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## Chapter 7: IFSP Development

The Individualized Family Service Plan (IFSP) is developed through a family-centered team planning process in which the family is supported to participate as an equal team member. The child's family helps the IFSP team and service providers understand the child's and family's daily routines and activities. The providers then assist the family in recognizing and utilizing existing learning opportunities and creating new ones that will help the child reach the desired IFSP outcomes. The resulting IFSP reflects the family's priorities, resources, and concerns; the child's functional strengths and needs; the IFSP outcomes the family would like to see for their child and family; and the supports and services necessary to achieve those IFSP outcomes.

### The Initial IFSP Meeting

Service Coordinator Responsibilities:

1. Conduct, in person, the initial IFSP meeting within the 45-calendar day timeline. If more than one meeting is needed to complete the IFSP, the first meeting must be within the 45-day timeline.
2. Ensure that the IFSP meeting includes determination of entry rating statements for the three child outcomes (positive social relationships, acquiring and using

knowledge and skills, and use of appropriate behaviors to meet needs), unless this was completed during the assessment for service planning. Details about the determination of entry ratings are provided in the "Completing the Assessment for Service Planning" section of Chapter 6.
3. Ensure that the meeting is conducted in the family's native language or other mode of communication unless clearly not feasible to do so.
4. Ensure that the IFSP team uses both information from the family regarding their priorities and results of the child assessment, including a review of pertinent records less than six (6) months old from the primary care physician and other sources related to the child's current health status, physical development, medical history, and other information regarding the child's development in determining which IFSP services and informal/formal supports and resources are needed.
5. Inform the family that inclusion in the IFSP of information from a family-directed family assessment related to enhancing the development of the child is voluntary and refusal to include information from such an assessment in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP.
6. Encourage and support the family to be a full and equal partner on the IFSP team. The service coordinator may support the family's participation in the IFSP meeting in a variety of ways, including, but not limited to, the following: by ensuring the family is able to lead discussions within the meeting (e.g., family resources, priorities and concerns) as desired by the family, raising issues the family has identified as important, ensuring the family is getting the chance to speak and share opinions, explaining any jargon, etc.
7. Establish and support a team approach to service planning that recognizes and respects the expertise of all team members, including the family.
8. Build team consensus on IFSP outcomes and the supports and services necessary to achieve the IFSP outcomes.
9. Begin a discussion with the family about transition. Depending on the child's age at the initial IFSP as well as family priorities and preferences, transition planning at the initial IFSP meeting will range from sharing basic and general information about what transition means and when it may occur to development of a Transition Plan with specific transition steps and services.

Responsibilities of Other Early Intervention Service Providers:
1. Participate in the IFSP meeting. This applies to service providers who were part of the eligibility determination team and/or conducted assessment for service planning. Providers who may be providing supports and services also participate in the initial IFSP meeting, as appropriate. Service providers who are not able to participate in the meeting in person may participate through other options, such as telephone consultations or providing written information. When participating by providing written information, service providers include assessment information related to service planning as well as recommendations related to intervention strategies for the rest of the IFSP team to consider when developing IFSP outcomes, strategies and necessary supports and services.
2. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.
3. Assist the family in developing desired IFSP outcomes by starting with the activity settings in which the family participates and identifies as important and/or activity settings the family would like to pursue.

4. When developing strategies to address the IFSP outcomes, focus on interest-based learning opportunities that occur throughout the child's and family's daily routines and activities.
5. Consider multiple factors when working as a team, with the family, to identify the supports and services necessary to meet the IFSP outcomes. These factors include the expertise needed to support the family in addressing the IFSP outcomes, the abilities and interests of the child and family, needs expressed by the family, and family and community resources. IFSP team members assist the family in examining the expertise and experience of individual providers across disciplines to determine which service can best meet the IFSP outcome(s).
6. Consider whether one primary provider can address all of the IFSP outcomes, with support from other team members. This is often the case since there is significant overlap in training and scope of practice across disciplines. Identify on the IFSP not only the primary service provider(s) but also the role of other team members in supporting the family and other service providers. These other team members may participate in joint early intervention visits with the primary provider(s) to the child and family and/or provide consultation to the primary provider(s) by suggesting strategies and techniques to enhance progress toward IFSP outcomes.
7. Consider the following kinds of questions in determining the frequency and length of supports and services needed to meet the IFSP outcomes:
    a. Is the relationship between the child/family/caregiver and the provider new (e.g., because they have just begun this service or because there has been a change in providers) or well-established?
    b. Will the strategies used to address the IFSP outcomes need to be modified frequently or will the same strategies be used for a long period of time?
    c. Is attainment of an IFSP outcome(s) especially urgent and able to be resolved quickly with intensive intervention (e.g., new referral of a child with non-organic failure-to-thrive, which needs quick resolution; or a child's behavior is preventing the family from finding a child care provider who will accept the child)?
    d. Are there a large number and/or wide variety of strategies involved in addressing the IFSP outcomes or are there relatively few or more similar strategies?
    e. Is the child progressing at the expected rate in meeting identified IFSP outcomes?
    f. What are the family's/caregiver's learning needs in relation to the child's developmental needs and the IFSP outcomes?
    g. Do the IFSP outcomes require a high level of specialized skill to address or are they more easily implemented with minimal guidance and instruction?
    h. Are the IFSP outcomes or strategies new for the child and family?
    i. Will the service provider(s) be working with only the family or with other caregivers as well in addressing IFSP outcomes?
    j. Is the parent's understanding of and/or his or her ability to assist with implementing suggested activities affected by his or her own cognitive or emotional issues?
    k. Does the child need intensive, one-on-one support to participate in his/her environment? (In this case, there also may be a need for an increase in support to the family in addressing the IFSP outcomes.)

8. Consider the information in the box on the next page when discussing a child's need for an assistive technology device.
9. Participate in the identification of a location(s) for supports and services that is based on the activities that are being addressed (as identified in the IFSP outcomes).

<u>When considering the purchase of an Assistive Technology Device</u>:

- Determine whether the assistive technology device is a medical device or a developmental device. If a physician must deliver the device, then it is considered a medical device and is not the responsibility of the Infant & Toddler Connection of Virginia. If providers other than a physician (e.g., nurse, physical therapist, occupational therapist, audiologist, speech-language pathologist, etc.) can deliver the device then it is considered developmental and can be considered an early intervention service under Part C. Medical devices include, but are not limited to, suction machines, glucose monitors, feeding pumps, apnea monitors, enteral and parental solutions and supplies, nebulizers, ventilators and surgically implanted devices (including a cochlear implant).
- First consider or try simple, low- or non-tech modifications or solutions and then build up to mid-tech and to high-tech modifications or devices as needed.
- Whenever possible, use loaner equipment for higher-tech devices* before purchasing a specific device for an individual child. This allows the family and provider to determine how well the device meets the needs of this individual child and his/her family before spending money on the purchase of the device.
- Assist the family in understanding the implications of the funding source for an assistive technology device:
    - If purchased with the family's health insurance (public or private), the assistive technology device belongs to the family and they may keep it when they leave the Infant & Toddler Connection of Virginia.
    - If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at $5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:
        - The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or trial basis.
        - If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it as long as the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.
        - If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.
    - Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.
- Ensure Part C funds are used as the payor of last resort in purchasing an assistive technology device and document efforts to access other funding sources, including, but not limited to, the following:
    - Equipment loan organizations, if appropriate
    - Equipment donation facilities
    - Local civic and community organizations
    - Public or private health insurance
    - Family fees

Efforts to access other funding sources prior to the use of Part C funds must be documented in contact notes or on a payor source checklist or similar form.

* The Virginia Hearing Aid Loan Bank is open to children under age 18 years of age whose hearing loss is confirmed by an audiologist. The bank loans hearing aids and FM systems for up to six months. The initial loan period can be extended for an additional 6 months in certain circumstances. To qualify, families must be residents of Virginia and be in the process of securing permanent hearing aids through insurance or other means. Parents can apply for hearing aids and FM systems by completing an application form. For more information about this program, call Lisa Powley at the Blue Ridge Care Connection for Children at (434) 924-0222 or 1-866-596-9367. See also http://www.vahealth.org/hearing/valoanerbank.htm.

Completing the IFSP form

Service Coordinator Responsibilities:

1. Ensure the development of an IFSP for each eligible child, with parent consent. The IFSP is developed using the statewide IFSP form and in accordance with the instructions detailed at the end of this chapter.
2. Explain the contents of the IFSP to the parent(s) and obtain written consent from the parent(s) by signature on the IFSP form prior to the provision of early intervention supports and services described in the IFSP. Ensure the IFSP is translated orally or in writing into the family's native language or other mode of communication unless clearly not feasible to do so. The IFSP must be complete (with the exception of the Addendum page) before asking the family to sign.
3. Retain a signed copy of the IFSP and provide a copy to the family (at no cost to the family) and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.
4. Send a copy of the IFSP**Error! Bookmark not defined.** to the child's primary care physician, with parent consent. Consent to send a copy of the IFSP to the physician is not covered by the consent statement on the IFSP and requires a separate release of information form.
5. Obtain physician (or physician assistant or nurse practitioner) signature on one of the following to document medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan.
   a. The IFSP; or
   b. A separate letter referencing the IFSP that is sent with the IFSP, like the *Physician Certification Letter*; or
   c. The IFSP Summary Letter.

   This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Physician certification is not needed if there is no third party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed in order to receive Medicaid reimbursement for assessments. The box on the next page provides additional information about the requirement for physician signature on the IFSP.

<u>Specific Requirements Related to Physician Signature for Medical Necessity</u>:

- The physician signature is required for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). For example, physician signature is
    - Required when adding assistive technology if it can be reimbursed by family's insurance
    - Required when increasing or decreasing frequency of services
    - Not required when the service location changes from one natural environment to another
    - Not required when ending a service
    - Not required when adding an assessment for children covered by Medicaid
- The physician signature must be dated by the physician.
- The physician certification of the IFSP is considered a part of the IFSP and must be attached to the IFSP. Medical necessity is established by the IFSP combined with physician certification.
- The IFSP must be certified as a whole (i.e. it is not acceptable to have more than one individual or agency obtain certification for individual services on the IFSP). The local system/Service Coordinator is responsible for assuring that the physician certifies the IFSP and that the physician certification is a part of the IFSP document. The local system may delegate this process, but only to one individual/agency so that physicians receive only one request for review and certification of the IFSP as a whole. If this responsibility is delegated to an individual/agency, that individual/agency must send the signed document to the local system to be filed with the IFSP in the child's EI record.
- Service coordinators are expected to make every effort to obtain physician certification quickly enough to ensure the timely start of services. Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization or physician certification, except by parent request. If there is difficulty in getting timely physician signature from the child's primary care physician, service coordinators may seek a signature from another physician on the child's medical team or IFSP team or may be able to get the signature of a physician assistant or nurse practitioner associated with the physician.
- In those rare instances when the service coordinator is unable to obtain the physician signature in a timely manner, Part C funds must be used, as needed, to avoid a delay in the start of services. Remember that Medicaid allows the service to start without a physician signature and will still reimburse for the service as long as the physician (or physician assistant or nurse practitioner) signature is obtained no more than 30 days after the first IFSP services (other than service coordination) begin.
- Follow-up to ensure physician certification is in place is a shared responsibility between the service coordinator and the service provider(s). Providers must assure that certification by the child's physician, physician assistant or nurse practitioner is obtained by the 30th day from the first visit. Providers are responsible for contacting the local system manager to work out alternate payment arrangements in those rare instances when physician certification is not obtained in a timely manner despite

collaboration between the provider, service coordinator and local system manager and multiple, ongoing efforts to obtain the certification. This discussion of alternate payment options must begin prior to the end of the 30-day period following the first service. Providers are responsible for paying back any Medicaid or FAMIS reimbursement retracted because the IFSP was not certified.

- Physical therapists must follow Virginia PT regulatory requirements governing physician referrals for services and will not be able to begin services without such a referral, except under the limited exclusions specified in the PT regulations, even if Part C funds are available as payor of last resort.

6. For children with Medicaid or FAMIS, request completion of the health status indicator questions by the child's physician every six months using either the combined *Physician Certification Including Health Indicator Questions* letter, the *Health Indicator Questions* letter, or another form or mechanism developed by the local system. The health status indicator questions must be asked as written in the *Health Indicator Questions* letter unless the local system has an alternate mechanism (e.g., request and review of well-child records) that provides the information necessary to answer all of the health status indicator questions. For purposes of completing the health indicator questions, "every 6 months" means making the request any time between 5 months and 7 months from the previous request to the physician about the health status indicator questions. Local systems are encouraged to follow-up with physicians in order to receive this information but are not responsible for ensuring the information is provided by the physician. While requesting completion of these questions is required only for children with Medicaid or FAMIS, local systems are encouraged to consider requesting this information for all children in order to support routine well-child care and positive health outcomes.
7. Ensure that if the family declines one or more early intervention services listed on the IFSP (but not all services listed on the IFSP), then the following steps occur:
    a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service(s) the family is declining. Both the service coordinator and family must sign and date the form.
    b. Explain that the services that are not declined will be provided at the frequency, length, intensity (individual/group) and duration listed on the IFSP.
    c. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
    d. Explain how the family may, at a later date, through the IFSP review process, accept a service previously declined.

> Examples:
> The top half of the *Declining Early Intervention Services* form would be used when:
> - At an initial IFSP, annual IFSP or IFSP review, the rest of the IFSP team believes the child needs a particular service, but the family does not agree and does not wish to receive that service; or
> - After a service has started, the family wishes to decline to continue receiving that service even though the rest of the team believes that service is necessary to achieve the IFSP outcomes.

8. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:
    a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.
        - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system).
        - Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
        - In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
    b. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.
    c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
    d. Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.
    e. Document in ITOTS, within 10 business days of the family declining all services, that eligibility determination was completed and the child was either eligible/declined services or eligible/chose other services. Enter the exit date (the date the family declined to proceed).
9. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, length, intensity (individual/group), location or method of delivering services that the rest of the team does not agree is necessary to achieve the outcomes identified on the IFSP, then the following steps occur:
    a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). If there is not enough space on the form to describe the reason for refusing to initiate the service, then additional documentation may be attached to the form and referenced in the "Reason" section of the form. Parent signature is obtained to acknowledge receipt of the form.

b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures.
c. For Medicaid/FAMIS recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.

10. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

<u>Selecting Service Providers</u>

1. Early intervention supports and services will be provided only by qualified early intervention practitioners who are affiliated with the local system. Practitioners who provide service coordination or other early intervention services, except audiology, nutrition services and medical services, must be certified by the Department of Behavioral Health and Developmental Services as an Early Intervention Professional, Early Intervention Specialist or Early Intervention Case Manager. See Chapter 12 – Personnel for more information about practitioner qualifications, certification and affiliation with a local system.
2. The service coordinator assists the family to select a provider(s). The service coordinator:
   a. Explains that the family has the opportunity to select from among the provider agencies (including independent practitioners) who are qualified to provide the service identified on the IFSP <u>and</u> who are in the family's payor network <u>and</u> who practice in the area where the child/family lives.
      - The family must be offered a choice of service coordination provider if there is more than one agency that provides service coordination in the local system. In accordance with federal guidelines, a family moving from one local system to another may request to keep their current service coordinator. However, it may be determined that this is not feasible because of distance, the service coordinator's incomplete knowledge about resources in the new local system, or other reasons.
      - If no practitioner who can support and assist the family in accomplishing the IFSP outcomes is available within the family's

Medicaid or private insurance network, then the family may choose a practitioner from outside their third party payor network.
- If the family would like to receive services from a practitioner who is not affiliated with the local system but who meets the Early Intervention Certification requirements and who is within the family's payor network, the local lead agency should make arrangements with that practitioner to become affiliated with the local system.
- The family may request a specific provider from within the selected provider agency.
- If there is only one provider agency, then the family must be offered a choice of providers from within that one agency for services other than service coordination. If the family has a concern about receiving services from that agency, then the local system must work to identify an additional provider.

The family must be offered the opportunity to select a provider agency any time a new service is added or when a change in provider agency is needed.

b. Contacts the selected provider agency and arranges for a service provider(s). If the selected provider agency is unable to provide the service due to full provider caseloads or the requested service provider within that agency is unavailable, then the service coordinator explains to the family their option to begin services right away with an available provider or to wait for their chosen provider to become available. If the family chooses to wait, the service coordinator documents this decision and the delay in start of services will be considered a family scheduling preference.

c. Ensures the process of selecting a service provider does not result in a delay in the timely start of early intervention services. Although the IDEA Part C program is not required to offer parents the choice of a specific provider, in the Infant & Toddler Connection of Virginia, the parent may choose a specific early intervention service provider agency or service provider. The IDEA Part C program will make available the IFSP service that is needed by the child in a timely manner even if it is not with the provider of the parent's first choice. If the parent wishes to select a specific provider, then the parent's consent to the IFSP service will begin once the parent's specific provider is available and services will be provided in a timely manner. The service coordinator will document the parent's decision to choose a provider, monitor the availability of the provider, and inform the parent if the parent's choice of provider will not be available within a reasonable period of time (within 30 days of when the parent notified them of their choice).

d. Informs the family that they may request to change their service provider at any time by contacting the service coordinator.

It is possible that some families may not have a preference for a specific practitioner or provider agency. In those situations, the local system should have a mechanism in place for assignment of providers. There still must be documentation by parent signature on the IFSP addendum page that the parent was offered the opportunity to choose a provider. If the family's choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.

3. The choice of service provider(s) is documented on the IFSP Addendum page, which may be completed after the IFSP itself is signed. The Addendum page documents not only the service provider selected but also the family's signature acknowledging that they were offered the opportunity to choose a provider.
    a. If the family's choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.
    b. Otherwise, the family's signature on the Addendum page may be obtained at the first visit with the family after provider arrangements have been finalized based on the family's choice.
    c. No services, other than service coordination, can be delivered until the addendum page is signed (though it is acceptable for the provider to have the family sign the addendum page at his/her first visit if it has not already been signed).

ITOTS Data Entry – IFSP Development

The local system manager ensures the following information is entered into ITOTS:

1. Assessment data in the Child Indicator Assessment section:
    a. Assessment date
    b. The rating (1-7) for each of the three child outcomes: Positive social relationships, Acquiring and using knowledge and skills, and Use of appropriate behaviors to meet needs.
2. If the family declines all services (and does not sign the IFSP), then within 10 business days of the family declining all services, indicate that eligibility determination was completed and the child was either eligible/declined services or eligible/chose other services. Enter the Exit Date (the date the family declined).
3. If the child is lost to contact between eligibility determination and the IFSP, enter the Exit Date (the date the local system closed the record).
4. IFSP Completed? Yes/No
5. Date (IFSP Completed)
6. Mitigating circumstances if exceeded 45-day timeline
7. Primary service setting
8. Medically Fragile? Yes/No
9. Risk factors
10. Initial planned services
11. Third party coverage

[Complete ITOTS instructions are available at http://www.infantva.org/documents/forms/INST1117eR.pdf]

Local Monitoring and Supervision Associated with IFSP Development

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. The 45-day timeline for conducting the initial IFSP meeting is met.
3. Mitigating circumstances are documented when the 45-day timeline is exceeded.
4. Development of IFSPs is in accordance with the IFSP Instructions provided at the end of this chapter.
5. ITOTS data entry is timely and accurate.
6. IFSP outcomes reflect family priorities and routines and the child's functional abilities and needs.

7. Planned supports and services are appropriate to meet the IFSP outcomes.
8. Efforts to secure foreign language and sign language interpreters to assist the family's active participation in the IFSP meeting are documented.

# INSTRUCTIONS FOR COMPLETING THE VIRGINIA IFSP FORM

## GENERAL INFORMATION

- Virginia's statewide IFSP has been designed to meet the IFSP requirements of Part C of IDEA and Medicaid plan of care requirements under the Medicaid Early Intervention Services Program. In order to maintain the integrity and official identity of the statewide IFSP form, only the following changes are permitted:
    - Local System Name (Required) – Before completing or printing the form, delete the words "Local System Name Here" and enter the local system name. The local system name must be the Infant & Toddler Connection of _________ and not a program or provider name. The local system has the option to enter on the line below Infant & Toddler Connection of _______, "Administered by {name of local lead agency}."
    - Child's County or City of Residence (Optional) – If the local system serves only one county or city, that information may be added permanently to the form (i.e., pre-printed). Other local systems may permanently add the list of counties and cities served to the extent that they fit in the available space (the applicable county or city can then be circled when the IFSP is completed).
    - Service Coordinator's Name, Agency, Address, etc. (Optional) – If all service coordinators in the local system work from one agency, then that agency information may be permanently added to the form (pre-printed) on page 1. Leave the top space blank in order to enter the Service Coordinator's name, but add all consistent information to the permanent form.
    - Assessment Sources – Tools that are listed but not used in the local system may be deleted from the IFSP form.

  **No other prompts or information may be added or pre-printed on the statewide IFSP form**.

- The form may be filled out electronically, or printed out and completed in handwriting, or through a combination of both. Instructions for using word processing to make the permitted changes described above and to complete the form electronically are provided in Attachment A of these instructions.

- Electronic signatures are acceptable if your local system has a mechanism to accommodate electronic signatures.

- All dates must be provided as month, day, and year.

- If/when errors are made when completing a handwritten IFSP for an individual child, they must be crossed out with a single line and initialed and dated by the reviser. Correct errors in an electronically-completed IFSP by following local agency requirements or by using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used.

- The Child's Name, Date of Birth, and IFSP Date are to be filled in at the top of each page after page one. This ensures that if pages of the IFSP become separated, each page will be easily identifiable. The IFSP Date and Date of Birth on each page help to further identify the child in case more than one child in a program has the same name and also serves to identify the IFSP in case the initial and/or subsequent IFSPs in a child's file become mixed together.

- Each section of the IFSP should be filled in (except that "Date Met" and "Date Outcome Added" do not need to be completed in Section IV of the initial or annual IFSP; items on the transition page should be filled in over time, as appropriate; and Child's Primary Language may be left blank if it is the same as the family's). If an item is non-applicable, place "N/A" in that space. If a space seems to ask for unnecessary or redundant information, review the instructions to ensure you have correctly interpreted the intent of the item.

- When columns are used, if the information is the same for each cell in the column, it is permissible to write "above" in each cell of the column after the first one.

- If a child with a current IFSP moves within Virginia, communication and coordination should occur between the sending local system and the receiving local system in advance of the move, whenever possible, to enable supports and services to be in place in the receiving local system based on the current IFSP. The sending local system should not record an end date for services in Section V of the IFSP simply because the child is moving to another local system in Virginia. The family's new service coordinator will schedule an IFSP review soon after the family moves in order for the new IFSP team to review the existing IFSP and make any necessary modifications. The revised IFSP must reflect the new local system name; new service coordinator; new demographic information (city/county, family contact information); any changes to IFSP outcomes, supports and services (based on child and family needs); and a completed IFSP review page (Section IX) with parent signature. Since there will be new information in several parts of Section I, it may be easiest to create a new Section I for the IFSP. In this case, maintain the old Section I in the child's early intervention record. [**Please note that when entering the IFSP date in ITOTS for a child who has transferred from another local system in Virginia with an active IFSP, the original IFSP date (the date on the IFSP he/she had in the previous system, rather than the date of the new review) is used**.]

## SECTION I: Child and Family Information

The information in this section is primarily for the purposes of the Infant & Toddler Connection system. Other demographic information required by third-party payors (e.g., Social Security number, insurance policy number/s, diagnosis codes) and possibly by individual local Infant & Toddler Connection systems (e.g., program ID numbers) is highly specific to individual companies, confidential, and irrelevant to many of the recipients of an IFSP (e.g., local school systems, childcare providers). Therefore, it should be provided, as required by individual circumstances, on a separate page as an attachment.

1) **Child's Name** - Fill in child's name

2) **Date of Birth** - Fill in child's date of birth

3) **Gender** – Check M or F to indicate whether the child is male or female

4) **Child's County or City of Residence** - Fill in child's city or county of residence. This is important for local systems that have more than one city or county in their catchment area. This may by pre-printed on the form for local systems who only serve one city or county. Other local systems may permanently add the list of counties and cities served to the extent that they fit in the available space (the applicable county or city can then be circled when the IFSP is completed).

5) **IFSP Date** - Enter the date the parent signs the IFSP (i.e., **the IFSP Date on page 1 and at the top of subsequent pages must match the date of parent signature on page 8 of the IFSP**). If the IFSP cannot be completed in one meeting, then the contact notes must reflect the dates of all meetings held to develop the IFSP.

6) **Initial/Annual** - Check the appropriate box to indicate if this is the child's initial IFSP or if it is an annual IFSP and write in which annual IFSP it is (e.g., #1, #2. The annual IFSP done one year after the initial IFSP is annual #1).

> If the IFSP form is used for an interim IFSP, then "Interim IFSP" should be hand-written on the cover page. When the initial IFSP is developed, the team starts with a new IFSP form.

7) **Date Six-Month Review Due -** Fill in the date by which the six-month IFSP review must be completed. This date will be 6 months from the IFSP Date entered above.

8) **Date(s) Review(s) Completed –** When the 6-month or other IFSP review is conducted, write in the date of the review. It is not necessary to rewrite the IFSP at every six-month review or when a review is held at a time other than 6 months, as long as the IFSP is updated to reflect the child's current needs and plans. However, a new IFSP form must be initiated at each annual IFSP meeting.

9) **Family's Primary Language and/or Mode of Communication** - Fill in the family's primary language or mode of communication. (Examples: English, Spanish, American sign language, augmentative communication system)

10) **Child's (if different)** - Fill in the child's primary language or mode of communication, if different from the family's. If it is the same, leave blank.

11) **Medicaid Number (Optional)** – If the child has Medicaid/FAMIS, the team may choose to enter the number here. This should be the child's permanent 12-digit Medicaid number (as opposed to a MCO number, for instance).

12) **Family's Name, Address, Phone, And Other Contacts** – Fill in all contact information for the family. The amount of space in this section allows for the wide range of potential *contacts* required, (e.g., surrogate parents, foster parents, social services or natural parents, child care provider), the variety of *methods* of contact possible for each contact listed (e.g., home phone, work phone, cell phone, pager, e-mail, personal fax), and allows room for updates as information changes. Some local systems may also wish to include the physician's name and contact information in this section. [When completing the IFSP electronically, this section is formatted into 2 columns. The section will allow you to continue entering information in column one until you click into column 2. You will need to click into column 2 when the last information on page 1 is at the bottom of the page (i.e., before it scrolls onto a new page).]

13) **Service Coordinator's Name, Agency, Address, Phone and Fax Numbers** – Fill in all contact information for the family's service coordinator, as assigned at the IFSP meeting, including if appropriate, cell phone, pager, e-mail, etc.

> Some families may prefer to handle most or all of their own service coordination duties; it is still a requirement of Part C, however, that they have an official service coordinator assigned.

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## SECTION II: Team Assessment

> The service coordinator is expected to gather information for Section II prior to the IFSP meeting, through conversations with the family beginning at the initial visit with family. This practice will assist families and providers in preparing for the development of IFSP outcomes during the IFSP meeting.

**A. Referral Information, Medical History, Health Status**

Record the referral source and reason for referral, any medical diagnoses (especially those related to the reason for referral), and pertinent health information (including pertinent medical history, clinical signs and symptoms, and current health status). The reason for the child's eligibility for early intervention may also be included here.

**B. Daily Activities and Routines**
Fill in information regarding the family's everyday activities and routines, including what is going well for the family, what challenges they have with specific routines, what the child and family normally enjoy, and what changes they would like to see in their routines and activities. This information is essential in developing functional, relevant, routine-based IFSP outcomes and will guide development of strategies for achieving those IFSP outcomes within the context of the child's and family's interests and naturally occurring activities, routines, and community supports. The information may be presented as a narrative, phrases, a diagram, or other format.

**C. Family Concerns, Priorities and Resources**
Record information shared by the family about their concerns, priorities and resources, related to enhancing their child's development. The service coordinator is responsible for informing the family that inclusion in the IFSP of information from a family-directed assessment related to enhancing the development of the child is voluntary and declining to include such a statement in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP. The information may be presented as a narrative, phrases, a diagram, or other format. If the family declines to provide this information or provides this information but does not want it to be included on the IFSP, they are to initial the appropriate statement in the box in this section of the IFSP form.

Since the purpose for collecting information about the family's concerns, priorities and resources is to guide identification of functional, relevant IFSP outcomes, it is crucial that this section describe how the concerns, priorities and resources relate to the family's routines and activities (rather than just presenting a list of concerns, priorities and resources). The IFSP team needs to understand how the concerns, priorities and resources impact the child and family.

My Family's Concerns – Describe the family's concerns (if any) about their child's health and development and any information, resources and/or supports that the family identifies that they want.

My Family's Priorities – Describe what the family identifies as most important to them.

My Family's Resources - Describe the resources the family has for support, including people, activities and programs/organizations. Include other caregivers in the child's life who the family indicates may be able to assist in addressing the IFSP outcomes. The extent to which other caregivers (such as child care providers, extended family members, respite care providers, etc.) are involved in addressing IFSP outcomes depends on a number of factors including, but not limited to, the following: the extent to which the family would like to have these other caregivers involved, how much time the child spends with these caregivers, and the willingness of these caregivers to learn and apply strategies for increasing the child's learning opportunities and ability to participate in everyday activities.

**D. Summary of Your Child's Development**

This section is organized by the three federally-required child outcomes (positive social relationships, acquiring and using knowledge and skills, and use of appropriate behaviors to meet needs), which serve as the foundation for the IFSP. For each child outcome:

- Provide a description of the child's functional developmental status, integrating information across all developmental areas covered by the child outcome (see *Child Indicators Booklet*), across all settings, and from all assessment sources (e.g., parent report, assessment tool, observation, informed clinical opinion, medical and other reports).
    - Skills should be discussed in the context of the child and family's routines. It is not simply a matter of whether children can produce particular behaviors, but how the child uses behaviors to interact with and affect people, objects, and symbols in the different contexts of the child's life. For example, it is not as helpful to say Johnny can crawl or that he did a nice job crawling as it is to describe how he uses this skill to get to his toys and other things that he wants. Or, the narrative might state that while Abby is able to say several words, she only uses them when looking at her books and does not use them spontaneously to communicate what she wants or needs.
    - While narratives need not include a list of things the child cannot do, it is important for the narrative to support the ratings for the child outcomes. Include a description of the expected skills that were not yet demonstrated or mastered so the reader understands why the child received the child outcome rating rating statement chosen. Including information about what the child is not yet doing provides documentation needed by payor sources to understand why intervention is necessary and provides a balanced picture for the child's parents about the child's development in relation to other children the same age.
    - It is sufficient to document in the summary what the parent reported without adding that it was not observed during the assessment unless what was observed by the assessor was different from what was reported. (i.e., did the assessor not observe rolling or did the assessor observe the child to roll without arching).
    - Include information about how the child is functioning in different settings, in different situations and with different people.
    - Avoid using statements about age levels in developmental domains in this section. These will be documented in Section III of the IFSP.
- Document the child's development in relation to other children the same age by using one of the following child outcome rating statements. Remember that child outcome rating statements are based upon the child's **chronological age and there is no adjustment for prematurity**.
    - {Child's name} has all of the skills that we would expect in this area.
    - {Child's name} has the skills that we would expect in this area. There are some concerns with {area of concern/quality/lacking skill}.
    - {Child's name} shows **many age expected** skills. He also continues to show some skills that might describe a younger child in this area.
    - {Child's name} shows **occasional use of some** age expected skills. He has more skills of a younger child in this area.
    - {Child's name} uses **many important** skills that are necessary for development of more advanced skills; he is not yet showing skills used by other children his age in this area.
    - {Child's name} is beginning to show **some** of the **early** skills that are necessary for development of more advanced skills in this area.
    - {Child's name} has the **very early** skills in this area. This means that {child's name} has the skills we would expect of a much younger child.

- Use the child outcome rating statements **as written** when completing the *Child's Development in Relation to Other Children* section. Do not add to or modify these statements to reflect the skills that justify the rating, except to add the areas of concern if using the statement that reads "{Child's name} has the skills that we would expect in this area. There are some concerns with {area of concern/quality/lacking skill}". Otherwise, information about the skills that justify the rating should be reflected in the narrative section for each child outcome. Use only the child outcome rating statement on the IFSP; do not include the rating number.

> In order to avoid duplication of assessments, the IFSP team may use assessment reports written by providers outside of the Infant & Toddler Connection of Virginia for development of the IFSP and service planning. When using outside assessment reports, relevant information must be transferred from that assessment report and integrated with information from other assessment sources to complete Section II of the IFSP, so that it is clear that all required assessment components have been completed. If a provider from outside the Infant & Toddler Connection of Virginia assessed only some, but not all, of the developmental areas required by Part C, the remaining areas of development must be assessed during the assessment for service planning. Assessments must have occurred no more than 6 months prior to being used for service planning.
>
> Any outside assessment reports used must be included in the child's record and may be attached to the IFSP.

## SECTION III: Age and Developmental Levels

### Age and Developmental Levels Table

- Fill in the child's age and adjusted age, if applicable.
- Fill in a developmental age equivalent or range for each area of development in the table based on the synthesis of information from all assessment sources marked in the section below this table. If the team finds the child's development to be atypical in one or more areas, it is acceptable to write an age level or range and note "atypical' in parentheses after that information, but it is not sufficient to write "atypical" without an age level or range. Any atypical development or behavior and its impact on the child's functioning in any of the three child outcome areas must also be described in the Summary of Your Child's Development, Section II.D of the IFSP.
- For vision and hearing, check off one box to indicate the results of the Virginia Part C Vision and Hearing screening tools. The box checked here must match with the box marked in the Findings section of the screening tool. In addition, provide information about the child's current vision and hearing status, including eye-specific and ear-specific information whenever possible.

### Assessment Sources

List and/or check off all sources of assessment information used to arrive at the information reported in Sections II and III of the IFSP. Please note that the

Virginia Part C Vision and Hearing Screening tools must be completed as part of each child's **initial** assessment.

**The following people participated in the assessment for service planning** (printed name, credentials, role/ organization, signatures, date)

Individuals who completed assessments should print their name and credentials, as appropriate, and sign and date (month, day, year) here. For example:

| | | |
|---|---|---|
| Mary Anderson, Parent | *Mary Anderson* | 9/15/09 |
| Cathy Jones, OTR, Independence, Inc. | *Cathy Jones* | 9/15/09 |
| Debbie Smith, SLP, ABC Therapists Inc. | *Debbie Smith* | 9/15/09 |

Providers who completed assessments must also check the appropriate box indicating their discipline. Parents participate in the assessment by sharing information about their child's health and developmental status and their observations about their child across settings and situations, and as a member of the assessment team should sign in Section III. Sections II and III of the IFSP must be completed (written) before requesting signatures from any team member.

**Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning** (p*rinted name, credentials, organization*)

The name, credentials and organization of any assessor who is not part of the Infant & Toddler Connection of Virginia system must be entered here.

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## SECTION IV: Outcomes of Early Intervention

IFSP outcomes are identified based on information gathered through the assessment for service planning process, including conversations with the family to identify current daily routines, activities and settings; potential child learning opportunities; and areas where the family would like assistance. Asking families questions like "What activities that your family participates in are most important to you?" and "What new activities would you like to pursue?" can assist families and the IFSP team in identifying the desired IFSP outcomes, and IFSP outcomes written with family routines and activities in mind become personal and important to the family.

The first IFSP outcome page in this section documents the IFSP outcome (pre-printed) and short-term goals for service coordination and must be completed for every child who has an IFSP, even if the family wishes to have only minimal service coordination from the local system and wants the service coordinator only to coordinate IFSP meetings. Parts of the page are partially completed in order to assure inclusion of required activities. For children receiving Early Intervention Targeted Case Management (EI TCM), the Initial Early Intervention Service Coordination Plan ends with the family's signature on the IFSP, and the IFSP and this IFSP outcome page in particular becomes the plan for continued provision of EI TCM.

1) **Short Term Goals** – The short-term goals provide the Part C-required ***criteria*** for determining the degree to which progress is being made toward achieving the IFSP outcome. The short term goals should be written from the perspective of what the service coordinator will do for the child and family and must include a target date. The short-term goals should be specific and based on family priorities and needs at the time the IFSP is developed. Please note that the third pre-printed short-term goal (providing information and support for accessing routine medical care) includes requesting physician completion of the health status indicator questions every 6 months. These questions are:
    - Is this child up to date (per CDC/ACIP guidelines for this year) on immunizations?
    - What is the date of this child's most recent visit with you?
    - What is the date of the most recent well child visit?
    - What month/year should this child see you for the next well-child visit?
    - Are there immunizations needed at time of next visit?
    - Does the child's record have any lead testing (either capillary or venous) results? If yes, date services provided and results.

    The questions may be posed using either the combined *Physician Certification Including Health Indicator Questions* letter, the *Health Indicator Questions* letter, or another form or mechanism developed by the local system. The health status indicator questions must be asked as written in the *Health Indicator Questions* letter unless the local system has an alternate mechanism (e.g., request and review of well-child records) that provides the information necessary to answer all of the health status indicator questions.

    For purposes of completing the health indicator questions, "every 6 months" means making the request any time between 5 months and 7 months from the previous request to the physician about the health status indicator questions. Local systems are encouraged to follow-up with physicians in order to receive this information but are not responsible for ensuring the information is provided.

    If the family only wants to address the three pre-printed short-term goals, then the rest of the lines for short-term goals may be left blank. The first (pre-printed) short-term goal must be listed for all families and the third one must be listed if the child has Medicaid/FAMIS. However, the second pre-printed short-term goal may either be deleted (if the IFSP is completed electronically) or struck through and initialed by the service coordinator (if the IFSP is handwritten) if the family does not wish to address this one. The third pre-printed short-term goal may be deleted or struck through if the child does not have Medicaid/FAMIS and the family does not want this goal included.

2) **Target Date *(for short term goals)* –** Provide target dates (month/day/year) for when each short-term goal could be expected to be achieved. The three pre-printed short-term goals are ongoing, and this has been pre-printed under Target Date.

3) **Date Met *(for short term goals)*** - Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.

The second IFSP outcome page in Section IV is to be duplicated and used for all IFSP outcomes other than service coordination. Each IFSP outcome must be recorded on a separate page. Each IFSP outcome should be numbered (e.g., since the service coordination outcome will be IFSP outcome #1 for all children, subsequent IFSP outcomes should be numbered from # 2 on).

1) **Date Outcome Added –** For IFSP outcomes developed at the initial IFSP meeting, this space is left blank. For IFSP outcomes added during IFSP review meetings, enter the date of the IFSP review during which the IFSP outcome was added (this is the start date for the new IFSP outcome). Section IX of the IFSP must also be completed when an IFSP review is held.

2) **Outcome** (Long-term functional goal) **# ___** - This statement is what the family would like to see happen as a result of their participation in early intervention. It may be a major developmental goal related to the child's participation in home and community activities, or it may be an outcome related to the family's ability to assist appropriately in their child's development. It must be functionally stated, reflect the family's priorities (i.e., the IFSP outcome focuses on the child's participation in activities that are important to the family), and be consistent with information gathered from the team assessment of the child's functional strengths and needs in relation to the three child outcomes and with information from the family-directed family assessment (if completed). IFSP outcomes can be stated in the family's words or they can be restated with help from the early intervention providers either in addition to the family's statement or instead of it if the family prefers. IFSP outcomes related to the child must be measurable and functional and represent what the child is expected to be able to do, e.g., "Jane will feed herself the entire supper meal each day." The prompts provided at the top of the IFSP outcome page remind the IFSP team that a well-written IFSP outcome addresses acquisition (describes the skill or behavior the child or family is to acquire or achieve), the context or setting within everyday activities and routines in which the desired behavior is expected, and the criteria for achievement (including the frequency/duration/rate for the new skill or behavior and over what specific period of time).

3) **Target Date** – Enter the date (month/day/year) by which the IFSP outcome could reasonably be expected to be achieved. Since an IFSP Review must be held anytime changes are made to the IFSP outcome (and/or short term goals), it is helpful to choose a target date that corresponds to a required review date.

4) **Date Met, Changed Or Ended** – Enter date (month/day/year) at any point at which the IFSP outcome was met, changed or discontinued. The change this date represents must be documented in contact notes in the child's record. An IFSP review must be held in order to change an IFSP outcome.

5) **Learning opportunities and activities that build on child's and family's interests and abilities** – List here activities that the child finds (or might find) enjoyable (based on child's interests and ability) and that could be incorporated

into the child's and/or family's existing or desired routines and activities. This should not be an exhaustive listing of all the activities possible, but rather an overview of the possible activities that will be explored in ongoing intervention (specific activities will be recorded in ongoing contact notes/lesson plans). All intervention should, however, be planned in the context of the family's daily routines, activities, and resources available in the community, consistent with the information recorded in Section II of the IFSP.

6) **Short Term Goals** – The short-term goals provide the Part C-required ***criteria*** for determining the degree to which progress is being made toward achieving the IFSP outcome. The short term goals should be written from the perspective of what the child will be able to accomplish, should represent an end result rather than a process, should be **functional and measurable**, and must include a target date. Ensure inclusion of measurable, functional criteria that <u>any</u> team member could use to review progress toward achieving IFSP outcomes. The short-term goals can be thought of as the building blocks leading up to achievement of the IFSP outcome, e.g., ***"****Child will pull to stand while holding on to the sofa in the family room several times each evening without physical assistance****."***

7) **Target Date *(for short term goals)* –** Provide target dates (month/day/year) for when each short-term goal could be expected to be achieved.

8) **Date Met *(for short term goals)*** - Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.

9) **Interventions (Treatment procedures and/or modalities)** – Enter the specific interventions (treatment procedures and/or modalities) that will be used to address the IFSP outcome. Specific interventions may include, but are not limited to, the following:

Balance/coordination
Positioning
Therapeutic exercise
Gait training
Community living skills
Functional activities/mobility
Assistive technology devices
Equipment/device training
Weight-bearing
Range of motion
Caregiver/parent training
Fine motor training
Developmental handling
Expressive language skills training
Visual perceptual skills training
Receptive language skills training
Feeding
Oral motor skills development
Swallowing
Pre-verbal skills
Cognitive skills development
Sign language
Behavior modification
Hearing aid tolerance/use
Sensory integration
Functional visual skills
Self-feeding skills
Articulation therapy/ phonological awareness
Cognitive linguistic therapy

## SECTION V: Services Needed to Achieve Early Intervention Outcomes

Determine the specific early intervention services that are necessary to help the child and family achieve the IFSP outcomes identified in Section IV of the IFSP. The IFSP team considers multiple factors when identifying appropriate supports and services to address IFSP outcomes, including the expertise needed to support the family, abilities and interests of the child and family, and family and community resources.

**Complete the table as follows**:

1) **Entitled Service –** Service coordination must be provided to every eligible child and family and has already been recorded in the table. Enter each additional early intervention service that was determined through the IFSP process to be necessary for the child/family to achieve the IFSP outcomes. The following list of early intervention services is not exhaustive and does not preclude the IFSP team from identifying another type of service as an early intervention service as long as that service meets the criteria of an early intervention service under Part C (i.e., services that are provided under public supervision, by qualified personnel, in accordance with the State's system of payments, selected in collaboration with the family, and designed to meet the developmental needs of the child or the needs of the family to assist appropriately in the child's development):

    Assistive technology devices and services*
    Audiology
    Developmental services (previously called Special instruction)**
    Counseling services
    Health services
    Medical evaluations
    Nursing services
    Nutrition services
    Occupational therapy
    Physical therapy
    Psychological services
    Service coordination
    Sign language, ~~and~~ cued language and listening and spoken language services***
    Social work services
    Speech-language pathology
    Transportation and related costs
    Vision services
    Other services, as identified by the IFSP team

*Important information about Assistive Technology:

- When listing assistive technology on the IFSP, please specify whether it is an assistive technology device or assistive technology service.
- When listing Assistive Technology Device, the length, intensity (individual/group), and location should all be marked N/A. The projected end date and actual end date should reflect the anticipated and actual date of delivery of the device to the child, respectively.
- It is not necessary to list Assistive Technology Device in Section V of the IFSP when the provider is trying out potential equipment with a child to determine whether or not it is appropriate to meet the child's and family's needs and the IFSP outcomes. Once an appropriate assistive technology device has been identified and will be acquired for this child (through loan or purchase), an IFSP review is held to add this device(s) to the entitled services listed in Section V of the IFSP.
- Assistive technology services should be listed according to the provider of that service (e.g., if the assistive technology service is being provided by the physical therapist, then list the service as Physical Therapy/Assistive Technology Services). The frequency, length, method, etc. should reflect both the physical therapy service and assistive technology service, combined.
- Assistive technology services are services that directly assist the child with a disability in the selection, acquisition or use of an assistive technology device and include the following: evaluation of the needs of the child with a disability, including functional evaluation of the child in the child's customary environment; purchasing, leasing or otherwise providing for the acquisition of assistive technology devices; selecting, designing, fabricating, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with education and rehabilitation plans and programs; training or technical assistance for the child, family, other caregivers or service providers; and collaboration with the family and other early intervention service providers. If a provider is delivering any of the services included in the definition of assistive technology services, then Section V of the IFSP should reflect both the service that provider generally provides (e.g., physical therapy if the provider is a physical therapist) and assistive technology service as indicated above.

A subsequent page in these instructions provides an example of how to record an assistive technology device and service in the Entitled Services table in Section V of the IFSP.

**Developmental Services Provided by Nurses:

- List "developmental services" as the service in Section V of the IFSP even when that service is provided by a nurse.
- When billing for developmental services provided by a nurse the provider will use billing codes G0154/G0154 U1 for services in natural environments and T1026/T1026 U1 for center-based services. Similarly, when a nurse is providing assessment, participating in IFSP meetings, team treatment activities, etc., the appropriate billing codes are T1023 U1 and T1024 U1. Billing code descriptions are provided in Chapter 11.

***Sign Language, Cued Speech and Listening and Spoken Language Services

- These are three separate services. The IFSP should list only the one(s) of these services that will be provided to this child.

- These services should be listed according to the provider of that service (e.g., if the sign language services will be provided by a Teacher of the Deaf, then list the service as Developmental Services/Sign Language Services). The frequency, length, method, etc. should reflect both the Developmental Services and Sign Language Services, combined.

Entitled Service Versus Intervention/Treatment Modality:
~~Auditory Verbal Therapy (AVT) and~~ Applied Behavior Analysis (ABA) or other such approaches to service delivery are not entitled early intervention services; but rather interventions/treatment modalities. The IFSP must list the entitled early intervention services based on the provider type who will implement the intervention/treatment modality ~~(e.g., if the IFSP team determines that a speech-language pathologist will be implementing AVT to address the IFSP outcomes for a given child, then speech-language pathology is the entitled service listed on the child's IFSP)~~.

## Section V. Services Needed to Achieve Early Intervention Outcomes

| ENTITLED SERVICE | FREQUENCY (# x/wk/ month/once) | LENGTH (# min/visit) | GROUP (G) / INDIVIDUAL (I) | METHODS** (a,b,c,d) | NATURAL ENVIRONMENT/ LOCATION (Must be a natural setting unless justified below) | PAYMENT 1 Family Fee 2 Insurance 3 Medicaid, 4. State Funds 5. Local Funds 6. Part C | PROJECTED START DATE | PROJECTED END DATE | ACTUAL END DATE |
|---|---|---|---|---|---|---|---|---|---|
| 1. Service Coordination | * | * | | Service coordination | | | | | |
| 2. Assistive technology device | NA | NA | NA | d | NA | donation | 12/31/09 | 12/31/09 | |
| 3. Physical therapy/Assistive technology services | 2/mo | 60 min | I | a | home | 3 | 12/1/09 | 6/1/10 | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |
| 7. | | | | | | | | | |
| 8. | | | | | | | | | |

* This is the minimum frequency and length of direct contact from your service coordinator. The frequency and length of service coordination actually provided will vary since service coordination is an active, ongoing process that changes based on your family's priorities and needs.

** Methods: a = Coaching, including hands-on as appropriate b = Consultation c = Assessment
d = Provision of assistive technology device

**EXAMPLE OF HOW TO RECORD ASSISTIVE TECHNOLOGY DEVICES & SERVICES IN SECTION V OF THE IFSP**

2) **Frequency -** Enter the number of visits per week/month/etc. each service is to be provided (e.g., 1x/wk). ***It is not acceptable to list a range (such as 1-2x/week) for frequency.*** It is acceptable to plan for and record a change in frequency of a service, such as weekly occupational therapy for two months, then occupational therapy every two weeks for three months. If a service will be provided only once, then write “once” in the frequency column.

The frequency for a service may be planned over a period of up to 6 months (e.g., 1x/week, 4x/month, 10x/6 months). Given that service frequency is based on a family’s need for support in implementing strategies to meet the IFSP outcomes, scheduling service frequency over a longer period of time is one strategy for addressing a known/expected family need for flexibility or fluctuation in that level of support. The following may be indicators that considering frequency over a period greater than one month is appropriate:

- The team determines there is a need for front-loading of services followed by a tapering of service frequency, and it is unclear exactly when it will be appropriate to taper.
- The team identifies a likely need for a burst of services along the way (e.g., child is scheduled to receive orthotics and a greater frequency of services will be needed for a short period after the child is fitted).
- There is a primary provider seeing the child at a more “traditional” frequency, and the team would like flexibility in the frequency with which the primary provider and family call on another team member to provide support.

This level of flexibility will not be necessary or appropriate for all families and must not be used to meet a local system’s or service provider’s need for flexibility.

**Documenting Service Frequency Over Period Longer than 1 Month**

If the planned frequency is for multiple visits over greater than a one-month period, contact notes must include:

- Justification for the frequency chosen and the need for flexibility for this specific child and family;
- For each visit, discussion with the family about when the provider will come next and why;
- Documentation of discussions with the family and other providers to ensure frequency remains appropriate based on child and family priorities and concerns; and
- Justification if the maximum number of services planned over the period were not delivered.

Someone reviewing the child’s record should be able to clearly understand how and why decisions were made about service delivery within the parameters of the frequency listed on the IFSP.

For service coordination, record the projected **minimum** frequency of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc. For children receiving EI TCM, there must be at least one

direct contact between the service coordinator and family every three (3) calendar months. Such contacts shall be person-centered with the choice of contact method determined by the family (face-to-face, phone, email, or text). The family's preferred method of contact (face to face, phone email, or text) for the family contacts that are required every three months can be documented in the contact note for the intake visit.

3) **Length -** Enter the length of time the service is to be provided during each visit (e.g., 60 min/visit). ***It is not acceptable to list a range (such as 30-45min/visit) for length.***

For service coordination, record the projected **minimum** length of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc.

<u>Frequency and Length for Service Coordination</u>

The Infant & Toddler Connection of Virginia Office recognizes that the frequency and length of service coordination actually provided will fluctuate since service coordination is an active, ongoing process that is responsive to individual family needs and circumstances. When the frequency and length of service coordination delivered vary from that planned on isolated occasions, the service coordinator's contact notes must reflect the reason for increase/decrease in frequency/length. If the frequency and/or length of service coordination delivered vary greatly from that planned on a consistent basis, then it is time for an IFSP review. During State monitoring of service delivery, local systems will NOT be cited as out of compliance if there is not an exact match between the planned and delivered frequency and/or length for service coordination as long as there is documentation that service coordination was active and ongoing and based on meeting the family's needs and IFSP outcomes. Similarly, for children receiving EI TCM, a provider will not be cited as out of compliance with the requirement for direct contact with the family every three months as long as there have been repeated and documented attempts to make that contact within the required 3-calendar-month period.

4) **Group/Individual** – Specify whether the service is to be provided on an individual or group basis. Although early intervention services are most often provided on an individual basis, an example of when group might be listed as the intensity would be when one service provider is working with twins, who are both eligible for early intervention, in the home, together on a shared IFSP outcome.

5) **Methods** – Using a, b, c, or d, specify whether the service is to be provided through coaching, including hands-on as appropriate; consultation; provision of an assistive technology device; or assessment.
   - Coaching, including hands-on as appropriate – Record this method any time the provider will provide a service (other than assessment, see below) to the child and/or family and/or other caregiver.

- Consultation – This method refers to consulting between service providers (i.e., the child and family are not involved in the consultation session). The IFSP will list the service (discipline) that is <u>providing</u> the consultation.
    - If the consultation between providers is planned at the time of the IFSP, then it should be documented as an entitled service in Section V of the IFSP. If a concern comes up later and the primary provider is just making a call to another provider, say the OT, to ask a question, then there is no need to have an IFSP review to record that call as consultation. However, depending on the outcome of that call, an IFSP review may be needed in order to add assessment or further consultation by the OT.
    - Consultation between team members who are both providing ongoing services to the child using the method "coaching, including hands on as needed" is <u>not</u> listed on the IFSP as consultation between the two providers (without the child and family). Instead this is considered teaming, an expected part of service delivery that is included in the EI rate paid for the service they are already providing.
- Provision of an assistive technology device – Record this method only when the service listed is Assistive Technology Device.
- Assessment – This method refers to assessment completed after the initial assessment for service planning and does not include ongoing assessment conducted at each session by the service provider. The need for follow-up or annual assessments (other than ongoing assessment) and parent consent for that assessment may be documented either on the IFSP or on the *Notice and Consent for Assessment for Service Planning* form, whichever is easier in a given situation. For instance, if the need for additional assessment comes up during an IFSP review, it will be easier to document that additional assessment on the IFSP Review page rather than using the consent form. On the other hand, if it is close to time to develop the annual IFSP and there is not enough information available through ongoing assessment, then the service coordinator may find it easier to use the *Notice and Consent for Assessment for Service Planning* form (marking Annual Assessment in the Action Proposed section) rather than going through the process of holding an IFSP review in order to add the needed assessment(s) to the IFSP.

6) **Natural Environment/Location -** Enter the natural environment/location where the service will take place. The choice of location is based on the activities that are being addressed (as identified in the IFSP outcomes in Section IV of the IFSP). For services that will be provided in a variety of community settings, it is acceptable to record several of the locations followed by "etc." ("park, home, daycare, grocery store, etc."). If listing two locations (for example, "daycare and home"), connect the two with "and" so that it is clear that both locations will be used. If the "etc." option was not used, it is still acceptable to use a natural environment other than those listed on the IFSP for one or two visits without an IFSP Review as long as documentation indicates the reason for using a different natural environment (perhaps it is a trial run to see if the new location will really work). If a new location is being considered on a more ongoing basis, an IFSP Review is needed.

If the location is not a natural environment, provide justification (in the designated place in Section V) for why the IFSP outcomes cannot be met in a natural environment.

| For service coordination, if the family wants contact to be by phone and e-mail, the service coordinator will see the family face-to-face at least for the annual IFSP. In this situation, the location listed on the IFSP would be the location where the service coordinator will be with the family for the annual IFSP meeting. |
|---|

7) **Payment** – Using the key in the header of this column, list the number(s) of the possible payment sources for each service. The final decisions about payment arrangements are recorded on the Family Cost Share Agreement form. Possible payment sources may include Medicaid, private insurance, family fees, donation, state, city, Part C funds, etc. If a possible payment source is not listed in the key, then write it in the appropriate box (see the example of the Services Needed to Achieve Early Intervention Outcomes table provided earlier in these instructions). "None" is not an option.

8) **Projected Start Date -** Enter the **projected** date (month/day/year) on which the service will begin. The projected start date should reflect the local system's best estimate of when services can start. The exact date of the first appointment is not required. The date should be within 30 calendar days of the date the parent signs the IFSP unless the IFSP team decides on and documents the reasons for a later start date in order to meet the individual needs of the child and family. It is not permitted to delay services while waiting for insurance authorization, except by parent request. The projected start date for a one-time service (e.g., an audiology evaluation) should reflect the anticipated date for delivery of that service. The IFSP is not valid or in effect until the parent signs the IFSP. The IFSP date would be listed as the projected start date only if (1) the family signs the IFSP on that date and (2) the service is anticipated to be delivered that same day.

   Please note that the 30-day timeline does not apply to delivery of an assistive technology device. The projected start date listed on the IFSP for an assistive technology device should reflect the anticipated date for delivery of that device.

9) **Projected End Date** – Enter date (month, day, and year) when the service can reasonably be expected to have met all IFSP outcomes, or a future IFSP review date. The projected end date for a one-time service would be the same as the projected start date.

10) **Actual End Date** - Enter the date the service, as written, was discontinued. This applies to discontinuation of the service, and it also applies to any ***changes*** in the service, such as a change in the frequency, length, method, or location. In the latter cases, the service as originally written on the IFSP has been discontinued. Accordingly, the date of the change (End Date) should be entered

here, and the "new" service (reflecting the changes made) should be added on the next empty line. Changes of this sort require an IFSP review and must be documented in Section IX – IFSP Review Record. For example, if the service on the IFSP is listed as physical therapy, 2 times per month, 1 hour per session, coaching with hands-on as appropriate, on an individual basis at home, then the actual end date for that service, as written, means the actual end date for physical therapy provided at that frequency, length, intensity (individual/group), method, and location. Physical therapy may be continuing but the frequency has been changed to once a month **–** the previous physical therapy service, as written, has ended and the new physical therapy service has begun.

When an annual IFSP is developed, the actual end dates must be completed for each service on the previous IFSP (the IFSP that ends when the annual IFSP is developed). To do this, write "continuing" in the actual end date column for those services that will continue, as written, on the annual IFSP. Fill in the actual last date of service for any services that will not continue, as written, on the annual IFSP.

An end date should not be recorded by the sending local system for services in Section V of the IFSP simply because the child is moving to another local system in Virginia.

**Justification of why early intervention outcomes cannot be achieved satisfactorily in natural settings and a plan with timelines and supports necessary to return early intervention services to natural settings –** If any service will be provided outside of a natural setting, explain here why IFSP outcomes cannot be achieved by receiving services in a natural setting within the context of the daily activities and routines of the child and family. The justification must document the IFSP team's decision that the child's IFSP outcome(s) could not be met in a natural setting even with supplementary support (e.g., adaptations or modifications to activities or environments; use of assistive technology). The justification must include ways that services provided in specialized settings will be generalized into the child's daily activities and routines and a plan with steps, timelines and supports necessary to return early intervention services to natural settings within the child's and family's daily activities and routines. The need for services to continue outside of natural settings must be monitored carefully, and IFSP reviews should be held more frequently to determine whether the child's IFSP outcomes can now be met within natural settings. Therapist or parent preferences are not acceptable justifications. (If services are not provided in natural settings within the context of the daily activities and routines of the child and family because of family preference, then the services are not Part C early intervention services and cannot be paid for with any federal, state or local early intervention funds).

**Reason for later projected start date (if services are planned to start more than 30 calendar days after the family signs the IFSP)** – For each service that is planned to start more than 30 calendar days after the family signs the IFSP, list here the service and indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs, or other. If the reason is that the team planned a later start date to meet child and family needs, then explain here or in a contact note how the delay in the start of services meets child and family

needs. If the reason is “other,” then this other reason must be fully documented/explained in the contact notes.

IFSP services may start more than 30 calendar days after the family signs the IFSP and still be considered “timely” if the IFSP team decides on and documents the reasons for a later start date in order to meet the individual needs of the child and family. It is also acceptable to plan a later start date due to family scheduling preference.

Provider unavailability is not a reason for planning a later start date, since it is not known for certain at the time of IFSP development that there will be no provider available. There are circumstances when the IFSP team anticipates a delay in the start of services due to a provider issue. For instance, if audiology is listed as an entitled service and the team knows it usually takes 6 weeks to get an appointment, then the projected start date should be realistic and reflect that fact. The reason for the later projected start date would be “other,” and the local system will work to get an earlier appointment either through a cancellation or by seeking the services of another audiologist, if possible. The contact notes will document the attempts to get an earlier appointment. Similarly, if the team anticipates a delay in the start of physical therapy because of a provider shortage, then the projected start date will reflect that fact, the reason given will be “other,” and contact notes will detail the circumstances as well as efforts to start the service as soon as possible.

Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization, except by parent request. In order for this to be considered an acceptable reason for the delay in starting a service(s), there must be documentation that contact has been ongoing with the insurance company and that the local early intervention system has been working with the company to determine if there will be coverage for early intervention services AND that the parent chose not to begin services until insurance issues were resolved. Otherwise, Part C funds must be used to avoid a delay in the start of services.

If a service has a projected start date on the IFSP that is within the 30-day time frame, but the actual start date is delayed beyond the 30 days, then the reasons for that delay are documented in the contact notes rather than on the IFSP. The contact notes also provide documentation of the actual start date of each service. Compliance with the requirement for timely start of services is based on the actual start date in relation to the date the family signed the IFSP.

**SECTION VI. Other Services** ***(services needed, but not entitled under Part C – include medical services such as well baby checks, follow up with specialists for medical purposes, etc.***) – List all medical and any other ongoing services a child and/or family may need but are neither required nor covered under Part C, e.g., follow-up by a medical specialist for a chronic health condition, orthopedic visits, etc. For each service, list the name of the provider of the service and the location at which the service is typically rendered. If those services are not yet being provided, describe the steps the service coordinator or family may take to assist the child and family in securing those services.

Entitled vs. Other:

- Any medical services for diagnostic or assessment purposes that the IFSP team identifies as necessary to determine the child's developmental status are considered entitled services and should be listed in the entitled services section.
- Services parents secure on their own outside of the Infant & Toddler Connection system (because they want more frequent services or a specific location, for example) should be listed as Other Services.

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## SECTION VII: Transition Planning

The activities in this section are intended to help service coordinators plan individual child/family transitions in compliance with Part C requirements. Chapter 8 of the Practice Manual provides additional information about transition requirements.

Generally, the information in the top 2 boxes will be shared with families during the initial IFSP meeting. All blanks within this page (except "other steps/activities") must be completed by the time the child transitions. If the child will receive no further services upon leaving early intervention, then non-applicable activities (e.g., sending child-specific information to the next setting) should be marked "N/A." Transition planning must be individualized for each child and family and take into account the family's priorities and preferences.

1) **The following information about transition is discussed beginning at the initial IFSP** – This box provides an outline of the general information about transition that must be shared with families beginning at the initial IFSP meeting. Enter the date this information was fully shared with the family and the initials of the service coordinator. It is acknowledged that this information may be discussed with the family on more than one occasion, but it is only necessary to document the date on which the information was first reviewed completely with the family.

2) **Important Dates for Transition Planning** – This information assists the service coordinator and family in knowing some of the important dates for transition planning with this specific child and family.

- **Target date for notification and referral to determine eligibility for early childhood special education services** – This date must always be at least 90 days before the anticipated date of transition. Generally, local systems will enter April 1 of the year that the child will be 2 by September 30th. This date provides the target date for notification and referral to the local school division in order for the child to begin receiving early childhood special education services on the first day of school. Some local systems may work with local school divisions that allow admission of 2-year-olds throughout the school year (rolling admissions) or have other agreed upon timelines for referral. In that case, enter the target date here accordingly.
- **Date of child's third birthday** – Enter the date of the child's third birthday and discuss with the family the eligibility and age requirements for early intervention so they understand their child will not be eligible for Part C early intervention services on or after the child's third birthday.

Both target dates (for transition at age 2 and at age 3) must be completed.

3) **Transition Plan –** Please see the Transition section of Chapter 8 for information about the transition plan and how to complete this section of the IFSP.

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## SECTION VIII: IFSP Agreement

1) **Parental Consent for Provision of Early Intervention Services –** This is a statement of agreement with and informed consent for the services as specified in the IFSP. The *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* must be given to the parent(s) and the rights and payment policies explained prior to asking them to sign the IFSP. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

   If the parent expresses disagreement with any portion of this statement, the service coordinator should determine the source of the disagreement and attempt to resolve it with the parent(s). If the parent(s) decide to opt out of one or more services or to opt out of early intervention, they must be provided with and sign the *Declining Early Intervention Services* form and their rights must be explained to them.

2) **Parent (s)/Legal Guardian Signature and Date-** Parents sign to affirm their agreement with the consent statement above. Check the appropriate box to indicate whether the signer is the child's Parent, Legal Guardian, or Surrogate Parent. The date must be entered with the parent signature since

the date of parent signature is the date the parent has consented to services listed on the IFSP and begins the 30-day timeline for the timely start of services.

3) **Other IFSP Participants** - Everyone else who participates in the development of the IFSP, in addition to the parent(s), (including anyone accompanying the parents and knowledgeable authorized representatives of anyone directly involved with the eligibility determination and/or assessment for service planning) must sign here and write the full date of signature (month, day, year). Providers must also list their credentials and check the box that indicates their discipline.

4) **The following individuals participated electronically or in writing** - The names of others who participated in the development of the IFSP via phone, internet conferencing, submission of written reports, etc., but were not physically present at the meeting must be entered here. List the specific manner in which each individual participated.

5) **Translator/Interpreter (if used) -** List the name and contact number of any individual(s) who either interpreted any portion of the IFSP development process for the family/child, or who was responsible for translating the IFSP into the family's native language.

6) **Related documents –** List any related documents that were used to develop the IFSP (for example, medical specialist's evaluation of an aspect of the child's health that is relevant to his developmental progress). These documents, while not part of the IFSP itself, must be included in the child's early intervention record.

7) **Copies to –** List here all individuals who will receive a copy of the IFSP. If the IFSP is to be sent to a provider or agency other than those within the Infant & Toddler Connection of Virginia who are or will be involved in providing early intervention services to this child and family, the parent must sign a separate release of information form. If information is attached to the IFSP that was received from other sources it must be made clear to the family that their consent to release the IFSP includes the release of the attached report.

8) **Physician certification** – This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, and date of signature may be obtained on a separate letter referencing the IFSP that is sent with the

   IFSP or on the *IFSP Summary Letter* instead of in Section VIII of the IFSP. Physician certification is not needed if there is no third party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed in order to receive Medicaid reimbursement for assessments. Please see the

text box in the “Completing the IFSP Form” section of this chapter for specific requirements associated with the physician signature.

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## SECTION IX: IFSP Review Record

This page is intended to provide documentation for the IFSP reviews that must be conducted every six months or more frequently as requested by the parent or other team members. The services page and the transition page often require updating during a review. Additions to the IFSP (updates) must be dated and signed. Section IX of the IFSP documents the parent’s consent for any changes to the IFSP made at the time of review.

Review Required?

**Yes:** An IFSP Review must occur whenever a change to the IFSP outcomes, short-term goals or service provision (frequency, length, intensity (group/individual), method, natural environments/location) specified in the IFSP is being considered.

**Yes**: An IFSP Review must occur to develop the Transition Plan and for the Transition Planning Conference unless that plan is developed or the conference is held during the initial or an annual IFSP meeting.

**No:** An IFSP Review is not required to add or change learning opportunities and activities or modalities or to add/document specific transition activities after the Transition Plan has been developed. The above additions should be written right on the form and must be initialed and dated. Changes to contact information for the family and/or change in the service coordinator do not require an IFSP review and should be documented on the IFSP as the changes occur.

**No**: An IFSP Review is not required if a short-term goal is not met by the target date. However, it may be appropriate to hold an IFSP review to discuss progress and whether there is a need to change the short-term goal. Otherwise, if the short-term goal is continuing, the team will revise the target date at the next IFSP review. An IFSP review is not needed when a short-term goal is met unless that progress means there is a need to add a new short-term goal(s) or IFSP outcome or change a service.

**No**: A review is not required when the frequency, length, etc. change if the changes were planned and documented on the IFSP during a prior IFSP meeting (e.g., the team planned and wrote on the IFSP that developmental services would be provided once a week for 3 weeks then change to once every other week).

**No**: A review is not required to change the service provider for an entitled early intervention service. If the change is to another provider within the same provider agency selected by the family, then a contact note must document that the family was informed of the change and of their options for informing the service coordinator if a change from the new provider is desired. The new provider should be added to the Addendum page but a parent signature is not needed. If a change in provider is necessary or requested by the family and no other provider from the same provider agency is available, then documentation of parent choice of a new provider agency is required on the Addendum page (i.e., the new provider must be added and parent signature is required).

**No**: Section IX of the IFSP does not need to be completed in order to "Close out" an IFSP prior to developing the annual IFSP.

Other Requirements Associated with IFSP Reviews:

- *Parental Prior Notice* and *Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to an IFSP review. These forms may be mailed ahead of the meeting if necessary (e.g., if the meeting will not be face-to-face and the service coordinator will not see the family before the meeting).
- At a minimum, the review must include the parent(s) and any other friend or family member(s) requested by the parent, the service coordinator, and any direct service provider(s) as appropriate.
- This does not have to be a face-to-face meeting. Any means of reviewing the IFSP that is acceptable to the parents and other participants is permissible, as long as all participants have the opportunity to provide input.
- If the IFSP review is held by means other than a face-to-face meeting, then the contact notes must document the date of the IFSP review. Even though the parent's signature may not be obtained on that date, it is the date the review is held that must be within 6 months of the date the initial or annual IFSP was developed. Contact notes then document efforts to obtain the parent's signature, which is required before any changes to the IFSP may be implemented.
- Any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs.

1) **Purpose of Review** – Check the appropriate box to indicate if the review is being held as the required 6-month review of the IFSP or has been specifically requested by the parent or another member of the team.

**Question**: If a service coordinator does a review at 3 months after the IFSP is signed and then again 6 months later (at the 9 month point following the IFSP), does the service coordinator check the 6 month review box at the top of the IFSP review form at the 3 month review or the 9 month review – or both – or never and just checks the "Upon request by _________" box for both reviews?

**Answer**: If the IFSP review is being held because it has been about 6 months since the IFSP was developed or reviewed, then check the "6 month review box" in Section IX of the IFSP form. If the review is being held because it was requested by the family or another team member and it is not near the 6-month mark, then check the "Upon request by ___" box. In the example given in the question, the review held at 3 months would be "Upon request by______," and the review held at 9 months would be marked "6 month review."

2) **Review Date** – Date of the IFSP review meeting. If the IFSP review occurs by phone, then the date of the phone call to review the IFSP is the review date.

3) **Summary** – Provide an overview of what was discussed and decided at the review. This should include:

   - Information from the family regarding their priorities and preferences; and
   - Information from ongoing assessment, including progress toward IFSP outcomes and goals and the child's current functioning and progress (since the initial IFSP) in the areas of positive social relationships, acquiring new knowledge and skills and use of appropriate behaviors to meet needs.

   Since information about the child's developmental progress and status is listed here, it is not necessary to complete a new Section II or Section III at an IFSP review. Include the manner in which the review was conducted and any other new information that might affect the IFSP. If there are changes made to the IFSP as a result of this review, include the rationale for the change(s) here.

4) **Changes** - Enter any changes that were made to the IFSP as a result of the meeting. This should consist of the current provision and what is changing about it, e.g., Physical Therapy is being changed from 1x/wk. to 1x/mo. If no change is recommended, write "none." Changes authorized here must be entered in the appropriate IFSP section(s), either Section IV - Outcomes, and/or Section V – Services Needed to Achieve Early Intervention Outcomes, by entering the end date for the old provision and writing in the new provision on the next open line/page. If a new IFSP outcome is added, the header should retain the original IFSP date and the date the outcome is added should be recorded by "Date Outcome Added." If a new short-term goal is added, include the date it was added when you write or enter the new short-term goal on the IFSP outcome page.

5) **Projected Start Date for Change –** Record the date the change is projected to begin. If the change is a change in a service, then the projected start date for change is the projected start date for the new service.

6) **Parental Consent –** The parent signs and dates to indicate his/her involvement in the decisions and his/her informed consent for the changes. Parent signature and date of parent signature are required even if no changes were made. A written copy of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* must be offered and explained to the parent(s).

7) **If services increased on this IFSP review and my child is covered by private insurance** – If the child is covered by private insurance and the parent has consented to use of that insurance to pay for early intervention services and services have increased (in frequency, length or duration, or gone from group to individual) on this IFSP, then the family must indicate here whether their private insurance can continue to be billed for covered

services. The family must check one of the two boxes, then sign and date where indicated.

If the family checks the second box, indicating that they no longer consent to use of their private insurance to pay for covered services, then a new *Family Cost Share Agreement* form must be completed and signed by the family showing that the family has declined use of their private insurance. If a new agreement form cannot be completed during the IFSP Review, then the checkbox and parent signature in this part of Section IX of the IFSP can be used for up to 30 days to allow the local system to update their billing information for this family and to stop billing the family's private insurance while the new *Family Cost Share Agreement* form is being completed and signed. If the family declines to continue using their private insurance to pay for early intervention services and the family has Medicaid/FAMIS, then complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance*.

If the family is not ready to make a decision about continued use of their private insurance to pay for early intervention services but signs the Parental Consent box in Section IX, then all services will continue/begin as planned at the IFSP Review. However, billing of private insurance must stop until the parent provides the required consent to continue billing their private insurance. Please see Chapter 11 for details.

8) **Other IFSP Participants -** Everyone else who participated in the IFSP review, in addition to the parent(s), (including anyone accompanying the parents and knowledgeable authorized representatives of anyone directly involved in assessment of the child) must sign here and write the full date of signature (month, day, year). Providers must also list their credentials and check the box that indicates their discipline.

9) **The following individuals participated electronically or in writing -** The names of others who participated in the IFSP review via phone, internet conferencing, submission of written reports, etc., but were not physically present at the meeting must be entered here. List the specific manner in which each individual participated.

10) **Physician certification** – This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by Medicaid/FAMIS, TRICARE or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, and date of signature may be obtained on a separate letter referencing the IFSP that is sent with the IFSP or on the *IFSP Summary Letter* instead of in Section IX of the IFSP. Physician certification is not needed if there is no third party payor source (Medicaid/FAMIS, TRICARE or private health insurance), nor is it needed in order to receive Medicaid reimbursement for assessments. Please see the text box in the "Completing the IFSP Form" section of this chapter for other specific requirements associated with the physician signature.

Physician Signature Needed at IFSP Review…

- If the projected end date has been reached and the service will continue? **Yes**
- If a new service (other than assessment, for children with Medicaid), is added? **Yes**
- If there is a change (increase or decrease) in frequency or length of an existing service? **Yes**
- If a service ends? **No**
- If the child is discharged from early intervention? **No**
- If services stay the same but an IFSP outcome(s) and/or short term goal(s) changes? **No**
- If the only entitled early intervention service listed on the IFSP is service coordination? **No**

Duplicate the page as necessary.

---

**ADDENDUM**:

Use this addendum page to document the provider for each entitled service listed in Section V. Generally, the providers are not known at the time of the IFSP meeting so this page may be completed after the IFSP is signed.

1) **Entitled Service** – List the entitled services from Section V of the IFSP, ensuring that each service is listed next to the same number on the Addendum as it is in Section V. This connects the service provider listed in the Addendum with the service details in Section V.

2) **Service Provider** – List the service provider's name (e.g., Jane Doe), agency, address and phone number on the top row next to the service. There are 3 rows available for each service in case there is a change in service provider. The provider for an assistive technology device may be listed as N/A.

3) **Current?** – If there is a change in service provider or the service as listed with the corresponding number in Section V of the IFSP has ended, check the N in this column next to the exiting service provider indicating that this provider is not a current provider. If the service is continuing but there has been a change of provider, then add the name of the new provider on the next row for that same service. Please note the following:

   - An IFSP review is not required in order to change the service provider as long as the service, as listed in Section V of the IFSP, remains the same.
   - If any aspect of the service changes (e.g., the frequency or the length), then the service as listed on the IFSP has ended and a new service has started (see #10 in the instructions for completing Section V). The new service is listed on a new line in Section V of the IFSP, and that same service must then be listed on the corresponding line of the addendum.

- Changing from one provider to another within the same provider agency does not require a new signature on the addendum. However, if a change in provider is needed and no provider is available from within the agency already selected by the family or if the family is requesting a change in provider agency, then the family must be offered a choice of provider agency and must sign the addendum form.
- If there will be a change of provider for a planned segment of time (e.g., summer, maternity leave), then this must be noted in the addendum. The family would need to sign to indicate that they have been provided a choice only if there will be a change in provider agency for this planned segment of time. If different therapists will fill in for individual sessions (e.g., therapist sick, make up sessions, etc.), then that substitution should just be noted in the contact notes and no change is needed on the addendum page.

4) **Parent Signature** – The parent signs and dates this page to indicate that he/she was given the opportunity to choose from among available provider agencies that work in their local system area and who are in their payor network. All parents must be given this opportunity. In the box called "For Service(s) #" indicate the number (from the list of services on the addendum page) of the service or services to which the signature applies. More information about parent choice of provider is available in the "Selecting Service Providers" section of this chapter.

Some local Infant & Toddler Connection systems are not allowed to remove original documents from the child's early intervention record once the document has been filed there. If this is the case, it is acceptable to use a new Addendum page to document the service provider and parent choice when a new service is added or when the provider agency changes.

---

## ***ANNUAL IFSP***

(Must be completed within 365 days)

Listed below are section-by-section considerations for the annual IFSP.

Other Requirements Associated with Annual IFSPs:

- *Parental Prior Notice* and *Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to the annual IFSP meeting.
- Prior to developing the annual IFSP, the child's continuing eligibility must be confirmed. This may occur prior to or during the IFSP meeting. The requirements for confirmation of the child's eligibility are specified in the "Annual IFSP" section of Chapter 8.
- At a minimum, the annual IFSP meeting must include the parent(s) and any other friend or family member(s) requested by the parent, the service coordinator, anyone involved in new or ongoing assessment, and any direct service provider(s) as appropriate.
- This must be a face-to-face meeting.
- Any new services added at the annual IFSP must begin within 30 days of the date the family signs the IFSP unless the team planned a later start date to meet child and family needs.

**Section I**

- Fill in the date of the annual IFSP
- Place a check beside "Annual" and note whether this is annual IFSP #1 or #2 (e.g., the annual IFSP done one year after the initial IFSP is annual #1).
- Fill in the date that the six month review is due (after the annual)
- Fill in the dates reviews are completed as they occur

**Section II**

- Include any updated medical and health status information in the Referral section. While it may be helpful to succinctly re-state the reason for referral, the Referral section of the annual IFSP should not repeat all of the information that was on the initial IFSP (e.g., no need to repeat the birth history).
- Otherwise, complete Section II in the same way as for the initial IFSP. The means of gathering the information may be different since much of it may be gathered through ongoing assessment and conversations during intervention sessions and service coordinator visits or calls. The providers who are serving the child are expected to be able to describe the child's functioning in each of the child outcome areas since ongoing assessment is a routine part of intervention. Re-assessment to determine the child's functioning in the child outcome areas at the time of the annual IFSP would only be completed if specifically needed because of individual circumstances such as the child has recently had major surgery that significantly impacted his/her developmental status or the child receives services infrequently and no provider has had the opportunity for ongoing assessment for a long period of time.
- In addition to describing the child's current functioning in the areas of positive social relationships, acquiring new knowledge and skills and use of appropriate

behaviors to meet needs, include information for each child outcome area about the child's progress since the initial IFSP. This progress information is important in supporting the yes/no response to the progress question (Has the child shown any new skills since the entry assessment?) that must be recorded in ITOTS and gives the family a picture of progress over time.

**Section III**

- Use of the Virginia Part C Vision and Hearing Screening tools are not required for the annual IFSP. Providers should be alert to any signs that the child may be experiencing difficulty with hearing or vision, as such issues can arise at any age. In such cases, administration of the Hearing or Vision Screening tool would be appropriate. If the child had no problems with vision or hearing when initially screened and does not show any indication of problems at the time of the annual IFSP, it is acceptable to record the status as "no problems noted." The status may also include examples of hearing and vision behaviors noted or updated eye or ear-specific status, if available.
- Providers who completed ongoing assessment should sign in this section since they provided the information that is incorporated into Sections II and III. The parent should also sign.
- If an assessment tool was completed as an age anchor for the child outcomes based on ongoing assessment and the provider does not feel comfortable marking the instrument as an assessment tool in Section III because it was not implemented according to its protocol, then mark "Other" and specify "used ___ {tool name} as age anchor."
- Complete the remainder of the page, including developmental levels in all areas of development, as done for the initial IFSP.
- The providers who are serving the child are expected to be able to make a statement concerning the child's present level of development in each of the developmental areas since ongoing assessment is a routine part of intervention. Re-assessment to determine the child's level of development at the time of the annual IFSP would only be completed if specifically needed in order to complete the annual determination of eligibility.

**Section IV**

- Begin numbering IFSP outcomes with number one (for the service coordination outcome) even if you will be re-writing an ongoing IFSP outcome.
- Fill in the target date for the IFSP outcomes and the short-term goals. The "date met, changed or ended" will be filled in during future IFSP reviews if/when changes are made to that IFSP outcome.

**Section V**

- The only difference for page 6 from the initial IFSP is that some services may already be in progress. These should be listed with "continuing" recorded as the "projected start date."

**Section VI**

- Complete Section VI as you did for the initial IFSP.

**<u>Section VII</u>**

- The transition pages from the child's initial IFSP are to follow the child through subsequent IFSPs so that each IFSP includes a complete picture of the transition process. Therefore, the transition pages from the initial IFSP can be either electronically copied into or photocopied and inserted into the annual IFSP. Likewise, the transition pages from the first annual IFSP will be copied and used in the second annual IFSP. The IFSP team will continue adding information on the original transition pages throughout the child's enrollment in early intervention. The date of the most current IFSP must be entered at the top of the transition page as it is used in subsequent IFSPs (e.g., the date of the annual IFSP is entered at the top so it is clear that this transition page goes with this annual IFSP).
    - When completing the IFSP electronically, enter the date of the annual IFSP as the IFSP date at the top of Section VII.
    - When completing the IFSP by hand, please <u>add</u> the new IFSP date on the second line under IFSP Date at the top of the page without striking through the previous IFSP date (so it does not appear to be an error).

**<u>Section VIII</u>**

- Complete Section VIII as you did for the initial IFSP.

**<u>Section IX</u>**

- Section IX remains the same as described in the instructions for completion of the initial IFSP.

**<u>Addendum</u>**

- Complete the Addendum as you did for the initial IFSP.

# ATTACHMENT A:

## Instructions for Using Word Processing to Customize and to Complete the IFSP Form

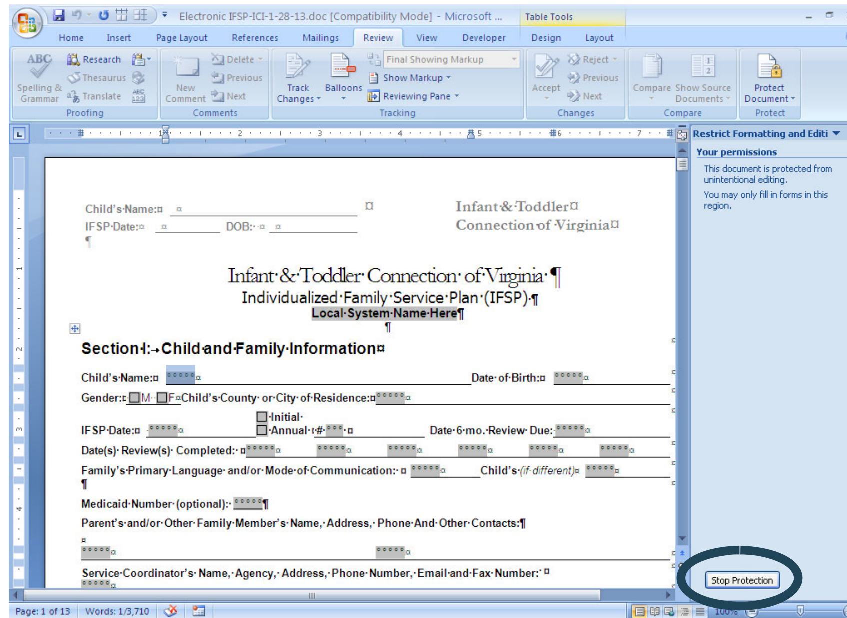
Making permanent changes to the IFSP form
The IFSP form may be customized with permanent changes for local use **only** in the ways described in the first point under General Information on the first page of these IFSP instructions.

**Handwritten version of the IFSP**
This version of the IFSP is not protected. To make permanent changes, click on the shaded box and type in the applicable information. When entering the local system name, you will need to first delete the words "Local System Name Here." Save the document to make these changes permanent, and then print it out for individual completion.

**Electronic version of the IFSP**:
When you first open the IFSP form on a word processor, a message may appear asking whether to enable macros. Click *yes* or *OK*.

**To make permanent changes**, you must first **unprotect** the form. To do this in MS Versions 2003 or higher:

- Click on the Review tab in the ribbon
- Click on *Protect Document*



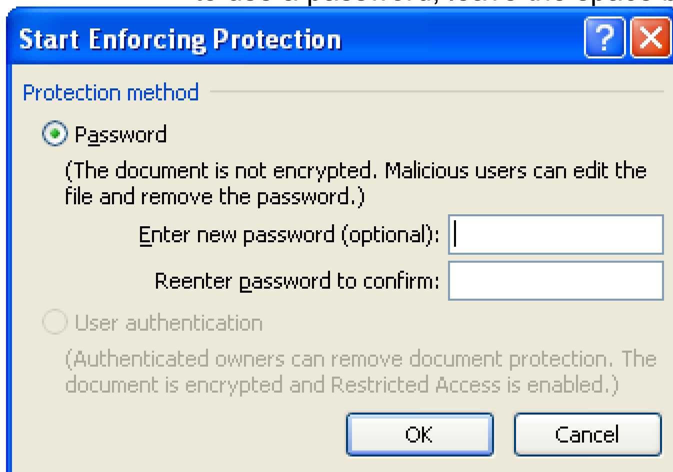

- At the bottom right of your screen you will see a button that reads "Stop Protection.
- Click this button and make the initial edits to the IFSP to customize it for your system.
- You will need to do this again for each child when you enter the child's name and associated dates into the header. You will need to only enter this once for the information to be carried over to each page.

If you will be entering information in a box where you will not need to enter additional information when completing the form for an individual child (e.g., Local System Name), then click on the shaded box, hit *delete*, and then type in the applicable information.

**After you make changes, be sure to protect the document again. If you don't, attempting to type new information will alter the document's format. To protect the document**:

1. Click on the Review tab in the ribbon
2. Click on *Protect Document*

3. Check to see that the editing restrictions are for filling in forms. Click on "Yes, Start Enforcing Protection".
4. The next window will give you an option to password protect. If you enter a passw*ord,* no one will be able to unprotect the document for further permanent changes unless they know that password. If you do not wish to use a password, leave the space blank and click *OK*.



Using Word Processing to complete the form

- When filling in the form electronically for an individual child, you must **save the completed IFSP under a different name such as the child's name and date.** This will create a new file and will maintain the blank form. Alternatively, you can save the "original" IFSP form as a template. You will need to name the document when you complete it for an individual child.
- Once protected you will only be able to type in the shaded text boxes. It is advisable to use your tab key to move forward from text box to text box (use shift + tab to move backwards). Your space bar will select and de-select the check boxes on the form.

For local systems that complete the Team Assessment sections in a separate Word document and then paste into the IFSP form

- If pasting the text into the IFSP form results in a page break after the word "Narrative," you can take the following steps to delete the page break:
    - Position the cursor in the first paragraph of the text you pasted in
    - Go to the menu bar at the top of the screen and select *Format*
    - Select *Paragraph*
    - Select the tab that reads *Line and Page Breaks*
    - Unselect the checkbox that reads *Keep with next*
    - Click *OK* and the paragraph will return to the correct page
- Pasting the text in from another document sometimes results in unexpected formatting changes within the pasted text. To prevent this, you need to paste the text without formatting.
    - In order to paste the text, go to the menu bar at the top of the screen and select *Edit*
    - Select *Paste Special*
    - Select *Unformatted Text*
    - Click *OK*

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## Chapter 11: Finance and Billing

Finance and billing practices in the Infant & Toddler Connection of Virginia system support compliance with federal Part C requirements to ensure non-supplanting and use of Part C funds as payor of last resort as well as promoting equity and parity across local systems and enhancing access to early intervention supports and services.

Definitions

1. **Ability to pay** – Amount the family is able to contribute toward the full cost of early intervention services, based on family size, income and expenses and as documented on the *Family Cost Share Agreement* form and/or the *Fee Appeal Form*.
2. **Family fee** (or "fee") – Amount required as payment from families for IFSP services based on the accrued charges and co-payments incurred as a result of the services a family receives each month. The family fee may not exceed the monthly cap.
3. **Inability to pay** – Family's inability to pay any dollar amount at all toward the cost of early intervention services. An inability to pay is determined and documented through the policies (including the fee appeal process) described in this chapter and results in the family receiving all early intervention services at no cost to the family.

4. **Monthly cap** (or "cap") – The maximum amount, as determined by the Family Cost Share fee scale or fee appeal process, that a family will be required to pay per month for IFSP services regardless of the number, type, frequency or length of services a child and family receive.

<u>General</u>
Local Lead Agency Responsibilities:

1. Ensure the following functions are carried out at no cost to families:
   a. Child find requirements;
   b. Eligibility determination;
   c. Assessment (this does not include the ongoing assessment that is integrated into and occurs as a routine part of service delivery);
   d. Service coordination;
   e. Development, review and evaluation of IFSPs; and
   f. Implementation of procedural safeguards.
2. Ensure that the charges for early intervention supports and services are consistent regardless of the anticipated payment source and that families with public or private insurance are not charged disproportionately more than families who do not have public or private insurance.
3. Make every effort during planning and implementation of the interagency system of early intervention supports and services to consider and access all available sources of funds prior to use of state and/or federal Part C funds. Every effort must be made to access private insurance (including private HMOs) and public insurance through the Department of Medical Assistance Services (DMAS) and TRICARE for all early intervention supports and services covered by these payors. Other potential resources include, but are not limited to the following:
   a. Private foundations, civic organizations (i.e., Kiwanis, Lions Club, etc.), and faith organizations that have potential supports/resources for children and families in early intervention;
   b. Publicly and privately funded initiatives (i.e., Healthy Families, Comprehensive Health Investment Project of Virginia, Early Head Start, etc.) that may have overlapping services and supports for families;
   c. Public and private agencies/organizations including health/medical, social services, education and mental health agencies; and
   d. Parent organizations.

   Funding for the various steps in the early intervention process (such as intake, determination of eligibility, assessment for service planning, provision of supports and services) varies according to the step in the process and to what is "covered" by the particular funding source. The two *Reimbursement Sources* tables at the end of this chapter show the potential funding sources for each step in the early intervention process.
4. Ensure that, in accordance with the Education Department General Administrative Regulations (EDGAR, § 80.25) and 34 CFR 303.520(e), all income generated by the local Infant & Toddler Connection system is retained by the local Infant & Toddler Connection system. For the purposes of Part C, income includes income from family fees and fundraising. Under 34 CFR 303.520.(d)(1), reimbursement from public or private insurance is not treated as program income. However, under Virginia's early intervention practices, agencies with programs in addition to Part C early intervention are strongly encouraged to put public and private insurance revenue generated by the early intervention program back into the early intervention program.

5. Develop interagency agreements, contracts or memoranda of agreement with as many providers as possible to meet the needs of children with disabilities and their families. These agreements or contracts must specify the responsibilities of each party including the requirement to comply with Part C of the Individuals with Disabilities Education Act, as well as the supports and services that will be provided and how these supports and services will be financed. Local lead agencies must allow families to have access to any certified practitioner in the family's payor network who is working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to allow for exchange of Part C funds.
6. Implement the family cost share practices specified below to ensure documentation that payor of last resort requirements are met and that no child and family are denied supports and services due to an inability to pay. The family cost share practices also specify the process for documenting the family's choices related to use of public or private insurance and payment of family fees.
7. Implement procedures for the use of Part C funds to cover the cost of supports and services pending reimbursement from the agency or entity that has ultimate responsibility for the payment or pending designation of the responsible agency or entity in order to prevent a delay in the timely provision of supports and services.
    a. During a dispute between/among local counterparts of participating agencies regarding financial or other responsibilities, the local lead agency notifies the State Lead Agency of the dispute and uses Part C funds until the dispute is resolved to ensure that no supports and services that a child is entitled to receive are delayed or denied. Upon resolution of the dispute, the agency determined responsible reimburses the Infant & Toddler Connection system as follows:
        - If reimbursements are not made by a State participating agency (or its local counterpart) within 45 days of resolution of the dispute, the State Lead Agency contacts the staff involved at the State participating agency of the given program.
        - If not resolved by the respective State agency within 14 days, the matter is referred to the Secretary of Health and Human Resources and/or the Secretary of Education.
    b. Under extraordinary circumstances, Part C funds may be utilized to ensure the provision of services until a monthly cap is determined through the family cost share practices described later in this chapter.

<u>Early Intervention Rates</u>

Standard rates are in place for reimbursement of early intervention services regardless of reimbursement source (though not all reimbursement sources will reimburse for all services listed below – see tables at the end of this chapter). These rates reflect the full cost of providing a unit of early intervention services, including not only salary and benefit costs but also travel and administrative and support costs. In the case of assistant-level practitioners, the rate also accounts for supervision costs. The table below reflects the standard rate for each type of service:

| Service | Location | Provider* | Rate (per 15 minute unit) |
|---|---|---|---|
| | Any location | RC 1 + audiologists | $37.50/unit |

| Service | Location | Provider* | Rate (per 15 minute unit) |
|---|---|---|---|
| Eligibility Determination - Travel required to be with family | | RC 2 + dietitians | $27.50/unit |
| Eligibility Determination - No travel to be with family | Any location | RC 1 + audiologists | $22.50/unit |
| | | RC 2 + dietitians | $16.49/unit |
| Initial Assessment for Service Planning | Natural environment or center | Reimbursement category 1 providers | $37.50/unit |
| | | Reimbursement category 2 providers + dietitians*** | $27.50/unit |
| | | Audiologists*** | $150/assessment |
| | | Physicians | Negotiated individually at local level |
| Initial or Annual IFSP Meeting | Natural environment or center | RC 1 + audiologists | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |
| Team Treatment activities (more than one professional providing services during same session for an individual child/family) | Natural environment** | RC 1 + audiologists | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |
| IFSP Review Meeting (family present) | Natural environment** | RC 1 + audiologists | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |
| Assessments that are done after the initial Assessment for Service Planning | Natural environment** | RC 1 | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |
| | | Audiologists | $150/assessment |
| | | Physicians | Negotiated individually at local level |
| Group (congregate) early intervention services | Natural environment** | RC 1 + audiologists | $25.13/unit |
| | | RC 2 + dietitians | $18.43/unit |
| Individual early intervention services | Natural environment** | RC 1 + audiologists | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |
| | Center | RC 1 + audiologists | $7.43/unit |

| Service | Location | Provider* | Rate (per 15 minute unit) |
|---|---|---|---|
| Center-based group (congregate) services | | RC 2 + dietitians | $5.44/unit |
| Center-based individual services | Center | RC 1 + audiologists | $22.50/unit |
| | | RC 2 + dietitians | $16.49/unit |
| Consultation (child and family not present) - No travel involved | Any location but must be face-to-face | RC 1 + audiologists | $22.50/unit |
| | | RC 2 + dietitians | $16.49/unit |
| Consultation (child and family not present) - Travel by provider required | Any location but must be face-to-face | RC 1 + audiologists | $37.50/unit |
| | | RC 2 + dietitians | $27.50/unit |

* Reimbursement category 1 providers are physical therapists, occupational therapists, speech-language pathologists, nurses (registered nurses or nurse practitioners; providing nursing services or developmental services), physical therapist assistants and occupational therapy assistants. Reimbursement category 2 providers are certified therapeutic recreation specialists, counselors, educators, family and consumer science professionals, family therapists, music therapists, orientation and mobility specialists, psychologists, social workers, early intervention assistants, certified nursing aides and licensed practical nurses.

** Includes center-based services with acceptable justifications AND for which travel by the provider is required. Such situations should be infrequent. Audiology and medical assessments are not required to occur in natural environments.

*** The rates listed for services provided by audiologists, dietitians and physicians are only guidelines and actual rates may be negotiated on an individual basis. Medically necessary services from audiologists, dietitians, and physicians are reimbursed by Medicaid outside of the Medicaid Early Intervention Program. Providers are required to accept the Medicaid reimbursement as payment in full for these services.

Application of rates:

1. Services are reimbursed for the time spent directly with the child/family. The family member or caregiver must physically be present and actively participate in the intervention session in order for the session to be reimbursed.
2. Providers may bill for their entire time spent in an IFSP meeting or assessment.
3. Services provided in excess of the frequency, length, or duration specified on the IFSP, without acceptable justification, will not be reimbursed.
4. Providers are required to accept Medicaid reimbursement for medically necessary early intervention services as payment in full.
5. When the child is covered by private health insurance or has no insurance, the rate for a delivered service may be paid through multiple payor sources (private insurance, family fees, Part C funds, etc.). These payor sources and billing procedures are discussed below.
6. The entity that bills receives the standard EI rate. If the Local Lead Agency bills for the service, the local lead agency receives the EI rate and pays the employee

or contractor who provided the services. Since the standard rates represent the total cost of providing a unit of service, including not only salary and benefit costs but also administrative and support costs such as billing and supervision, as well as costs for personnel development and teaming, local lead agencies can negotiate with contracted providers regarding the portion or amount of the standard EI rate that will be "paid" to the local lead agency for the functions the local lead agency is doing. For example, the standard EI rate for PT is $150/hour. If ABC provider delivers 20 hours of PT services and is doing all of their own billing and supervision, then ABC provider will receive the $150 rate multiplied by the number of PT hours provided. If, on the other hand, the local lead agency does all of the billing for ABC provider, then the local lead agency would negotiate with ABC provider to determine how much ABC provider will pay the local lead agency to do their billing. While the rate remains $150/hour, the amount that the local lead agency will pay ABC provider for PT will be reduced by the amount the provider is paying the local lead agency for billing.

7. A provider will not be reimbursed for participation in consultations or IFSP meetings by phone.
8. For eligibility determination:
    a. While eligibility determination does not have to be a face-to-face meeting, it must be planned ahead of time.
    b. A provider may participate by phone, protected email, videoconference, etc. or a combination of those mechanisms to allow for review of available information and team interaction. Both the time spent for review/preparation and the time for team interaction are reimbursable.
    c. No separate reimbursement is needed or appropriate if the provider participating in eligibility determination is a salaried employee of the local lead agency or if the eligibility determination is combined with the assessment for service planning (and the child is found eligible).
9. An Individualized Education Plan (IEP) meeting is not a medically necessary treatment service and participation by service providers other than service coordinators is not covered by Medicaid/FAMIS. The State Lead Agency considers participation in an IEP meeting to be a teaming activity that cannot be billed by the provider and will not be reimbursed by Part C.

<u>Family Cost Share Practices</u>

Local Lead Agency Responsibilities:

1. Identify the individual(s) who will be responsible for explaining the family cost share practices to families and assisting the family to complete the *Family Cost Share Agreement* form.
2. Ensure that the individual(s) who are responsible for implementing the family cost share practices are trained to:
    a. Explain financial information, including use of Medicaid/FAMIS, Medicaid waivers, TRICARE and private insurance for early intervention services, availability of other resources to support early intervention service provision, family fees and monthly caps; and
    b. Collect and record the required financial information from families in a sensitive, confidential and accurate manner.
3. Ensure all families are advised that:
    a. With the exception of the functions that must be provided at no cost to families (listed in #1 in the "General" section above), all other early

intervention services are subject to the family cost share practices detailed here.

b. They must be charged the cost of care (i.e., full charge) to comply with federal Medicaid requirements that indicate all services must be charged in like manner; and

c. A sliding fee scale is available to reduce charges based on family size and income.

This and other critical aspects of the family cost share practices are explained in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*, which outlines Virginia's family cost share policies. *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* is given to all families at the same time they receive *Notice and Consent to Determine Eligibility*, when consent is sought for services on the initial and annual IFSP, at an IFSP review, and any time there is a change in the parent's choices regarding use of public or private insurance on the *Family Cost Share Agreement* form. The family must be offered a copy of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share* at each of the points listed above. However, if the family has previously received a copy of the document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

4. Ensure billing for and collection of all family fees for the local Infant & Toddler Connection system. The local lead agency may: 1) do all billing and collection of family fees, 2) contract with a single entity to bill for and collect all family fees for the local Infant & Toddler Connection system, or 3) assign the billing and collection of the family fee to a specific agency/provider for each child.
5. Maintain and report quarterly to the State Lead Agency data on the total amount of family fees collected. Data must be on file at or accessible to the local lead agency and made available to the State Lead Agency, upon request, to document charges billed, payments received, and the status and follow-up for those families who are required to pay but do not do so.
6. Assist the family in accessing the Part C administrative complaint process, mediation and/or a due process hearing if disagreements regarding family cost share cannot be resolved.
7. Require providers to routinely (at least once a month) confirm with families whether or not their insurance has changed. The provider must notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit, and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage.
8. For children with Medicaid/FAMIS, the following specific procedures apply:
   a. Confirm eligibility: The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid/FAMIS benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid/FAMIS eligibility prior to every visit, changes in Medicaid/FAMIS eligibility tend to occur at the beginning or end of the month. The provider must:
      - Contact the Infant & Toddler Connection of Virginia Office if the Medicaid EI benefit is not added within a week; and

- Retain documentation of all contacts with the Local System Manager and with the Infant & Toddler Connection of Virginia Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

Options for verifying a child's Medicaid/FAMIS coverage are discussed in the text box that follows, titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification."

b. Ensure the following steps occur if notified by a provider that a child is not showing the Medicaid EI benefit:
   - The local system manager must:
     - Check to be sure that all information is entered correctly in ITOTS;
     - Notify the Infant & Toddler Connection of Virginia Office immediately but no later than 60 calendars days from the date the Medicaid EI benefit dropped, if applicable; and
     - Retain documentation of contacts with providers and with the Infant & Toddler Connection of Virginia Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.
   - For a child who no longer has Medicaid/FAMIS coverage, the service coordinator must check with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements. Approximately 20% of the Medicaid/FAMIS population loses their benefit for a variety of reasons, including failure to complete the re-application process. If the family is in the process of re-applying, then the service coordinator should:
     - Connect with the local Department of Social Services Office so the child's eligibility worker can assist the family with completion of the steps necessary to restore the benefit;
     - Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and
     - Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.
   - If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form, and the Medicaid/FAMIS information must be deleted in ITOTS. If Medicaid/FAMIS coverage is later restored, Medicaid/FAMIS must be selected in ITOTS and the 12 digit number re-entered.

9. Check for Medicaid/FAMIS eligibility, with parent consent, for all children in the local system using one of the eligibility mechanisms below to identify children whose families have forgotten to inform the service coordinator that they have Medicaid/FAMIS coverage, which can occur especially when Medicaid is secondary. This is important because DMAS can not be billed retroactively if the timelines for adding the EI benefit are not met, and Part C funds cannot be used for children who have Medicaid or FAMIS coverage.

Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification:
There are several options for providers to use to verify Medicaid/FAMIS benefits, including the Medicaid Early Intervention benefits.

**Eligibility and Claims Status Information**
DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderLogin. Click on Provider Resources, then click on Automated Response System (ARS).

**Eligibility Vendors**
DMAS has contracts with the following eligibility verification vendors offering Internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

| Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1-888-661-5657 | SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1-610-219-2322 | Emdeon www.emdeon.com Telephone: 1-877-363-3666 |
|---|---|---|

**Medicaid Medical Case Management Programs and Contacts**
A list of the contacts for the various Medicaid Managed Care Organizations can be found at: http://www.dmas.virginia.gov/downloads/mcrguides/Chapter_9.pdf. Though early intervention services are "carved out," many of the infants and toddlers enrolled in Medicaid/FAMIS are enrolled in Managed Care. This list can be used by Service Coordinators in order to coordinate children's other services with the Managed Care Organization. In addition, the MCO can assist with questions about the child's Medicaid number and eligibility.

Responsibilities of the Individual(s) Designated to Implement Family Cost Share Practices for the Local Infant & Toddler Connection System:

1. **Conduct financial intake** following eligibility determination and prior to the initial IFSP meeting unless the child has Medicaid/FAMIS (in which case the *Family Cost Share Agreement* form must be completed at the intake visit to ensure timely entry of Medicaid/FAMIS data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services).
    a. Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or

assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.

- If eligibility can be determined based on medical or other records and the family will be combining the assessment for service planning and the IFSP meeting, then financial intake can be conducted prior to the combined activities.
- Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.

b. Under extraordinary circumstances, Part C funds may be utilized to ensure the timely provision of services until a monthly cap is determined through the family cost share practices. Any extenuating circumstances that result in the financial intake not being conducted prior to initiation of IFSP services must be clearly documented. In the event of such circumstances:

- The family cost share process still must be fully explained to the family prior to IFSP development;
- All family cost share forms must be shared with the family prior to IFSP development;
- The family must sign the *Temporary Family Cost Share Agreement Form*, indicating in Section A whether they are opting to delay services until they can provide financial information or to begin services and decide within 30 days about providing financial information. The temporary agreement form explains the family's obligation to provide financial information within 30 days of the date they sign the IFSP and the options available to them at the end of those 30 days. It should also be made clear that the family will be obligated to pay, in accordance with the terms of the agreement form that is signed no later than 30 days after the IFSP, for any services (other than those that must be available at no cost) delivered prior to the agreement form being signed.
    - If the family opts to delay services, this would be a family reason for a delay in start of services.
    - Part C funds must be reimbursed once the monthly cap is established and payment is received.
    - If the family has private insurance or TRICARE and wants to use that insurance to pay for early intervention services, then the family must complete a *Family Cost Share*

*Agreement* form in addition to the *Temporary Family Cost Share Agreement* form. The Family Cost Share Agreement form will document the parent's consent to use their private insurance or TRICARE and the "Charges" section of that Agreement form must reference the fact that a *Temporary Family Cost Share Agreement* form is in effect.

- Section B of the temporary agreement form must be completed no later than 30 days from the date the parent signed the IFSP to document the family's decision about completing the *Family Cost Share Agreement* form and starting services. Section B gives the family three options:
    - Complete the *Family Cost Share Agreement* form and begin services, in which case a completed *Family Cost Share Agreement* form may be used to document the family's choice rather than completing Section B of the temporary agreement form;
    - Delay further services (other than those available at no cost) until they can provide income information; or
    - Decline further services.

c. The financial intake must include providing families with the following:
- A list of chargeable services as well as services for which there are no charges;
- Charges and/or fees for the services;
- Family Cost Share Agreement forms; and
- A copy of the family cost share fee scale.

d. Financial intake also includes explaining the following:
- No child and family will be denied services because of an inability to pay. The family cost share practices determine a family's ability or inability to pay.
- Families will be charged a monthly fee towards the full charge of their IFSP services unless:
    - The child has Medicaid (including FAMIS, FAMIS Plus, FAMIS Select). For children with FAMIS, Part C funds will be used to pay the family's co-pay for early intervention services listed on the child's IFSP;
    - The family has an income that puts them at $0 on the fee scale; or
    - The child and family receive no services other than those that must be provided at no cost to families.
- The family fee covers all IFSP services, including assistive technology devices, regardless of the number, type, frequency or length of services provided.
- The family fee may not exceed the total of any applicable co-payments, deductibles, and/or the full early intervention reimbursement rate (if the service is not covered by insurance) for delivered IFSP services in a given month.

<u>Background Information: How the family fee works for assistive technology devices</u>
There is no separate fee to the family for assistive technology devices. The family's responsibility for payment toward the cost of such devices is covered by their use of insurance and/or the family fee just like all other IFSP services. (Note: Resources other than insurance also may be available to assist in the purchase of an assistive technology device. If available, these resources must be accessed prior to the use of Part C funds.)

An assistive technology device is considered a one-time cost that is incurred in the month of purchase. If the full charge for IFSP services other than the assistive technology device is less than the family's monthly cap, the family may pay a higher fee (up to the monthly cap) in the month the assistive technology device is purchased.

Example: Family's monthly cap is $207. The child is receiving PT weekly and their insurance co-pay for each PT visit is $25. Therefore, the family has been paying $100/month. This month, the assistive technology device listed on the child's IFSP was purchased at a cost of $500. Insurance did not reimburse for any of that cost. This month the family will pay not only the $100 they've been paying for PT but also an additional $107 toward the cost of the assistive technology device since this brings them up to their monthly cap of $207.

- Families who will be charged a fee have the opportunity to provide documentation of taxable income that will be used along with family size to determine a monthly cap, or maximum amount, for their family fee, based on the family cost share fee scale. Because it is based on taxable income, the family cost share fee scale automatically takes into consideration normal living expenses, including medical costs associated with the child's disability.
- The monthly cap established by the family cost share fee scale is the same regardless of the number of children the family has enrolled in the Infant & Toddler Connection system at the same time (e.g., if the family's monthly cap is $231 based on the fee scale, then that family pays no more than $231 per month, total, regardless of the number of children in their family who are enrolled).
- If the family chooses not to provide income information then the family has declined to access the family cost share fee scale.
    - If the family has health insurance and agree to have it billed for reimbursable IFSP services, then they are required to pay all applicable co-payments and deductibles for those services.

  - If the family does not have health insurance, declines to have their insurance billed or the service is not covered by their health insurance, they must pay the full EI reimbursement rate for IFSP services.
- There are parent consent requirements, no-cost protections and general categories of costs that parents must be aware of before the local system can use the child's or parent's Medicaid benefits to pay for early intervention services. Notification to parents of these requirements is included in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share.*
  - Families cannot be required to apply for or enroll in Medicaid/FAMIS in order to access Part C early intervention services.
  - Parent consent is required in order to bill Medicaid/FAMIS if the child is not already enrolled in Medicaid/FAMIS. If the parent does not provide consent for use of Medicaid in this situation, then the local lead agency must still make available all IFSP services to the child and family in accordance with a signed *Family Cost Share Agreement* form.
  - Parent consent is required in order for the local system to release a child's personally identifiable information to the Department of Medical Assistance Services for billing purposes. Parents may withdraw this consent at any time.
  - In Virginia, families incur none of the following costs as a result of using Medicaid/FAMIS to pay for early intervention services:
    - Decrease in available lifetime coverage or other insured benefit for the child or parent under the Medicaid/FAMIS program;
    - Requirement to pay for services that would otherwise be covered by the public benefits or insurance program;
    - Increase in premiums or discontinuation of public benefits or insurance for the child or the child's parents; or
    - Risk of loss of eligibility for the child or the child's parents for home and community-based waivers based on aggregate health-related expenses.
  - The only potential cost to parents from using their Medicaid/FAMIS for early intervention services would be the required use of their private insurance, if they have that and if they have consented to use of that private insurance, prior to billing Medicaid.
- Parent consent is required in order to bill private insurance or TRICARE for IFSP services. Consent is required in order to use private insurance or TRICARE to pay for the services listed on the child's initial IFSP and any time there is an increase (in frequency, length, duration or a change in intensity from group to individual) in the provision of services listed on the child's IFSP. When

obtaining parent consent to bill private insurance or TRICARE, the parent must receive a copy of the family cost share policies, including the potential costs to the family of using their private insurance or TRICARE to pay for early intervention services. These policies are provided in the Facts About Family Cost Share section of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share.*

- As long as the necessary financial information is provided, the family cost share fee scale can be accessed by families who decline consent for use of their insurance. Lack of consent to use TRICARE or private insurance to pay for early intervention services cannot be used to delay or deny those services to families who have been determined unable to pay. The family cost share fee scale can also be accessed by families:
  - With insurance that does not cover early intervention services; or
  - Who do not have access to a provider in their insurer's network within the local Infant & Toddler Connection system.
- Families that use their insurance as well as accessing the family cost share fee scale are responsible for covering the cost of insurance co-pays and deductibles up to the monthly cap except that the family cost share fee scale may not be used to reduce co-pays and deductibles that are automatically paid to the family or the provider through the family's flexible spending account.
  - As long as the family does not have a flexible spending account that automatically pays the provider or the family, Part C funds may be used to cover the remaining balance of the co-pays and deductibles above the family's monthly cap. Deductibles and co-pays are an obligation between the subscriber and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-pay from the family, and these cannot be waived. Therefore, the full deductible/co-pay (minus the amount the parent pays that month) is the responsibility of Part C.
  - Families with flexible spending accounts that automatically pay the provider or the family must pay the full cost of any co-pays or deductibles until the funds in their flexible spending account have been exhausted.

Example: Family Cost Share When Family has Flexible Spending Account that Automatically Pays the Family or the Provider:

- A family has private insurance and has $1,000 in their health care flexible spending account.
- Based on the family cost share fee scale, the family's monthly cap is $50.
- Their child is receiving Physical Therapy (PT) and Developmental Services.

> This family is responsible for all co-pays and deductibles for the PT services until their flexible spending account is exhausted. In addition, the family will pay up to $50 per month toward the cost of Developmental Services. Once their flexible spending account is exhausted, the family will pay no more than $50 per month to cover all services

- If the family feels the monthly cap calculated on the family cost share fee scale is more than they can afford, they may request to reduce the monthly cap through completion of the Fee Appeal Form. The fee appeal process is detailed later in this section
- In cases where services are anticipated to extend over one year, the family is informed that an annual re-evaluation of their financial circumstances is required.

2. Prior to development of the initial and each annual IFSP, complete the following steps to **determine the family cost share**:
   a. Determine whether the child is covered by Medicaid/FAMIS, TRICARE and/or private health insurance.
      - Request written parent consent on the *Family Cost Share Agreement* form to access Medicaid/FAMIS (if the child is not already enrolled in Medicaid/FAMIS), TRICARE and/or private insurance for reimbursable early intervention supports and services.
        - When there is an increase in service provision (in frequency, length, duration or intensity changes from group to individual) as a result of an IFSP Review, parent consent for continued use of their private insurance or TRICARE to pay for early intervention services is documented in Section IX of the IFSP.
        - If the parent declines continued use of their private insurance or TRICARE as a result of an increase in service provision, then this is documented in Section IX of the IFSP and a new *Family Cost Share Agreement* form must be completed. If a new *Family Cost Share Agreement* form cannot be completed during the IFSP review, then the checkbox and parent signature in Section IX of the IFSP can be used for up to 30 calendar days to stop billing to private insurance or TRICARE while a new *Family Cost Share Agreement* form is being completed and signed.
        - If, at the IFSP Review, the family provides consent to continue services/begin new services but wants more time to consider whether to continue using their private insurance to pay for early intervention services, then services may be provided but the family’s private insurance may not be billed until the family provides consent for continued use of that private insurance.
      - Use the Information Release and Assignment of Benefits page of the *Family Cost Share Agreement* form or an agency release form to document the parent’s consent for disclosing personally

identifiable information to the Department of Medical Assistance Services (DMAS) for children with Medicaid/FAMIS or to private insurance companies or TRICARE for billing and care coordination purposes. If a child is enrolled in CCC-plus, then "Medicaid and "*the name of the MCO*" must be listed as the recipient/sender of the information from/to the local system on the release of information that is signed by the parent. It is not acceptable to list "Medicaid and affiliated MCOs."

b. Determine family size. All related or non-related persons who share income as an economic unit are considered part of a family unit. "Shared income" is income that is pooled or commingled to support the economic unit. "Shared expenses" is not the same as "shared income," and does not define an economic unit.

<u>Examples for Determining Family Size</u>:

- A pregnant woman counts as 2 family members (or more in the case of multiple gestation). A woman's statement that she is pregnant is sufficient, and medical confirmation is not required.
- A college student living away from home but receiving financial support from his family counts as part of the family unit.
- Multiple families who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family unit.
- A child and her mother live with the grandparents. The mother is employed and pays her own expenses. She pays rent to her parents. The child and her mother would be considered a family unit of 2, and only the mother's income would be used to determine the family cost share because payment of rent to grandparents does not constitute pooling of income.
- A child lives with his unmarried father and his father's companion. Both adults are employed. They are both signators on their apartment lease and pay living expenses for food, utilities, etc. out of both incomes. The child, father and the companion would be considered an economic unit of 3 and both adults' incomes would be used in determining the family's cost share.
- A family member who is paying child support for the eligible child is not considered a part of the child's family unit.
- In cases where there is joint custody of the child, the parents must designate which of them is the head of the family (e.g., will the child be considered part of the mother's family unit or the father's family unit). If the head of the family unit is not designated, the parent presenting for services will be considered the head of the family.
- A husband and wife who are separated and are not living together are considered separate units. If a husband and wife are legally separated, but are living together and sharing their income, the two of them become a single economic unit despite their separated status.

When situations arise that do not match exactly with one of those listed above, local systems are encouraged to use the given examples to make their best effort in determining who constitutes the family unit in the specific situation being considered.

c. Determine the family's monthly cap using the family cost share fee scale. Request that the family provide proof of income by presenting (1) a copy or transcript of last year's federal 1040 tax returns; or (2) an estimated taxable income calculated by using the federal 1040 format (i.e., by completing a blank federal 1040 form, either the short form or the long form, from last tax year); or (3) if the family is unable to provide a copy of last year's tax return or estimated taxes in accordance with (1) or (2) above, proof of net monthly income in accordance with steps outlined in the fee appeal process.
   - Taxable income must be taken from the most recent federal 1040 tax return. Taxable income found on the state return may not be used.
   - In situations where family conditions have materially changed since the most recently filed federal 1040 form, the family is required to notify their service coordinator. A revised taxable income will be determined by estimating taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form), or by providing proof of net monthly income in accordance with the steps outlined in the fee appeal process.
   - In situations where families have not retained copies of their most recent tax return, families should take two steps: (1) request a transcript of the most recently completed federal 1040 from the IRS (see note below); and (2) estimate their taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form) for immediate use until the requested information is received. This will prevent a delay in the start of services. NOTE: Families are encouraged to request a transcript from the IRS and not a copy of their most recent tax return. Copies of tax returns cost approximately $23 and can take several weeks to receive. Transcripts are sent at no cost within one to three weeks and can be requested by calling 1-800-829-1040 or accessing a request form (IRS Form 4506T) at www.irs.gov.
   - Completion of the federal 1040 form is the responsibility of the family and under no circumstances is it the responsibility of the individual designated by the local system to implement family cost share practices to assist the family in preparing estimated and/or annual income taxes.
   - If the family's income level is low enough to make the child eligible for Medicaid or FAMIS, there is no family ability to pay and the monthly cap for the family fee is automatically assessed at zero ($0). A family with income below the level that requires completion of federal income tax returns also has a monthly cap of zero ($0) under the family cost share practices. To determine if a family's income is too low to require a tax return, visit www.irs.gov

3. **Complete the *Family Cost Share Agreement* form**. The *Family Cost Share Agreement* form is designed to clearly identify the specific responsibilities of the parent(s), document the choices parents have made regarding the manner in which they will pay for their services (i.e., use of insurance, full EI rate vs.

monthly cap), identify the information used to determine the amount of the monthly cap, and obtain a written agreement from the parent(s) to pay for their early intervention services within their financial ability. Only one *Family Cost Share Agreement* form is needed for each family, regardless of the number of children the family has enrolled in the Infant & Toddler Connection system. If the family wishes to access the family cost share fee scale, then proof of income must be viewed by the individual designated by the local system to implement family cost share practices. Proof of income must be one of the following:

a. A copy of the family's most recent federal 1040 form (only the page showing taxable income); or
b. If the federal 1040 form is grossly misrepresentative of the current financial status (e.g., due to birth of new baby, change in employment or marital status, etc.) or is non-existent, an estimate of their taxable income using a blank federal 1040 form with current financial information filled in; or
c. If no pay stub or income documentation of any kind exists, then a written statement from the employer verifying the net income amount; or
d. If the family's income qualifies them for Medicaid/FAMIS, then documentation of Medicaid/FAMIS eligibility; or
e. If the family states they have no income and no Medicaid/FAMIS and no proof of this is available, then a signed statement by the parent certifying that they have no income.

Visual regard of the income documentation is adequate verification of income, and it is not necessary under federal and state Part C requirements to retain a copy of the document viewed. Signatures on the *Family Cost Share Agreement* form of the parent and the individual reviewing the income documentation confirm that the required income documentation was viewed. Local agency or local system requirements may be different from the state practice that allows visual regard of income and expense documentation. The individual designated to implement the family cost share practices for the local Infant & Toddler Connection system must be aware of and comply with any local requirement to receive and maintain a copy of income and expense documentation. The *Family Cost Share Agreement* form must be maintained in the child's early intervention record or in a separate financial file. If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.

4. **Ensure that re-evaluation of the family's cost share occurs at least annually (at each annual IFSP)** and whenever the family's financial circumstances change. Make sure the family knows to inform their service coordinator of any significant changes in their financial status, including a change in their insurance coverage, income, or family size, throughout enrollment in services unless the family has chosen to pay all applicable co-pays, deductibles and/or the full EI reimbursement rate (if the service is not covered by insurance) for IFSP services.
    a. Once notified by the family of a change in the family's financial circumstances, the service coordinator facilitates completion of a revised *Family Cost Share Agreement* form that reflects the family's new financial circumstances. The revised *Family Cost Share Agreement* form is signed by the family. If there is a new monthly cap, it becomes effective on the date of signature on the *Family Cost Share Agreement* form.

Any delay in signing the *Family Cost Share Agreement* form annually must be handled the same was as a delay in initially signing the form. Under extraordinary circumstances, Part C funds may be utilized to ensure the continued provision of services until the agreement form is signed. In the event of such extraordinary circumstances:

- The family must sign the *Temporary Family Cost Share Agreement Form*, indicating in Section A whether they are opting to delay services until they can provide financial information or to continue/begin services and decide within 30 days about providing financial information. The temporary agreement form explains the family's obligation to provide financial information within 30 days of the date they sign the IFSP and the options available to them at the end of those 30 days. It should also be made clear that the family will be obligated to pay, in accordance with the terms of the agreement form that is signed no later than 30 days after the IFSP, for any services (other than those that must be available at no cost) delivered prior to the agreement form being signed.
    - If the family opts to delay services and those services have not yet started, this would be a family reason for a delay in start of services.
    - Part C funds must be reimbursed once the monthly cap is established and payment is received.
    - If the family has private insurance or TRICARE and wants to use that insurance to pay for early intervention services, then the family must complete a *Family Cost Share Agreement* form in addition to the *Temporary Family Cost Share Agreement* form. The Family Cost Share Agreement form will document the parent's consent to use their private insurance or TRICARE and the "Charges" section of that Agreement form must reference the fact that a *Temporary Family Cost Share Agreement* form is in effect.
- Section B of the temporary agreement form must be completed no later than 30 days from the date the parent signed the annual IFSP to document the family's decision about completing the *Family Cost Share Agreement* form and continuing/starting services. Section B gives the family three options:
    - Complete the *Family Cost Share Agreement* form and begin services, in which case a completed *Family Cost Share Agreement* form may be used to document the family's choice rather than completing Section B of the temporary agreement form;
    - Delay further services (other than those available at no cost) until they can provide income information; or
    - Decline further services.

Fee Appeal Process:

1. The intent of the fee appeal process is to provide families with the opportunity for individual consideration of financial circumstances including documentation of extraordinary expenses, such as medical or other expenses related to the child's disability, and to appeal for additional reduction of the monthly cap. The fee appeal process is also used when the family is unable to provide a copy of last year's tax return or estimated taxes as described in the section on determining the family cost share.
2. There should be no duplication of processes between the family cost share fee scale and the fee appeal process. If a family expresses financial hardship after the monthly cap is established using the family cost share fee scale and accesses the fee appeal process, the monthly cap established through the fee appeal process is the final determination of the family's monthly cap.
3. The following steps are used consistently with all families who access the fee appeal process:
    a. Families are informed of all factors considered in the fee appeal process, including, but not limited to, the following:
        - The basis for the fee appeal is disposable income derived from taxable income or net monthly income less actual expenses;
        - For items on the fee appeal form specifying a fixed average allowable amount (i.e., food, gasoline, clothing), no proof of expenses is needed unless the family's actual expenses exceed the average allowable amount. ~~The fee appeal process specifies the following average allowable amounts:~~
            - ~~Auto insurance - $75 per month per family~~
            - ~~Utilities - $310 per month~~
            - ~~Food - $200 per person per month*~~
            - ~~Telephone - $70 per month~~
            - ~~Internet - $20 per month~~
            - ~~Cable - $65 per month~~
            - ~~Gasoline - $100 per adult per month~~
            - ~~Clothing - $35 per person per month~~

          The average allowable amounts may be exceeded only if the family provides documentation. The family is required to provide documentation of expenses for all items on the fee appeal form where an average allowable amount is not specified. Visual regard of the expense documentation is adequate unless the local agency or local system does not allow this practice.
          (* This average amount includes the cost of groceries as well as the cost of eating some meals at restaurants.)
        - The amount allowed for **recreation/entertainment** is limited to $25 per person per month and may not exceed that amount. This is an automatic deduction of $25 per person.
        - **Credit card payments** may be deducted for families carrying a credit card balance. Use the current minimum monthly payment amount or the documented monthly payment negotiated with the creditor, through a debt counseling service or court-ordered. This monthly amount does not need to be updated more than annually

unless there is a significant change, which substantially impacts the family's ability to pay.

- Child support payments should be included under **Other Debt Payment**. However, if taxable income is being used on the Fee Appeal form, be certain that child support has not already been deducted on the individual's tax form.
- **Educational expenses** include tuition, books, room and board and may be for any member of the family. Costs for programs like Gymboree classes or recreational programs may not be included as educational expenses.
- **Expenses to maintain the home in a livable condition** include expenses associated with adaptations necessary to make the home accessible and safe for a family member with a disability or to make repairs as a result of a natural disaster, fire or similar damage. Costs associated with a lawn service, weekly housecleaning service or remodeling for a purpose other than maintaining the home in a livable condition (e.g., cosmetic improvements) are not allowed.
- The category of **job-related necessities** includes expenses incurred when the wage earner must purchase job necessities that the employer does not furnish or reimburse, such as tools, equipment, materials or uniforms.
- The following are not allowed as family monthly expenses on the fee appeal form: tithing; contributions to retirement or education savings accounts.

<u>Frequently Asked Questions About Allowable Expenses for Fee Appeal</u>:

1. For the elder care deduction, do the parents need to be declared as a dependent on their income tax return to get this deduction? **No**
2. If families have second homes or vacation homes, are they an allowable deduction? **Yes**
3. For car repair bills under transportation deductions, are these outstanding bills or does this line item account for past repairs? **Outstanding bills**
4. For medical expenses, do you take into account bills they've already paid and if so how far back or do you just allow routine monthly expense (i.e. doctor visits and prescriptions)? **Take into account expenses from the past 12 months; divide that number by 12 to get a monthly amount to enter on appeal form**
5. The credit card payments category is only used if they carry a balance, right? **A deduction can only be taken if the family carries a credit card balance and not if they pay their bill in full each month.**
6. What if a family is doing unreimbursed medical/child care pretaxed? **If the family has set aside pre-tax dollars in a flexible spending account for medical or child care expenses, then expenses paid with these pre-tax dollars cannot be deducted on the fee appeal form since these dollars have already been deducted in determining the taxable income or net monthly income figure**. **For example, if the family put $1,000 into a medical flexible spending account this year and had $1,000 in medical expenses (all of which were paid through the flexible spending account), then the amount the family can deduct for medical expenses on the Fee Appeal Form is $0.**

b. The monthly cap is calculated by first subtracting expenses from taxable income (or net monthly income) and then taking 5% of that total. For example, if taxable income minus expenses equals $100, then the monthly cap is 5% of $100, which is $5. Five percent (5%) of the disposable income is the amount determined as the monthly cap.

c. The *Fee Appeal Form* is completed and signed, and the family must provide documentation of their expenses as required by the *Fee Appeal Form*.
   - If using taxable income, the family will have already provided documentation of their taxable income in order to complete the *Family Cost Share Agreement* form. No further documentation of income is required. Divide the family's taxable income by 12 and enter that amount on the "Monthly Family Income" line at the top of the *Fee Appeal Form*.
   - If using net monthly income, then enter this amount (based on pay stubs or written statement certifying income) on the "Monthly Family Income" line at the top of the *Fee Appeal Form.*
   - In situations where the family's taxable or net monthly income puts them at $0 on the family cost share fee scale, no documentation of expenses is required (because the family would already be at $0 and showing further expenses would have no effect on the monthly cap amount).

d. Information on the monthly cap resulting from the fee appeal process is transferred to the *Family Cost Share Agreement* form.

4. A family's inability to pay is different from a family's unwillingness to pay. If a family has been given access to the family cost share fee scale and fee appeal process but is unwilling to pay for services that have been delivered, then providers may proceed with their own agency's process for collecting delinquent accounts.
5. If the family refuses to pay the fee determined through the fee appeal process, then the local system manager and service coordinator are notified. The service coordinator notifies all other service providers and provides a *Parental Prior Notice* form to the family indicating that all services, other than those that must be provided at no cost (e.g., service coordination, assessment, IFSP review) will not start or will end due to parent refusal to pay. The family must receive a copy and explanation of the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures.
6. Parents have the right to access the administrative complaint, mediation and/or due process procedures if they disagree with assigned fees or other decisions related to family cost share.

Billing Procedures

General:

1. In order to be reimbursed, services must be provided in accordance with the IFSP. The frequency and length for a service cannot exceed that listed on the IFSP over a one month period unless the provider is making up missed sessions from another month or there is documentation of other unusual circumstances that clearly justify the one-time variance.
2. With the exception of physicians, audiologists and registered dietitians, only certified early intervention providers and agencies who employ certified early intervention providers can bill for early intervention services.
3. Billing for early intervention services occurs at the local level. Each provider must have a mechanism to bill for services, either by:
    a. Being employed by or contracted with an agency (including a local lead agency) that does the billing or contracts out the billing function; or
    b. Doing their own billing.
3. Providers must have a National Provider Identifier, NPI, or Atypical Provider Identifier, API, for billing (group number if employed by an agency that is doing the billing, or an individual number if an independent practitioner). The National Provider Identifier is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, a unique identification number for covered health care providers. An Atypical Provider is an individual or business that bills DMAS for services rendered but does not meet the definition of a healthcare provider according to the NPI Final Rule 45CFR 160.103.

Medicaid/FAMIS:

Medicaid Early Intervention Services Program

1. Under the Medicaid Early Intervention Services Program, providers bill DMAS (for children with Medicaid or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the codes listed in the Medicaid Early Intervention Services Program Reimbursement Information table at the end of this chapter.
    a. Children enrolled in FAMIS Select are not eligible for the Medicaid Early Intervention Services Program. These children have private insurance coverage and their co-pays and deductibles will be covered by Part C (since eligibility for FAMIS Select will put the family at $0 on the family cost share fee scale).
2. Medically necessary audiology, nutrition, medical services and assistive technology devices are reimbursed by Medicaid outside of the Medicaid Early Intervention Services Program and require different codes.
3. In order to be reimbursed by Medicaid for early intervention services:
    a. Providers must be EI Certified;
    b. Providers must enroll with the Department of Medical Assistance Services (DMAS) as an early intervention provider, even if already enrolled as a rehab provider. Follow the instructions on the DMAS Web Portal (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) to enroll as an early intervention provider;
    c. All Early Intervention service providers participating in the Virginia Medicaid Medical Assistance Services Program and Managed Care Organizations (MCOs) must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of early intervention services, as well as both of

the Early Intervention Practice Manuals (DMAS and Infant & Toddler Connection of Virginia).

d. Services must be provided to children who are determined eligible for early intervention are receiving early intervention services, which may include an assessment for service planning, through the Infant & Toddler Connection system. Please see "Initial Data Entry for Enrollment in Medicaid EI Benefit" and "Maintaining Enrollment in Medicaid EI Benefit" text boxes on the next two pages for specific information on the ITOTS information required for children who are eligible for early intervention and who have Medicaid/FAMIS); and

e. Services must be covered services identified on an IFSP signed by the parent and, with the exception of assessments and IFSP meetings, approved by a physician, physician's assistant or nurse practitioner (for specific requirements associated with physician signature, please see the "Completing the IFSP Form" section of Chapter 7).

For additional information about early intervention services through the Medicaid Early Intervention Services Program, visit the DMAS Web Portal (see link above), click on the link to provider manuals, and then select Medicaid Early Intervention Services.

4. No service that is planned solely for the parent is reimbursable by Medicaid. However, if the child falls asleep during an intervention session, it is okay to provide teaching/coaching to the caregiver and to bill for this service. This situation should be infrequent and well-documented; and the length of the session will generally be shorter than planned since the provider and caregiver are not able to practice the strategies with the child. In addition, Medicaid reimbursement is available for providers participating in IFSP meetings even if the child is not present.
5. Rounding the minutes of service provided up or down is allowed in accordance with the 8-minute rule when billing DMAS for the service. This rule is used for rounding up when eight (8) minutes or more of service are rendered and rounding down when seven (7) minutes or less are rendered.

| **Units - Number of Minutes** |
| --- |
| 1 unit: ≥ 8 minutes *through 22 minutes* |
| 2 units: ≥ 23 minutes *through 37 minutes* |
| 3 units: ≥ 38 minutes t*hrough* 52 minutes |
| 4 units: ≥ 53 minutes t*hrough* 67 minutes |
| 5 units: ≥ 68 minutes t*hrough* 82 minutes |
| 6 units: ≥ 83 minutes t*hrough* 97 minutes |

The ability to round minutes up or down for billing does not change the requirement to deliver services in accordance with the length listed on the IFSP.

6. Providers also may bill for a range of dates within a month.
7. For children with Medicaid/FAMIS and commercial insurance coverage, providers must bill the commercial insurance first except in the following circumstances:
   a. If a family has declined access to their private health/medical insurance for covered early intervention services, then the following steps may be taken to secure Medicaid reimbursement without billing the commercial insurance first:

- Check "yes" for box 11-D on the CMS 1500 form; and
- Complete and sign a *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form and attach it to the claim form.

b. Edits (requirements to submit proof of billing commercial insurance if the client has Medicaid/FAMIS as secondary) have been removed for the following billing codes: T1023 and T1023 UI; T1024 and T1024 U1; T1027 and T1027 U1; T1015 and T1015 U1; and T2022. This means providers do not have to go through the additional paperwork step of providing an explanation for why commercial insurance is not being billed or is not paying for developmental services, assessments or early intervention targeted case management/service coordination.

Medicaid Early Intervention Targeted Case Management (EI TCM)

1. EI TCM providers bill DMAS (for children with Medicaid fee for service, MCO or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the billing code T2022.
2. In order to be reimbursed monthly by Medicaid for service coordination:
   a. The service coordinator must be certified as an Early Intervention Case Manager;
   b. The agency providing service coordination must be enrolled with the Department of Medical Assistance Services (DMAS) as an early intervention provider with specialty type 119. Follow the instructions on the DMAS Web Portal (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) to enroll. The Local Lead Agency determines which agency(ies) within the local system will provide and bill for early intervention service coordination;
   c. Service coordination must be delivered in accordance with a signed Initial Early Intervention Service Coordination Plan or a signed Individualized Family Service Plan (IFSP);
      - In order to bill DMAS for service coordination starting at intake, an Initial Early Intervention Service Coordination Plan must be completed, signed and dated at Intake.
      - The Initial Early Intervention Service Coordination Plan ends when the child is found ineligible for early intervention, the IFSP is signed, or 90 calendar days from the date of intake, whichever comes first, with billing not to exceed three calendar months.
      - The month in which a child is determined to be ineligible or no longer eligible is the last month that service coordination can be billed.
   d. During the month being billed, at least one of the allowable activities listed in the text box on the next page must be provided by the service coordinator with the child, the family, service providers, or other organizations on behalf of the child/family. The contact must be relevant to the child/family needs and the Initial Early Intervention Service Coordination Plan or Individualized Family Service Plan (IFSP). The service may not duplicate any other Medicaid service. The documentation must include the length of time documented in minutes for conducting the allowable activity (either as the total time spent or by recording the start time and end time for the activity);

e. The contact or communication and the length of time in minutes for conducting the contact must be documented completely and correctly, as outlined in the contact note requirements in Chapter 9;
f. At a minimum, a phone, email, text, or a face-to-face contact with the family must occur every three calendar months, or there must be documented attempts of such contacts. Three-calendar months does not mean every 90 days, nor does it mean quarterly. The contacts must begin no later than the next month after the month that the initial IFSP is signed, and the 3-calendar-month period restarts after each contact (i.e., if the service coordinator contacts the family on October 7 and November 10, then the next contact must be made no later than the last day of February).
    - The family's preferred method of contact must be documented. This can be documented in a contact note for the intake visit and any time the family's preference changes. (see Chapter 9 for more information about documentation requirements).
    - The following requirements must be met in order to offer and use texting as the preferred method of contact:
        - The service coordinator may only offer texting as an option if she has the capability to receive and send texts.
        - Texting may only be used if the family selects texting as their preferred method of contact and signs the *Permission for Texting* form, which notifies the family that there may be some level of risk that the information in the text may be read by a third party. The *Permission for Texting* form must be kept in the child's Early Intervention Record.
        - The communication that occurs via texting must constitute service coordination. Sending a text to the family to ask how things are going and getting a reply of "Fine" is not service coordination. That is true for contacts via email, phone, or in person as well. The job of service coordination does not change based on the preferred method of contact. For that reason, contact notes must substantiate that the communication between the service coordinator and the family is substantive and does constitute actual service coordination.
        - The service coordinator must either print out and attach a copy of the texts to the contact note or include in the note a thorough summary of the communication.
        - If, at any point, it becomes clear that texting is not a viable method of communication with a particular family, then the service coordinator needs to work with the family to identify a different method of contact.
    - The provider may not bill for a month in which the only activity was attempted contacts with the family, but these attempted contacts within the three calendar month period will prevent the provider from losing all billing during the three calendar month period (e.g., they could bill for another month in that

period during which an allowable activity was completed even though their attempts to make the required contact with the family by phone, email, text or face-to-face every three calendar months were unsuccessful);

g. There must be documented face-to-face interaction between the service coordinator and the family at the development of the initial IFSP and the annual IFSP along with documentation that the service coordinator observed the child during the calendar month that the IFSP meeting was held; and
h. The health status indicator questions must be submitted to the child's physician every six months or an alternate local mechanism (e.g., request and review of well-child records) used to collect the answers to these questions.
i. EI TCM may not be billed for any month in which the child was hospitalized for the entire month. However, EI TCM can be billed if service coordination/case management activities occur when the child is not hospitalized for the entire month and the allowable service coordination/case management activities occur before or after the hospitalization.

3. When a child transitions from one local system to another and both systems provide service coordination during that month, only one of the local systems can bill for EI TCM. If the child is transferred on or before the 15th of the month the receiving local system would bill. If the is child transferred from the 16th of the month to the end of the month, the sending local system would bill.
4. Early Intervention (EI) enrollees must receive EI targeted case management. Since DMAS allows only one case management program to be billed during the same time period, DMAS cannot be billed for ID or MH TCM for EI enrollees.
   a. DMAS does allow an exception for BabyCare case management to be billed simultaneously along with EI targeted case management during the same time period.
   b. Because case management is built into the reimbursement for therapeutic foster care, EI and Therapeutic Foster Care (TFC) case management cannot be billed to DMAS for the same service month. If an EI enrollee is receiving TFC, the EI case manager should review the child's needs and services with the TFC case manager to determine if the child's services are better monitored and coordinated by the EI case manager or the TFC case manager. The two case managers are responsible to make the determination of which TCM is better suited for the child's particular needs and services. If it is determined that Therapeutic Foster Care will be billed, then Part C funds may be used as payor of last resort to cover the costs of Part C service coordination.

EI TCM Allowable Activities for Billing Medicaid

Allowable activities include but are not limited to the following:

1. Coordinating the initial Intake and Assessment of the child and planning services and supports, to include history-taking, gathering information from other sources, and the development of an Individualized Family Service Plan, including initial IFSP, periodic IFSP reviews, and annual IFSPs. This does not include performing medical assessments, but may include referral for such assessment;
2. Coordinating services and supports planning with other agencies and providers;
3. Assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Enhancing community integration through increasing the child and family's community access and involvement;
5. Making collateral contacts to promote implementation of the Individualized Family Service Plan and allow the child/family to participate in activities in the community. A collateral contact is defined as "Contact with the child's significant others to promote implementation of the service plan and community participation, including family, non-family, health care entities and others related to the implementation and coordination of services;"
6. Monitoring implementation of the Individualized Family Service Plan through regular contacts with service providers, as well as periodic early intervention visits;
7. Providing instruction and counseling that guide the family in problem-solving and decision-making and developing a supportive relationship that promotes implementation of the Individualized Family Service Plan. Counseling in this context is defined as problem-solving activities designed to enhance a child's ability to participate in the everyday routines and activities of the family within natural environments where children live, learn, and play;
8. Submitting to the client's physician (semi annually) the health status indicator questions or using an alternate local mechanism to collect the information necessary to answer these questions. Based upon the results of the questionnaire from the physician, following-up with the family/caregiver to inform and/or assist in obtaining needed medical services;
9. Coordinating the child/family's transition from Part C early intervention services; and
10. Making contacts (face-to-face, phone, email, text) with the family (see #2f in the section directly above for minimum requirements).

For all children with Medicaid/FAMIS

1. The local system manager (or designee) must provide oversight to ensure Medicaid/FAMIS information is correctly entered into ITOTS within the required timeframes in order to begin and maintain enrollment in the Medicaid EI benefit. The following text boxes and the one titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification" in the Family Cost Share section of this chapter provide further information.

Initial Data Entry for Enrollment in Medicaid EI Benefit:

In order for providers to receive Medicaid reimbursement for Part C early intervention services the following ITOTS data fields must be completed promptly and accurately:

- Medicaid/FAMIS must be selected in the Third Party Coverage section of ITOTS;
- An accurate 12-digit Medicaid number must be entered in the ID field next to Medicaid. The 12-digit number is used by the State Lead Agency to locate the child's record in the Department of Medical Assistance Services (DMAS) database, VaMMIS.
- The Intake Visit Date must be recorded in ITOTS.
- Entering the child's social security number can facilitate locating the child's record in VaMMIS.

**Child has Medicaid/FAMIS when the Child is Referred to the Infant & Toddler Connection**

- ITOTS data entry must be completed (Medicaid/FAMIS selected, 12-digit Medicaid number and Intake Visit Date entered) within 10 business days of the Intake Visit Date in order to bill for Initial Early Intervention Service Coordination. (An Initial Early Intervention Service Coordination Plan also must be in place in order to bill for this service).
- If any of the required information is entered in ITOTS more than 10 business days after the Intake Visit Date, then the date the required information is entered in ITOTS will be the start date for the Medicaid Early Intervention benefit.

**Child Enrolled in Medicaid/FAMIS after the Child is referred to the Infant & Toddler Connection system**

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in ITOTS within 60 calendar days of the Medicaid Disposition Date (the date the decision was made that the child was eligible for Medicaid or FAMIS) and if the child has an Initial Early Intervention Service Coordination Plan in place, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Intake Visit Date. If the Medicaid/FAMIS start date precedes the Intake Visit Date, then the Intake Visit Date will be the start date for the Medicaid EI benefit.
- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 60 calendar days after the Medicaid Disposition Date, then the date the required information was entered in ITOTS will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the time period that is not covered.

NOTE: Medicaid reimbursement is available only for service coordination (Early Intervention Targeted Case Management) until it is determined that the child is eligible for early intervention.

Maintaining Enrollment in Medicaid EI Benefit:

**Child's Medicaid Early Intervention Benefit is "Dropped" in the Medicaid VaMMIS System:**

- Occasionally, a child's EI benefit in the Medicaid MMIS system may be dropped, which can occur when the child has changes in their Medicaid/FAMIS benefits. If this happens, the local system must notify the Infant & Toddler Connection of Virginia Office within 60 calendars of the date the Medicaid EI benefit dropped (the date the EI benefit was ended by the VaMMIS system) in order for the EI benefit to be added back to the Medicaid VaMMIS system starting the next day from when the benefit had ended.

**Child Loses Medicaid/FAMIS Coverage, Then Coverage is Restored:**

- The local system must notify the Infant & Toddler Connection of Virginia Office within 60 calendar days of the Disposition Date (date the decision was made to restore Medicaid/FAMIS). When the local system meets this timeline, the date the Medicaid/FAMIS is restored will be the start date for restoration of the Medicaid EI benefit. Please note that local systems should delete the Medicaid/FAMIS information from ITOTS when they become aware that the child's coverage has ended. Re-entering the Medicaid information in ITOTS flags the Infant & Toddler Connection of Virginia Office staff to add back the benefit. (If the Medicaid/FAMIS information had not been deleted from ITOTS, then the local system must notify the Infant & Toddler Connection of Virginia Office via email or fax to request that the EI benefit be added back).
- If the local system notifies the Infant & Toddler Connection of Virginia Office (through email or by entering the Medicaid/FAMIS information in ITOTS) more than 60 calendar days after the Medicaid Disposition Date, then the date the local system notifies the Infant & Toddler Connection of Virginia Office will be the start date for the Medicaid EI benefit and reimbursement will not be available through Medicaid or Part C for the time period that is not covered.
- If the child lost Medicaid/FAMIS coverage and the Medicaid/FAMIS information was deleted from ITOTS, the local system must re-enter the Medicaid/FAMIS information in ITOTS within 60 calendar days of the Medicaid Disposition Date.

**Child is Transferred from One Local System to Another Local System in Virginia:**

- The "sending" local system must complete the discharge data entry, including transferring the record to the new ("receiving") local system prior to the date that the child will be starting services within the new local system.
- When a child transfers from one local system to another, the start date for the Medicaid EI benefit under the new, "receiving" local system must be after the discharge date from the original, "sending" local system.
- There must not be two open records in ITOTS for the same child.

If the local system is responsible for Medicaid/FAMIS not being available to reimburse for services (through failure to enter child information in ITOTS on time or to notify the Infant & Toddler Connection of Virginia Office if a child has lost Medicaid/FAMIS and then regained it or to request on time that the Infant & Toddler Connection of Virginia Office add the Medicaid EI benefit), the funds that can be used to pay for services are local funds or revenue from private insurance, Medicaid/FAMIS, other third party payors, or family fees. If funds from these sources are not adequate to pay for the service(s), then the local system manager must contact his/her Infant & Toddler Connection of Virginia Technical Assistance Consultant.

Private Insurance and TRICARE

1. Providers bill third party payors according to the requirements (including billing codes and forms) of the particular payor.
2. Virginia has enacted third party payor regulations that mandate coverage for early intervention services. Insurance companies that are domiciled in Virginia and that are part of the fully insured market must include coverage for physical therapy, occupational therapy, speech-language therapy and assistive technology for infants and toddlers enrolled in the Infant & Toddler Connection of Virginia.
    a. The benefit is capped at $5,000 per year.
    b. The mandate specifies that money paid through this benefit cannot be applied to the insured's lifetime maximum benefit.
    c. Organizations who contract with insurance companies to manage their employee health benefits, but who "self-fund" the benefit are exempt from the mandate.
    d. A similar mandate is included for insurance for state employees.

   Insurance companies based outside of Virginia (even if operating and covering services provided in Virginia) as well as self-insured policies are not covered by the early intervention insurance mandate. For more information on these insurance mandates click on http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3418.5 and http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-2818.
3. Private insurance plans may not be billed for services where no consumer liability can be established (i.e., where services must be provided at no cost to the family).
4. TRICARE is the uniformed services health care program for active duty service members and their families, retired service members and their families, members of the National Guard/Reserve and their families, survivors and other eligible beneficiaries. TRICARE is a public third party payor. As such, TRICARE can be billed for assessments conducted under Part C (whereas, private insurance cannot). To learn more about TRICARE, including information about the managed care support contractor for TRICARE North Region, which includes Virginia, click on www.tricare.mil.
5. Since private insurance companies typically do not reimburse for the increased costs incurred when services are provided in natural environments, Part C funds are used to bring the reimbursement to the provider up to the standard early intervention rate or up to the rate charged by the provider, whichever is less.

Part C Funds

1. In order to receive Part C reimbursement as the payor of last resort (e.g., for services not covered by third party payors or to bring provider reimbursement up to the standard rate), providers must have a contractual relationship with the local Infant & Toddler Connection system.
2. Providers are required to submit a contact log or contact notes to the local lead agency no later than the 21st of each month for the previous month for all services provided, including any service for which reimbursement is sought from Part C funds.
    a. Local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.
    b. When submitting a contact log, the log must include the type of service delivered (e.g., physical therapy, developmental services, OT, etc.), date(s) of service delivery, amount of time service was provided on each date, and signature of the provider or an authorized individual from the provider's agency.
    c. When insurance reimbursement is pending for a service, include that service on the log for the month in which the service was delivered and mark it "insurance pending." Once the insurance company has acted, if Part C funds are being requested, then submit that service again on a later log for payment by Part C.
3. Part C funds cannot be used to reimburse a provider for a Medicaid billable service when the child has Medicaid/FAMIS, except when necessary to prevent a delay in the timely start of services. Once Medicaid funds are received they must be used to reimburse the local system for the Part C funds originally paid. For example, suppose a family is in the process of applying for Medicaid/FAMIS when an early intervention service begins on March 16. The child's Medicaid/FAMIS eligibility is established on April 1 and coverage is backdated to March 1. If Part C funds were used to pay the provider for the service delivered on March 16, then DMAS must be billed for that service and the local system must be reimbursed for the Part C funds originally used to pay for that service.
4. Sample billing and reimbursement scenarios are provided on the next page to illustrate use of Part C funds as payor of last resort when the family allows their private insurance to be billed for early intervention services.

Purchase of Assistive Technology Devices

1. Public procurement policies must be followed when using public funds to pay for all or part of an assistive technology device.
2. If purchased with the family's health insurance (public or private), the equipment belongs to the family and they may keep it when they leave the Infant & Toddler Connection of Virginia system.
3. If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at $5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:
    a. The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or a trial basis.
    b. If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may

receive the assistive technology device and utilize it as long as the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.

   c. If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.

4. Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.
5. The Local Lead Agency must maintain a comprehensive, up-to-date inventory of all assistive technology devices purchased with federal or state Part C funds paying more than 50% of the cost and valued at $5,000 or more. This inventory will cite the device, appropriate serial numbers, location of the device, and anticipated disposition of the device including timeline.
6. Please see the text box titled “When considering the purchase of an Assistive Technology Device” in “The Initial IFSP Meeting” section of Chapter 7 for information about what is considered an assistive technology device under Part C.

Sample Billing/Reimbursement Scenarios:

| Family Cost Share Agreement Form Says: | Charges and Reimbursement |
|---|---|
| 1. Private insurance (w/permission to bill)<br>Full fee | Provider Charge: $180<br>Insurance Co-Pay: $20<br>Insurance Deductible: $500<br>Insurance Allows: $95<br>Amount applied to deductible: $0<br><br>Part C Standard Rate: $150<br>Insurance Pays: $75<br>Family Pays: $20<br>Part C Pays: $55 |
| 2. Private insurance (w/permission to bill)<br>Fee Cap = $0 | Provider Charge: $180<br>Insurance Co-Pay: $25<br>Insurance Deductible: $1,000<br>Insurance Allows: $90<br>Amount applied to deductible: $0<br><br>Part C Standard Rate: $150<br>Insurance Pays: $65<br>Family Pays: $0<br>Part C Pays: $85 |
| 3. Private insurance (w/permission to bill)<br>Family has PPO allowing balance billing<br>Fee Cap = $0 | Provider Charge: $180<br>Insurance Co-Pay: $0<br>Insurance Deductible: $1,000<br>Insurance Allows: $80.50<br>Amount applied to deductible: $80.50<br><br>Part C Standard Rate: $150<br>Insurance Pays: $0<br>Family Pays: $0<br>Part C Pays: $150 |
| 4. Private insurance (w/permission to bill)<br>Fee Cap = $0 | Provider Charge: $180<br>Insurance Co-Pay: $25<br>Insurance Deductible: $1,000<br>Insurance Allows: $180<br>Amount applied to deductible: $180<br>(co-pay amount included in deductible)<br><br>Part C Standard Rate: $150<br>Insurance Pays: $0<br>Family Pays: $0<br>Part C Pays: $180* |

* Deductibles and co-payments cannot be bound by the contract rate that the Infant & Toddler Connection system has with a private agency for direct services that are not covered by insurance since the insurance reimbursement rates and co-payment and deductible amounts are determined and set by the insurer. Deductibles and co-payments are an obligation between the subscriber (family) and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-payment from the family. These cannot be waived. Therefore, the full deductible and co-payment (minus the amount the parent pays that month) is the responsibility of Part C.

# Reimbursement Sources and Medicaid EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage

| Step | | | Medicaid EI TCM | Medicaid EI | Medicaid EI Codes | Other Medicaid | Other Funds* | Part C – POLR |
|---|---|---|---|---|---|---|---|---|
| **Referral Steps** | | | | | | | X | X |
| **Intake** | | | X | | T2022 | | X** | X** |
| **Developmental Screening** | | | X | | T2022 | | X** | X** |
| **Hearing and Vision Screening** | | | X | | T2022 | | X** | X** |
| **Eligibility Determination** | **SC** | | X | | T2022 | | X** | X** |
| | **EIP** | | | | | | X | X |
| **Assessment for Eligibility** | **SC** | | X | | T2022 | | X** | X** |
| | **EIP– Combined w/ASP and Child found eligible** | **PT, OT, SLP, N** | | X | T1023 U1 | | | |
| | | **Other EIP** | | X | T1023 | | | |
| | **EIP – Separate from ASP or Child found not eligible** | | | | | | X | X |
| **Assessment for Service Planning** | **SC** | | X | | T2022 | | X** | X** |
| | **EIP** | **PT, OT, SLP, N** | | X | T1023 U1 | | | |
| | | **Other EIP** | | X | T1023 | | | |
| **Initial and Annual IFSP Meeting** | **SC** | | X | | T2022 | | X** | X** |
| | **PT, PTA, OT, OTA, SLP, N** | | | X | T1023 U1 | | | |
| | **Other EIP and EIS** | | | X | T1023 | | | |
| **Provide Individual EI Services in Natural Environments** | **PT, PTA, OT, OTA, SLP, N** | | | X | G0151 U1<br>G0152 U1<br>G0153 U1<br>GO495 U1- | | | |
| | **Other EIP** | | | X | T1027 U1 | | | |
| | **Other Disc: AUD, Diet., etc.** | | | | | X | X | X |
| | **EIA, Nurse Aide** | | | X | T1027 &<br>T1027 U1 | | | |
| **Provide Group (Congregate) EI Services in Natural Environments** | **PT, PTA, OT, OTA, SLP, N** | | | X | G0151,G0152, G0153, G0495 | | | |
| | **Other EIP** | | | X | T1027 | | | |
| | **Other Disc: AUD, Diet., etc.** | | | | | X | X | X |
| | **EIA, Nurse Aide** | | | X | T1027 | | | |
| **Provide Individual EI Services in Center Setting** | **PT, PTA, OT, OTA, SLP, N** | | | X | T1026 U1 | | | |
| | **Other EIP** | | | X | T1015 U1 | | | |
| | **Other Disc: AUD, Diet., etc.** | | | | | X | X | X |
| | **EIA, Nurse Aide** | | | X | T1015 U1 | | | |
| **Provide Group (Congregate) EI Services in Center Setting** | **PT, PTA, OT, OTA, SLP, N** | | | X | T1026 | | | |
| | **Other EIP** | | | X | T1015 | | | |
| | **Other Disc: AUD, Diet., etc.** | | | | | X | X | X |
| | **EIA, Nurse Aide** | | | X | T1015 | | | |
| **IFSP Review Meeting: Family present** | **PT, PTA, OT, OTA, SLP, N** | | | X | T1024 U1 | | | |
| | **Other EIP and EIS** | | | X | T1024 | | | |

| Step | | Medicaid EI TCM | Medicaid EI | Medicaid EI Codes | Other Medicaid | Other Funds* | Part C – POLR |
|---|---|---|---|---|---|---|---|
| **Consultation: without child/family** | **EIP and EIS** | | | | | X | X |

**PLEASE NOTE that Federal Regulations and Virginia Policies and Procedures require that ….*no services that a child is entitled to receive are delayed or denied because of disputes between agencies regarding financial or other responsibilities.***

**Key:**

| | |
|---|---|
| * | State and local non-Part C funds, grants, donations, etc. |
| ** | For children receiving therapeutic foster care |
| **POLR** | Payor of Last Resort |
| **AUD** | Audiologist |
| **Diet** | Dietitian |
| **ECE** | Early Childhood Educator |
| **EIP** | Early Intervention Professional (PT, OT, ECSE, etc.) |
| **EIS** | Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide) |
| **Other EIP** | Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners |
| **SC** | Service Coordinators |
| **TCM** | Targeted Case Management |

NOTE: Other EIP are early intervention professionals who fall in Medicaid's Category 2 classification

# Reimbursement Sources for Components of the Early Intervention Process for Children with Tricare, Private Insurance or No Third Party Payor Source

| Step | Provider | TRICARE | Private Insurance | Other Funds* | Part C - POLR |
|---|---|---|---|---|---|
| Referral Steps | | | | X | X |
| Intake | | | | X | X |
| Developmental Screening | | | | X | X |
| Hearing and Vision Screening | | | | X | X |
| Eligibility Determination | SC | | | X | X |
| | EIP | | | X | X |
| Assessment for Eligibility | SC | | | X | X |
| | EIP– Child found eligible: PT, OT, SLP, N | X | | X | X |
| | EIP– Child found eligible: Other EIP | | | X | X |
| | EIP – Child found not eligible | X | | X | X |
| Assessment for Service Planning | SC | | | X | X |
| | EIP: PT, OT, SLP, N | X | | X | X |
| | EIP: Other EIP | | | X | X |
| Initial and Annual IFSP Meeting | SC | | | X | X |
| | PT, PTA, OT, OTA, SLP, N | | | X | X |
| | Other EIP and EIS | | | X | X |
| Provide Individual EI Services in Natural Environments | PT, PTA, OT, OTA, SLP, N | X | X | X | X |
| | Other EIP | | | X | X |
| | Other Disc: AUD, Diet., etc. | X** | X** | X | X |
| | EIA, Nurse Aide | | | X | X |
| Provide Group EI Services in Natural Environments | PT, PTA, OT, OTA, SLP, N | X | X | X | X |
| | Other EIP | | | X | X |
| | EIA, Nurse Aide | | | X | X |
| Provide Individual EI Services Center | PT, PTA, OT, OTA, SLP, N | X | X | X | X |
| | Other EIP | | | X | X |
| | Other Disc: AUD, Diet., etc. | X** | X** | X | X |
| | EIA, Nurse Aide | | | X | X |
| Provide Group EI Services in Center Setting | PT, PTA, OT, OTA, SLP, N | X | X | X | X |
| | Other EIP | | | X | X |
| | EIA, Nurse Aide | | | X | X |
| IFSP Review Meeting: Family present | PT, PTA, OT, OTA, SLP, N | | | X | X |
| | Other EIP and EIS | | | X | X |
| Consultation: without child/family | EIP and EIS | | | X | X |

**Key:** * State and local non-Part C funds, grants, donations, etc.
** **Reimbursement depends on the child's third party payor policy**

**POLR** Payor of Last Resort **AUD** Audiologist **Diet** Dietitian **SC** Service Coordinators
**ECE** Early Childhood Educator **EIP** Early Intervention Professional (PT, OT, ECSE, etc.)
**EIS** Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide)
**Other EIP:** Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners

# *Medicaid Early Intervention Services Program*
# **Reimbursement Information**

| Code | Rate | Who bills | When is This Used | Location | Limits |
|---|---|---|---|---|---|
| T2022 | 132.00/mo | Service Coordinator | • Service coordination | N/A | 1 charge/child/month |
| T1023 | 27.50/unit | Reimbursement Category 2 Providers | • Initial Assessment for Service Planning<br>• Development of initial IFSP<br>• Annual IFSP | Natural Environments or Center-based | 24 units/day and 36 units/year |
| T1023 U1 | 37.50/unit | Reimbursement Category 1 Providers | | | |
| T1024 | 27.50/unit | Reimbursement Category 2 Providers | • Team Treatment activities (more than one professional providing services during same session for an individual child/family<br>• IFSP **Review** Meetings (must be in person)<br>• Assessments that are done <u>after</u> the initial Assessment for Service Planning | Natural Environments* for team treatment activities; NE or center for IFSP reviews and assessment | The maximum daily units/per child/ per (service) code/ per individual practitioner is **6 units** with a maximum of **18 units** (for any combination of codes) per day per child for all agency/providers combined.<br><br>[The 18 units can be a combination from 2 or more agencies/providers or can be all from one agency as long as no individual practitioner exceeds the 6 units/individual practitioner/per day limit] |
| T1024 U1 | 37.50/unit | Reimbursement Category 1 Providers | | | |
| T1027 | 18.43/unit | Reimbursement Category 2 Providers | • Developmental Services and other early intervention services provided for more than one child, in a group (congregate), by one Reimbursement Category 2 Certified EI Provider | Natural Environments* | |
| T1027 U1 | 27.50/unit | | • Developmental Services and other early intervention services provided for one child by one Reimbursement Category 2 Certified EI Provider | | |
| T1026 | 7.43/unit | Reimbursement Category 1 Providers | • Center-based group (congregate) early intervention services | Center-based | |
| T1026 U1 | 22.50/unit | | • Center-based individual early intervention services | Center-based | |
| T1015 | 5.44/unit | Reimbursement Category 2 Providers | • Center-based group (congregate) early intervention services | Center-based | |
| T1015U1 | 16.49/unit | | • Center-based individual early intervention services | Center-based | |
| G0151 | 25.13/unit | Physical Therapists, PTAs (RC 1) | • Group (congregate) PT | Natural Environments* | |
| G0151 U1 | 37.50/unit | | • Individual PT | | |
| G0152 | 25.13/unit | Occupational Therapists, OTAs (RC 1) | • Group (congregate) OT | Natural Environments* | |
| G0152 U1 | 37.50/unit | | • Individual OT | | |
| G0153 | 25.13/unit | Speech Language Therapists (RC 1) | • Group (congregate) SLP | Natural Environments* | |
| G0153 U1 | 37.50/unit | | • Individual SLP | | |
| G0495 | 25.13/unit | RN or RNP (RC 1) | • Group (congregate) Nursing Services or Developmental Services provided by a nurse | Natural Environments* | |
| G0495 U1 | 37.50/unit | | • Individual Nursing Services or Developmental Services provided by a nurse | | |

* May include rare situations where services are provided in a center with acceptable justifications <u>AND</u> for which travel by the provider is required. See Infant & Toddler Connection of Virginia Practice Manual for information.

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# Infant & Toddler Connection of Virginia

***FAMILY COST SHARE PROCEDURES***

## Fee Appeal Form

The family must provide proof of income and documentation of expenses that exceed the average monthly allowable amount. Do not include any items that were previously deducted in calculating taxable income.

Child/ren's Name(s): ____________________________________________

Number of Family members: __________

**Monthly family income**
(Annual Taxable Income ÷ 12 or Net monthly income) **$**__________

Monthly Family Expenses:

| | |
|---|---|
| Housing (rent, mortgage) | $__________ |
| Transportation (public transit, cab, repairs, license, tolls) | $__________ |
| Loans and Credit Debt | |
| Credit card payment | $__________ |
| Car loan payment | $__________ |
| Other loan/debt payment | $__________ |
| Auto Insurance ($100/month/car) | $__________ |
| Utilities ($430/month) | $__________ |
| Food ($265 per person) | $__________ |
| Telephone ($120/month) | $__________ |
| Gasoline ($130 per adult) | $__________ |
| Clothing ($65 per person) | $__________ |
| Elder Care | $__________ |
| Child Care | $__________ |
| Health Insurance | $__________ |
| Life Insurance | $__________ |
| Medical | $__________ |
| Educational Expenses | $__________ |
| Job-Related Necessities | $__________ |
| Expenses to maintain home in livable condition | $__________ |
| Recreation/Entertainment (up to $25 per person) | $__________ |

**Total Monthly Family Expenses** **$**__________

**Disposable Income** (Income less Expenses) $__________

**Fee Cap @ 5% of Disposable income** (No fee if disposable income ≤ $0) **$**__________

I certify that the information I have provided regarding my financial status is complete and accurate to the best of my knowledge.

______________________________ Parent Signature & Date

______________________________ Staff Signature & Date

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## Chapter 12: Personnel

Practitioner Qualifications

1. Personnel providing Part C early intervention supports and services in Virginia must meet the discipline-specific qualifications specified in Table C at the end of this chapter.
2. Individual practitioners of early intervention services, except physicians, audiologists and registered dietitians, must be certified by the State Lead Agency as an Early Intervention Professional, Early Intervention Specialist, or Early Intervention Case Manager*. Audiologists who provide early intervention services other than audiological testing are strongly encouraged to become certified as Early Intervention Professionals.
3. In order to provide both service coordination and another early intervention service, a practitioner must be certified as both an Early Intervention Professional and an Early Intervention Case Manager or as both an Early Intervention Specialist and an Early Intervention Case Manager.
4. A one-page fact sheet for individuals interested in providing early intervention services in Virginia is available at http://infantva.org/documents/Info%20for%20New%20Providers%20-%205-26-17.pdf.

* In order to allow Medicaid reimbursement for service coordination provided to children with Medicaid/FAMIS through the Early Intervention Targeted Case Management (EI TCM) program, the legislative terminology of “case manager” must be used for the certification. The service provided by certified Early Intervention Case Managers is service coordination.

Scope of Practice

1. Qualified practitioners have those responsibilities designated in Table C.
2. Certified Early Intervention Specialists must work under the supervision of an Early Intervention Professional who has completed the Infant & Toddler Connection of Virginia

supervision training module and passed the competency test with at least 80% accuracy. Early Intervention Specialists may be supervised by an Early Intervention Professional from any discipline unless discipline-specific regulations specify otherwise.
3. Certified Early Intervention Case Managers who have completed the supervision training module may supervise other certified Early Intervention Case Managers only.

Early Intervention Certification

There are three early intervention certifications: Early Intervention Professional, Early Intervention Specialist, and Early Intervention Case Manager. Certifications are granted for a three-year period. The date an individual initially receives his/her first certification (regardless of whether that's Early Intervention Practitioner, Early Intervention Specialist or Early Intervention Case Manager) will determine the 3-year certification cycle. If an additional certification is issued to that practitioner within that 3-year cycle, then the new certification will expire on the same date as the original certification.

Requirements and Process for Initial Certification as an Early Intervention Professional or Early Intervention Specialist:

1. Practitioners interested in providing early intervention services in the Infant & Toddler Connection of Virginia system complete an online application that can be found on the Infant & Toddler Connection of Virginia website at https://eicert.dbhds.virginia.gov. A *Practitioner Application Manual* is also available on the website at http://www.infantva.org/documents/ei-Cert-usermanual.pdf to assist applicants. The applicant must:
    a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline; and
    b. Complete the following Infant & Toddler Connection of Virginia online training courses, passing the competency test for each with at least 80% accuracy:
        - Overview: Mission and Key Principles of Early Intervention
        - The Early Intervention Process
        - Effective Practices for Implementing Early Intervention
        - Responsibilities of Early Intervention Practitioners
        - Child Development; and
    c. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the practices specified in the *Infant & Toddler Connection of Virginia Practice Manual*.
2. Once the online application is submitted, the applicant will receive a confirmation on the computer screen and in an email that the application has been submitted. If the applicant cancels his/her application before submitting it, a notice on the screen will confirm the cancellation.
3. The applicant is notified of the status of his/her application:
    a. If the applicant has met all certification requirements, then the applicant receives notification that certification is granted.
    b. If the application is incomplete, then the applicant receives notification that it is necessary to provide the missing information.
    c. If the applicant does not meet all certification requirements, then the applicant receives notification that the request for certification is denied.
4. All certified practitioners are listed in the Infant & Toddler Connection of Virginia practitioner database, which is maintained by the State Lead Agency. The database will include the practitioner's name, discipline, licensure and certification information, and

contact information (which can include not only the practitioner's direct phone number and email address but also the name and contact information of the agency with which the practitioner is employed).

Requirements and Process for Initial Certification as an Early Intervention Case Manager:

1. The requirements and process for initial certification as an Early Intervention Case Manager are the same as those for an Early Intervention Professional or Specialist except that:
    a. Instead of meeting the discipline-specific licensure/certification requirements that apply to his/her discipline, the applicant must hold:
        - A minimum of a bachelor's degree in any of the following fields:
            - Allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;
            - Child and family studies;
            - Counseling;
            - Early childhood;
            - Early childhood growth and development;
            - Early childhood special education;
            - Human development;
            - Human services;
            - Music therapy;
            - Nursing;
            - Psychology;
            - Public health;
            - Social work;
            - Special education – hearing impairments;
            - Special education – visual impairments;
            - Other related field or interdisciplinary studies approved by the State Lead Agency; or
        - An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing; or
        - A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, plus three years' full-time experience coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements. Parents' experience coordinating their child's services in Part C early intervention and in Part B early childhood special education will be considered to meet the requirement for full-time experience, and both the time coordinating their child's services in early intervention and in Part B will count toward the requirement for three years' experience.
            - Three years means 36 months or more;
            - Full-time means 32 hours/week.
    b. The applicant must complete the following Infant & Toddler Connection of Virginia online training courses, passing the competency test for each with at least 80% accuracy:
        - Overview: Mission and Key Principles of Early Intervention

- The Early Intervention Process
- Effective Practices for Implementing Early Intervention
- Responsibilities of Early Intervention Practitioners
- Child Development
- Authentic Assessment for Early Intervention
- The Many Facets of Service Coordination

Requirements and Process for Recertification:

1. Practitioners interested in renewing their certification to provide early intervention services in the Infant & Toddler Connection of Virginia system complete an online application that can be found on the Infant & Toddler Connection of Virginia website at https://eicert.dbhds.virginia.gov at least 30 business days before their current certification expires. The applicant must:
    a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline;
    b. Complete 30 hours of training over the 3-year certification period with content that addresses one or more of the following and is applicable to early intervention:
        - Evidence based practices
        - Changes in policies, procedures and practices
        - Topics identified on ~~the~~a practitioner's own professional development plan (~~see Responsibilities of Certified Practitioners section below for more information on professional development plans)~~; and
        - Training needed for new responsibilities.
    c. Complete Kaleidoscope training within 15 months of initial certification as an Early Intervention Case Manager unless the applicant completed this training prior to certification. When completed after certification, the Kaleidoscope training counts towards the 30 hours of training required for the practitioner's first recertification.
    d. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the practices specified in the Infant & Toddler Connection of Virginia Practice Manual.
2. Once the online application is submitted, the applicant will receive a confirmation on the computer screen and in an email that the application has been submitted. If the applicant cancels his/her application before submitting it, a notice on the screen will confirm the cancellation.
3. The applicant is notified of the status of his/her application:
    a. If the applicant has met all certification requirements, then the applicant receives notification that the certification is granted.
    b. If the application is incomplete, then the applicant receives notification that it is necessary to provide the missing information.
    c. If the applicant does not meet all certification requirements, then the applicant receives notification that the request for certification is denied.

Lapsed Certification

1. A practitioner with a lapsed certification may neither provide nor bill (Part C or DMAS) for early intervention services until his/her certification has been restored.

Restoration of Lapsed Certification:

1. The State Lead Agency may restore an expired certification under the following conditions and with the following documentation from the practitioner:
   a. The individuals' certification has lapsed for a period less than one year; and
   b. The certification has lapsed because:
      - The practitioner failed to complete the three-year recertification requirements and the individual provides documentation to the State Lead Agency demonstrating (i) he/she meets the discipline-specific licensure/certification requirements that apply to his/her discipline , and (ii) he/she has completed at least 30 hours of training related to evidence-based practices in early intervention; changes in policies, procedures and practices; topics identified on the practitioner's professional development plan; or training needed for new responsibilities; or
      - The practitioner's discipline-specific qualifications expired and the practitioner documents that he/she now holds a current license, certification, endorsement, or other qualification for the practice of his/her discipline or profession in the Commonwealth of Virginia.
2. When a practitioner's certification is restored, he/she is restored to active status in the practitioner database.

Termination of Certification:

1. A practitioner's early intervention certification will be terminated if:
   a. The practitioner's discipline-specific license, certification, or endorsement has been suspended or terminated; or
   b. The practitioner, after a year of having a lapsed certification, fails to comply with the recertification requirements; or
   c. The practitioner fails to comply with the signed assurances.

Procedures for Reconsideration of Decision to Deny or Terminate Certification:

1. If a practitioner disagrees with the decision to deny or terminate certification, he/she may request reconsideration by the commissioner of the State Lead Agency. The request must be made in writing within 30 days of the date of the written notice of denial or termination and may include relevant additional information or documentation to support the request.
2. The commissioner will review the request for reconsideration and information presented and will issue a decision in writing within 30 business days following receipt of the request. The decision of the commissioner is a final case decision that may be appealed under the Virginia Administrative Process Act.

<u>Responsibilities of Certified Practitioners</u>

1. Certified Early Intervention Professionals who provide supervision of certified Early Intervention Specialists must document their ongoing clinical supervision of services provided by the early intervention specialist and must maintain that documentation for at least 3 years. Although the Infant & Toddler Connection of Virginia does not prescribe the frequency of supervision, there must be documentation that the supervision is ongoing and that supervision is at a clinical level and not just an administrative level (i.e., documentation of annual or semi-annual performance reviews is not adequate). If an Early Intervention Professional observes an Early Intervention Specialist during a service session, then both the Early Intervention Professional and the Early Intervention Specialist must sign the contact note for that session.

~~2. Maintain a Professional Development Plan – This requirement recognizes the individualized nature of the training and experience of individuals providing early intervention services and provides a mechanism for individuals to customize their continuing education to meet their specific needs. Each practitioner needs to only develop and manage one professional development plan regardless of the number of early intervention certifications held or added during a 3-year certification cycle. If an additional certification is granted during the 3-year certification cycle, the practitioner is expected to review his/her existing professional development plan to determine whether revisions are needed to address the new certification area. Each practitioner is responsible for maintaining a copy of her/his own professional development plan and for making that available to the local system manager and the State Lead Agency upon request.~~

   ~~a. Practitioners may use the *Early Intervention Individual Professional Development Plan* form available at http://www.infantva.org/Pr-PracticeManual-Forms.htm or may use an alternate form provided through their agency.~~

   ~~b.~~a. ~~Practitioners who work independently, rather than for an agency, must have their plan reviewed and signed by the local system manager or designee in at least one of the local Infant & Toddler Connection systems in which they work.~~

~~The professional development plan is fluid and can change over the 3-year period to reflect emerging/changing needs.~~

~~3.~~2. Complete 30 hours of training every 3 years that meets the recertification requirements specified above. All training hours completed count toward all certifications held by the practitioner (e.g., it is not necessary to complete 30 hours for the Early Intervention Professional recertification and another 30 hours for Early Intervention Case Manager recertification).

   a. What Constitutes a Training Activity: In order to count toward the required hours for recertification, a training activity must be at least ~~1 hour~~ 15 minutes in length.
   b. Training Opportunities: The State Lead Agency provides information to local systems and practitioners about available training opportunities that have been made known to the Infant & Toddler Connection of Virginia Office, which include a mix of trainings that are free and those that require a fee. It is expected that practitioners will also investigate additional available training opportunities. Most, if not all of the training required to maintain early intervention certification also will meet discipline-specific continuing education requirements.
   c. Documentation of Completed Training: For each training activity, documentation maintained by the practitioner must include a description of the activity and sponsoring organization, if applicable; the date or dates of training; the number of hours; and a copy of a certificate or verification of attendance, if applicable. Practitioners are required to retain documentation of successful completion of the 30-hour training requirement for recertification for three years following issuance of the renewal certification (i.e., until the issuance of their next renewal certification). That documentation must be made available to the State Lead Agency upon request.
   d. Types of Training Allowed: Table A following this section specifies the categories of training activities that may be completed as part of the 30 hours of training required for recertification. Following the table is a text box that addresses Frequently Asked Questions about what counts and what does not count as training for Part C recertification.

~~4.~~3. Beginning October 1, 2017, all certified Early Intervention Specialists and Early Intervention Professionals who provide services other than eligibility determination and

assessment for service planning must complete fidelity assessment requirements as follows:

a. New practitioners who are hired by or contract with a local Infant & Toddler Connection system on or after October 1, 2017 must, in each of their first two years in the Infant & Toddler Connection of Virginia, complete at least 2 self-assessments using the *Coaching in Action* checklist and be observed at least once by a qualified observer. In the first year, one of the self-assessments and the observation may be completed using the requirements detailed in the *Orientation to Coaching and Natural Learning Environment Practices* checklist instead of using the *Coaching in Action* checklist.
b. Practitioners already working in a local Infant & Toddler Connection system as of October 1, 2017 must complete at least 2 self-assessments using the *Coaching in Action* checklist by September 30, 2018 and at least 2 additional self-assessments between October 1, 2018 and September 30, 2019. Each practitioner must also be observed at least once by a qualified observer by September 30, 2019.

Once the requirements are met in the second year, the need for and frequency of additional self-assessment and observation will be determined by the supervisor for each individual practitioner based on the results of the year two self-assessments, observation, record reviews, and ongoing supervision. Please note that practitioners who work for more than one local Infant & Toddler Connection system are not required to complete the fidelity assessment requirements separately for each local system with which they work. Table B, at the end of this section, provides further details regarding fidelity assessment requirements.

~~5.~~4. Complete the *Early Intervention Training Record* form, which is available along with a sample, partially-completed form at http://www.infantva.org/Pr-PracticeManual-Forms.htm. Practitioners must use this form to track the professional development activities completed during each 3-year certification cycle. Practitioners must retain a copy of the completed training record form for three years following issuance of the recertification that is based on that training record.
a. The practitioner's supervisor must sign off on each line of the training record to indicate his/her awareness of the trainings/activities the employee is accessing as well as approval of the activities.
b. Independent practitioners who practice without a supervisor are required to obtain the initials of the local system manager or designee in at least one of the local Infant & Toddler Connection systems in which they work.

~~6.~~5. Ensure the correct and current profile information (contact information, affiliations with local systems, etc.) is listed in the online Early Intervention Certification (EICERT) website. This includes ensuring correct and current discipline-specific licensure, certification or endorsement information, updating the expiration date for each qualification (license, certification or endorsement), as needed, to match the date on the most current license, certification or endorsement. For more specific instructions, practitioners can go to the EICERT website (https://eicert.dbhds.virginia.gov) and click on the User Manual link at the top of the left menu.

~~7.~~6. Immediately notify the State Lead Agency of any change that may affect their certification status or their participation in the Infant & Toddler Connection of Virginia.

**Table A: Types of Training Allowed**

| Training Category | Description | Hours | Documentation Required |
|---|---|---|---|
| College | • Must be earned at a | 1 semester hour = | Transcript |

| | | | |
|---|---|---|---|
| courses | regionally accredited 2-year or 4-year college;<br>• Must be taken for credit;<br>• Must earn passing grade;<br>• Could be pass-fail. | 10 hours | |
| Professional development activities | • Self-study: online; journal; book group; may be group or individual.<br>• Mentoring<br>• Online training<br>• In-service training: Examples include a training within the practitioner's own agency; attending a meeting with speaker (only the time when the speaker is presenting counts as training); a brown bag lunch series; etc.<br>• Fidelity self-assessment and/or observation | Hours based on amount of time spent (1 hour spent = 1 hour)<br><br>**Maximum of 5 hours of training per 3-year period may be self-study**<br><br>**Maximum of 15 hours per 3-year period may be claimed by qualified observer for time spent doing observation** | • Self-study: Written summary of what was done, amount of time spent, sources used<br>• Mentoring: Written summary of activities completed, amount of time spent, name and qualifications of mentor<br>• Online training: Printed certificate, if available, or printed summary of training topic, sponsor organization, training content<br>• In-service training: Certificate, if available, or written summary of training topic, sponsor organization, training content<br>• Fidelity assessment: Copies of completed fidelity checklists, written record of amount of time spent |
| Professional conference | 4 or more hours in length | Certificate will give # of hours, which will include time in conference sessions, not counting breaks or meals | Certificate |

Frequently Asked Questions about What Counts as Training for Recertification:

1. Is it possible to use an observation as a training activity (i.e. someone wants to learn about how speech therapy works by observing a therapist)?
   In order to be considered as part of the 30 hours, the experience would need to be more structured than simply observing. For example, the activity might include preparation of the learner prior to the observation (reading materials, identification of what to be on the lookout for during the observation) and follow up discussion/mentoring after the observation.
2. How much flexibility do we have in using coordination with those who have expertise in a particular area – i.e. scheduling 1:1 to meet with a system manager about Part C updates?
   One-on-one training with individuals with the expertise the learner is seeking makes sense. However, discussion with system managers about Part C Updates would not meet the intent of the training requirements.
3. To what extent can meetings serve as trainings – particularly in the area of updating on Part C – i.e. council meetings, service coordination meetings?
   Meetings do not count toward the 30 hours of required training.
4. ~~Does the Part C Leadership Academy count?~~
   ~~Yes, if for the individual attending the training it addresses one of the 4 topic areas specified in 1b under "Requirements and Process for Recertification."~~

~~5.~~4. When a service coordinator attends Kaleidoscope I and II, does that count towards her 30 hours?
   Yes

~~6.~~5. Does it count toward my 30 hours if I'm the one providing the training?
   Being the trainer does not give you hours toward recertification.

**Table B: Fidelity Assessment Requirements Beginning October 1, 2017**

**Practitioner Responsibilities**

- Ensure required self-assessments are completed at least 4 months and no more than 6 months apart, unless completing more than 2 self-assessments per year
- Record the amount of time spent completing the self-assessments and reviewing the results of the self-assessment and observation with supervisor and/or observer for credit toward the 30 hours of professional development required for EI certification
- Maintain a copy of the completed checklists (self-assessments and observation) for at least 3 years and make available to the local system manager and the State Lead Agency upon request
- Share results of the self-assessment with his/her supervisor and revise his/her Professional Development Plan as needed, based on the self-assessment and/or observation results and need for additional professional development and support

**Qualified Observer Responsibilities**

- Meet one of the following qualifications:

<table>
<tr><td>
<ul>
<li>Master Coach plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions. For purposes of this qualification, Master Coach is defined as an individual who has completed the 3-day face-to-face Master Coach training by Dathan Rush and M'Lisa Shelden and the 6-month community of practice following that training (completing coaching logs and participating in the monthly technical assistance call in at least 4 of the 6 months). This training may have occurred in Virginia or elsewhere. Documentation of completion may include a certificate of participation, a letter of commendation from Catherine Hancock (that was sent to Virginia Master Coaches after completion of the community of practice), or other records maintained in the individual's personnel file documenting completion of these requirements at the time they were completed</li>
<li>At least 6 months experience using Rush and Shelden or similar model of coaching plus 8 hours of professional development* on coaching plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions</li>
<li>At least 4 months experience using Rush and Shelden or similar model of coaching plus 4 hours of professional development* on coaching and observed plus approved by master coach or other qualified observer plus completion of the Texas Early Childhood Intervention Coaching Families Module in accordance with Infant & Toddler Connection of Virginia instructions</li>
</ul>
*Professional development may include but is not limited to: Rush and Shelden regional training, book study of Early Childhood Coaching Handbook, Coaching Implementation Project participation, local or regional coaching training, participation in coaching community of practice, book study, classes, webinars, supervision of and feedback on your own coaching practices, observation/work with mentor
<ul>
<li>Maintain documentation of his/her qualifications to be an observer for fidelity assessment and produce those upon request by the local or state lead agency. To document completion of the Texas Early Childhood Intervention Coaching Families Module, document the time spent and date completed and keep the Coaching in Action checklists (one for Henley and one for Lennox) filled in during the Practice Activities section of the module.</li>
<li>When the observer is not the practitioner's supervisor, coordinate with the practitioner and supervisor to ensure information from the observation is shared and used to identify and meet the practitioner's need for ongoing supervision, professional development and support related to coaching.</li>
<li>Record the amount of time spent completing the observation and reviewing the results of with the practitioner and/or his/her supervisor for credit (up to 15 hours) toward the 30 hours of professional development required for EI certification.</li>
</ul>
</td></tr>
<tr><td>
Supervisor Responsibilities:
<ul>
<li>Review results of the self-assessments and observation to inform ongoing supervision and support</li>
<li>Review the practitioner's Professional Development Plan to determine the need to add activities related to coaching</li>
</ul>
</td></tr>
<tr><td>
Local System Manager Responsibilities:
<ul>
<li>Submit fidelity assessment data to the State Lead Agency as required by the terms of the Local Contract for Participation in Part C Early Intervention</li>
<li>Use fidelity assessment results to identify and address local professional development needs related to coaching</li>
</ul>
</td></tr>
</table>

## TABLE C: PRACTITIONER QUALIFICATIONS AND RESPONSIBILITIES

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Audiologist | Licensure in Audiology by the Board of Audiology and Speech-Language Pathology | X | | X | X | X | X | X | X | Audiology, Developmental Services, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services |
| Assistant Behavior Analyst | Licensed as Assistant Behavior Analyst by the Virginia Board of Medicine | | X | X w/training | | | X w/supervision | X | | Developmental Services |
| Behavior Analyst | Licensed as Behavior Analyst by the Virginia Board of Medicine | X | | X | X | X | X | X | X | Developmental Services |
| Certified Therapeutic Recreation Specialist | Certification through the National Council on Therapeutic Recreation Certification | X | | X | X | X | X | X | X | Developmental Services, Assistive Technology Services |
| Counselor - including Licensed Professional Counselor | Licensure as Licensed Professional Counselor by the Virginia Board of Counseling | X | | X | X | X | X | X | X | Counseling Services |
| School Counselor | Licensure with an endorsement as a School Counselor (pre K – 12) by the Virginia Board of Education | X | | X | X | X | X | X | X | Counseling Services |

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Early Intervention Assistant | GED, High School Diploma or College Degree | | X | X w/training | | | X w/Supervision | X | | Developmental Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services |
| Early Intervention Service Coordinator | Combination of education and experience that meets requirements specified earlier in this chapter | N/A | N/A | X w/training | | | X | X | X other SCs | Service Coordination |
| Educators -including Early Childhood Special Education | Licensure with an endorsement in Special Education - Early Childhood (birth-5) by the Virginia Board of Education | X | | X | X | X | X | X | X | Developmental Services, Assistive Technology Services |

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Educators (cont.)<br>Educator | Licensure with endorsement in Early/Primary Education (PreK – 3) or NK-4 or elementary education (PreK-6) by the Virginia Board of Education<br><br>Licensure with endorsement in adapted curriculum (K-12) or general curriculum (K-12)<br><br>Licensure with endorsement in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education<br><br>Technical Professional License in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education | X | | X | X | X | X | X | X | Developmental Services, Assistive Technology Services |
| Educator of the Hearing Impaired | Licensure with endorsement in Special Education - Hearing Impairments (pre K – 12) by the Virginia Board of Education | X | | X | X | X | X | X | X | Developmental Services, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services |

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Educator of the Visually Impaired | Licensure with endorsement in Special Education - Visual Impairments (pre K – 12) by the Virginia Board of Education | X | | X | X | X | X | X | X | Developmental Services, Vision Services, Assistive Technology Services |
| Family and Consumer Science Professional | Employed in Virginia's Part C system before July 1, 2009: Certification through the American Association of Family and Consumer Sciences.<br><br>Employed on or after July 1, 2009: Certification with successful completion of the concentration examination in human development and family studies through the American Association of Family and Consumer Sciences. | X | | X | X | X | X | X | X | Developmental Services, Assistive Technology Services |
| Family therapist | Licensure as Marriage and Family Therapist by the Virginia Board of Counseling | X | | X | X | X | X | X | X | Counseling Services |
| Music Therapist | Certification by Certification Board for Music Therapy (MT-BC) | X | | X | X | X | X | X | X | Developmental Services |
| Nurse - Includes Registered Nurse and Nurse Practitioner | Licensure by the Virginia Board of Nursing as a registered nurse or Licensure by the Virginia Board of Nursing as a nurse practitioner | X | | X | X | X | X | X | X | Nursing Services, Developmental Services, Assistive Technology Services |
| Occupational Therapist | Licensure as Occupational Therapist by the Virginia Board of Medicine | X | | X | X | X | X | X | X | Occupational Therapy, Assistive Technology Services |

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Occupational Therapy Assistant | Licensure as Occupational Therapy Assistant by the Virginia Board of Medicine | | X | X w/training | | | X w/Supervision | X | | Occupational Therapy, Assistive Technology Services |
| Orientation and Mobility Specialist | Certification by the National Blindness Professional Certification Board as a National Orientation and Mobility Certificant (NOMC); OR certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as a Certified Orientation and Mobility Specialist (COMS) | X | | X | X | X | X | X | X | Developmental Services, Vision Services, Assistive Technology Services |
| Physical Therapist | Licensure as Physical Therapist by the Virginia Board of Physical Therapy | X | | X | X | X | X | X | X | Physical Therapy, Assistive Technology Services |
| Physical Therapist Assistant | Licensure as Physical Therapist Assistant by the Virginia Board of Physical Therapy | | X | X w/training | | | X w/Supervision | X | | Physical Therapy, Assistive Technology Services |
| Physician | Licensure in Medicine or Osteopathic Medicine by the Virginia Board of Medicine | X | | X | X | X | X | X | X | Medical Services |
| Psychologist – including Clinical psychologist | Licensure as Clinical Psychologist by Virginia Board of Psychology | X | | X | X | X | X | X | X | Psychological services |
| School psychologist | Licensure with endorsement in School Psychology through the Virginia Board of Education | X | | X | X | X | X | X | X | Psychological services |

| Discipline | Qualifications | Practitioner Level | | Scope of Responsibilities | | | | | | EI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Professional | Specialist | Screening | Elig Det. | Assess-ment | Direct Child/Family | Teaming | Supervise Staff | |
| Applied psychologist | Licensure as Applied Psychologist by Virginia Board of Psychology | X | | X | X | X | X | X | X | Psychological services |
| Registered Dietitian | Registration by the Commission on Dietetic Registration | X | | X | X | X | X | X | | Nutrition Services |
| Social Worker – including Licensed Social Worker | Licensure as Licensed Social Worker by the Virginia Board of Social Work | | X | X w/training | | | X w/Supervision | X | | Social Work Services |
| Licensed Clinical Social Worker | Licensure as Licensed Clinical Social Worker by the Virginia Board of Social Work | X | | X | X | X | X | X | X | Social Work Services |
| School Social Worker | Licensure with endorsement as a school social worker by the Virginia Board of Education | X | | X | X | X | X | X | X | Social Work Services |
| Speech-Language Pathologist | Licensure in Speech-Language Pathology by the Virginia Board of Audiology and Speech-Language Pathology | X | | X | X | X | X | X | X | Speech-Language Pathology, Assistive Technology Services, Sign Language Services, Cued Speech Services, Listening and Spoken Language Services |
| Licensed Practical Nurse | Licensure as Practical Nurse by the Virginia Board of Nursing | | X | X w/training | | | X w/Supervision | X | | Nursing Services, Developmental Services |
| Certified Nurse Aide | Certification as Nurse Aide by the Virginia Board of Nursing | | X | X w/training | | | X w/Supervision | X | | Nursing Services, Developmental Services |

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Early Intervention Training Record

Name: ___________________________________

As part of the Early Intervention Certification requirements for the Infant & Toddler Connection of Virginia, practitioners must maintain a summary of training and activities completed. Please use this form to track your professional development during the three-year cycle. Professional development must be applicable to early intervention and address one or more of the following: (1) evidence-based practices; (2) changes in policies, procedures or practices; (3) topics identified on a practitioner's own professional development plan; or (4) training needed for new responsibilities. Practitioners must retain documentation of successful completion of the training requirements for this certification for three years following the issuance of the renewal certification. A copy of your completed form must be made available upon request to the Department of Behavioral Health and Developmental Disabilities.

| **Name of Training or Training Activity** | **Sponsor** | **Number of Hours** ***Minimum of 15 minutes per activity** | **Date** |
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