Nassau County
Department of Health

EARLY INTERVENTION BEST PRACTICE MANUAL

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Early Intervention Program

Mission and Goals

Introduction

The Local Early Intervention Coordinating Council (LEICC) and the Nassau County Department of Health (NCDOH) are dedicated to improving the quality of Early Intervention services provided to children from birth to age three and their families.

Toward this continuing goal, the Inter-Agency Sub-Committee of the LEICC generated a plan to develop a best practice manual.

This **Best Practice Manual** is designed to standardize practices and establish professional guidelines for Early Intervention services across Nassau County.

The **Best Practice Manual** , a collaborative effort of Early Intervention providers, families and the Nassau County Department of Health, is issued to all Early Intervention providers. It is the intent of the Inter-Agency Sub-Committee to make revisions or additions as appropriate.

It is the expectation of the LEICC and NCDOH that this manual will be used to guide Early Intervention providers so that services to children and families will be consistently delivered in accordance with the highest ethical and professional standards.

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Early Intervention Program

Mission and Goals

The mission of the Early Intervention Program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve child and family development.

FAMILY-CENTERED:

Support families in meeting their responsibilities to nurture and enhance their children's development.

COMMUNITY-BASED:

Create opportunities for full participation of children with disabilities and their families in their communities by ensuring services are delivered in natural environments to the maximum extent appropriate.

COORDINATED SERVICES:

Ensure Early Intervention services are coordinated with the full array of early childhood, health and mental health, educational, social and other community-based services needed by and provided to children and their families.

MEASURABLE OUTCOMES FOR CHILDREN & FAMILIES:

Enhance child development and functional outcomes and improve family life through delivery of effective, outcome-based, high quality Early Intervention services.

EARLY INTERVENTION & THE MEDICAL HOME:

Ensure Early Intervention services complement the child's medical home by involving primary and specialty health care providers in supporting family participation in Early Intervention services.

LOCAL CONTROL, FISCAL REFORM & PROGRAMMATIC ACCOUNTABILITY:

Assure equity of access, quality, consistency and accountability in the service system by ensuring clear lines of public supervision, responsibility, and authority for the provision of Early Intervention services to eligible children and their families.

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I. PROFESSIONAL BOUNDARIES

A. ETHICS IN EARLY INTERVENTION

Early Intervention providers must hold paramount the welfare of the children and families that they serve professionally. When engaged in their duties, providers must act on behalf of the child's and family's best interest, respect family values and reinforce trust.

The following ethical considerations and principles are recommended:

- ♦ Families will be provided with considerate and respectful care.

- ♦ Families will be provided, in writing by each agency, the name, address, phone number, agency contact person, treatment provider and discipline quality assurance professional (i.e., occupational therapy, physical therapy, etc.) responsible for providing Early Intervention services to the child and family.

- ♦ Families will be given complete information by their provider concerning their child's evaluations, service provision, and on-going assessments in terms that the family can understand. To the extent feasible, the consent, confidentiality requirements, due process rights, written and oral summary of the evaluation and all communication must be provided in the native language or other mode of communication of the family.

- ♦ Families' written records will be treated with privacy and confidentiality in accordance with the Family Educational Rights and Privacy Acts (FERPA). Child records and other materials contained in each child's file are personally identifiable, are confidential and may not be released or made available to persons other than those authorized. Discretion should be used when and where Ongoing Service Coordinators (OSC), Service Providers, and/or Administrative Personnel discuss information about an Early Intervention child and family. Information should be discussed on a "need to know" basis.

- ♦ Families will continuously be kept informed about transition by their OSC and provider. The OSC has primary responsibility to discuss transition dates at the Initial Individualized Family Service Plan (IFSP) meeting and to ensure that the transition process is completed.

- ♦ Families who agree to participate in projects that are not conducted by the Nassau County Department of Health Early Intervention Program (NCDOH EIP) (research, surveys, etc. regarding Early Intervention services) will be given pertinent information about the specific project, by the project originator. Families will be accepted only after full and complete discussion and upon the families' understanding of the nature of that project. Full informed written consent by the parent or guardian shall be required.

- ♦ Families will receive services from only New York State Department of Health (NYSDOH) licensed/certified professionals who are qualified to provide Early Intervention services.

*If an individual (student) completing his/her professional degree accompanies a licensed provider to a home or child care facility, he/she is permitted to provide hands-on treatment, providing the licensed provider offers continuous supervision and that written permission has been received by the parent or guardian.

- Families shall not be asked to sign blank consent forms at any time. When consent is requested, families will be fully informed of the purpose.

- Families shall be provided services without discrimination as to race, color, religion, gender, or national origin. For culturally and linguistically diverse children, every effort must be made to locate appropriately licensed/certified bilingual professionals.

- Families will be serviced by providers, knowing they have the competencies necessary to treat their particular children.

- Families will have providers who continue their professional development through continuing education courses as mandated by their professional license.

- Families will receive services by professionals who can evaluate the effectiveness of services rendered and who will provide services or dispense products or use other devices only after providing justification for its use and when benefit can reasonably be expected.

- Families will be given 30 days' notice if a service provider needs to discontinue services for any reason. This is a professional responsibility that must be extended to each Early Intervention family.

- For additional guidelines regarding ethics please see **Implementing Professional Boundaries: A code for Ethics for Early Childhood Service Providers Working in the Home.** (Appendix A)

*Refer to NYSDOH Qualified Personnel Matrix NYSDOH website

B. INDIVIDUAL PROVIDER AND AGENCY ETHICS AND MANDATES

All individual providers and agencies will:

- Maintain current certification/licensure.

- Maintain current health status reports of all providers, including **annual** updates.

- Maintain each child's records until the child turns 21 years of age.

- Follow advertising/publication guidelines as per the NYSDOH agreement.

- Develop and follow a written policy on universal precautions.

- Provide their staff/contract employees with photo identification badges.

- Adhere to the confidentiality practices.

- Assure that providers rendering services to a child have the competencies to treat that child.

- Assure that service providers have copies of all related evaluations as well as IFSPs and have reviewed them carefully.

- Conduct face to face interviews with prospective staff or contract employees prior to employment of their services, check references, and maintain such information in the employee's file. All licenses/certifications are to be viewed in their original format.

- Assure that at **no time** a provider or agency accepts cash or gifts. Only those services authorized in an IFSP can be provided by **any** Early Intervention provider.

- Hold service providers to the Ethics and Standards and/or Practice Acts of their professional discipline.

- Assure that service providers report fraudulent activities of other professionals to the appropriate New York State Professional Board.

To verify New York license information, access information on final Regents disciplinary actions and learn more about other professionals licensed by the Board of Regents, contact the Office of the Professions:

General Customer Service:	(518) 474-3817
Fax:	(518) 474-1449
TDD/TTY:	(518) 473-1426
E-Mail:	op4info@mail.nysed.gov
Web Page:	www.nysed.gov/prof/prohome.htm
Address:	Cultural Education Center, Albany, NY 12230

State Board for Occupational Therapy (OT):	(518) 473-3817 ext. 100 *or* otbd@.nysed.gov
State Board for Physical Therapy (PT):	(518) 474-3817 ext. 180
State Board of Psychology:	(518) 474-3817 ext. 150 psychbd@nysed.gov
State Board for Speech-Language (ST): Pathology and Audiology:	(518) 473-3817 ext. 100 *or* speechbd@nysed.gov
State Board for Social Work:	(518) 474-3817 ext. 450 *or* swbd@nysed.gov
Office of Teaching Initiatives:	(518) 474-3901or www.highered.nysed.gov/tcert/teach

To file a complaint about the professional conduct of a New York professional or about someone who is practicing without a license:

Office of the Professions	
E-Mail:	conduct@.nysed.gov
Call:	1-800-442-8106
Long Island Regional Office:	(631) 425-7758

When child abuse or neglect is observed or suspected the following must occur immediately:

- The provider will report the allegation to the New York State Child Abuse and Maltreatment Register by telephone at **1-800-635-1522** and in writing within 48 hours of the oral report.

- If the allegation involves non-familial abuse, the Special Victims Squad of the Nassau County Police Department will be notified by telephone at **516-573-8055**.

- Notify the Director of the Early Intervention Program at the Nassau County Department of Health at **516-227-8648** (8:30 A.M. – 4:45 P.M. Monday – Friday). All other times call **516-742-6154.**

- Notify the OSC and EIOD (Early Intervention Official Designee) **immediately**.

- If a service provider arrives at a home and there are no parents (adults) home, a call is to be made **immediately** to the Nassau County Police Department (911) and to the Director of the Early Intervention Program at the Nassau County Department of Health (see phone number above). New York State Education Laws of **1988** require that some health and school professionals, as mandated reporters, complete the required course titled "Training in the Identification and Reporting of Child Abuse and Neglect." Those mandated reporters are:

  Physicians and Surgeons
  Hospital Personnel, Residents, and Interns
  Christian Science Practitioners
  School Officials
  Social Service Workers and Foster Care Workers
  Residential Care Custodians, Service Providers, and Child Care Workers
  Family and Group Day Care Providers and Employees
  Child Care Center Employees
  Psychologists, Social Workers and Mental Health Professionals
  Peace Officers, Police Officers, District Attorneys and Law Enforcement Officials

- Early Intervention provider agencies are responsible for clearing any person who is actively being considered for employment or for a contract to deliver Early Intervention services, and who will have the potential for regular and substantial contact with children, through the State Central Register of Child Abuse and Maltreatment (SCR) using the most current version of the OFCS form. (Social Services Law Section 424 and NYSDOH policy)

C. CONFIDENTIALITY

Policy for Confidentiality of Early Intervention Provider Records

In accordance with the Family Educational Rights and Privacy Act (FERPA) child records and other material contained therein which are personally identifiable, are confidential and may not be released or made available to persons other than those authorized. All approved EI providers and service coordinators must adhere to FERPA.

All individual providers and agency records are to be kept in locked, fireproof files and are made available only to authorized individuals. Every individual provider and agency must have a written confidentiality procedure.

Only administrators, service coordinators, office and provider staff employed by the contracted agency, who have a need to know, will have access to children's records.

No staff member may duplicate or remove from the premises any personally identifiable data relating to any child receiving Early Intervention services without the explicit permission of the agency administrative staff.

Requests for access to a child's record by a person other than an authorized employee shall be directed to the administrator of each program or individual provider. If the request for access is approved, a record of such access shall be maintained in the child's file, which will indicate the date, person, and reasons for the access. Child records may be inspected during monitoring visits by NCDOH EIP or NYSDOH EIP at the place they are regularly maintained and procedures shall be utilized to ensure that such records are not destroyed or altered in any way.

II. ELIGIBILITY REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM

Children's eligibility under the Early Intervention Program (EIP) can be established in one of two ways (Section 69.4.23 NYS EI regulations):

- Presence of a developmental delay which meets the New York State definition of developmental delay.

  Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, adjusted for prematurity, in one or more of the following areas of development (domains): cognitive, physical (including vision, hearing, and oral motor/feeding and swallowing disorders), communication, social/emotional or adaptive.

  A developmental delay for purposes of the EIP is a delay that has been measured by qualified personnel using appropriate diagnostic procedures and/or instruments, informed clinical opinion, and documented as:

  a. a twelve month delay in one domain; or
  b. a 33% delay in one domain or a 25% delay in each of two domains; or
  c. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one domain or a score of at least 1.5 standard deviation below the mean in each of two domains.

- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Refer to Appendix B for a list of these conditions and the appropriate ICD-9* codes. Link: www.health.ny.gov/guidance/oph/cch/bei/99-2.pdf

** please note, ICD-10 codes will be effective in the near future*

While the NCDOH acknowledges the NYSDOH criteria for eligibility based on age equivalents, testing instruments which offer standardized scores should be used to determine eligibility as they offer a more valid representation of the child's true abilities in comparison to age equivalents. Therefore, eligibility is expected to be determined on the basis of standardized scores. No single procedure or instrument may be used as the sole criteria or indicator of eligibility (Section **69-4.8** NYS EI regulations).

In instances where the evaluator determines that standardized scores do not accurately or fully reflect the child's true functioning, clinical judgment may be used to determine eligibility. A written explanation as to why the evaluator determined that the testing did not capture the child's true functioning (i.e., the standardized test "A" does not assess pragmatic skills [language use] and therefore does not reflect the child's inability to initiate language, maintain eye contact or predominant use of echolalia) must be included.

A. THE EVALUATION PROCESS

The multidisciplinary evaluation team must include two or more qualified personnel from different disciplines who are trained to utilize appropriate methods and procedures, have sufficient expertise in child development and at least one of whom shall be a specialist in the area of the child's suspected delay or disability. The multidisciplinary evaluation may include up to four supplemental evaluations without additional authorization. The multidisciplinary evaluation is necessary to:

- Determine whether a child is eligible for the EIP;
- Assess the status of the child's physical*, cognitive, social-emotional, communication and adaptive development;

  *NYS EI Regulations Section 69-4.8 (a)(4)((i)(a):

  > "…the evaluation of the child's physical development shall include a health assessment including a physical examination, lead screening, routine vision and hearing screening and, where appropriate, a neurological assessment…"

- Identify areas of developmental strengths and needs, and determine the parents' resources, priorities and concerns related to their child's development.

The complete multidisciplinary evaluation forms the basis for decisions about all aspects of the services included in the Individualized Family Service Plan (IFSP) to meet the child's developmental strengths and needs.

B. MULTICULTURAL/MULTILINGUAL EVALUATIONS

Evaluations are conducted in the cultural context of the family, requiring the evaluator to be responsive to cultural and linguistic diversity. Professionals conducting bilingual evaluations need to be acutely aware of the subtle interplay between language and cognitive development and the potentially complicating influence of cultural differences. Evaluation reports should state the primary language of the child, the validity of the evaluation instruments for the child's cultural/linguistic group and whether an interpreter was used during test administration. To help determine whether a bilingual evaluation is appropriate, a home language survey should be done. In bilingual assessments, valid testing instruments:

- Are normed on the child's ***cultural-linguistic*** group
- Are designed in the primary language of the child, or, at a minimum, have versions that have been translated into this language
- Contain only culturally appropriate items

In many instances, tests meeting these criteria are not available for certain cultural/linguistic

groups. When this is the case, evaluators may rely upon clinical interpretations of observations, age equivalents instead of standardized scores, behavior and language samples, play-based assessments and interviews with parent(s) and other caregivers to determine the child's developmental status.

It is essential that evaluators speak the primary language of the child and family. Evaluators must be fluent in this language, and aware of the dialectical differences that may affect the evaluation results. Test results may be suspect if the evaluator and child do not speak the same language. It is also important for the evaluators to be able to communicate effectively with the family about the evaluation process and findings.

C. USING AN INTERPRETER OR TRANSLATOR

Only in situations when an evaluator fluent in the primary language of the child and the family cannot be found it is permissible to conduct an evaluation using an evaluator-***interpreter*** team. The most appropriate interpreter would be a bilingual Early Intervention professional. If this is not possible, the next choice of interpreter is a person not known to the family. Both the evaluator and **interpreter** need to be specially trained to conduct evaluations in this manner. This team must have knowledge of child development, characteristics of early language development, evaluator behavior and procedures during the testing session, rapport building with the child and family, test stimuli, accurate interpretation of the child's test responses and suggestions when modifications are appropriate.

Testing in which parents or caregivers function in the interpreter role may not give an accurate and objective evaluation of the child's skills and should only occur when all other options have been fully exhausted.

> An **interpreter** interprets the spoken word, either from one language to another or to another mode, such as sign language.
>
> A **translator** translates the written word.

D. EVALUATORS INITIAL CONTACT WITH FAMILY

A comprehensive multidisciplinary evaluation stems from a collaborative approach and emphasizes working in partnership with the family to address their concerns. One of the basic goals of Early Intervention is the establishment of a partnership between providers of EI services and the family. The evaluation process is the ideal time to plant the seeds for this partnership. In addition to providing information on the child's strengths and areas of concern, the evaluation process can help establish the family as an "expert" on their child's development. It will help define the family's role as a resource and full partner in the decision making process for their child with the professional team and within the parameters of the laws and regulations governing the Early Intervention Program.

For a family first entering the EIP this initial period is often a time of stress, fear and confusion. Families frequently look to professionals for information, guidance, validation and acceptance.

Accordingly, the individuals with whom the family first comes in contact often set the tone for future involvement in Early Intervention.

Since evaluations usually occur early in the process, it is important that the evaluation team attempt to set the family at ease by:

- Eliciting the family's resources, priorities and concerns for their child.
- Scheduling the evaluation, taking into consideration such factors as convenience for the family, child's nap time and parent's work schedule in order to allow for the optimal testing of the child and parental participation at the evaluation.
- Reviewing with the family each step of the evaluation process.
- Explaining the evaluation of the five developmental domains, the roles of the evaluator, what to expect during the evaluation and timelines for the evaluation process.
- Assuring the family that their input is an important part of the process and that they will be provided with an opportunity to share their input during the evaluation.
- Assuring parents that their child may not be able to answer every question or complete every task successfully and that 100% correct response is not expected. Testing is not predictive of future abilities but identifies a child's strengths and possible areas of intervention.

Families must be informed that the evaluation is not complete, nor can eligibility be determined, without a review of the Health Status Report completed by the child's primary care provider. The physical exam must have occurred within sufficient recency as determined by the child's age and recommendations of the American Academy of Pediatrics. The Health Status Report must be completed by the child's primary care provider and sent to the evaluating agency in a timely fashion in order for the evaluation reports to be completed and electronically submitted in NYEIS prior to the scheduled IFSP meeting within mandated time lines. The evaluation is not complete without the physical and the lead report for children over one year of age.

With parental consent, evaluators may obtain and review any current medical information/reports that are pertinent to the decision making for the child's eligibility and EI services.

Schedule evaluations as soon as possible following receipt of referral from the NCDOH in order to insure compliance with the following:

> The evaluator shall complete screenings and evaluations within 10 working days after receipt of a written request for evaluation from the NCDOH except to the extent that a parent requests in writing that the screening and/or evaluation be delayed and the 45-day time period to convene the IFSP meeting be extended. If the evaluator cannot comply with the 10-day time frame (due to workload or scheduling issues), the evaluator shall notify both the parent and the Initial Service Coordinator (ISC) prior to scheduling the evaluation. Best practice would be to notify the ISC within 48 hours so another evaluator may be chosen and the mandated timelines for the evaluation process can be met.

E. CONDUCTING THE EVALUATIONS

In conducting the evaluation, evaluators will take into consideration the following:

- The evaluation team **will** wash their hands at the site prior to the evaluation.
- A Family Assessment must be offered as an option to identify family resources, priorities, and concerns. If family participates, complete and submit with child's evaluation. (See Appendix C)
- The evaluation team values the family as an integral part of the evaluation and a partner in the process.
- The parent/guardian must be present during all components of the Core Evaluation, whether it is performed at a childcare center, education site or home.
- Evaluators will be mindful of any type of comment or response, either verbal or nonverbal, as it relates to the child's responses.
- If a child is fatigued or becomes unresponsive or noncompliant, evaluators should look to reschedule the evaluation appointment. Evaluators should never judge a child's response during testing as incorrect if fatigue was a factor. The assessment should not continue if the child is or becomes ill.
- **Evaluators must not make written or verbal recommendations during the evaluation regarding specific services, frequency, duration or providers.**
- At the conclusion of the evaluation, the evaluator will elicit and document a statement from the family whether they felt the evaluation depicted a typical picture of their child.
- Evaluators will leave strategies for families to enhance their child's development.
- All components of an evaluation must be in person (not by telephone).
- An audiological assessment may be done as part of the initial evaluation if there are significant concerns.
- Evaluators should keep the ISC informed of any reasons that may cause a delay in meeting time lines, i.e., child sick or evaluation date cancelled.
- All contacts by evaluators with parents or others involved in the evaluation process must be dated, documented, signed and placed in the child's record.

F. WRITTEN REPORTS AND CONTENT

Each evaluation packet submitted to the DOH must include:

- **NCDOH Evaluation Summary Eligibility Determination Packet (3 pages) for children in the Kids system**

- The Summary Narrative should include the following:

  1. A description of the assessment/process.
  2. The child's responses.
  3. The family's belief of whether the child's response was optimal.
  4. An explanation of the scores and measures reported.
  5. A statement of eligibility (ICD-9 Code and a Diagnosed Condition), including a diagnosis with a high probability of developmental delay and/or developmental delay in accordance with the New York State definition of delay.
  6. **A statement about whether or not there are any transportation needs, including how the child is currently being transported to destinations in the community.** NYS EI Regulations Section 69-4.8.(4)(v)

- The Evaluation Summary Narrative must be **written collaboratively by both members of the evaluation team, not by an additional member conducting interviews or the Family Assessment.** The NCDOH Health Status Report must be attached and incorporated within this Narrative.

- All evaluation results from all evaluators should be fully integrated in order to present a clear picture of the child's functioning and needs. Any differences in findings (i.e., discrepancies between standardized testing results and clinical observations between evaluators' testing or between parent perception and clinical findings) must be explained in full.

- A child's age is adjusted for prematurity up to 2 years of age.

- To determine eligibility, the youngest a premature baby may be evaluated by standardized testing is when the CORRECTED AGE presents the child at 40 weeks gestational age.

- Infants born 999 grams and under (extreme prematurity) are automatically eligible for EIP until the child reaches a chronological age of 12 months. Infants and young children having other diagnosed physical and mental conditions (see Appendix B) with a high probability of developmental delay are automatically eligible for EIP.

- The evaluator must provide the family with a copy of the evaluation reports, summary and family assessment (if applicable). The written/oral summary must be in the family's dominant language.

Multidisciplinary Evaluation Report

- Section 69-4.8(a)(14)(ii) of the NYS EI Regulations read no single procedure or instrument may be used as the sole criteria or indicator of eligibility.

- The evaluation team must include two or more qualified personnel from different disciplines. One discipline must be a specialist in the area of the child's suspected delay. The other discipline must assess the child in all five areas (physical, cognitive, social, communication and adaptive) including the suspected area of delay.

- A child referred to Nassau County DOH EIP who has been diagnosed on the autism spectrum without a comprehensive assessment will be referred to a qualified EIP evaluator for additional assessments (ADOS, CARS and DSM 5) that are needed to support this diagnosis prior to the development of the IFSP through Early Intervention.

Content

- Components of the evaluation report and summary must include the names and professional titles of those performing the evaluation and family assessment. All attempts at standardized testing must be indicated in the report as this is clinically significant information.

- Evaluations should be written in family friendly language (jargon-free or jargon-reduced). If a professional term must be utilized that is not readily apparent in meaning, an explanation should be inserted.

- If a child is demonstrating delays in the cognitive domain, the evaluator should analyze and determine if this delay is related to a language delay. It would be most family friendly and reassuring to a family to state this in the evaluation report. This would also be important information for the EIOD in helping determine types of services. For example, a child who has communication delays and language related cognitive delays may only need the services of a speech/language pathologist and not necessarily a special educator.

- When evaluating a child who was born premature (36 weeks or less gestation), the evaluator must adjust for prematurity and use CORRECTED AGE, according to the testing manual, when determining the existence of a developmental delay. If the specific standardized test being used does not adjust for prematurity, the child's chronological age should be used.

- It should be noted that **it is developmentally age appropriate for children under the age of three years to present with numerous articulation errors, phonological processes and unintelligibility.** This is an important factor to consider in determining eligibility. Those children demonstrating significant oral motor difficulties and atypical phonological development should be more closely reviewed for consideration for eligibility for the EIP.

- Describe a child's strengths as well as areas of concern. The evaluation report should be strength-oriented rather than deficit-focused. However, if the child does demonstrate a delay, the area of deficit must be clearly described. When describing a child's inability or lack of a particular skill, make sure it is age expected and indicate when it is expected. **Do not list skills a child is unable to perform if they are skills expected above the child's age level.**

- Supplemental evaluations as part of the core may be **requested** by any member of the evaluation team. PT, OT and/or ST services may only be authorized following an evaluation by that appropriately licensed professional as per their PRACTICE ACTS. Audiologicals should be considered for a child with a history of ear infections or if there is a parental concern.

- **Evaluators must not make a written recommendation in the individual evaluation report regarding eligibility and specific services, frequency or duration. Specific services must be discussed at the IFSP meeting.**

- If a child does not meet the NYS eligibility criteria for Early Intervention, the evaluator must make such a statement. The evaluator should recommend that if families continue to have concerns for their child after utilizing strategies offered by the evaluation team, they may contact the Early Intervention Program for re-evaluation.

G. HEALTH STATUS REPORT (PHYSICAL EXAM)

The Health Status Report must be attached and incorporated into the Evaluation Summary Narrative. In reviewing the Health Status Report the following must be considered:

- The date of the physical exam and immunizations must comply with the time schedule recommended by the American Academy of Pediatrics. (See Appendix D)

- Lead screenings for children ages one year or older must be indicated .

- Vision and hearing screening performed by the pediatrician, should be reflected in the Health Status Report. Many primary care providers do not perform these screenings on children under the age of three.

- A history of ear infections may support referral for an audiological.

Any diagnosed conditions, (e.g., prematurity or low birth weight) should appear with documentation substantiating the diagnosis from the professional who made the diagnosis.

H. SHARING OF EVALUATION RESULTS

Evaluation results must be shared fully with the family in a manner understandable to them prior to the IFSP meeting to ensure that the family's questions, concerns and observations have been addressed. The evaluator should provide the complete evaluation and summary narrative to the parents. **If the evaluator has any question about a child's eligibility, the ISC must be contacted prior to notifying the family of evaluation results.**

It is imperative that evaluations be provided to NCDOH and families within ten working days of completion of the evaluation. No faxed copies of multidisciplinary evaluations will be accepted.

Evaluators should be mindful that parental informing, which involves discussion of a child demonstrating significant delays, should be done in a sensitive and supportive manner.

I. ATTENDANCE AT THE IFSP MEETING

One of the evaluators must attend the initial IFSP meeting. The designated evaluator must be fully familiar with the evaluation reports, results and recommendations. He/she must have conferred with the entire evaluation team and be prepared to help families develop outcome oriented strategies for their child's IFSP. Parental permission must be obtained for attendance by any non-evaluation team representative and NCDOH must be so notified prior to IFSP meeting.

III. ONGOING SERVICE COORDINATION

Service Coordination must be provided to all children referred to an Early Intervention Official/Designee (EIO/D) as suspected of having a disability. Since infants and toddlers with disabilities require a comprehensive array of services that may be provided by multiple agencies or individuals, federal and state laws require the provision of a service coordinator. The service coordinator is responsible for ensuring communication, collaboration, and coordination among providers to eligible children and their families.

Early Intervention service coordination combines the traditional case management activities of organizing and coordinating needed services with the philosophy of family-centered care. A major goal of service coordination is to create opportunities for the provision of collaborative, family centered services for infants and toddlers with disabilities and their families. Service coordinators help families identify and prioritize concerns, assist parents in developing plans and strategies to meet the needs of their children and family units, and strengthen families' competencies and sense of control over life events.

The role and responsibilities of the Ongoing Service Coordinator (OSC) is described to parents/caregivers at their initial meeting with the Initial Service Coordinator (ISC) and then again at the initial IFSP meeting. It is at this time that the OSC is assigned. Parents/caregivers may choose the OSC from any NYS DOH approved OSC/agency. Upon receiving authorization for Service Coordination (SC), the designated agency will assign an individual provider as the OSC. The OSC will contact the family and introduce him/herself and provide his/her contact information. The OSC will explain the role of the Ongoing Service Coordinator and how it differs from the ISC and EIOD.

RESPONSIBILITIES OF THE ONGOING SERVICE COORDINATOR (OSC)

- OSC will gather information about the child, understand the reason for referral and the concerns of the parents/caregivers.
- OSC assists parents of eligible children in gaining access to all services identified in the IFSP.
- The OSC submits and updates new and/or revised child and family information into the NYEIS system.
- OSC is responsible for assigning the service providers and ensuring that services begin in a timely manner. The OSC documents (in notes and NYEIS) all circumstances related to the start of the IFSP services, including all factors which affect the timeliness and all steps taken to facilitate timeliness. If the start of services is anticipated to be delayed (past 30 calendar days), the OSC should make the EIOD aware of the circumstances.
- OSC is responsible for making sure there are current prescriptions in place for all related services prior to services beginning and maintains a copy in the OSC file. The provider agency is responsible for obtaining prescriptions.

- OSC is responsible for monitoring and coordinating the delivery of these services and ensuring parent/caregiver satisfaction by making a minimum of one monthly family contact.

- OSC is responsible for verifying the accuracy of current insurance information during monthly contact with the family.

- The OSC will collect the Non-Delivery of Services form (if there is an extended absence of more than 3 sessions), submit it to the EIOD, and maintain a copy in the child's file.

- OSC is responsible for obtaining current progress reports for IFSP meetings.

- OSC ensures the IFSP outcomes and strategies developed reflect the family's priorities, concerns and resources, and that changes are made as the family's priorities, concerns, and resources change.

- During IFSP reviews, the OSC will:
  - inform families of their rights and procedural safeguards
  - ensure insurance information is updated as needed, and obtain and update the family's third party information, including Medicaid
  - give parent/caregiver information on OPWDD eligibility, if appropriate
  - inform families of the availability of advocacy services, if appropriate

- OSC is responsible for coordinating IFSP review amendment requests for supplemental evaluations, changes in services and/or for any requests for changes (i.e. ATD equipment etc.) to the child's current IFSP.

- OSC is responsible for entering the approved services after the development of a new IFSP and assuring that there is no disruption in services.

- OSC will help facilitate the child/family's transition from the Early Intervention Program to Preschool Special Education services, if necessary, or will help develop a transition plan for community supports. This includes completion of the Transition Tool Kit.

- OSC coordinates and oversees the provision of EI services and may facilitate a request to amend the services (if applicable) in order to benefit the development of the child for the duration of the child's eligibility.

- It is recommended that the OSC make a home visit to establish a relationship with the family and child. Additional home visits can be made, if appropriate and necessary, to ensure the implementation of the IFSP.

A. FINDING A SERVICE PROVIDER

- OSC will ask families for scheduling preferences.
- OSC will contact agencies/individual service providers.
- OSC will provide agencies/individuals with locale, child concerns, schedule/ preference of family and coordinate with service providers.
- OSC can either call agencies by telephone or use an email blast. No confidential information on children should be included in the email blast (i.e. last name etc.). Locale, language, reference to age and concern is acceptable.
- OSC will provide agency/individual with basic information to allow the service provider to contact the family and arrange a schedule.
- OSC will submit the 5400 form (see Appendix E) to the EIOD when service providers are confirmed at the onset of EI services. OSC will complete the 5400 form at the time of the first IFSP and for any additional or amended services.
- If, after a thorough search, a provider has not been found, the OSC contacts the EIOD to authorize the remaining services by completing the 5400 form with the services which have been secured.
- The EIOD will enter the initial authorizations for services into NYEIS and a start date will be given.
- OSC and/ or the agency will notify the service provider and the family of the authorized start date.
- After services are authorized, the OSC/agency must make sure that the Service Providers have a copy of IFSP and Rx for related services.
- OSC must follow up with the family or agency to ensure services have started and document the actual start date of each service.

B. THE IFSP MEETINGS

- OSC is responsible for scheduling the IFSP meetings. The meeting must be held before the end of the current IFSP period. The provider progress reports (including current functioning levels of child/appropriate testing) are due to the OSC, EIOD, and parent three weeks prior to the end of the IFSP period. If continued eligibility is established, the OSC contacts the parent and the EIOD to schedule the meeting.

- OSC discusses with the parent/caregiver that their participation in the EIP is voluntary.
- OSC discusses with the family that their priorities, concerns, and resources will play a major role in the establishment of outcomes and strategies among the parent, provider, service coordinator, and EIOD.
- OSC is responsible for discussing the composition of the IFSP team.
- A “Review Meeting” is held at 6, 18, and 30 month intervals, and an “Annual Review Meeting” is held at the 12 and 24 month marks. The EIOD may participate in the 6 Month Review Meetings via telephone, and must attend the Annual Review Meetings in person. The OSC contacts the family and the EIOD to discuss scheduling the IFSP meeting, either in the home or in another location (i.e., DOH, center-based program).
- It is preferable to schedule a meeting when a provider member of the IFSP team can also attend, but it is not required.
- If the IFSP meeting is not being held before the end of the IFSP period, the new IFSP will be back-dated so there will be no disruption in services.
- If the IFSP meeting is not scheduled to be held prior to the end of the IFSP period, the OSC must “clone” the IFSP in NYEIS no later than two days before the end date, otherwise the IFSP will close 10 days after the end date.
- OSC is responsible for reviewing updated progress reports, coordinating and participating in all subsequent IFSP meetings, and updating the new IFSP outcomes and strategies developed by the family and providers, taking into account the concerns and priorities of the parent.
- OSC is responsible for reviewing the *Early Intervention Program Make-up Policy and Billing Regulations* with the family.
- OSC enters the IFSP information into NYEIS.
- OSC assigns the evaluation agency (if a supplemental evaluation is necessary).
- OSC creates the Service Authorization (SA) to submit to EIOD for approval.
- OSC clones and creates the IFSP and submits to the EIOD for approval.
- OSC ensures that SA’s are received by assigned providers.
- OSC is responsible for ensuring that within 10 days of the IFSP meeting, the parent receives a copy of the completed and authorized IFSP each time there is a review.

C. AMENDMENTS TO THE CURRENT IFSP

- OSC verifies with the EIOD that the new or amended SA's are approved.

- OSC confirms acceptance of the SA's by the provider agency.

- OSC confirms that any added new service has started within 30 calendar days.

D. TRANSITION TO CPSE

- OSC completes the Transition Tool Kit with the family at the IFSP meeting closest to the child's second birthday.
  (See Transition Tool Kit distributed by NYS)

- OSC identifies important transition dates using the *Transition Table* or the calculator at http://eservices.nysed.gov/ei.

- OSC develops a transition plan with the family for all children (*IFSP Transition Plan Forms A/B* can be used, but are not required.)

- OSC explains transition options for all children, including Committee on Preschool Special Education (CPSE), Head Start, local play groups, etc.

- OSC will explain transition steps to CPSE to the parent, including but not limited to: notification, conference, referral, choose/share EIP records, evaluation by CPSE, initial CPSE meeting, and determining transition date.

E. NOTIFICATION

- OSC explains the opt-out policy and deadline for objecting to CPSE notification. The Parent must be given the option to Opt-Out of the notification to the school district. The parent must be informed of their right to Opt -Out at least 30 days before the 120 Day Notice must be submitted. The parent is offered three options on this Opt-Out form:
  - They can agree to send the written notification without waiting the 30 days,
  - They can indicate that they have been informed of the notification requirement and understand that they have 30 days from the date the form is signed to opt-out, either orally or in writing, to the notice being sent to the school district. (If there is no oral or written request to opt out after 30 days from the signing of this form, the 120 Day Notice is sent to the school district by the service coordinator), or
  - The parent has been informed of the notification requirement and chooses to opt-out of the written notification being sent to the school district. (The parent may still refer their child to the school district on their own. A parent may initially opt-out and later agree to notification. Please try in these cases to get the 120 Day Notice to the school district on time.)

- OSC obtains parent signature on the *Parent Form: Written Notification and Opt-Out Requirements and Timeline.*

- OSC will send *Written Notification of Potential Eligibility* to the CPSE of the child's local school district at least 120 days prior to the date the child is first eligible for services through the CPSE, if the parent has not objected. For children born from January 1st through June 30th, notification is due to the school district by September 1st; for children born July 1st through December 31st, notification is due to the school district by March 1st. Copies must also be submitted to the Department of Health.

F. TRANSITION CONFERENCE

- OSC explains the purpose of a transition conference held with the CPSE chairperson and obtains parental consent or declination. This conference is in addition to meeting with the OSC to develop a transition plan.

- If requested by the parent, the OSC arranges for the transition conference with parent(s), CPSE chairperson/designee, and other members of the IFSP team as invited.

- OSC maintains documentation of the invitation to the transition conference sent to the CPSE (If the CPSE chairperson does not attend, the service coordinator can meet requirements for convening the conference as long as documentation of this invitation in maintained.)

- OSC provides the parent with the documents titled *Transition Information for Parents including Steps to Transition* and *Comparison of the EIP and Preschool Special Education Program.*

G. REFERRAL

- OSC provides the parent with *Form for Parent Referral to the CPSE* to assist the parent in making the referral to the CPSE.

H. TRANSMITTAL OF CHILD RECORDS

- OSC obtains parental *Consent for Transmittal of EIP Evaluations and Records.*

- OSC assists parent in choosing the Early Intervention records to send to the CPSE and/or other programs, including IFSPs and evaluation records.

- OSC sends child records, with copy of parental consent, to the CPSE and/or other programs.

I. INITIAL CPSE MEETING

- OSC will attend the initial CPSE meeting at the parent's request.

J. DOCUMENTATION

- For each step above there are standardized forms in the service coordination Transition Tool Kit.

- The OSC maintains copies of all completed and signed forms in the child's record.

- The OSC attaches all transition forms in NYEIS (not required).

- The OSC completes transition pages in NYEIS at the time of the IFSP meeting closest to the child's second birthday. These pages should be continually updated with new information as needed.

K. INSURANCE

- OSC maintains and updates medical insurance information including Medicaid and Child Health Plus policy information.

- New Insurance information must be entered into NYEIS and an end date for the prior insurance must be added.

- OSC reviews with the family the requirements in NYS Public Health and Insurance Law as needed.

- OSC updates insurance information from the family using the Collection of Insurance Information, mails to insurance company and sends copy to EIOD.

- OSC assesses whether the family's insurance plan is regulated by NYS Insurance Law using information provided by the Bureau of Early Intervention.

- OSC initiates the process to obtain information from the insurer on the extent of benefits available to the child under the child's/family's insurance policy. The OSC will obtain from the parent a written referral from the child's primary health care provider.

- OSC obtains the health insurance information from the family and documents the information on the 'Collection of Insurance Information' Form A.

- OSC contacts the insurance company to confirm billing and claiming address.

- OSC searches for insurance company in NYEIS and verifies billing & claiming address.

See the *Insurance Tool Kit for Service Coordinators* for further details and clarification

- Information gathered from return of the *Collection of Insurance Information* from the insurance company must be entered into NYEIS when services will not be covered by an insurance company so that no billing will occur. **(OSC does not receive that information- it is sent to NCDOH. NCDOH will upload into NYEIS so that it may be viewed by the OSC)**

L. PRIOR AUTHORIZATIONS AND PRIMARY CARE PHYSICIAN REFERRALS

- If required, information on the need to obtain prior authorizations must be captured in NYEIS.

- The OSC utilizes *NYSDOH BEI Written Referral from Primary Care Practitioner Prescription for Therapeutic Services Documentation of Medical Necessity for Third Party Claiming*.

M. NOTIFICATION TO OPWDD

- It is the specific responsibility of the Initial Service Coordinator to consult with the evaluators regarding OPWDD notification and to send this notification if appropriate. However, this notification can be made at any point during the time that the child is eligible for EIP services.

- OSC provides the family with information on OPWDD if the child may be provisionally eligible.

- Notification to OPWDD should only be made for EI eligible children with significant developmental issues.

- OSC refers parent(s)/guardian(s) to the local Developmental Disabilities Regional Office (DDRO) if they have questions regarding OPWDD eligibility or services.

- If the parent(s)/guardian(s) give consent, the OSC should submit the *OPWDD Notification Form* attention to:

    Children's Services – c/o Nicole Suto
    NYS OPWDD 44 Holland Avenue, Albany, NY 12229

IV. IFSP MEETINGS

IFSP meetings (both initial and reviews) are a time for a family to share their concerns, resources and priorities with regard to their child's needs and development. It is a time when the family will develop, in collaboration with their service coordinator, evaluator and /or team of service providers, a plan to address the child's needs so that he/she may continue to grow and develop.

A. INITIAL MEETING

Prior to the Initial IFSP

At the time a child is referred to the Early Intervention Program, instructions are provided to parents for accessing the New York State publication, "The Early Intervention Program: A Parent's Guide" on the website www.health.state.ny.us/nysdoh/eip/. This guide includes information on what the family should expect to occur at the initial IFSP meeting.

At the initial home visit with the team, the child's ISC reviews the information contained in the New York State publication, "The Early Intervention Program: A Parent's Guide." The ISC establishes with the family a date and time for the initial IFSP meeting. The location and time of the meeting will be agreed upon at that time by the family and ISC. The scheduled meeting will occur no more than 45 days from the date of referral, unless the family requests a delay.

As soon as possible following the child's multidisciplinary evaluation, but within sufficient time to enable convening the IFSP meeting within 45 days from date of referral, the evaluator(s) will provide the child's parent(s) and ISC with a complete evaluation and summary narrative.

The Initial IFSP Meeting

In accordance with NYSDOH regulations, the following individuals must be present at the initial IFSP meeting: the child's parent or surrogate; the Early Intervention Official Designee (EIOD); the evaluator; the ISC and any other persons the parent or ISC (with parental consent) invite. The ISC serves as the EIOD at the meeting. The meeting will be conducted in the dominant language of the family whenever possible.

The ISC will facilitate the meeting as follows:

- The evaluator(s) will review with the family the evaluation reports and any other pertinent information that has been gathered regarding the child and which will be used in the development of the IFSP.

- Discuss with the family their resources, concerns and priorities for their child and include this information in the IFSP.

- In conjunction with family and evaluator(s), develop meaningful goals that the family feels are important for the child as well as strategies for meeting these goals in the child's natural environment.

- Include strategies and activities the parent/caregiver can engage in with their child during their daily family routines as well as professional services, as necessary.

- Address the transition process from EI and timelines.

Once completed, the ISC will have the parent(s) read through the IFSP. Parents will be given the opportunity to ask questions and to insure they understand and are in agreement with the IFSP. Parent(s) will sign the IFSP to indicate their agreement with the service plan for their child.

If there is disagreement regarding the IFSP that cannot be resolved through discussion, the parent will initial the statement included in the IFSP indicating their disagreement. They will complete a "Consent Withheld Form" and will be reminded of their due process rights. Parts of the IFSP not in dispute will be implemented.

B. IFSP REVIEW MEETING

NYSDOH regulations require that the IFSP be reviewed at six month intervals and the plan evaluated annually to determine the degree to which progress has been made toward achieving outcomes and whether there is a need to modify services or outcomes. Upon request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals. The individual provider must discuss any requested change in service with the OSC/EIOD prior to discussing with the family. Before implementing any change, approval and an effective date must be determined by the EIOD.

Prior to all six month and annual reviews, each of the child's service providers will submit to the child's parent(s), EIOD, and OSC copies of the Provider Progress Reports. Provider Progress Reports must be received three weeks prior to the end of the child's current IFSP period in order to reflect the child's most current level of functioning. Providers will review written reports with parent(s) prior to the review meeting.

The OSC is responsible for scheduling IFSP review meetings and completing them in a timely manner. This should be conducted in consultation with family and service providers.

Once completed, the OSC will have the parent(s) read through the IFSP (for annual reviews) or the IFSP Review Plan (for six month reviews). The parent(s) will sign the IFSP or IFSP Review Plan to indicate their agreement with the plan of services for their child. If there is disagreement regarding the IFSP that cannot be resolved through discussion, the parent will be reminded of their due process rights. Parts of the IFSP not in dispute will be implemented.

Six month reviews may be done without a meeting only with the prior approval of the EIOD. This should only occur if all the following conditions exist:

1) the child receives one IFSP service;

2) there is no need to change services on the IFSP and;

3) the parent(s) agrees that a meeting is not necessary.

The OSC will insure that the family has received, understands, and is in agreement with the Provider Progress Report. The OSC will complete the IFSP Review Plan, send to the parent(s) for signature and have parent(s) sign, indicating their agreement, and forward the signed copy to the EIOD for authorization of continued services.

Annual reviews of the IFSP must be conducted at a meeting. The following individuals are required to be in attendance: the child's parent(s)/surrogate; OSC; EIOD; provider(s); and any other persons invited by the parent(s) or OSC, with parent(s) permission.

The OSC will facilitate the meeting as follows:

- Review with the parent(s) and provider(s) the Provider Progress Reports and any relevant updated material that has been gathered regarding the child and which will be used in updating the IFSP.

- Discuss with the family their current resources, concerns, and priorities for their child and include any new information in the IFSP.

- In conjunction with parent(s) and provider(s), develop meaningful goals for the child, as well as strategies for meeting these goals in the child's natural environment. Goals will be developed by reviewing progress toward outcomes written in the previous IFSP and updating them as necessary.

- Include strategies and activities the parent/caregiver can engage in with their child in daily family routines, as well as professional services, as necessary. Consideration must be given to providing services in natural environments and utilization of community services.

C. CHOOSING AN ONGOING SERVICE COORDINATOR

During the initial home visit with the family, the ISC will inform the family that, as part of the initial IFSP, they will be asked to choose an OSC. The ISC will explain the role of the OSC and will refer the parent to the section of "Early Intervention Program: A Parent's Guide" that provides information on choosing an OSC.

The ISC will explain the difference between the role of the OSC and the role of the EIOD. The family will select an individual to be their OSC and this information will be written into the IFSP. The family will be advised of their ability to change OSC should they feel that the chosen OSC is not fulfilling his/her role or that another individual would be a more suitable OSC. The family should understand that this change does not have to wait until the next scheduled IFSP meeting.

V. WORKING IN HOME, OFFICE/FACILITY & CHILD CARE CENTERS

NATURAL ENVIRONMENTS

According to US Federal Law (34CFR303.12(b)(2)) the definition of natural environment is settings that are natural and typical for the child's same age peers who have no disabilities. Federal law does not require the involvement of peers in the service delivery system, but rather that Early Intervention services occur within the context of the natural routines and activities of the family. The reauthorization of IDEA in 1997 changed the focus of Early Intervention from working directly with children to supporting families to meet the developmental needs of their children. It is important to recognize the power of the relationship between the parent/caregiver and the child. New skills are best learned from the adults and children in the child's daily life.

For children from Birth to age 3, the natural environment can be:

- The child's home
- A community setting where the child and family typically spend their time
- A community setting where the family would like to spend time with their child in the future
- A community setting where typically developing peers and their families are typically located

It is the IFSP team that determines the location of the services. It further becomes the responsibility of the IFSP team to develop strategies to enable families to incorporate interventions into their routine and activities.

The service provider's role in the natural environment is to model activities for the families and to ensure effective provision of services. This can be accomplished by empowering the family and the service provider's role should include:

- Assisting the child to improve their developmental skills as they relate to the child's everyday natural learning opportunities.
- Assisting where the child lives, learns and plays by interacting with their typically developing peers in the community.
- Assisting the family to exchange skills and knowledge with the team and other community members.
- Assisting the family to identify and develop their skills and strengths.
- Assisting the family to utilize materials that are accessible to them.
- Becoming culturally competent to families of diverse backgrounds.
- Collaborating with other team members.

A. GENERAL INFORMATION AND REMINDERS

Introduce yourself as you would like to be addressed. Use last names with appropriate titles (e.g., Mrs. Jones) unless the parent/caregiver asks you to use first names. **The service provider is there as a professional, not a friend.** Some providers find that continuing to use more formal address helps maintain a professional relationship.

All providers are to wear visible photo identification as provided by their agency. Independent providers must provide their own photo ID. All photo ID should include name, picture, professional title, and, if applicable, the agency name.

Cellular phones/electronic messaging devices should be off. Take no phone calls or messages during the session. Wait until after the session to return any messages.

The service provider will not discuss personal information or problems with the parent/caregiver. This helps keep boundaries between personal and professional relationships and allows the focus to remain on treatment. If the parent/caregiver shares with you their personal problems (e.g., marital issues), encourage them to talk to their OSC about a referral to an appropriate professional. Talk to your supervisor about specific situations.

When providing treatment in a New York State regulated child care setting (family/group family child care program, child care center, Head Start program), service providers are required to sign in on the program's visitor's log.

Scheduling

Keep family considerations in mind i.e. nap times, work and family program schedules. It is important to maintain a consistent schedule throughout the IFSP period (e.g., Tuesday at 10:00 a.m. and Friday at 11:30 a.m.) Keep as close to your scheduled appointment times as possible. Notify the family/caregiver as soon as possible if the provider will be significantly late. If the appointment must be cancelled due to illness or emergency, contact the family/caregiver directly. It is always important to have the current phone or work number of the family/caregiver.

If the parent/caregiver states that the child is not up to a session, respect their decision. When a session is cancelled indicate the cancellation on the Daily Note/Attendance sheet as well as who cancelled. Offer a make-up session, when possible, according to the NCDOH guidelines. (see Appendix F)

Families/Early Childhood Education (ECE) Programs as members of the team

The provider should discuss his/her working style with the parent/ECE program (NYS regulated family/group child care program) when beginning services. EI philosophy encourages parents/ECE teachers to be involved in the child's treatment. If a parent/ECE teacher cannot be present during a session it is still important to discuss what IFSP goals are being addressed with the parent/ECE teacher. This can be accomplished with phone contact, daily notebook, etc. but it is the provider's responsibility to initiate the contact.

Many families/ECE teachers ask for suggestions about what they can do to carry over the provider's activities with the child. Be sure to coordinate with other team members so families/ECE teachers do not become overwhelmed by too many "assignments." Use a notebook to communicate with other team members as well as to provide written information for families/ECE teachers about the treatment. Select activities for the family/ECE teacher to do to incorporate into the child's daily activities in their natural environment.

Discuss any recommended changes in service provision with other members of the child's team, provider agency, the OSC and EIOD before discussing them with the family/ECE teacher.

If the family/ECE teacher or team members feel that services should be changed, the OSC would submit an IFSP Review Request.

In conversation with the family/ECE teacher, do not diagnose outside your professional discipline, comment on another provider's intervention, or answer questions related to another field. It is appropriate to direct questions to the provider in that field. If a parent/ECE teacher is unhappy with a provider's intervention, encourage the parent to contact the OSC.

Be respectful and aware of cultural differences (e.g. taking off shoes, child rearing practices, ECE program policies and mandated regulations, appropriate dress, etc.)

Acknowledge the needs of siblings/classmates in a positive way. If appropriate, involve them in a treatment session. Siblings/classmates can sometimes be great motivators.

Child Abuse and Neglect

When child abuse or neglect is observed or suspected, the service provider **must immediately notify**:

- The NYS Child Abuse and Maltreatment Register by telephone at 1-800-635-1522 and in writing within 48 hours of oral report.
- The Special Victims Squad of the Nassau County Police Department if the allegation involves non-familial abuse at 516-573-4022.
- The Director of the Early Intervention Program at the Nassau County Department of Health at 516-227-8648 (8:30 AM to 4:15 PM) and after business hours at 516-742-6154.
- The Ongoing Service Coordinator and EIOD.
- The Director/Family or Group Family Child Care Provider of the ECE program who are required to report it to NYS Office of Children & Family Services.

Many professionals in New York are mandated to take a course in the "Identification and Reporting of Child Abuse and Maltreatment" to obtain or maintain certification/licensure. It is strongly recommended to take the course even if not required to do so.

Health and Safety Procedures

Wash hands at the beginning and end of each visit and explain to the family why that is important. NYS Office of Children & Family Services (the regulatory agency for child care in NYS) regulations require adults and children to wash their hands when entering a classroom; before and after eating, after assisting a child in wiping their nose and in diapering/toileting, when coming in from outdoor play, before using a water table, etc. After a session, toys and equipment must be washed with an appropriate cleanser before using them with another child. **It is preferable to use the child/family's toys.** In an ECE program, it is appropriate to ask permission prior to using their toys or equipment.

Diapering and toileting needs that occur during a visit should be taken care of by the parent/ECE teacher who is in attendance. Diapering and toileting needs in center based program can be met by program staff; refer to program policy. Gloves must be worn while changing or toileting a child and hands must be washed immediately afterwards. Soiled diapers should be disposed of in a covered pail.

Before beginning feeding therapy, the provider must obtain medical clearance. Gloves must be worn at all times when working with food or having direct contact with a child's mouth. Food reinforcers should not be used without the parent/ECE program's permission. Dietary restrictions and cultural rules, as indicated by the family, need to be strictly adhered to.

Do not enter a building if it does not appear to be safe. Leave a building if you do not feel safe. Immediately notify the agency supervisor and the child's OSC with safety concerns. It may be possible to modify the IFSP to provide services in a different location. Discuss with the family ways to make your visit safer. For example, ask them to restrain a dog or have someone meet you outside a multi-family dwelling.

B. WORKING IN THE HOME

If a service provider arrives at a home and there are no parents (adults 18 or over) home, a call is to be made **immediately** to the Nassau County Police Department (911) and to the Director of the Early Intervention Program at the Nassau County Department of Health (**516-227-8648**).

Establish specifics such as where to park, what materials (toys) will be used (preferably the family's), and where in the house to work with the child. A responsible adult must be present in the home at all times. Ask the parent/caregiver to remain within close proximity during the session and to be available as needed. Do not close a door or go into another area of the house.

Ask to use the bathroom if needed, but do not ask to use other facilities in the home (e.g., refrigerator, telephone). Do not bring any food or beverages for consumption during a session.

Do not bring your children, other family members, friends, or other non-professionals on a home visit. Obtain parental consent before bringing a supervisor, student/intern, or other professional to the home. Do not drive children and/or family members anywhere, ever. Do not take children to your home.

C. WORKING IN AN OFFICE/FACILITY

Parents/caregivers must remain on-site at all times during their child's session according to the policy of the facility. Make sure the family has directions to the facility, is familiar with the parking arrangements and other aspects of the facility: handicapped accessibility, elevators vs. stairs, etc.

If a child comes to an Office/Facility-Based program with signs or symptoms of an illness, it is at the discretion of the program director/administrator whether or not to cancel that session.

Do not have any discussions with parents concerning their child or any other child in any public area. Respect family's privacy and confidentiality and maintain the same level of confidentiality when discussing a child with other professionals. Never show frustration or anger in the presence of families.

Never, under any circumstances, leave a child unattended in any area of the facility. It is the parents' responsibility to always accompany children to the restroom. Appropriate facilities and supplies must be available and utilized when needed for diaper changing.

Use of a two-way mirror is intended for the family/caregiver for observation and to assist in family training. The door to the observation room should be closed when not in use, as should all other treatment room doors.

D. WORKING IN A CHILD CARE CENTER

Child care can take place in a registered or licensed family or group family child care provider's home or a non-residential setting in a licensed child care center. Nursery schools (children are in program less than 3 hours a day) are not required to be licensed or registered. Camp programs are regulated by Nassau County Department of Health. They may operate all year long or just during the school year and may offer part-time, vacation and holiday care schedules. Any EI service provider can verify the validity of a regulated Childcare Center & Education Facility by asking to see the program's license or registration issued by the New York State Office of Children & Family Services. Any further questions or clarifications regarding a regulated Childcare Center & Education Facility can be addressed by contacting the Child Care Council of Nassau, Inc at (516) 358-9250 or NYS Office of Children & Family Services at (631) 240-2560. For regulated camps contact Nassau County Department of Health at (516) 227-9697.

Additional considerations for working in Childcare Center & Education Facilities are as follows:

- New York State Office of Children & Family Services (NYSOCFS) (the regulatory agency for all forms of child care) regulations prohibit any individual who has not been fingerprinted and cleared through the State Registry for child abuse and neglect from working with a child in isolation. The child and provider must be under direct supervision of program staff at all times.

- Any child care facility that has a contract or agreement with Nassau County Department of Social Services requires that all individuals be fingerprinted and have a criminal record check. In those facilities there is also a requirement that any child receiving services remain

under direct supervision of program staff.

- A letter of introduction must be sent by the service provider prior to the onset of services at any Childcare Center & Education Facility.

- EI service providers should request an orientation of the Childcare Center & Education Facility at the beginning of the first visit. Be sure to obtain a copy of the safety procedures and all other facility policies regarding scheduling, cancellations, etc.

- Implement a procedure for the inclusion of both parent/ECE program staff on updates and any other applicable communications.

- A plan must be developed in order for service providers to train childcare staff to accommodate needs of child.

E. WORKING IN EARLY INTERVENTION CENTER BASED PROGRAMS

Program personnel, families, service providers and OSC/EIOD must work collaboratively to provide services for children and families in center-based settings.

Ongoing communication is essential in order to assess appropriate provision of services and to monitor the well being of children and families.

If a child comes to a Center Based program, with signs or symptoms of an illness, it is at the discretion of the program director/administrator whether or not to send that child home.

The following procedures must be established and implemented in each center-based program:

- Any recommended change in services and/or concern about program placement must be discussed with the OSC/EIOD. Decisions should be made collaboratively with staff, OSC/EIOD, service providers, and families.

- Any incident on a bus or within a center-based setting, regarding any suspicion of sexual and/or physical abuse must be documented and immediately reported to the New York State Child Abuse and Maltreatment Register (Phone # 1-800-635-1522), OSC/EIOD (DOH Phone # 516-227-8648), and/or the Special Victims Unit (in cases of sexual or physical abuse when the allegation involves non-familial abuse) (Phone #516-573-4022).

- Any incident on a bus (e.g., accident and/or injury) must be documented and reported to OSC and EIOD.

- Any significant change in a child's medical status and/or medical emergency that occurs during the center-based program must be documented and reported to the OSC and EIOD.

F. PARENT DOS & DON'TS

Parent Dos

- Read and be familiar with your child's IFSP (Individualized Family Service Plan) and "The Early Intervention Program - A Parent's Guide," which is available at www.health.state.ny.us/nysdoh/eip/
- Make sure to have the names, disciplines, and phone numbers of all service providers, providing agency and ongoing service coordinator.
- Participate in sessions learning techniques to be used throughout daily routines.
- Be flexible when scheduling sessions.
- Notify your child's school / childcare center & education setting if sessions are provided at these sites.
- Daily Notes must be signed by you or your designated representative (at least 18 years old) only after each session.
- Call provider(s) if your child is sick or is unavailable for services that day.
- Keep your personal life personal.
- Be part of a team.
- Be respectful.
- Set aside an appropriate space for provision of services.
- Have your child ready for services.
- Shovel your walkway in the snow.
- Confine your pets.
- Inform your service provider of food allergies or medical concerns.
- Expect your service provider to be on time, consistent, professional and wear appropriate photo identification.
- Contact your EIOD /OSC providing agency supervisor if you have any concerns regarding your child's provider.
- Accompany your service provider to any community locations where services are being provided.

- Allow the service provider to use your child’s toys in your home during provision of services.
- You or designated representative (at least 18 years old) must be present during provision of services.
- You are always responsible for transporting your child to a community site.
- Notify the providing agency and OSC if provider is not providing services to your child.
- Expect to receive signed and reviewed copies of your child’s progress reports every six months in every discipline.
- No more than one session of the same discipline per location can occur each day.
- No more than three service sessions can occur in a single day.

Parent Don’ts

- Don’t sign for services not provided.
- Don’t sign in advance for missed sessions.
- Don’t ask your service provider to stay for other than the time stated on the IFSP.
- Don’t allow service provider to take your child anywhere anytime.
- Don’t ask your service provider to change diapers.
- Don’t serve food/drink to your service provider.
- Don’t offer gratuities.
- Don’t contract with your child’s service provider (s) for any additional services.
- Don’t pay any fees for services provided.

G. SERVICE PROVIDER DO'S AND DON'TS

Service Provider Do's

- Make sure you have an IFSP for the child you are servicing. Read and be familiar with it.
- Call parent to introduce yourself and leave contact phone number(s).
- Explain your role and responsibilities.
- Set up a regular session time/day.
- If child is not seen at home, have family notify school/childcare center & education location.
- Introduce yourself to the childcare center director.
- Wear an ID badge.
- Discuss your role with the director and classroom teacher.
- Have parent or parent designated representative (at least 18 years old) sign the Daily Notes after each session, whether provided or missed. If the session is missed this will be clearly indicated on the log sheet, it is never blank.
- Notify parent/school/Childcare Center & Education Program if you will be absent or if there are any changes in your schedule.
- Notify your agency/school if services are interrupted for more than five consecutive sessions. If you are an independent provider, contact the EIOD/OSC. All providers document and forward to agency and NCDOH.
- Observe confidentiality.
- Report any suspicion of child abuse/neglect to the NYS Child Abuse and Maltreatment Register at 1-800-635-1522. Afterwards contact the OSC, EIOD and your agency. If appropriate, contact director/family/group family child care provider in NYSOCFS regulated programs.
- Be respectful.
- Wash hands at the beginning and end of each session.
- Speak in positive terms when referring to the child.
- Be personable not personal.

- Leave cell phone on vibrate.
- Work as a team.
- Ask family/Childcare Center & Education Program to set aside a space to work.
- Dress appropriately for the setting.
- Arrive on time, leave on time.
- In NYSOCFS regulated programs, sign in on visitor log.
- Stay the authorized amount of time.
- Check for food allergies before using food during a therapy session.
- Follow universal precautions.
- Provide suggestions for generalization for carryover.
- Maintain a communication notebook.
- Have parent /guardian/ parent designated representative (at least 18 years old)/Childcare Center & Education Program staff present during each session.
- Provide services at a productive time and location to address goals.
- Respect cultural differences.
- Use the family's toys and if using your toys or the Childcare Center & Education Program's toys make sure that they are cleaned after each session.
- Make sure you have completed the required NYDOH professional development training hours and are familiar with New York State regulations and the NCDOH Best Practice Manual.
- Any significant event and/or observed change in family status must be documented and reported to the OSC/EIOD.

Service Provider Don'ts

- Don't discuss another service provider with the parents/Childcare Center & Education Program staff, refer parents/ECE staff to appropriate professional.
- Don't sign blank session notes.
- Don't accept gifts or cash.

- Don’t be alone with a child behind closed doors.
- Don’t eat in a home/classroom.
- Don’t talk on cell phone during session.
- Don’t give advice on another discipline professional.
- Don’t take recommendations without discussing it with OSC.
- Don’t drive a child/family in your car – anywhere, ever.
- Don’t change diapers.
- Don’t provide services to a child in an outside location without parent/guardian present.
- Don’t work privately to add extra sessions to Nassau County authorized sessions.
- Don’t bring your own children to treatment sessions or IFSP meetings.
- Don’t allow parents to leave home during sessions.
- Don’t take a child from one area of the home or program to another without the parent’s/program’s knowledge.

VI. DELIVERY OF SERVICES

A. COLLABORATION BETWEEN PROFESSIONALS AND ONGOING SERVICE COORDINATORS

Professional Collaboration

The IFSP team consists of the family, the child's Childcare Center & Education Program, EIOD, OSC, and licensed/certified professionals. Agencies, individual providers and OSCs should work together to effectively implement the IFSP. As members of the IFSP team communication is essential. Everyone must have the phone numbers of the IFSP team. Providers of the same discipline should be especially vigilant in communicating with each other their goals, objectives, and interventions. Communication is accomplished through phone calls, notebook, meetings, and co-treatments to maximize the benefits to the child. Development of a notebook provides an organized and cohesive means in which providers can communicate with each other and the child's family. This notebook will also include the phone numbers of each team member and the times when they are available.

The IFSP team must communicate to assure that the needs of families are identified and that appropriate interventions are implemented. Maintaining the collaborative relationship will enable the IFSP team to function in their appropriate roles and provide the appropriate intervention to the families. Service providers can refer families to their OSC directly if concerns exist in obtaining appropriate medical professionals, respite care, and/or childcare.

B. CO-TREATMENT

"Co-treatment" is a collaborative session in which providers from different disciplines treat a child simultaneously.

Plans for co-treatment must be written in the IFSP. Co-treatment among providers may be useful in devising problem-solving techniques, addressing family issues, and developing a more cohesive treatment plan. Co-treatment can be beneficial in incorporating a variety of strategies and techniques when working with children and families. Therapists can intermittently collaborate (both providers working with same child at same time) for up to 9 minutes without requiring documentation on the IFSP. Collaboration is not a substitute when ongoing treatment sessions are needed.

If a child's development could be enhanced by co-treatment, one provider should contact the other provider and schedule a session that is convenient for the family, the Childcare Center & Education Program, and themselves. Providers should organize goals to be addressed and plan ideas and activities that will be introduced to the child during the session.

Providers should carefully observe the technique and style of the other professional during the session and note how the child responds to the treatment. After the session is completed, providers should discuss the outcome of the session and give feedback and suggestions to one another, the Childcare Center & Education Program and to the parent in order to continue or improve the effectiveness of the services for the child. All co-treatments must be documented on Daily Notes/Attendance Sheets.

If a recommendation for on-going co-treatment of a child is made, approval from the Nassau County Department of Health (EIOD) must be obtained before sessions are discussed and scheduled with the family and Childcare Center & Education Program. These co-treatments must be added to a child's IFSP.

C. SPEECH-LANGUAGE PATHOLOGY – CLINICAL FELLOWSHIP YEAR (CFY)

An individual completing their Clinical Fellowship Year (CFY) in speech language pathology or audiology who is supervised by a New York State licensed speech-language pathologist or audiologist, may provide speech-language pathology services or audiology services in the Early Intervention Program. Individuals completing their CFY may perform evaluations as a member of the multidisciplinary evaluation team or as a supplemental evaluator. **The supervising licensed speech language-pathologist/audiologist must co-sign evaluation reports.** Families must be informed that the evaluator is completing their CFY.

The supervision plan for a CFY must meet national ASHA and state NYSSHLA requirements. In order to verify the status of an individual who is completing their CFY, the agency responsible for the individual will attain and keep a copy of the "Form 6" issued by the State Board for Speech Pathology. **The IFSP must include details of this supervision plan**, including the name and the license number of the supervising qualified personnel, and the frequency of observation, treatment, and assessment by the supervising qualified personnel. The provider must maintain documentation identifying the licensed speech-language pathologist or audiologist who provides supervision to the individual completing their CFY, as well as the terms of supervision.

The provider must notify the EIP, EIOD, OSC and parent that an individual completing their CFY is providing Early Intervention services under the supervision of a licensed speech/language pathologist or audiologist.

An individual completing their **CFY cannot be hired as an independent contractor.**

(Adapted from the New York State Early Intervention Memorandum 00-1 March 15, 2000 Qualified Personnel in the Early Intervention Program).

D. PHYSICAL THERAPIST ASSISTANTS AND OCCUPATIONAL THERAPIST ASSISTANTS

For information regarding Physical Therapist Assistants and Occupational Therapist Assistants in the Early Intervention Program, refer to the New York State Early Intervention Memorandum 00-1 March 15, 2000 Qualified Personnel in the Early Intervention Program.

E. STUDENT THERAPISTS

A student who is enrolled in an accredited University program may provide Early Intervention services **only under the direct on site supervision of a licensed practitioner. The licensed professional always has the legal responsibility and liability for the treatment of the child.**

Parents must provide prior written consent for a student to be present in their home and/or to provide services for their child under the onsite supervision of a licensed professional. This written consent must be maintained in the agency and NCDOH file. The licensed practitioner responsible for supervising the student must obtain and maintain records of the student's affiliation and liability insurance. Any student providing Early Intervention services must submit the appropriate medical documentation as required by the NCDOH to their agency.

It is the **responsibility** of the licensed practitioner to observe, provide student supervision, and review his/her treatment plans. Daily Notes/Attendance Sheets, Provider Progress Reports, and evaluations must be reviewed and co-signed by the licensed practitioner.

A CFY is not considered a student but must follow guidelines as established by ASHA (see preceding page).

(Adapted from New York State Early Intervention Memorandum 00-1 March 15, 2000)
Qualified Personnel in the Early Intervention Program.)

F. PRESCRIPTIONS/ORDERS FOR THERAPY

In order to render OT, PT or ST treatment, a written prescription is required, for ST a referral from a speech language pathologist will satisfy this requirement. The following medical professionals can prescribe PT: a licensed physician, a physician's assistant, or nurse practitioner. The following medical professionals can prescribe OT: a physician, a physician's assistant, or nurse practitioner. The following professionals can prescribe or refer ST: a physician, a physician's assistant, nurse practitioner or a speech-language pathologist. Initial prescriptions are typically issued by a child's primary care physician. Initial and updated prescriptions must be kept in the child's file at the location of the provider. **Copies must be sent to NCDOH.** The OT/PT/ST prescription must be renewed every 12 months, unless the service changes, in concert with the annual IFSP. If the OT/PT/ST is recommending continued services, **it is the responsibility of the treating provider to obtain the renewed prescription.**

G. MEDICAL CLEARANCE

If a child's health status (e.g., heart condition, hip instability) may pose a risk in treatment, medical clearance should be secured from the appropriate medical professional (i.e., pulmonologist, cardiologist, or orthopedist).

Medical clearance must be obtained any time there is a significant change in the medical status of a child. Prior to returning to treatment, the medical professional responsible for the treatment of the child should write a prescription for resuming therapy. The prescription should clearly state that **PT and/or OT activities can resume without any restrictions**.

Services provided without securing the appropriate prescription are illegal and a violation of Education Law for OT (Article 156) and PT (Article 136).

VII. REQUIRED PAPERWORK

A. DAILY NOTES/ATTENDANCE SHEETS

The NCDOH requires accurate Daily Notes/Attendance Sheet records, therefore, observe the following procedures:

- **Accurately record the date of service rendered.** The date of service recorded must be the actual date the service was provided. **Never falsify a date of service for any reason**. Parent/caregiver must sign the daily notes /attendance sheet following each session. **Never have a parent/caregiver sign in advance or for any time other than the current date.** This is **fraudulent** and **illegal.**

- **Accurately record your arrival and departure time. Any proven falsification of records will result in notification to NYS BEI, and may be grounds for revocation of professional license/certification. In addition, full legal action will be pursued.**

- NYSDOH regulations do not allow a child/family to receive more than three individualized services a day at **any one location**. Also note: two services of the same discipline cannot be offered on the same day at the same location. When scheduling a make-up session, it is **the responsibility of the provider** to confirm with the parent/caregiver that this limit is not being exceeded. NCDOH will not reimburse the provider for excess sessions. However, exceptions can be made when approved by the EIOD/OSC and authorized (i.e. for ABA services).

- As per the New York State Provider Agreement, the provider must notify the child's OSC and the NCDOH within 24 hours of a child's absence from more than three consecutive days of scheduled sessions or two weeks, whichever occurs sooner. Notification shall indicate the reason for said absence, if known. Document **all** canceled sessions including date and reason and indicate who canceled. If you are unable to treat the child during any period of time due to illness and/or other reason, Daily Notes/Attendance Sheets must indicate the reason for lapse in services.

- Written parental consent is required to allow a caregiver other than parent/guardian to sign the Daily Notes/ Attendance Sheet.

- Daily Notes/Attendance Sheets must be kept for all sessions as well as for **all contacts** with the family and other professionals who are involved in the ongoing delivery of services for the child.

Instructions for Completion of Daily Notes/Attendance Sheets if using Nassau County's Form

- Daily Notes/Attendance Sheet must be typed or written legibly in black ink.

- Fill in all blanks completely. The following information is available from the child's IFSP and/or the child's authorization:

- DOH EIOD: Fill in the name of the Department of Health Early Intervention Official Designee.

- Fill in the child's name, DOB /age and current IFSP period.

- Ongoing Service Coordinator: Fill in the name of the ongoing service coordinator chosen by the family.

- Service:
- Type: Refers to type of session (e.g. Speech Therapy, Physical Therapy, etc.)
- Location: Home, office, school and/or child care
- Frequency: How often the child receives services
- Duration: Length of each session

- # of Authorized Sessions: The number of sessions authorized in the specific IFSP period.

- Authorization #: An authorization number is located on the child's authorization found either in NYEIS or on a KIDS authorization.

- An ICD-9 code must be included in designated space as provided on the child's IFSP and/or as indicated on the prescription/recommendation for service (i.e. PT ,OT, Speech, Psych) if applicable.

- Provider/Agency Name: Fill in the name of the individual or agency assigned to provide services.

- Provider: Fill in the name of the individual providing services.

- Professional Title: Fill in the appropriate professional title: (e.g. Speech Language Pathologist, Occupational Therapist, etc.).

- Each entry must include the date (month/day/year), explanation of contact (see key i.e. [C] = Clinician cancelled), time session began (in :) and session ended (out :), parent/caregiver signature, and the date the signature was applied.

  If a session is missed, the reason should be written across the Daily Notes/Attendance Sheet. When services are not provided a parent/caregiver's signature is still required and 'missed' should be written **across** the Daily note/attendance sheet.

- Session #: Should include a cumulative (actual treatment sessions) number of sessions that do not exceed the authorized number of sessions for that IFSP period.

- Fill in Make-up date as appropriate.

- CPT codes must be applied as appropriate for all EIP services. Providers should use the list provided by NCDOH/NYEIS.

- Daily Notes/Attendance Sheet content must be related to the expected outcomes that are developed at the IFSP meeting and should include the activities, strategies, and materials used. In addition, include the child's response to the intervention, interaction with the parent/caregiver and any other pertinent or anecdotal information that is important to the description of the intervention. Daily Notes/Attendance Sheet notes should include recommendations

- Each entry must include a legible full signature of the provider including license initials (professional credentials).

- Fill in Recommendations **for support, education, and guidance** that have been provided to parent/caregivers in the space designated. For each Daily Notes/ Attendance Sheet page submitted, an entry should be made.

- Fill in **Specific monthly Contacts and Comments** between IFSP team members, DOH and other professionals. Record all communication with the IFSP team members, DOH and other professionals in the space designated for contacts and comments on the Daily Notes/Attendance Sheet. Use codes printed on bottom of Daily/Notes Attendance Sheet to indicate type of contact (i.e., TC: Telephone Contact).

Reminders:

♦ Daily Notes/Attendance Sheets are considered **legal** documents. Do not use white out or erasures. Cross out with one line and initial and date any changes.

♦ Daily Notes/Attendance Sheet must contain the necessary information to support claims for third party or Medicaid reimbursement (i.e. appropriate CPT and ICD-9 codes)

♦ Daily Notes/Attendance Sheet entry must be signed by a caregiver 18 years or older.

♦ Daily Notes/Attendance Sheet should record intervention when done in conjunction with another provider (Co-treatment). The name and discipline of that provider should be included in the Daily Notes/Attendance Sheet. Co-treatment must first be approved by NCDOH.

♦ Daily Notes/Attendance Sheet should include only generally accepted abbreviations.

♦ Daily Notes/Attendance Sheets should be maintained in the child's file in a manner that ensures appropriate access and confidentiality. For certified professionals, Daily

Notes/Attendance Sheets should be kept for a period of three years after the child reaches the age of 18. For licensed professionals Daily Notes/Attendance Sheets should be kept for a period of one year after the child reaches the age of 21.

B. MAKE-UP POLICY

Providers

The service provider should report, in writing, to the child's OSC, any absences of three consecutive sessions. The OSC will communicate with the family to find out the cause of the absences and determine if adjustments to the child's services are indicated. Any changes to the child's services must be discussed with and approved by the EIOD and documented by an amendment to the child's IFSP.

Parent/Caregiver

Parents/Caregivers should notify the provider of service as soon as an illness is recognized in order for the service provider to rearrange her/his schedule. Please be advised that if the service provider arrives at your home and the session is cancelled at the door, **the provider will not be reimbursed.** If your child is attending a center based program you must notify both the agency and the bus company that your child will not be attending the program that day. You must call the bus company as soon as possible.

MISSED INDIVIDUAL SESSIONS

The IFSP team will discuss the appropriate number of makeup sessions indicated for each individual child/family. Individual sessions, which are missed for the following reasons: illness of child/family member, illness of therapist, inclement weather, therapist vacation time**;** may be made up **within two weeks of the missed session.**

There are no make-up sessions for family vacations and scheduled agency closings (agencies must provide a calendar to family prior to initiation of services.) If a family discharges a therapist(s), any missed sessions that result will NOT be made up. **Make-ups are subject to provider availability and are NOT mandatory.**

EXTENDED ABSENCES

Extended absences must be discussed with the OSC/EIOD. The municipality may close a child's IFSP during extended absences. Upon the child's return, a meeting will be held and a new IFSP will be developed. The municipality will assign service providers. **NOTE: The assigned providers will not necessarily be the same therapists who previously worked with the child.** The municipality may request an additional MDE if eligibility is questionable.

C. PROVIDER PROGRESS REPORT

Service providers must complete a typed 6 Month Provider Progress Report (see Appendix G) for each child for whom they provide service. This report must be completed for any service provided during the IFSP period. The 6 Month Provider Progress Report should be submitted three weeks prior to the due date (end date of IFSP). The reports must be submitted to the OSC, EIOD, and the parent/caregiver.

The service provider should complete all of the information at the top of the progress report form.

The Provider Progress Report must be completed in **narrative form** and include the following information:

For 6 Month reviews:

1. a) In the section referred to as Progress Summary include information on:
   Child's age and services/duration
   Information on the last six months of service
   Child's reaction to therapy (Behavioral Observations)
   Where sessions take place, who is involved (parent/caretaker participation)
   Treatment techniques and strategies to address IFSP goals
   Progress towards IFSP outcomes
   List any ATD or medical issues/concerns

   b) In the section on communication and contact include:
   How often communication occurs between IFSP team members
   Document the specific means of communication used by team members.

   c) In the section on formal assessment include:
   current levels of functioning (using formal and informal assessments) and the child's present level of ability and skills achieved at these levels so that the parents/caregivers will understand the significance of the developmental age represented. Also be certain that justification for services to continue is adequately stated by either the current level of functioning, formal testing and/or supported by clinical judgment. Best practice supports use of formal testing for the 6 month report.

2. Therapeutic Plan
   List long term goals for the next 6 months and measures of success.
   List short term objectives for the next 6 months including level of success.

3. List suggestions given to family/caregiver to help facilitate attainment of IFSP goals and describe how family/caregiver has been able to integrate "activities" into their daily lives.

General Reminders:

- ♦ Standardized testing should be conducted if recommending discharge. If a child is within 1 standard deviation of the mean and has reached age appropriate level you must discharge the child ASAP. Recommendation for monitoring of skills at age level will not be accepted as a justification for continuation of services.
- ♦ Write recommendations (i.e. goals, change in frequency/duration, supplemental evaluations, discharge, etc.) Any recommendation for change in services, etc. should be reviewed by the OSC and the EIOD. All changes must be agreed upon by the family.
- ♦ Check off the correct IFSP period.

- The service provider must sign their name at the end of the Provider Progress Report along with their license/certification initials.
- An appropriate person must sign and verify review of Progress Reports.
- All Provider Progress Reports must be maintained in the child's file in a manner that ensures appropriate access and confidentiality.

D. IFSP REVIEW REQUEST/AMENDMENT

Form EI 5093A and Form EI 5093B

Therapists and/or parents who are requesting an IFSP amendment should be directed to the OSC to obtain the forms to complete and submit to DOH.

Form EI 5093A

Section I

- This section must be completed when discharging from EI, discharging from a single service, changing location, provider or service coordinator
- If discharging from EI or a single service, a discharge note should be attached
- The appropriate box is checked and details/reason completed
- The form is signed at bottom by the parent and person making request
- Form is sent to EIOD at DOH

Section II

- This section must be completed when requesting a supplemental evaluation, change of frequency or duration of a service, or to add a new service
- The appropriate box is checked and form **EI 5093B** is attached, **COMPLETED**
- The form is signed at bottom by the parent and person making request
- Form is sent to EIOD at DOH

The EIOD will then make a determination using form **EI 5093C** and upload this form, along with **EI 5093A/B** into NYEIS for OSC to view and send to parents for their records.

Important Points

- Forms EI 5093A and EI 5093B are for Ongoing Service Coordinators to distribute
- Form EI 5093C is for DOH, EIOD use ONLY
- DOH will upload all forms into NYEIS and the OSC will distribute to appropriate parties
- OSCs are responsible for locating a service provider for any added IFSP service and sending form 5400 (Appendix E) to the EIOD indicating name of provider/agency
- EIOD will enter any service authorizations needed into NYEIS

Decreasing Services

If significant progress toward the IFSP goal(s) has been documented on the Daily Notes/Attendance Sheets, but the child still requires intervention, the level of service may be decreased. For example, Speech can be reduced from 2x weekly to 1x weekly; Special Instruction can be reduced from 1x weekly to 2x monthly.

If a decrease in any service is indicated, do not wait until the end of the IFSP period to request this change.

Discontinuing Services

When the provider has determined through formal and informal testing that the child has reached an age appropriate level of development and the desired IFSP outcome(s) have been attained, such recommendation should be discussed with the OSC/EIOD **prior** to discussion with the family. **Do not wait until end of IFSP period to request this change**.

E. ASSISTIVE TECHNOLOGY DEVICES/SERVICES

An **Assistive Technology Device (ATD)** is any item, piece of equipment or product system. It may be acquired commercially, modified, or customized. It is provided in order to increase, maintain, or improve the functional capabilities of a child with a disability in one or more of the following areas of development: physical; communication; cognitive; social-emotional; and adaptive.

An Assistive Technology Service (ATS) is defined as a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Examples of assistive technology services include installing, customizing, or adapting equipment, constructing new equipment and fitting commercial items to an individual child, as well as training parents and childcare providers in using devices.

In determining whether an assistive technology device should be provided, it is important to consider whether the device is needed to increase, maintain, or improve the child's functional abilities due to a chronic condition affecting the child's development and resulting from a:

diagnosis with a high probability of developmental delay
or
significant and continuing developmental delay

Based on the above, it is appropriate to provide an assistive technology device (for example, ankle-foot orthotics, braces, or similar equipment) for a child with cerebral palsy to increase, maintain or improve the child's functional mobility. In contrast, medical equipment that might be provided as part of a child's routine health care (e.g., treatment for an acute condition resulting from an injury or life sustaining equipment) is not considered an assistive technology device.

According to NYSDOH Guidelines, all assistive technology devices included on the Medicaid Durable Medical Equipment (DME) list require a signed written order by a physician or nurse practitioner regardless of whether the child is eligible for the Medicaid Program. Examples of devices on the Medicaid DME list are wheelchairs, wheelchair trays, orthotics, prosthetics, and augmentative communication systems or devices.

Augmentative and alternative communication devices require an order by a licensed physician based on an evaluation by and a recommendation from a licensed speech/language pathologist. Hearing aids require an evaluation by and a recommendation from a licensed audiologist or otolaryngologist. Wheelchairs require an order by a licensed physician based on an evaluation and recommendation from a licensed physical therapist.

Signed written orders are *not* necessary for simple assistive technology devices such as adapted toys, switches, or simple environmental controls. However, it is always important to engage the child's primary health care providers in discussions related to ways, in which assistive technology devices can increase, maintain or improve a child's functional capabilities.

Procedures for Ordering Assistive Technology Devices/Services

Effective December 1, 2014:

- The treating therapist will complete the ATD Medical Necessity Justification Form, obtain parent signature and send to their agency
- Agency of treating therapist will send ATD Medical Necessity Justification Form to OSC agency along with latest progress note
- OSC will secure prescription and send to EIOD with Medical Necessity Justification Form and progress note from provider requesting ATD
- Nassau County Early Intervention Program will make a determination, and if approved, send IFSP Amendment Determination form to family for signature. Once IFSP amendment is returned, EIOD will enter service authorization and fax ATD packet to the NYS fiscal agent. The fiscal agent will obtain bids from vendors to secure the device.
- Once family receives ATD device, the treating therapist must complete the ATD Notification of Item Delivery, Condition & Status form along with the family and send to OSC agency
- OSC will then forward this form to the EIOD
- EIOD will forward this form to NYS fiscal agent

Assistive Technology Services, such as office visits for hearing aids/molds, will no longer be requested or approved using the ATD forms. Instead, the services should be included in the IFSP.

If there is a discussion of a need for orthotics and/or hearing aids at an IFSP meeting, these items can be written directly on the IFSP at that time, eliminating the need for an IFSP amendment. The items should be added to the IFSP as strategies to meet IFSP goals.

Further Guidance and Resources

The Assistive Technology Coordinator (ATC) at PCG (the State Fiscal Agent) is currently Sherree Sinclair, and can be reached at 615-983-5355, (fax) 518-935-9258, or e-mail ssinclair@pcgus.com.

Information regarding NYSDOH guidelines on assistive technology devices and services for children eligible for the Early Intervention Program can be found in "Early Intervention Memorandum 99-1," dated February 1, 1999.

Regional TRAID (Technology Related Assistance for Individuals with Disabilities) Centers are federally funded to provide a comprehensive system of access to assistive technology usable by individuals with disabilities. Early Intervention loan closets exist in each center. Equipment in a loan closet may be provided to the child based on a child's IFSP. Regional TRAID Center staff can also offer valuable information related to the area of assistive technology. The TRAID center on Long Island is housed at Long Island Communities of Practice and can be reached by calling 631-668-4858 or 631-682-9034.

Types of Assistive Technology Devices

The following is reproduced from NYSDOH ATD Guidance Document (2/01/99)

The assistive technology available to young children is changing and expanding at a rapid pace, and it should be noted that this list is not an exhaustive list of assistive technology devices. This list is intended to provide *guidance* for local decisions about assistive technology devices for individual eligible children. There may be other items not listed that would appropriately meet the needs of children under the Early Intervention Program.

- *Devices to increase, maintain or improve self-help skills and functional abilities related to daily living activities and routines.* Examples include adapted feeding utensils and devices that assist with seating and positioning, such as side lyers and prone standers, and insertions and adaptations necessary to correctly position or support an infant or toddler in a seating position.

- *Devices to increase, maintain or improve functional mobility.* Examples include orthotics, prosthetics, scooter boards, walkers, therapeutic strollers, and wheelchairs.

- *Vision and hearing aids for children with diagnosed visual impairments and hearing impairments.* Examples include eyeglasses, external contact lenses and magnifiers for children with diagnosed visual impairment and assistive listening devices, such as hearing aids or other forms of amplification, for a child with a diagnosed hearing impairment.

- *Devices to increase, maintain or improve communication skills and development, consistent with expectations for age-appropriate development.* Examples include communication boards, augmentative and alternative communication aids, and more complex communication

systems.

- *Devices to increase, maintain, or improve cognitive development.* Examples include adapted toys, switches and necessary connections to toys to enable an infant or toddler with disabilities to become more independent in their interactions with the physical environment

  (e.g., adapted toys with auditory signals for infants and toddlers with visual impairments).

The following are *examples* of items that are **NOT** considered assistive technology devices under the Early Intervention Program:

- Equipment or medical supplies solely related to a medical condition or chronic illness *unrelated to the child's disability and developmental status* or that are life-sustaining in nature. Examples include medical equipment such as suction machines, feeding pumps, nebulizers, ventilators, apnea monitors and pulse oximeters which are life sustaining and/or that would be needed by any child to maintain his or her health.

- *Toys that are not adapted.* Examples include items such as building blocks, dolls, puzzles, balls and other common play materials that are used by all children and are not specifically designed or adapted to increase, maintain, or improve the functional capabilities of children with disabilities.

- *Generic items typically needed by all children.* Common child items such as car seats, high chairs, youth beds, play tables, bath seats, infant swings, or potty chairs which are typically needed by all children are not considered assistive technology devices reimbursable under the EIP.

- *Standard equipment used by service providers in the provision of Early Intervention services (regardless of the service delivery setting).* Examples include tables, desks, chairs, therapy mats, tumble forms, therapy balls, vestibular swings, gait ladders, or other supplies, equipment and materials needed in the provision of a service.

VIII. REQUIRED RECORD KEEPING – RECORD MAINTENANCE

A. PERSONNEL FILES

In accordance with the terms of the New York State agreement the following information should be in each individual provider's personnel file, whether an employee, agent or subcontractor to an agency or an independent contractor:

- ♦ Health Status Form – each form should contain the following documentation:
    - a statement from a health care provider which documents that the Provider, and employees and Individual Providers under contract with an Agency Provider, has no diagnosed disorder or condition that would preclude him/her from providing services. Such statement shall be obtained prior to the provision of services and updated on an annual basis thereafter.
    - proof from a health care provider that the Provider, and/or employees and Individual Providers under contract with an Agency Provider, meet the following requirements prior to provision of services: measles, mumps, and rubella titer and/or vaccine and annual Mantoux/PPD or chest X-ray, with the exception of EI Providers who are also licensed day care providers by the NYC Bureau of Day Care.
    - NYC Bureau of Day Care Providers must demonstrate that upon commencement of work, a record of testing performed for tuberculosis infection, and further testing at any time, if required by the NYC Bureau of Day Care.
    - Have the following recommended vaccines or has documented refusal, prior to the provision of EI Provider services: Hepatitis B vaccine; Tetanus immunization within the past 10 years, Diphtheria; Pertussis; Varicella; and Influenza.

If a licensed physician or health care practitioner practicing under the supervision of a licensed physician certifies that immunization with measles or rubella vaccine may be detrimental to the employee's health, the requirements of this section relating to immunization shall be inapplicable until such immunization is found no longer to be detrimental to such employee's health. The nature and duration of the medical exemption must be stated in the employee's employment medical record.

- ♦ Current state licensure, certification, or registration in appropriate discipline.
- ♦ Documentation of face to face interview.
- ♦ Reference letters/contact indicating character and competence of the individual.
- ♦ NYSDOH individual approval letter when applicable.
- ♦ SCR clearance.
- ♦ Record of in-service attendance in accordance with NYSDOH agreement.
- ♦ Performance appraisals.

B. CHILDREN'S FILES

Every child receiving EIP services must have a complete file. The following information is to be included:

- Child information (name, date of birth, gender, address, parent/guardian, etc.).
- A copy of child's evaluations.
- A copy of child's IFSP.
- Record of each date of service, length of session, description of the services provided and the child's response to the services, and the profession and signature of the practitioner providing the Early Intervention Service.
- Parental consent(s).
- Periodic Provider Progress Reports.
- Order(s) by physician(s) or other health care professional(s) as required.

NOTE: All records must be retained in accordance with NYSDOH agreement

C. RECORD ACCESS

Files must be available for review by representatives of the NYSDOH and NCDOH during working hours at the Contractor's place of business.

Under Federal Law and NYS EI regulations:

> The parents of a child must be afforded the opportunity to inspect and review records relating to evaluations and assessments, eligibility determinations, development and implementation of IFSPs, individual complaints dealing with the child, and any other area under this part involving records about the child and the child's family.

D. RECORDS FOR CHILDREN IN FOSTER CARE

Any requests for information on children in foster care should immediately be referred to the EIOD.

IX. MONITORING

All providers must monitor and oversee the quality and appropriateness of the services that are provided for children and families in the Early Intervention Program.

Agencies:

- Agencies should consult with their individual providers on an ongoing basis in order to establish and maintain communicative relationships and assure appropriateness of ongoing therapy.
- Each agency should provide a designated professional(s) responsible for supervision.
- Providers are encouraged to attend NYSDOH trainings and other professional conferences, in-services and meetings.
- Per the New York State Early Intervention agreement, effective April 1, 2013, the requirement for professional development has changed.

Providers:

Per the NYS agreement:
"Provider shall participate in a **minimum of 10 hours of professional development activities per year**. Such professional development activities are not restricted to Department trainings (meaning NYS EI department trainings) and may include other professional activities necessary for licensure and activities identified by the Provider to increase the Provider's professional skills and knowledge."

Evaluators:

"Providers who render evaluation and screenings shall participate in a minimum of 1 professional development activity totaling 1.5 clock hours per year related to the provision of evaluation and assessments to children under the age of 5 years old."
This 1.5 hours counts toward your required 10 hours of professional development.

Service Coordinators:

"Providers rendering service coordination services ….shall participate in a minimum of 1 professional development activity totaling a minimum of 1.5 clock hours directly related to service coordination per calendar year, such activity is not limited to Department sponsored training (NYS EI Department Training) but can include activities which focus on enhancing skills necessary for service coordinators to increase their competency to provide service coordination activities."
This 1.5 hours counts toward your required 10 hours of professional development.

- After services begin, and at periodic intervals, make contact with families. Phone calls and parent surveys provide valuable information and help to develop open communication with the families. Intermittent supervisory visits to families can also provide information about the quality of services provided.

- Consistently review evaluations, IFSPs, Daily Notes/Attendance Sheets and Provider Progress Reports, and IFSP review requests. Agencies should provide feedback and recommendations.

Independent Providers (Non-Agency Providers):

- Independent providers should have access to peer review of their professional practice.

X. TRANSITION TO PRESCHOOL

"Transition" is the process of moving from the Early Intervention Program (EIP) into the Preschool Special Education Program, commonly called the Committee on Preschool Special Education (CPSE). The CPSE is under the New York State Education Department rather than the New York State Department of Health (NYSDOH). It requires families to learn a new language and negotiate with new people in a new setting with different laws and regulations. A child must be evaluated and qualify for eligibility under CPSE for services even though they were receiving prior EIP services. The OSC is ultimately responsible for ensuring that the transition takes place in a timely manner to avoid a gap in services when the child leaves the EIP. However, everyone working with the family and child should adhere to Best Practices for Transition.

EIP Eligibility

If a child demonstrates continued eligibility, he may remain in the Early Intervention Program until his third birthday. Only those children who have had a **4410 Evaluation and CPSE meeting** where they were determined eligible for Preschool Special Education services will have the potential to remain in the Early Intervention Program beyond their third birthday. Consequently, **a child's eligibility for EI services ends at their third birthday unless that child has been determined by a school district CPSE to be a preschooler with a disability and an IEP was developed**. If a child is deemed eligible by the CPSE:

- A child turning 3 between January 1 and August 31 ***may*** continue in EIP until August 31.
- A child turning 3 between September 1 and December 31 ***may*** continue in the EIP until December 31.

CPSE Eligibility

- A child turning 3 between January 1 and June 30 is eligible to receive CPSE services as of January 2.
- A child turning 3 between July 1 and December 31 is eligible to receive CPSE services as of July 1.

Service Coordinator Responsibilities for the Transition Process

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♦ Initial Service Coordinator (ISC) discusses the concept of transition at the Initial IFSP meeting and informs the parent that the child can only remain in EI if eligible until age 3 unless the child's eligibility for CPSE has been established and an IEP has been developed.

♦ Ongoing Service Coordinator and providers must be knowledgeable about the differences between the EIP and CPSE programs.

♦ OSC discusses transition with families and completes the Transition Plan at the IFSP meeting closest to the child's second birthday.

- OSC must provide to the parent during discussion of transition process the following handouts:
  - NYS DOH BEI Transition Information for Parents and Steps to Transition
  - Transition Packet (Forms from the Tool Kit)
  - Positive Connections (See Appendix H)
  - Parent Letter

- Transition dates for the child can be calculated at http://eservices.nysed.gov/ei/

- OSC must explain the NYS DOH BEI Written Notification and Opt-Out Requirements and Timeline Parent Form to the parent at least 150 days prior to the date that the child is first potentially eligible for services through CPSE.

- OSC sends NYS DOH BEI Notification of Potential Eligibility to the Committee on Preschool Special Education at the child's school district at least 120 days prior to date the child is first potentially eligible for services through the CPSE if the parent has not opted out.

- OSC informs the parent of the option to request a Transition Planning Conference with the CPSE Chairperson and other members of the IFSP team as invited to be held at least 90 days before the child is first eligible for services through the CPSE. OSC obtains the parent's consent or declination on the Consent Form for Transition Conference; and if parent consent received, sends the Consent Form for Transition Conference to the CPSE.

- OSC informs and encourages the parent to attend EIP/Long Island Early Childhood Direction Center (LI ECDC) Transition Trainings. Call the LI ECDC at 516-364-8580 for dates.

- OSC assists the parent with completing the parent referral to the CPSE. Give the parent contact information for the CPSE Chairperson in the child's school district. Emphasize that the school district is there to work with the parent on the child's behalf. With parent consent, OSC sends Form for Parent Referral to the Committee on Preschool Special Education to the CPSE.

- OSC ensures parent understands that they must also register their child at the school district.

- OCS encourages the parent to follow-up with the school district.

- OSC explains to the parent that they have the option of sharing EIP reports and records with the CPSE and preschool evaluator. Obtain the parent's consent on the form Consent for Transmittal of EIP Evaluations and Records if parent is willing to share EIP reports and records. Assist in choosing which reports and records to share. If consent received, transmit chosen EIP reports and records to the CPSE of the school district in which the child resides.

- OSC informs parent that they must notify their child's OSC once they receive the initial CPSE meeting date.

- OSC should notify EIOD of the initial CPSE meeting date.

- OSC ensures that parent understands that the child needs to meet CPSE eligibility criteria to qualify for services in the Preschool Special Education Program and/or to receive services through the EIP beyond the child's third birthday.

- OSC informs parent that they may invite the OSC or a representative from the EIP to attend the initial CPSE meeting, and if invited, the OSC must inform the CPSE chairperson that the OSC or representative will attend.

- OSC should reference the NYS DOH Transition Tool Kit for Service Coordinators and utilize the standardized forms for transition.

Important Phone Numbers for Transition Assistance and Training for Providers, Ongoing Service Coordinators and Parents:

Nassau County Department of Health Early Intervention Program (NCDOH EIP) (516) 227-8661
Long Island Early Childhood Direction Center (LIECDC) (516) 364-8580

Phone numbers for CPSE Chairs and School Districts will be provided by the OSC and LIECDC.

XI. CULTURAL COMPETENCE

Culture includes traditions, customs, and values associated with ethnicity. Cultural issues are not only language issues; they include the present experience of individuals as well as their past. There are often many sub-groups within a particular culture. The population of the United States is becoming more diverse year after year.

Early Intervention providers need to be aware of the need to develop greater cultural competencies. Providers must act in a professional manner and demonstrate understanding of the family's cultural, familial, and individual diversity. This cultural sensitivity and cultural awareness should be a priority when services are provided.

Guidelines to consider when working with families from diverse cultures:

- Become aware of the family's culture, child raising practices and language.
- Ask the family about their own cultural beliefs.
- Be aware of your own personal beliefs and do not let them influence your professional behaviors.
- Understand how the family's culture treats children with special needs.
- Be aware of how cultures view verbal and non-verbal communication differently.
- Know how the culture views gender roles.
- Learn some basic words or simple phrases to help better communicate with the family.
- Project a positive, non-judgmental attitude with all families.
- Participate in training programs on cultural competence.
- Be aware of availability of bilingual services in the community.
- When possible, provide the family with information in their language.
- Use the home language survey. (See Appendix I)

XII. AUTISM / ABA SERVICES

A. EVALUATIONS

Diagnostic psychological evaluations may be performed by clinical psychologists, developmental pediatricians, licensed clinical social workers, or pediatric psychologists who are qualified and trained in the approved test measures to rule in or rule out Autism Spectrum Disorder. The supplemental evaluation may be part of the initial core evaluation or it may be suggested at a later date by the therapists treating the child to the Nassau County EIOD/Service Coordinator if behaviors symptomatic of Autism Spectrum Disorder are observed. If a service provider or parent observes two or more behaviors characteristic of Autism Spectrum Disorder, an IFSP Review Request may be suggested to the Nassau County EIOD/SC for the supplemental evaluation.

B. SERVICES

IFSP

After evaluations are complete, the proper level of service for the child will be discussed at the IFSP meeting. The New York State Department of Health Clinical Practice Guidelines on Autism and PDD (available on line at: http://www.health.state.ny.us/community/infants_children/early_intervention/autism/index.htm) recommends Applied Behavior Analysis (ABA) services for children diagnosed with Autism Spectrum Disorders (ASD). While this is the recommended service for children, there are children with ASD who may be served with other methodologies of therapy.

ABA is an all-encompassing methodology and addresses learning readiness and language skills to focus on the areas of concern as identified from the diagnostic evaluations. All domains including language, social emotional, cognitive, motor, and adaptive skills are targeted through the ABA special instruction sessions; related service sessions may or may not be recommended by the IFSP team.

Family training is an integral part of the child's schedule of therapy as it incorporates the child's home and natural environment into the educational plan. Family training offers a forum for parents to review their child's progress, discuss concerns and develop and maintain the child's program. In addition, this training helps incorporate behavioral and communication techniques into the daily routines of the child and family. Family training also provides the team leader access to be able to observe other team members in order to ensure consistency of services as well as the child in alternate settings. The parent trainer must have an authorized number of co-visits for this to occur.

Level of Service

In accordance with the frequency and duration of authorized services by the EIOD as per the IFSP, a service plan schedule is formulated with attention to the child's and family's schedule and needs. Any service plan schedule must first be approved by Nassau County EIP before services are implemented. Any change to the child's service plan schedule must be first approved by the agency and DOH. Family training services are scheduled as part of the weekly service plan schedule as well as team meetings for all service providers to attend. When ABA

services are solely provided in a center based enhanced group, a service plan schedule is not required and parent training is scheduled at a minimum of 1x monthly and may be conducted in the home or at the center based program.

An ABA session is 90 minutes in length. Time during the session may be allocated for activities that include review of progress since last visit, set up of materials for the session, provision of direct instruction and recording of data, writing comments in notebook at the conclusion of instruction, review of session with family/caregiver, and clean up. In general, direct instruction is between 60 – 70 minutes.

C. TEAM MEETINGS

Team meetings may be recommended as a strategy on the IFSP.

ABA team meetings are held at a time convenient to the family/caregiver and agreeable to the majority of team members. Team meetings are typically held in the family/caregiver's home. If an alternative site is requested by the family, confidentiality and professional boundaries must be maintained. All ABA team members including related service providers should attend.

The purpose of the team meeting is so all members can communicate, share concerns and recognize achievements. Strategies should be expanded and explored as a team to ensure that the child is making optimum progress. Parents should have ample opportunity to share any of their concerns. Related service providers should report on their methods, goals, and any reinforcers that they are using.

If a child is receiving a service at a center based program, as well as home services, a representative from that program should attend as well.

At the conclusion of the team meeting, the team leader should collect the attendance sheets, summarize the main points of the meeting, and set the schedule for the next meeting.

The ABA Team Meeting Notes and Attendance Sheet signed by all in attendance including the parent/caregiver must be submitted to the EIOD by the end of the month in which the meeting is held.

D. PAPERWORK: RECORD KEEPING AND DOCUMENTATION

ABA service providers use separate Intensive Behavioral Intervention progress report forms for the 6 month report intervals.

Team Leaders:

6 Month ABA report: Intensive Behavioral Intervention Team Leader 6 Month Progress Report. (See Appendix J).

6 Month Family Training Report: Intensive Behavioral Intervention Team Leader Progress Report: Family Training (See Appendix J).

Team Members:

6 Month ABA Report: Intensive Behavioral Intervention Team Member Progress Report (See Appendix J).

All team members are responsible for giving the agency and parent/caregiver their individual reports.

Related Service Providers on ABA teams should fill out 6 month IFSP Provider Progress Reports (See Appendix G for form: EI 5077). If a child is receiving services in the home and center based program, the classroom teacher would typically submit a six month or annual report with testing.

E. DATA COLLECTION

Teaching with ABA includes the use of program sheets, data sheets, and graphic display of data. Data based decision making is a key component of ABA and data is essential to evaluating the effectiveness of the teaching. Each child should have an individualized curriculum represented in their program book; refer to specific agency guidelines for forms and record keeping. The program books are the property of the lead agency.

The communication notebook and ABA program book are kept in the child’s home for all providers to record data and pertinent information. The communication notebook remains the property of the family.

All members of the team, which include parents, are encouraged to write brief and objective observations of the child's day and progress that supplement the data in the program book.

XIII. HEALTH AND SAFETY

Early Intervention Program regulations require individual and agency providers approved to deliver services in a facility-based setting to develop and maintain written health and safety policies and procedures applicable to their particular practice.

Examples of Health, Safety and Sanitation Components to Include in Written Policies and Apply When Delivering Facility-Based Early Intervention Services

Providers delivering services in a facility-based setting should apply the following health, safety, and sanitation components into their written health and safety policies and apply them in their practices, as appropriate. This includes, but is not limited to, the following:

1. **The facility provides a safe physical environment for children, persons delivering services, and other individuals that access the premises:**
   - Building access and egress is secure, including preventing accidental access to outside areas.
   - Fire extinguishers and smoke detectors are available.
   - If a sprinkler system is available, it is in working order.
   - No obstructions in hallways and exits.
   - No insect/rodent infestation.
   - Toxic materials, including cleaning supplies, flammable substances, prescription drugs, over-the-counter medicine, plants, lighters, and matches are stored appropriately, and are restricted from children and away from food.
   - Access to building hazards is restricted, including to portable heaters, pools, ditches, wells, open or easily accessible windows, etc.
   - Any pets on premises pose no threat to children.
   - Stairs, walkways, ramps, and porches are free of ice, snow and other hazards.
   - Furniture is safely arranged and secure, including highchairs with safety straps.
   - Fire extinguishers and smoke detectors are in working order as demonstrated by recent documented inspection or gauge showing full charge; extinguishers with seals must have unbroken seals and providers must have knowledge of how to work extinguisher(s). Smoke detectors must be tested on monthly basis and a log maintained of testing.
   - Evacuation routes are known to all staff and clearly posted.
   - Evacuation drills are conducted at least monthly.
   - Radiators and electrical outlets are properly covered and child proof.
   - No peeling or significantly damaged paint and plaster.
   - Bathroom facilities are clean and appropriately sanitized and supplied with toilet paper, soap, and disposal towels.
   - Diapering facilities are available and include appropriate disposal containers; surfaces are sanitized after each use.
   - Linens, blankets, bedding, cribs, cots, mats are clean and are sanitized before use by another child.

- Small objects, plastic bags, Styrofoam, and other potentially harmful objects are inaccessible to children.
- No obvious dampness or odors.
- Trash is covered and stored appropriately.
- No clutter in hallways.
- Toilets/sinks are accessible to children (special bathroom facilities, potty chairs, stepstools, etc.). There is adult supervision during toileting.

2. The provider delivers services in a way that protects the health and safety of children and other persons involved in the delivery of services, including employing a policy for adequate emergency procedures.

For all providers:

- Children are supervised at all times.
- Consumption of, or being under the influence of, alcohol or controlled substances is prohibited.
- Universal precautions are used, as appropriate, including hand washing/sanitation before providing services to children, after diapering, handling animals and contact with any bodily fluids, before eating, etc,; availability and use of disposable gloves, appropriate disposal of bodily fluids and hazardous waste, cleaning and disinfection when necessary.
- Smoke in indoor areas, in outdoor areas in use by children, and in vehicles while children are being transported is prohibited.
- Equipment/materials/toys are age appropriate, in good condition, cleaned between uses, and sanitized weekly or after use by children who are ill or if in contact with bodily fluids
- Emergency contact numbers are readily available.
- Provider illness, emergency, or other inability to provide services is addressed.
- Child illness and emergencies are addressed including:
    - procedures for addressing routine, non emergency child illnesses;
    - procedures to address emergency health situations such as administration of first aid/CPR, if certified, or contacting emergency medical personnel;
    - emergency contact procedures, including notifying parents and obtaining emergency consents;
    - procedures for notification to the Early Intervention Official of serious problems, when appropriate; and,
    - procedures for addressing self-injurious behavior.
- All health/safety "incidents" are documented.

For agency providers only:

- If applicable, food sanitation and safety in preparation, serving, and storage is addressed according to Part 14 of the State Sanitary Code. This includes monitoring of temperatures in refrigerated storage; use of suitable utensils and/or sanitary gloves to prepare food; use of suitable utensils, sanitary gloves, waxed paper, or napkins to serve food; frequent cleaning and appropriate sanitizing of food contact surfaces; washing, rinsing and sanitizing of tableware after each use; etc.

- Prescription and over the counter medications are administered and stored in a safe manner according to the requirements of the applicable state standards that apply to the provider. Administration of any medication (prescription or over-the-counter) is documented.

3. **The provider is in compliance with other applicable local or state standards that apply.**

   For all providers:
   - Copies of:
     - ✓ Current Certificate of Occupancy
     - ✓ Current building, equipment, fire inspection documentation, etc.
   - Copies of, or knowledge of, relevant documentation related to local and state building, zoning, and fire codes.
   - For day care providers outside NYC, current NYS day care licensure if operating more than 3 hours per day with 3 or more children. For day care providers within NYC, current NYC day care licensure if operating more than 5 hours per day with 7 or more children.
   - Reporting suspected child abuse and maltreatment occurs, as appropriate, including notification directly, or to an appropriate supervisor, to the Statewide Central Register of Child Abuse and Maltreatment according to Section 413 of the Social Services Law, and notification to the Early Intervention Official of the county where the child is located.

   For agency providers only:

   As appropriate, all new employees and contracted individuals are screened through the State Central Register for Child Abuse & Maltreatment.

4. For agency providers delivering facility-based services only:

   All current and future provider staff receive training regarding health and safety policies and procedures and are evaluated to ensure procedures are being followed. All contractors delivering services on behalf of the provider are made aware of appropriate health and safety practices and are monitored to ensure appropriate health and safety practices are being followed.

Examples of Health, Safety and Sanitation Components to Apply When Delivering Home & Community-Based Early Intervention Services

Providers approved to deliver home and community-based Early Intervention services should apply the following health, safety, and sanitation components to their practices, as appropriate. This includes, but is not limited to the following:

1. **The provider delivers services in a way that protects the health and safety of children and other persons involved in the delivery of services, including during emergencies:**
   - Children are supervised at all times.

- Consumption of, or being under the influence of, alcohol or controlled substances is prohibited.
- Universal precautions are used, as appropriate, including hand washing/sanitation before providing services to children and contact with any bodily fluids, etc; availability and use of disposable gloves, appropriate disposal of bodily fluids and hazardous waste, cleaning and disinfection when necessary.
- Equipment/materials/toys are age appropriate, in good condition, cleaned between uses, and sanitized weekly or after use by children who are ill or if in contact with bodily fluids.
- Emergency contact numbers are available.
- Provider illness, emergency of other inability to provide services is addressed.
- Child illness and emergencies are addressed, including:
  - ✓ procedures for addressing routine, non emergency child illnesses;
  - ✓ procedures to address emergency health situations such as administration of first aid/CPR, if certified, or contacting emergency medical personnel;
  - ✓ emergency contact procedures, including notifying parents and obtaining emergency consents;
  - ✓ procedures for notification to the Early Intervention Official of serious problems, when appropriate; and,
  - ✓ procedures for addressing self-injurious behavior.
- All health/safety “incidents” are documented.

2. **The provider is in compliance with other applicable local or state standards, as appropriate.**

   For all providers:

   Reporting suspected child abuse and maltreatment occurs, as appropriate, including notification, directly or to an appropriate supervisor, to the Statewide Central Register of Child Abuse and Maltreatment according to Section 413 of the Social Services Law, and notification to the Early Intervention Official of the county where the child is located.

   For agency providers only:

   As appropriate, all new employees and contracted individuals are screened through the State Central Register for Child Abuse & Maltreatment.

3. Agency providers delivering home/community-based services only:

   All current and future provider staff receives training regarding health and safety procedures and is evaluated to ensure procedures are being followed. All contractors delivering services on behalf of the provider are made aware of appropriate health and safety practices and are monitored to ensure appropriate health and safety practices are being followed.

INVENTORY OF PSYCHOEDUCATIONAL TESTS

Cognitive Ability Measures:

- Stanford-Binet Intelligence Scales, 5th Edition (SB-V)
- Wechsler Preschool and Primary Scale of Intelligence, Third Edition (WPPSI-III)
- Bayley Scales of Infant Development-III
- Differential Abilities Scales (DAS)
- Wechsler Intelligence Scale for Children, 4th Edition (WISC-IV)
- Miller Assessment for Preschoolers (MAP)
- Bracken Basic Concept Scale, Revised (BBCS-R)
- Kaufman Assessment Battery for Children –II (KACB-II)
- Woodcock-Johnson Psychoeducational Battery-3rd Edition (Cognitive) (WJPEB-III)

Academic Achievement Measures:

- Wechsler Individual Achievement Test, 2nd Edition (WIAT-II)
- Wide Range Achievement Test (WRAT)
- Battelle Developmental Inventory (BDI)
- Developmental Indicators for Assessment of Learning-3rd Edition (DIAL-3)
- Kaufman Assessment Battery for Children –Achievement Scales (KABC)
- Mullen Scales of Early Learning

Behavior/Personality Functioning Measures:

- Vineland Adaptive Behavior Scales- Parent Interview Survey, Expanded Interview and Classroom versions
- Conner's' Rating Scales- Parent and Teacher versions
- Behavior Assessment System for Children (BASC) Parent and Teacher versions
- Achenbach Child Behavior Checklist (CBCL)- Parent and Teacher versions
- Attention Deficity Disorder Scale (ADDS)
- Adaptive Behavior Scales:2 (ABS:2)
- Early Childhood Attention Deficit Disorders Evaluation Scale (ECADDES)

Autism Measures:

- Childhood Autism Rating Scale (CARS)
- Autism Diagnostic Observation Schedule (ADOS)
- Autism Screening Instrument for Educational Planning-2 (ASIEP-2)

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