorization has been approved above.

Total reimbursement requested for the approved items listed above and dispensed on _____ is $_____

Signature : _____ Date:_____

Total reimbursement requested for the approved items listed above and dispensed on _____ is $_____

Signature : _____ Date:_____

Total reimbursement requested for the approved items listed above and dispensed on _____ is $_____

Signature : _____ Date:_____

Total reimbursement requested for the approved items listed above and dispensed on _____ is $_____

Signature : _____ Date:_____

Assistive Tech. Reimbursement

Program Name: **Date submitted:**

Child's Name: **DOB:**	**Birth to Three #:**

PROGRAM is REQURIED to attach the following: ___ Proof of payment ___ Proof of insurance acceptance/denial ___ PreAuth/when required

Product:	**Procedure Code**	**Quantity**	**Cost $**	**Less 3rd Party Reimb.**	**Dates Delivered Required ***	**Total Cost**
Audio Shoes						
BAHA						
Hearing Aid						
FM Transmitter						
FM Receiver						
Warranty						
Hearing Aid Insurance						
Other DME/List Device:						
shipping charges						
Dispensing Fee (one ear)	V5090					
Dispensing Fee (both ears)	V5090 -U1					
Ear Mold (one ear)	V5264				*	
Ear Molds (both ears)	V5264				*	
Batteries (Regular)	V5266				*	
Batteries (Rechgble AA)	V5266				*	
Supplies: Not to exceed the monthly amount posted on the Ctdssmap.com website, unless a prior authorization has been approved.						
Adhesive Tape	V5267					
Air Blower	V5267					
BAHA Listener	V5267					
Battery Tester	V5267					
Dri Aid Kit	V5267					
Headband B/C	V5267					
Huggie Aids	V5267					
Otoslik	V5267					
Safe N Sound Clips	V5267					
Shipping Charges	V5267					
Soft Bands	V5267					
SS Refill Kit	V5267					
Super Seals	V5267					
Tamper Proof Doors	V5267					
Test Kit	V5267					
Wax Loop	V5267					
Other	V5267					

Total Requested Reimbusement

NEAT Trial Agreement (3-13) Form
Vendor Equipment Trial *(Short Term)*

Oak Hill's NEAT Equipment Restoration Center (ERC), has a limited supply of vendor owned adaptive equipment that can be borrowed by Birth to Three providers to help in the assistive technology assessment process. Birth to Three providers can have access to and borrow from this inventory utilizing this form: 3-13.

The adaptive equipment requested on this form is for trial purposes only and can be trialed for up to 4 weeks. This device should be returned to NEAT once the trial period has concluded. *Consideration should be given to the age of the child with regard to the timeline for borrowing equipment (*CT. Birth to Three Assistive Technology Procedure*).*

The Birth to Three provider is responsible for returning the equipment to NEAT, in good condition with all of the equipment pieces and accessories intact.

Birth to Three Contact Information

Birth to Three Interventionist Signature			
Birth to Three Interventionist Name (Printed)			
Title/Role		Provider Agency	
Address			
Phone		Email	

Birth to Three Trial of Assistive Technology Device process:

1. Determine that this trial will help identify whether the device will meets the needs of the child and is consistent with CT Birth to Three Procedures for Assistive Technology.
2. Complete this Trial Agreement Form, 3-13 and return it to NEAT via email at NEAT.B23@oakhillct.org or by mail at NEAT, 33 Coventry St. Hartford, CT, 06112. Incomplete forms will not be processed.
3. **Identify a specific equipment request (contact NEAT to determine what vendor equipment is available for trial):**

How would you like to obtain your trial device?

Adaptive Equipment Options	
	Birth to Three Provider will pick up at NEAT
	Deliver to Birth to Three Provider Agency, at address listed above.
	Deliver **oversized** equipment to the Family's address listed below. ***See important information below.**

***** Upon delivery of equipment, an interventionist MUST be available to sign as a representative of the Birth to Three Provider agency. Equipment will NOT be left without a representative present.

Family Contact Information

Child Name		Child's Birth Date	
Child's ID/Case #		Birth to Three Exit Date	
Parent/Guardian Name		Primary Language	
Address			
Phone		Email	

NEAT USE ONLY

Assistive Technology Trial Device Description

Identify Device:	
1.	
2.	
3.	
4.	
Loan Start Date:	

Acknowledgement of Delivery of Trial Device

Birth to Three Provider's Signature _____

NEAT Staff's Signature _____

Date Delivered _____

NEAT Loan Agreement (3-14) Form
Birth to Three Inventory *(Long Term Loans)*

NEAT, an Oak Hill Center, organizes an inventory of CT's Birth to Three owned <u>adaptive equipment</u> as well as <u>iPads dedicated for communication purposes</u>. Birth to Three providers can have access to and borrow from this inventory utilizing this form: 3-14.

The loaned device should be returned to NEAT once the child no longer is using the device. Consideration should be given to the age of the child with regard to the timeline for borrowing equipment (see Birth to Three Procedure on Assistive Technology). The child can keep the loaned assistive technology device after exit from Birth to Three as long as it is still appropriate, it is being regularly used, and there is a plan for acquisition of the device through other means.

The Birth to Three provider is responsible for informing parents/guardians that NEAT will be making follow-up phone calls and/or emails to see if the child and family are still using the device. Parents/guardians are responsible for reaching out to NEAT in the event that they no longer need/want the device, or if they are moving out of state. Provider should assist with the process, when possible. As soon as NEAT receives notification that the assistive technology device is no longer in use, a plan will be made for returning the device to NEAT.

Birth to Three Contact Information

Birth to Three Interventionist Signature			
Birth to Three Interventionist Name (Printed)			
Title/Role		Provider Agency	
Address			
Phone		Email	

Birth to Three Inventory Loan process:

1. Determine that the device meets the needs of the child and is consistent with CT Birth to Three Procedures for Assistive Technology.
2. Complete this Loan Agreement Form, 3-14 and return it to NEAT via email at NEAT.B23@oakhillct.org or by mail at NEAT, 33 Coventry St. Hartford, CT, 06112. Incomplete forms will <u>not</u> be processed.
3. Identify what type of device will be borrowed from the Birth to Three Inventory and follow the steps below.

	iPad for Communication		**Adaptive Equipment**
Identify a specific equipment request and include any apps or accessories (e.g., iPad Mini with amplification or Rifton Stander):			

How would you like to obtain your assistive technology device?

Adaptive Equipment Options		**iPad for Communication** Options	
	Birth to Three Provider will pick up equipment at NEAT		Birth to Three Provider will pick up iPad at NEAT
	Deliver equipment to Birth to Three Provider Agency, at address listed above.		Mail iPad to Birth to Three Provider Agency, at address listed above (must be insured).
	Deliver **oversized** equipment to the Family's address listed below. ***See important information below.**		NEAT will NOT deliver iPad to the Family's home address.

***** Upon delivery of equipment, an interventionist MUST be available to sign as a representative of the Birth to Three Provider agency. Equipment will NOT be left without a representative present.

Family Contact Information

Child Name		Child's Birth Date	
Child's ID/Case #		Birth to Three Exit Date	
Parent/Guardian Name		Primary Language	
Address			
Phone		Email	

NEAT USE ONLY

Assistive Technology Description

Identify Device Being Loaned:		**Inventory #:**
1.		
2.		
3.		
4.		
Loan Start Date:		

Acknowledgement of Assistive Technology Device Delivery

Birth to Three Provider's Signature _____

NEAT Staff's Signature _____

Date Delivered _____

AUTHORIZATION FOR PROGRAMS TO <u>OBTAIN</u> CONFIDENTIAL INFORMATION

Child's Name: _____ DOB: _____

The following individual/agency has my authorization to release the confidential information identified. *(Only one individual or agency per release form.)*

_____
Name or Agency/Individual

_____
Address

Information to be released:
(Please do not release any information or records that have not been specifically authorized for release.)

_____
document date

Information to be released to:

_____
Birth to Three Program

_____
Address

_____ _____
Signature of Parent/Guardian Date

AUTHORIZATION FOR PROGRAMS TO <u>RELEASE</u> CONFIDENTIAL INFORMATION

Child's Name: _____ DOB: _____

The following Birth to Three Program has my authorization to release the confidential information identified.

_____
Birth to Three Program

_____
Address

Confidential Information to be released:

_____
document date

Information to be released to:

_____
Name of Agency/Individual Address

_____ _____
Signature of Parent/Guardian Date

This information has been disclosed from records whose confidentiality is protected by CT law (Sec. 19a-585). State law prohibits you from making any further disclosure of it without specific written consent of the parent/guardian.

BIRTH TO THREE NUTRITION SCREENING

Child's Name: _____ **D.O.B.** _____ **Date of Screening** _____
Age:_____ **Parent / Caregiver:** _____
Address:_____ **Date:** _____
_____ **Tel. No.** _____

Health / medical condition:_____
Service Coordinator_____

To the parent or questioner: Circle or check the correct answer or answers.

1. How does your child eat? Check choices below that best describe how.
   - __ uses bottle
   - __ breastfeeds
   - __ takes sips from a cup
   - __ drinks from a cup with/without lid
   - __ uses a straw
   - __ takes oral feeding supplements (Pediasure®, Boost®, Kindercal®, and Neocate®)
   - __ has feeding tube
   - __ finger feeds
   - __ fed by spoon
   - __ self-feeds with spoon/fork
   - __ uses special feeding equipment, what?
   - __ takes foods other than milk from a bottle

2. Do you have any concerns about whether your child is eating at an appropriate stage for his age?
   ☐ No ☐ Yes

3a. Are you concerned about the amount or variety of foods your child takes in from the following food groups?
   ☐ No ☐ Yes *(If yes, check all that apply)*

   - __ milk and dairy foods
   - __ vegetables
   - __ breads, cereals, rice, beans, and grains
   - __ snack foods (chips, soda etc.)
   - __ meats, eggs, fish, poultry
   - __ fruits
   - __ fats
   - __ sugars/sweets

3b. Please note any dietary restrictions in your child's diet:

4. Do you or your doctor have concerns about your child's size? No Yes *(If yes, explain)*
   Child's latest length_____weight_____

5. Does your child have food allergies? ☐No ☐Yes (*If yes, list)*

6. Does your child take any medications or other supplements (vitamins, iron, fluoride, or herbal supplements) on a regular basis? ☐No ☐Yes (*If yes, list)*

7. Does your child experience any of the following: ☐No ☐Yes (*If yes, check all that apply)*

__ difficulty with sucking
__ difficulty with swallowing
__ difficulty with chewing
__ difficulty tolerating food textures
__ difficulty tolerating food temperature
__ choking
__ diarrhea
__ constipation
__ vomiting/reflux
__ rashes
__ gagging
__ other:

8. Do you have concerns about your child's mealtime experiences and eating behaviors? ☐No ☐Yes

If yes, check the choices below:

__ child refuses to eat
__ child spits out food
__ child throws food or utensils
__ child eats too slowly
__ child stuffs mouth
__ child takes bottle to bed
__ no scheduled mealtimes
__ child unable to sit through meal
__ mealtimes are hectic
__ meal seems to take too long
__child eats items, which are not food, (i.e. paint chips, crayons, dirt, paper, cigarettes, etc.)

9. Has your child ever had a history or diagnosis of any of the following: ☐No ☐Yes *(If yes, check all that apply)*

__ AIDS/HIV *
__ Autism
__ Bronchopulmonary Dysplasia
__ Cardiac Problems
__ Cerebral Palsy
__ Cleft / Lip or Palate
__ Congenital Heart Disease
__ Cystic Fibrosis
__ Diabetes
__ Down Syndrome
__ Failure to Thrive
__ Fetal Alcohol Syndrome
__ Gastrointestinal disorders
__ Hyperinsulinemia
__ Inborn Errors of Metabolism - Galactosemia, Glycogen storage disease, Phenylketonuria (PKU),
__ Lead Exposure
__ Muscle disorders (MS, Spinal Muscular Atrophy)
__ Myelomenigecele / Spina Bifida
__ Nutrition Support (tube or IV feedings, Other- please specify)
__ Prader–Willi Syndrome
__ Premature birth / Very Low birth weight (VLBW)
__ Renal Disease
__ Seizure Disorder
__ William's Syndrome
__ Other - please specify

*** Any information shared regarding child or family's AIDS/HIV status will be kept confidential in accordance with CT State Law (Sec. 19a-585).**

IF THERE ARE TWO OR MORE YES ANSWERS FOR QUESTIONS 2-9 THE CHILD IS LIKELY TO HAVE A NUTRITION PROBLEM

10. Do you feel you have enough foods, formula for your child? ☐ Yes ☐ No

11. Would you like to meet with someone about your child's nutrition or eating habits? ☐Yes ☐No ☐Later

ACTIONS TAKEN:

❑ Refer to a nutrition specialist.
❑ Caregiver requests referral to nutrition specialist.
❑ No nutrition intervention needed at this time. Recheck again _____.
date
❑ Is currently receiving nutritional services from _____
These services are:_____
_____
❑ Nutrition services included as early intervention service in IFSP.

Completed by: _____ Title:_____
Date: _____

VISION SCREENING

Child's Name: _____ DOB: _____ Date of Screening: _____

Parent's name: _____

Name of person completing form: _____

Relationship to child, if not parent or guardian: _____

Please answer these questions, adding explanations as needed.

Has your child ever been seen by a vision specialist? □ Yes □ No

Who: _____ When: _____

Results reported: _____

Does your child:

1. have turning of one or both eyes? □ Yes □ No _____

   □ Turns inward □ Turns outward □ Turns in and out at different times

2. persistently poke, rub, or cover his/her eyes? □ Yes □ No _____
3. have unusual and persistent watering of the eyes? □ Yes □ No _____
4. have little "fluttering" or jerky movements of the eyes? □ Yes □ No _____
5. make little or no eye contact? □ Yes □ No _____
6. hold his/her head in a tilt or other unusual angle? □ Yes □ No _____
7. get very close to toys or books in order to see? □ Yes □ No _____
8. act fidgety or disinterested during circle time and/or story hour? □ Yes □ No ___
9. avoid looking at objects or a face that is within 24 inches of his/her face? □ Yes □ No

When looking straight ahead, does your child miss seeing objects or people in a particular field of vision?

to the child's right? □ Yes □ No _____

to the child's left? □ Yes □ No _____

below the child's gaze? □ Yes □ No _____

above the child's gaze? □ Yes □ No _____

Vision Screen page 2 **child's name** _____

Does your child bump into objects? □ Yes □ No _____
On one side more often than the other?
Left □ Yes □ No _____

Right □ Yes □ No _____

Does your child fall down a lot? □ Yes □ No

Does your child seem to look at things with his/her side vision rather than looking directly at it?
□ Yes □ No _____

Does your child have difficulty with balance and movement?
□ Yes □ No _____

Does your child frequently knock over or spill items (i.e. a glass) when reaching for it?
□ Yes □ No _____

Does your child often reach past an object or not far enough?
□ Yes □ No _____

When you move an object across the area in front of your child, does he/she look at the object for the entire range of movement, side-to-side?
□ Yes □ No _____

Have you ever wondered if your child has a vision problem? □ Yes □ No

Does your child's parent or brother/sister have a vision problem? □Yes □ No

Please make additional comments:

_____

_____

_____

_____

_____

_____ _____
Printed name of screener Signature of Screener

If any items are answered "yes", results should be forwarded, with parent permission, to the child's primary health care provider with a cover letter.

Definitions for Outcome Ratings:
For Use with the Child Outcomes Summary Form (COSF)

Overall Age-Appropriate	**Completely** *means*:	**7**	• Child shows functioning expected for his or her age in **all or almost all everyday situations** that are part of the child's life. Functioning is considered **appropriate** for his or her age. • No one has any concerns about the child's functioning in this outcome area.
		6	• Child's functioning generally is considered **appropriate** for his or her age but there are **some significant concerns** about the child's functioning in this outcome area. These concerns are substantial enough to suggest monitoring or possible additional support. • Although age-appropriate, the child's functioning may border on not keeping pace with age expectations.
Overall Not Age-Appropriate	**Somewhat** *means:*	**5**	• Child shows functioning expected for his or her age **some of the time and/or in some settings and situations**. Child's functioning is a mix of age-appropriate and not age-appropriate behaviors and skills. • Child's functioning might be described as like that of a **slightly younger child*** .
		4	• Child shows occasional age-appropriate functioning across settings and situations. More functioning is **not** age-appropriate than age-appropriate.
	Nearly *means:*	**3**	• Child does **not yet** show functioning expected of a child of his or her age in any situation. • Child uses **immediate foundational skills,** most or all of the time, across settings and situations. Immediate foundational skills are the skills upon which to build age-appropriate functioning. • Functioning might be described as like that of a **younger child*** .
		2	• Child occasionally uses **immediate foundational skills** across settings and situations. More functioning reflects skills that are **not** immediate foundational than are immediate foundational.
	Not yet *means*:	**1**	• Child does **not yet** show functioning expected of a child his or her age in any situation. • Child's functioning does **not yet include immediate foundational skills** upon which to build age-appropriate functioning. • Child functioning reflects skills that developmentally come before immediate foundational skills. • Child's functioning might be described as like that of a **much younger child*** .

* The characterization of functioning like a younger child only will apply to some children receiving special services, such as children with developmental delays.

Connecticut Birth to Three System

Combination Child Outcomes Summary Form / Decision Tree*

Child:	**Today's Date:**	**Circle one per form:** Entry / Exit
Who was involved?	Name:	Role: Parent
	Name:	Role:
	Name:	Role:
Information based on (Check all that apply)	☐ Family Observations	
	☐ Assessment information, please circle one: HELP / Carolina / AEPS (with crosswalks)	
	☐ Other, please describe (i.e. Child Care Observations)	

Families, please check the box to record how you feel right now about this statement:

I can clearly describe my child's abilities and challenges with family, friends, medical providers and others in our community.

☐Very Strongly Disagree ☐Strongly Disagree ☐Disagree ☐Agree ☐Strongly Agree ☐Very Strongly Agree

Outcome A Positive social-emotional skills – including relationships with adults and children (and following rules if over 18 months old)

Does _____ (name) do things we'd expect to see for his or her age?	☐Yes	Do we see these skills in all or ***almost all settings and situations****?*	☐ Yes, Examples	Does anyone have concerns about this outcome area?	☐ No	7
					☐ Yes, Examples:	6
			☐ No/ Not yet	Do we see these skills in any different ***settings or situations****?*	☐ **Sometimes** there is a mix in different settings and situations, Examples:	5
					☐ **Rarely,** Examples:	4
	☐ No/ Not yet	Do we see skills that are related to this area but that develop earlier? (sometimes called Foundational Skills)	☐ Yes, Examples	Do we see these earlier skills in different settings / situations?	☐ **Most or all of the time** in different settings and situations, Examples:	3
					☐ **Sometimes** in different settings and situations, Examples:	2
			☐ No/ Not yet			1

Exit only: Have any new skills been acquired since entry? ☐ No / Not yet ☐ Yes

Outcome B Acquiring and using knowledge and skills – thinking, reasoning, remembering, problem solving, language / communication

Does _____ (name) do things we'd expect to see for his or her age?	☐Yes	Do we see these skills in all or ***almost all settings and situations?***	☐ Yes, Examples	Does anyone have concerns about this outcome area?	☐ No	7
					☐ Yes, Examples:	6
			☐ No/ Not yet	Do we see these skills in any different ***settings or situations***?	☐ **Sometimes** there is a mix in different settings and situations, Examples:	5
					☐ **Rarely,** Examples:	4
	☐ No/ Not yet	Do we see skills that are related to this area but that develop earlier? (sometimes called Foundational Skills)	☐ Yes, Examples	Do we see these earlier skills in different settings / situations?	☐ **Most or all of the time** in different settings and situations, Examples:	3
					☐ **Sometimes** in different settings and situations, Examples:	2
			☐ No/ Not yet			1

Exit only: Have any new skills been acquired since entry? ☐ No / Not yet ☐ Yes

Outcome C Taking appropriate action to meet needs – basic needs (e.g., showing hunger), getting around, using "tools" (i.e., a spoon)

Does _____ (name) do things we'd expect to see for his or her age?	☐Yes	Do we see these skills in all or ***almost all settings and situations?***	☐ Yes, Examples	Does anyone have concerns about this outcome area?	☐ No	7
					☐ Yes, Examples:	6
			☐ No/ Not yet	Do we see these skills in any different ***settings or situations***?	☐ **Sometimes** there is a mix in different settings and situations, Examples:	5
					☐ **Rarely,** Examples:	4
	☐ No/ Not yet	Do we see skills that are related to this area but that develop earlier? (sometimes called Foundational Skills)	☐ Yes, Examples	Do we see these earlier skills in different settings / situations?	☐ **Most or all of the time** in different settings and situations, Examples:	3
					☐ **Sometimes** in different settings and situations, Examples:	2
			☐ No/ Not yet			1

Exit only: Have any new skills been acquired since entry? ☐ No / Not yet ☐ Yes

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: _____ Date: _____

Service Coordinator's Name: _____ 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.

Autism Spectrum Disorder Checklist

(DSM-5 Diagnostic Criteria)

Child: DOB B23#	Evaluator: Program:

Please indicate in the space next to each criterion how the diagnostician knows that the child meets the criteria (for example, an ADOS 2 or other instrument, or observation).

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all the following, currently or by history:	
Criterion	**Please indicate how documented in this column:**
1. Deficits in social-emotional reciprocity	
2. Deficits in nonverbal communicative behaviors used for social interactions	
3. Deficits in developing, maintaining, and understanding relationships.	
B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:	
1. Stereotyped or repetitive motor movements, use of objects or speech	
2. Insistence on sameness, inflexible adherence to routines or ritualized patterns of verbal or nonverbal behavior	
3. Highly restricted, fixated interests that are abnormal in intensity or focus	
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment	
Specifiers:	
1. With or without accompanying intellectual impairment	
2. With or without accompanying language impairment	
3. Known etiological factor (s) present (for example medical condition, genetic syndrome, environmental factor):	
4. Associated with another neurodevelopmental, mental, or behavioral disorder	
5. Severity (Please circle appropriate level): Level 1: Requiring support: Level 2: Requiring substantial support: Level 3: Requiring very substantial support:	

Person completing form (print and sign) credentials/date

Connecticut Birth to Three System Autism Assessment Results

Child's Name:	**DOB:**	**Date:**
Current Program Name:	**Service Coordinator Name and Phone #:**	

WHAT WE DID TODAY:

Location of Assessment: ❒ Home ❒ Community Program ❒ Other_____

Assessment Process: ❒ Parent/Caregiver Interview ❒ Observation ❒ Other:_____

Evaluation Instruments: ❒ Battelle Developmental Inventory ❒ Vineland
❒ Preschool Language Scale-5
❒ Autism Diagnostic Observation Schedule 2 Module ____, Toddler Module
❒ Other:

WHO PARTICIPATED FROM _____ **(program name)**

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

OUR FINDINGS (see checked item below):

❒ As a result of this assessment your child meets the criteria or measures against which an autism diagnosis is set by the Diagnostic and Statistical Manual-5 (DSM-5)*****.
Because of this determination, you may choose an autism specialty program for services or if you are currently with a comprehensive program, you may choose to remain with this program. Please see list of program options for your town below.

❒ As a result of this assessment your child does not meet the criteria (DSM 5) for an autism diagnosis*****

***** Regardless of the results a full typed report will be given or mailed to you within 2 weeks.

NEXT STEPS: (Autism Guidelines can be found on http:www.birth23.org)

Autism Specialty program options in your town (also available at https://www.birth23.org/locations/):

If you have any questions please contact your service coordinator.

Parent Signature _____ **Date**_____

NOTICE OF BIRTH TO THREE RECORD RETENTION AND DESTRUCTION

Child's Name: _____ DOB:_____

Parent's Name: _____

Address: _____

Phone Number: _____Email: _____

Anticipated date that determines when records will be destroyed (exit date, evaluation date when not eligible):_____

This form and the Parent Rights Brochure serve as notification that your child's Birth to Three record will be maintained for at least six years. You may request copies of documents as needed during the six-year retention period.

It is important to keep your copies in a secure location. Reasons when you may need copies of Birth to Three documents include:

- ✓ Preschool Registration
- ✓ Public School Special Education Services
- ✓ Social Security Disability Services
- ✓ Medical Appointments

This is your only notification that your child's record will be destroyed after six years from the date listed above. Please keep this with any documents you have received.

Please initial line 1.

1) _____I have received a copy of my rights and have been notified about my child's record in accordance with the Birth to Three records retention policy.

Initial line 2 only <u>when applicable</u>.

2) _____I have received (circle one) a copy / the original (if program no longer needs the original) of my child's evaluation report or our full record. I understand that the record will be maintained for at least six years from the date above.

My record will be maintained by:

Agency Name: _____Contact:_____

Address: _____

Phone Number: _____Email:_____

If the agency listed above is no longer in operation and you would like to request copies from your child's record during the six-year retention period, please call the Connecticut Birth to Three System at 860-500-4400 or visit Birth23.org for assistance.

For programs as applicable (if family exits prior to completing form)

DATE form was mailed to family: _____

This form is in accordance with State policy; CGS § 17a-248 et seq. and Section 303.403 of the IDEA Part C Federal Regulations

Remote Early Intervention (Remote EI) Consent and Prior Authorization (PA) Request Form

Family Consent for the Use of Remote EI:

I understand that my visits will be completed remotely using the phone or a secure video connection. I have been given technical assistance to make this happen effectively.

I understand that I can revoke this consent at any time.

Printed Name:_____

Signature: _____ Date:_____

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Birth to Three Program ONLY email SECURELY to CTBirth23@ct.gov as required (PA waived during COVID-19 PHE except for audio only EITS.)

Program Name:	Child's Name:		Birth to Three Number:
DOB:	Start Date:	Proposed End Date:	Service Type: ☐ Eval. ☐ Assmt. ☐ IFSP ☐ EITS
Reason: Please describe in detail: ☐ Complete IFSP must be attached			
Which technology will be used: ☐ OEC listed HIPAA Compliant Web-Based application: _____*(name)* ☐ Phone ☐ Other (Describe):			
Office of Early Childhood Only:			
Date request received: Date returned to program:	☐Approved ☐Denial Reason: ☐Need Additional Information:		Authorized Signature and Date:

☐ I revoke this consent:

Printed Name:_____

Signature: _____ Date:_____
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Referral for Registration for Developmental Monitoring

Child's Name: _____DOB:_____

You are receiving this form as a parent of a child who was in Birth to Three and was referred to your local school district for an evaluation to determine whether your child was eligible for preschool special education.

On _____ we were notified that your child was determined to be ineligible for participation in preschool programs under Part B of the Individuals with Disabilities Education Act.

Connecticut law requires that within two months of the date above Birth to Three programs is required to provide you with a form to help you register for continued screening for developmental and social-emotional delays in partnership with your school district. You are getting this form on: _____ (today's date).

Depending on the town in which you live you may have options for how this continued developmental screening will be done.

☐ SPARKLER is a mobile application that offers the Ages & Stages Questionnaires® as well as tips for parents and activities to promote early childhood growth and learning.
- o New users can download the Sparkler mobile application to their phones or tablets from the Google Play Store or the Apple App Store
- o Open the app and tap "Create a New Account." Use the code **CTFam** to place your account in Connecticut. Answer the questions to create an account for yourself and a profile for your child. You must enter your child's birthday correctly because Sparkler assigns screenings and other content based on your child's age.

☐ If you don't want to use the mobile application you can register for Ages and Stages directly by going to https://www.asqonline.com/family/0ba1ca or for Spanish https://www.asqonline.com/family/337104

☐ If your school district is offering another option, it is described below:

_____

_____

Your school district will follow up with you if the results indicate that your child may need to be re-evaluated. If you choose not to register for developmental monitoring at this time your school district will touch base with you in 6 months and again in one year.

Consent to Receive Early Intervention Service (EIS) Over Age 3

Child's Name: _____ DOB: _____

Connecticut's Birth to Three System offers a group of families the choice to continue to be eligible for Part C of the Individuals with Disabilities Education Act (IDEA) beyond their child's third birthday, when all of the following criteria are met. The child must:

- currently be receiving early intervention services (EIS),
- turn age 3 between May 1 and the start of their school year after the 3rd birthday, and
- have been determined to be eligible for Part B preschool special education.

I understand that I have the following rights:

1. None of the transition planning requirements in the IDEA are waived by this extension.
2. All early intervention services outlined in my child's IFSP continue while my school district determines eligibility for Part B preschool special education.
3. None of the requirements for a free appropriate public education (FAPE) by age 3 are waived by this extension.
4. If eligible for Part B preschool special education, I will have an opportunity to review my child's Individualized Education Plan (IEP) before choosing whether or not to implement the IEP as written.
5. My school district will not be required to provide FAPE for Part B preschool special education while my child receives Part C "Birth to Three" EIS services even after age 3.
6. EIS provided through an IFSP over age 3 will include an educational component that promotes school readiness and incorporates pre-literacy, language and numeracy skills.
7. With my signed consent to share information (Form 1-3), my private insurance will be billed for EIS over age 3 as for EIS before age 3 with no additional out-of-pocket costs.
8. My family may exit Birth to Three at any time but only one time once my child reaches age 3 and no later than the day before the implementation date on page 11 of my child's IEP.

❒ I have received a copy of the Birth to Three *Parent's Rights* brochure, the *Procedural Safeguards in Special Education* and *Your Rights and Options after Your Child Turns Three Between May 1 and the Start of Your School District's School Year*. I consent to the continuation of IDEA Part C Birth to Three Early Intervention Services (EIS) beyond age 3, but no later than the start of the school year after my child's 3rd birthday. I have signed Form ED626 notifying my school district that I consent to an initial placement in special education but choose to delay implementation until the beginning of the school year. I understand that I may revoke this consent at any time and exit Birth to Three but that we cannot re-enroll after my child's 3rd birthday.

❒ By checking this box, I consent to sharing a copy of this form with my school district.

❒ I do not elect to continue Birth to Three EIS after age 3 and have received Prior Written Notice that my IFSP services will end on _____(date).

_____ _____

Signature of parent Date

_____ _____

Signature of parent Date

Your Rights and Options after Your Child Turns Three
Between May 1 and the Start of Your School District's School Year

In Connecticut, families who are receiving Early Intervention Services (EIS) in Birth to Three with children who turn three between May 1 and the start of their school district's school year may be able to continue to receive EIS after age three until the start of their school year. This is called EIS Over 3. This notice will walk you through the steps and will review your rights and options along the way. There are a number of acronyms that have been spelled out.

First: Families who want to explore EIS Over 3 must approve of including their school district (also known as a local education agency or LEA) in transition planning because EIS Over 3 is only available to families with children who are determined to be eligible for preschool special education or Part B, Section 619 of the Individuals with Disabilities Education Act (IDEA) and are currently receiving IDEA Part C services.

Next: Your service coordinator will convene a transition conference and invite your LEA to participate. The LEA will then hold planning and placement team (PPT) meetings with you to determine eligibility and, if eligible, develop an Individualized Education Program (IEP).

Once you have an IEP, you can compare the services being proposed with your IFSP and then make a choice. You can

1) consent to implement your IEP as written and receive a free appropriate public education (FAPE) from your LEA and exit the Birth to Three program;
2) choose to stay in Birth to Three with an IFSP that includes an educational component and then implement your IEP on a later date after your child's third birthday but no later than the start of the next school year following your child's third birthday; or
3) choose to discontinue all services and exit Birth to Three at any time and not implement your IEP but if you later change your mind, you can ask for your IEP to be implemented.

IMPORTANT: Choosing EIS Over 3 is a one-time election. Once you exit Birth to Three after your child turns three, you are no longer eligible to receives EIS from a Birth to Three program.

A note about Extended School Year or "ESY" from the Connecticut Department of Education
Under the IDEA, decisions regarding a child's eligibility for ESY services are to be made on an individual basis based on the needs of the child. Not all children eligible for Part B services are eligible for ESY.

The state standard in Connecticut has included both regression/recoupment criteria and non-regression criteria for determining if a child is eligible to receive ESY services. Factors include:
The nature or severity of the student's disability (non-regression);

*The student is likely to lose critical skills or fail to recover these skills within a reasonable time as compared to typical students (regression/recoupment);
*The student's progress in the areas of learning crucial to attaining self-sufficiency and independence from caretakers (non-regression);
*The student's stereotypic, ritualistic, aggressive or self-injurious interfering behaviors prevent the student from receiving some educational benefit from the program during the school year (non-regression); or
*Other special circumstances identified by the IEP team such as: the ability of the student to interact with other non-disabled students; the areas of the student's curriculum that need continuous attention; the student's vocational needs; or the availability of alternative resources.

Extended School Year (ESY) Services March 15, 2007

NOTE: If your child is not eligible for ESY, the services from your school will not start until the implementation date on your IEP. This means that if you do not elect to continue in Birth to Three, you will not receive supports from Birth to Three or services from your school over the summer.

Effective communication about your child's strengths and needs plays a critical role in supporting your family's choice. For example, a family with a child who has social-interpersonal needs may prefer to transition to preschool special education to promote social interactions with other young children. Another family may decide to continue receiving EIS Over 3 because they already have many opportunities during the week for their child to spend time with peers.

Each family's choice is unique and should be based on the best fit for your family.

For families who choose to continue EIS Over 3 the IFSP will include an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills.

Know your rights!

In addition to this notification, there are two important forms and two guides about your rights.

IDEA Part C Birth to Three EIS	*IDEA Part B Preschool Special Education*
Form 5-5 Consent to receive EIS over Age 3	Form ED626 Consent for the Initial Provision of Special Education
Parent Rights Brochure	Procedural Safeguards in Special Education

The table that starts below and continues on pages 3 and 4 includes statutory and regulatory references about your rights and the different components that make up IDEA Part C (Birth to Three or EIS) and Part B (Preschool Special Education).

It is hope that this will help you compare your options so that you are well informed when you make a decision.

Components	**Part C - Birth to Three**	**Part B - Preschool Special Education**
Individualized Plan/Program	*Individualized Family Service Plan* 20 USC §303.20, 34 CFR §303.344	*Individualized Education Program* 20 USC §1414, 34 CFR §§300.320–300.324
	Individualized Family Service Plan (IFSP) means a written plan for providing early intervention and other services to an eligible child and the child's family; the IFSP is revised at least annually by an IFSP team, which includes the child's parent. The IFSP requires designation of a service coordinator to ensure appropriate implementation and coordination of the plan. The IFSP focuses on both the child and the family within their daily routines. For the EIS over 3 program, the IFSP must include an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills.	Individualized Education Program (IEP) means a written statement for a child with a disability that is developed, reviewed, and revised in a meeting in accordance with IDEA. An IEP must include: • A statement of the child's present levels of academic achievement and functional performance • A statement of measurable annual goals, including academic and functional goals The IEP, among other things, focuses on how the child's disability affects the child's participation in their education.

This table continues on the next page

Components	Part C - Birth to Three	Part B - Preschool Special Education
Procedural Safeguards	*Parent Rights Brochure* §1415, 34 CFR §303.7	*Procedural Safeguards in Special Education* 20 USC §1414, 34 CFR §§300.505–300.518
	These rights apply from the time you are referred to a Birth to Three Program until the point at which you exit the Birth to Three System. Includes: • Opportunity to Examine Records • Prior Notice • Native Language • Parent Consent • Surrogate Parents • Dispute Resolution • Written Complaint • Services During Pendency of Proceeding • Mediation • Resolution Session • Confidentiality	These rights apply from the time of referral with respect to any determination made with regards to eligibility. Includes: • Opportunity to examine records • Prior Notice • Native Language • Parental Consent • Surrogate Parents • Dispute Resolution • Written State Complaint • Services During Pendency of Proceeding • Mediation • Resolution Session • Confidentiality • Independent educational evaluation • Impartial Due Process Complaint • Discipline of Children with Disabilities • Attorney's Fees • Unilateral placements • Civil actions • Extended School Year Services
Types of Services	*Early Intervention Services* 20 USC 34 CFR §303.13	*Special Education & Related Services* 20 USC 34 CFR §§300.34, 300.39, and 300.106
	Early intervention services necessary to meet the unique needs of the child and the child's family through an integrated service delivery model. These early intervention services include: • Assistive technology devices and assistive technology services • Audiology services • Family training, counseling, and home visits • Medical services only for diagnostic or evaluation purposes • Nursing • Nutrition services • Occupational therapy • Psychological services • Physical therapy • Service coordination • Social work services • Special instruction designed to meet the developmental needs of an infant or toddler with a disability • Speech-language pathology services • Transportation • Vision services • Continuous year-round services	Special Education & Related Services include: • Assistive technology devices and services • Audiology services • Early identification and assessment • Interpreting services • Medical services for diagnostic or evaluation purposes • Occupational therapy • Parent counseling and training • Psychological services • Physical therapy • Recreation, including therapeutic recreation • School health and nurse services • Social work services in schools • Specialized instruction • Student counseling services, including rehabilitation counseling • Speech and language pathology services • Transportation • Vision services, including orientation and mobility services • Extended School Year services if IEP team determines necessary

Components	Part C - Birth to Three	Part B - Preschool Special Education
Location of Services	*Natural Environments* 34 CFR §303.13(a)(8), 303.26, 303.126.	*Least Restrictive Environment* 34 CFR §300.114
	Settings that are natural, including the home and community settings in which children without disabilities participate: • Home • Public school preschool • Private community preschool • Head Start • Child care centers • Family child care providers • Parks and recreation programs • Play groups • Libraries • Other child serving programs	The LEA shall insure that to the maximum extent appropriate, students with disabilities, including students in public or private institutions or other care facilities, are educated with students who are not disabled; • Public or Private Community Settings, including but not limited to: Public school preschool and pre-kindergarten programs Private community preschool and pre-kindergarten programs Head Start • Group child development centers and child care • Home • Hospitals
Parent Consent for Service	*Early Intervention Services (EIS)* 34 CFR §303.420	*Special Education & Related Services* 34 CFR 300.300
	A parent is required to consent for the initial evaluation. A parent may accept or decline any particular early intervention service on the IFSP, or withdraw consent to any particular early intervention service after it is first provided.	A parent is required to consent for the initial evaluation prior to the LEA conducting any assessments. A parent must also sign consent for the initial provision of services prior to the development of the IEP.
System of Payment	*Early Intervention Services (EIS)* 34 CFR §303.521	*Special Education & Related Services* CFR 300.700
	Families are not charged out-of-pocket costs for EI services provided over age 3. The Birth to Three "System of Payments" policy continues after a child turns age three with one difference. EIS programs will continue to bill Medicaid and private insurance with no out-of-pocket costs to families.	Parents are not charged out-of-pocket costs for IEP services. LEAs use other funding sources including Medicaid for only health-related services and case management

If you have any questions about Part C, please ask your service coordinator and if you have any questions about Part B please ask your school district.

The Connecticut Parent Advocacy Center (CPAC, Inc.) is available to help at (860) 739-3089 or online at cpac@cpacinc.org.