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, parent fees, as well as 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 and have an additional monthly fee added to your family cost participation fee if applicable (See Form 1-9 for more information).

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. I understand I will have an additional monthly fee added to our family cost participation fee if applicable.

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, private health insurance, and family cost participation fees. (See Forms 1-3a and 1-9 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 and parent fees 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 and, if applicable, my monthly Family Cost Participation fee will increase.
____ 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

PRIMARY HEALTH CARE PROVIDER
AUTHORIZING STATEMENT AND SIGNATURE
FOR DIAGNOSTIC/EVALUATION SERVICES

Connecticut Birth to Three System

Dear Physician or Advance Practice Nurse,

Your patient _____ , _____
Child's Name Child's Date of Birth

had a developmental evaluation completed on _____. The
Date
following evaluations were completed _____

_____

As a result this child is:

☐ Not eligible for Birth to Three Services;
☐ Eligible and the family is not seeking services at this time.

Your signature on this form allows the Connecticut Birth to Three System to pursue third party reimbursement for eligible medical services.
Please fax/mail as soon as possible to: _____
Program Name

_____ _____
Address fax #

I am a ☐ physician or ☐ advanced practice registered nurse (please check one) licensed by the Connecticut Department of Public Health or by a state contiguous to Connecticut. I am authorized to provide health care services within the scope of my practice under state law. I am familiar with the above named child's medical condition. I confirm the medical necessity of the evaluation(s).

_____ _____
Print or Type Name Signature

_____ _____
License Number State Date of Signature

I authorize the release of this information for the purpose of third party billing.

_____ _____ _____
(Print Parent/Guardian Name) (Signature) (Date)

Relationship to child: _____

The following written material(s) is attached: _____

Connecticut Birth to Three System

FAMILY COST PARTICIPATION FORM

(Do not complete this if insured by Medicaid/Husky)

Your Birth to Three program's contact information:

SECTION 1: Child and Family Information

Name of Child		Child's DOB	
Parent/Guardian Name		Birth to Three #	

SECTION 2: What is your Family's Annual Adjusted Gross Income (AGI) Amount?

☐ We decline to share information regarding our annual family income and, therefore, we will be billed at the highest income level per month on the chart found on this form based on our family's size. – *Please proceed to Section 4.*

For verification purposes, please list one Parent's SSN: _____

☐ Our family's AGI is: $_____ (*The AGI may be found on your state/federal tax forms: Form 1040 – use Line 37, Form 1040A use Line 21, Form 1040NR use Line 34. For all other forms, please look for the line that states "adjusted gross income" and use that amount.)*

☐ We have an annual adjusted gross income of less than $45,000. NOTE: Your family is not required to pay a monthly fee at this time. Please enter $0.00 below in Section 5 on this side for your fee and sign Section 7. *Please proceed to Section 3.*

SECTION 3: Changes Since Filing Last Tax Return (if applicable)

Since your AGI is based on what you filed last year, there may have been some changes with your family's income that should be taken into consideration when determining your family's monthly fee. These changes may increase what was reported last year (such as a parent returning to work or receiving an increase in pay) OR it may be due to a decrease in what was reported last year. For example:

- Reduction in income due to Maternity Leave
- Layoffs or Furloughs
- Reduced Hours due to Natural Disasters
- Loss of Work Hours

Please Note: Overtime pay and one-time bonuses may be reflected on last year's tax return, but are not considered a sustainable increase and should reduce what was reported.

Please choose A or B below.

☐ A. We do not have any changes to be considered at this time. – *Please proceed to Section 4.*

☐ B. We do have changes to be considered. Our family's current income level is ☐ higher ☐ lower than the AGI shown on last year's tax returns due to: (please explain and attach documentation as needed).

Based on these changes, our current yearly income level is: $_____ – *Please proceed to Section 4.*

SECTION 4: Family Size

"Family" is defined as a group of two or more persons related by birth or adoption, or adults who share legal responsibility for dependent children living in that household. *Please enter the number here* → *Please proceed to Section 5.*

My total family size is:

Family Cost Participation Monthly Fee Schedule Family's Annual Adjusted Gross Income	Family Size 2-3	4	5	6+	*If you did not consent to share information with your insurance carrier (See Form 1-3), add this amount*
☐ $ 45,000-$55,000	$ 24	$ 16	$ 8	$ 8	$0
☐ $ 55,001-$65,000	$ 32	$ 24	$ 16	$ 8	$8
☐ $ 65,001-$75,000	$ 40	$ 32	$ 24	$ 16	
☐ $ 75,001-$85,000	$ 56	$ 48	$ 40	$ 32	$16
☐ $ 85,001-$95,000	$104	$ 96	$ 88	$ 80	$32
☐ $ 95,001-$105,000	$120	$112	$104	$ 96	$75
☐ $105,001-$125,000	$152	$144	$136	$128	
☐ $125,001-$150,000	$192	$184	$176	$168	
☐ $150,001-$175,000	$232	$224	$216	$208	
☐ Over $175,001	$272	$264	$256	$248	
☐ I do not wish to disclose our income	$272	$264	$256	$248	

SECTION 5: Your Family Cost Participation Fee

Using the Family Cost Participation Monthly Fee Schedule above, please determine your fee by locating the row that shows your current Annual Adjusted Gross Income Amount (please refer to Section 2 or 3) and then move across to the column that shows your current family size. Families with multiple children currently enrolled in Birth to Three will receive only one fee per month. Enter →

My family's current monthly fee is: $

To complete this form, please go to the next page (or flip if double sided) and sign SECTION 6.
If you are also requesting an adjustment, sign both SECTION 6 and SECTION 9 when required documentation is available.
*Note: This form must be completed and submitted to your program **before the first service after signing your initial IFSP.***

If you have any questions regarding the Family Cost Participation Fees or this form, please contact your family's Service Coordinator. If you will be paying a monthly fee, this is managed by a company named Public Consulting Group (PCG). They will help you set up an online account where you can view and pay your invoice.

SECTION 6: Parent/Guardian Signature and Agreement – *Please check each line in this section and sign below.*

____ I acknowledge that our monthly Family Cost Participation Fee will be the amount shown in Section 5, and that I will receive our first invoice during the month following the first full month of Birth to Three services. The month when our initial IFSP meeting is held is considered a partial month. I understand that our financial responsibility was calculated based on the information provided on this form, and I certify to the best of my knowledge that the information is correct. If our financial situation changes, I will inform our Service Coordinator and complete a new form.

____ I understand that unpaid balances on monthly financial contributions that equal three months of payments or more will result in the suspension of all early intervention supports, other than service coordination, evaluation, assessment, IFSP development and review, and parental rights. I also understand that other early intervention supports will not resume until my balance is paid in full.

____ I have received a copy of our parent rights.

Parent/Guardian Signature: _____ **Date:** _____

_____ Please initial this line only when applicable: I understand that because I did not give permission to bill my private or public insurance on Form 1-3 or 1-3a, and there will be an additional monthly fee as noted.

$0-$55,000 = none	$55,001-$75,000 = $8	$75,001-$85,000 = $16	$85,001-95,000 = $32	$95,001 & up = $75

Only compete the Sections below if you are requesting and adjustment to your FCP monthly fee.

SECTION 7: Income Adjustment Worksheet ~ OPTIONAL ~

Parents/Legal Guardians may seek an adjustment to their family's reported annual income if they currently have certain categories of extraordinary expenses, thereby reducing their monthly family cost participation fee. ***Please complete the worksheet below and attach required documentation*** *to determine if there are any adjustments that may be made at this time. Check off box where documentation is attached.*

Description of Other Expenses that may be included in determining your family's monthly fee	Total Expenses/Year
A. Childcare costs (up to $20,000 per child) – $_____ /month X 12 months. Must submit copy of cancelled checks or monthly childcare bills/invoice	$ ☐
B. Documented, unreimbursed family medical expenses that exceed 6% of the annual adjusted gross income. ▪ This may include, for the child enrolled in Birth to Three, prescription diets, durable medical equipment (the portion that is not reimbursed by health insurance), unreimbursed dental or orthodontia expenses; ramps, lifts or other accessibility modifications. ▪ This may include, for the immediate family (parents and brothers and sisters of the enrolled child), unreimbursed medical expenses, unreimbursed prescription medications, and health insurance premiums and deductibles	$ ☐
C. Payments made to support persons outside the household such as elderly or sick parents. Amount paid $_____/month X 12 months *(Include explanation and documentation of payment)*	$ ☐
D. Home repairs necessary to maintain the home in livable condition (furnace, roof etc.) Must submit copy of cancelled checks with an explanation of each repair	$ ☐
E. Educational expenses (up to $12,000). Must submit copy of cancelled checks with an explanation of each expense incurred. This includes payment for student loans for past attendance.	$ ☐
F. Job-related necessities: Job title and copy of relevant portion of IRS 1040 or receipts with an explanation for each expense	$ ☐
G. Court Mandated payments on large accumulated debts. Copy of court order or written payment plan or written agreement with creditors $_____ /month X 12 months	$ ☐
H. Child support and alimony paid: $_____ /month X 12 months *(Include explanation and documentation of payment)*	$ ☐
I. Your Total Requested Amount of Adjustments (Add Lines A-H)	$
J. Enter the Amount of your family's AGI or yearly income (based on Section 3 or 4 on reverse side)	$
K. Subtract Line **I** from Line J to find your family's Annual Income Amount (after Adjustments); Proceed to Section 8.	$

SECTION 8: Your Adjusted Family Cost Participation Fee –

Using the Family Cost Participation Monthly Fee Schedule on the reverse side, please determine your fee by locating the row that shows your current Annual Income Amount with adjustment (from Section 7-K above) and your current family size. Enter amount in this box →

My family's adjusted monthly fee is: $

SECTION 9: Parent/Guardian Signature and Agreement – with Income Adjustment and Documentation

I acknowledge that our Adjusted Family Cost Participation Fee will be the amount shown in Section 8 above provided that I have submitted all required documentation,

Parent/Guardian Signature: _____ Date: _____

The information on this form was reviewed and approved by: Print Name:	Signature of Birth to Three representative Date

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: _____

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):

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_____, _____

Signature:_____ Name:_____ *Date:_____

Optional Sig: _____ Name:_____ *Date:_____

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 RELEASE 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 each 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:

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

REIMBURSEMENT REQUEST

Date_____ Revision (Date)_____

Child's Name_____Date of Birth_____Record #_____

Parent Name/Address_____

Program Name_____

AT Contact (name)_____Discipline_____

Contact phone_____email_____

Child's functional concerns and identified need:
AT Device requested (DSS *procedure codes, model and any related equipment, etc.*):
How does AT device support the child be increasing, maintaining, or improving the child's functional capabilities (*functional IFSP outcome addressed*)

	YES	NO
Does the device support the child's functional participation in activities and daily routines as noted in an Outcomes on the IFSP?		
Is Assistive Technology listed in the Supports & Services section of the IFSP?		
Has the family participated in the AT assessment and received information about the actual equipment being requested?		
Is training arranged for the family in use of the device once delivered?		
Has the full team (including parents) agreed that this is the most appropriate device to meet the child's need *(e.g. Can the communication device be mounted on the mobility equipment)*?		
Communication AT: Does child demonstrate intentional communication? (i.e. through vocalization, eye gaze, pointing, pictures, sign, PECS)		
Did the team consider a range of devices from low tech to high tech? If lower tech device was not selected, give rationale:		
Does the device need to be addressed when developing a transition plan? (i.e. will school be purchasing a similar device for use in next setting?)		

ASSISTIVE TECHNOLOGY

REIMBURSEMENT REQUEST

Child's Name_____ (Page 2)

Additional Information:	YES	NO
Does NEAT have a suitable AT device for loan?		
Will DME vendor be ordering AT?		
Will AT be ordered directly by Birth to Three program?		

COSTS	
Cost of AT	$
Tax & shipping	
Dispensing fee as applicable	
Other - specify or attach information:	
TOTAL NOT TO EXCEED	

	Check type of Insurance:	Date sent to insurance:	Estimate of insurance reimbursement:	Status/Amount reimbursed:
Medicaid				
Commercial Insurance				
No insurance		n/a	n/a	n/a

Lead Agency Administration Only:			
DATE: _____Approved _____Denied _____Need Additional Information	Amount Approved:	Additional details:	
Date request received:	Cost to state not to exceed:	Authorized Signature:	Date returned to program:

FAX this with any attachments to CT. Birth to Three Fiscal 860-920-3156

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.

Connecticut Birth to Three System

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.

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)	

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**_____

TECHNICAL ASSISTANCE REQUEST FORM

❑ Program /Contact Name: _____

Date: _____ Phone: _____ E-Mail: _____

How was the need for TA identified?

- ❑ Staff request
- ❑ Program director
- ❑ Other_____
- ❑ Accountability and Monitoring
- ❑ Self Assessment
- ❑ Complaint

Topic area(s) needs:

- ❑ Coaching caregivers
- ❑ Transition
- ❑ Natural environments
- ❑ 0-3 procedure on _____
- ❑ Data system_____
- ❑ Credentialing
- ❑ Cultural diversity
- ❑ Discipline specific TA or mentorship: _____
- ❑ Service coordination
- ❑ Evaluation/Assessment
- ❑ Monitoring process
- ❑ Supervision/Program management
- ❑ Writing objectives/outcomes
- ❑ Working with medical providers
- ❑ Working with child care providers
- ❑ Working with families
- ❑ Other: _____

Proposed TA outcomes

1. _____

2._____

Proposed Audience

- ❑ Program Director
- ❑ Program Staff/Discipline
- ❑ Office staff

What format might work best?

Group size

- ❑ Small (<10)
- ❑ Medium (10-20)
- ❑ Large (20+)

Format(s)

- ❑ Meeting
- ❑ Workshop
- ❑ Reading materials
- ❑ Home visit
- ❑ Other _____

Scope

- ❑ 1 time
- ❑ 1 time/mo. For ___ months
- ❑ Other

FAX REQUEST: Birth to Three Training, Personnel & Practice Office, 860-418-6003
Or call/email any member of the Training Team.

For Central Office Staff

Date program was contacted_____ **Date TA scheduled for**_____

Date TA completed_____

_____

TECHNICAL ASSISTANCE EVALUATION FORM

Program Name: _____

Name of TA Provider(s): _____ Date(s): _____

I. Please rate the following

- Timeliness of response
- The process for obtaining TA

	Not Helpful			Very Helpful
NA	1	2	3	4
NA	1	2	3	4

II. For this TA topic please rate:

- Quality of materials
- Quality of presenter
- Quality of overall process

	Not Helpful			Very Helpful
NA	1	2	3	4
NA	1	2	3	4
NA	1	2	3	4

III. Did TA meet the outcomes listed on Your TA request?

	Not Helpful			Very Helpful
NA	1	2	3	4

IV. What changes have you made or do you anticipate making as a result of this TA?

_____

_____

_____

_____

Comments:

_____

_____

_____

NOTICE OF BIRTH TO THREE RECORD RETENTION AND DESTRUCTION

Child's Name: _____ DOB: _____

Parent's Name: _____

Address: _____

Phone Number: _____ Email: _____

Date that determines when records will be destroyed (exit date, date child turns 3, 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 email CTBirth23@ct.gov or call 860-500-4400.

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