NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM

ELIGIBILITY:

Children's eligibility for services under the Early Intervention Program (EIP) can be established in one of two ways:

1. A child may have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

2. A child may have a developmental delay which shows that s/he has not attained expected milestones for the child's chronological age (adjusted for prematurity) in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional or adaptive development.

   A developmental delay is one that has been measured by qualified personnel using appropriate diagnostic procedures and/or instruments, informed clinical opinion, and documented as:

   a. A twelve month delay in one functional area; or
   b. A 33% delay in one functional area or a 25% delay in two or more functional areas; or
   c. When appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviation below the mean in two or more functional areas.

3. Standardized, norm-referenced instruments should be used whenever available and appropriate to determine eligibility as they offer a valid representation of the child's true abilities. Criterion-referenced instruments typically offer a range of age equivalents

   Whenever possible, eligibility should be determined on the basis of standardized, norm-referenced instruments. If a criterion-referenced instrument is used, the evaluator must be fully cognizant as to how the achieved score ranges are to be interpreted. This is usually described in the test's instruction manual and must be indicated in the report.

4. NYC EIP has identified a list of standardized, norm-referenced instruments that are presumed appropriate for this purpose. Thus, **evaluators who use instruments not on this list must provide supporting clinically-based documentation** for their usage relevant to the needs of the particular child.

5. In instances in which the evaluator finds that neither standardized, norm-referenced nor criterion-referenced instruments accurately or fully reflect the child's true functioning, informed clinical opinion may be used to determine whether there is a 33% or 25% delay in the functional area of concern. A written explanation must be provided as to why the evaluator determined that the testing did not capture the child's true functioning (e.g., the standardized test "A" does not assess pragmatic skills [language use] and therefore does not reflect the

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

child's predominant use of echolalia or his/her inability to initiate language, maintain eye contact).

6. No single procedure or instrument may be used as the sole criterion or indicator of eligibility. (10 NYCRR 69-4.8).

THE EVALUATION PROCESS:

A. THE MULTIDISCIPLINARY EVALUATION

The multidisciplinary evaluation (MDE) team must include two or more qualified personnel from different disciplines who are trained to utilize appropriate methods and procedures, and have sufficient expertise in child development. At least one member of the MDE team shall be a specialist in the area of the child's suspected delay or disability. The multidisciplinary evaluation is required to:

1. Determine whether a child is eligible for services under the Early Intervention Program. If a child has a diagnosed condition, which makes him/her eligible for the EIP, an MDE is necessary to assist in guiding the development of the IFSP;

2. Assess the status of the child's physical*, cognitive, social-emotional, communication and adaptive development;

   *10NYCRR Sec. 69-4.8 (a)(4)(i):
   …the evaluation of the child's physical development shall include a health assessment including a physical examination, routine vision and hearing screening and, where appropriate, a neurological assessment…

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

The complete multidisciplinary evaluation forms the basis for decisions about all aspects of the services included in the Individualized Family Service Plan (IFSP) to meet the child's developmental needs and the priorities, resources and concerns of the family related to their child's development.

The need for supplemental evaluations beyond the area(s) of suspected delay should be reflected in the report from the core evaluation team that assessed development in the five domains. The reason for the supplemental(s) must be explained.

B. MULTICULTURAL/MULTILINGUAL EVALUATIONS

Evaluations are conducted in the cultural context of the family, requiring the evaluator to be responsive to cultural and linguistic diversity. Professionals conducting bilingual evaluations need to be acutely aware of the subtle interplay between language and cognitive development and the potentially complicating influence of cultural differences. Evaluation reports should state the primary language of the child/family, the validity of the evaluation instruments for the child's cultural/linguistic group and whether an interpreter was used during test administration. If an interpreter was used,

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

his/her name should be documented. **The evaluation report should include an assessment of the child's language development in his/her native language(s) as well as his/her use of English**.

Whenever possible, in bilingual assessments, testing instruments should be in the primary language of the child, or, at a minimum, have versions that have been translated into this language.

In many instances, tests meeting these criteria are not available for certain cultural/linguistic groups. When this is the case, evaluators may rely upon clinical interpretations of observations, age equivalents instead of standardized scores, behavior and language samples, play-based assessments and interviews with parent(s) and other caregivers to determine an estimate of the child's developmental status. Evaluators must provide appropriate explanation in the report explaining the methods used.

Whenever possible, evaluators should speak the primary language of the child and family. Test results may be suspect if the evaluator and child do not speak the same language. It is also important for the evaluators to be able to communicate effectively with the family about the evaluation process and findings.

C. USING AN INTERPRETER

Only in situations when an evaluator fluent in the primary language of the child and the family cannot be found is it permissible to conduct an evaluation using an evaluator-***interpreter*** team. The most appropriate interpreter would be a bilingual Early Intervention professional. If this is not possible, the next choice of interpreter is a person not known to the family. Ideally, both the evaluator and **interpreter** should be specially trained to conduct evaluations in this manner.

Testing in which parents or caregivers function in the interpreter role may not give an accurate and objective evaluation of the child's skills and should only occur when all other options have been fully exhausted. The reason for using an evaluator-interpreter team rather than a bilingual evaluator should be explained in the MDE summary.

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

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

D. CONDUCTING THE MULTIDISCIPLINARY EVALUATION

A comprehensive multidisciplinary evaluation stems from a collaborative approach and emphasizes working in partnership with the family to address their concerns. One of the basic goals of Early Intervention is the establishment of a partnership between providers of EI services and the family. The evaluation process is the ideal time to plant the seeds for this partnership.

The evaluator should:

1. Elicit the family's resources, priorities and concerns for their child.

2. Inform families that the evaluation is not complete, nor can eligibility be determined, without a review of the assessment of the child's health status completed by the child's primary care provider. The physical exam report should be completed by the child's primary care provider. It is the evaluator's responsibility to obtain this medical. If the parent is unable to obtain a recent physical exam report, a supplemental evaluation may be performed by a physician contracted or hired by the evaluation site. The physical exam report should be received by the evaluating agency in a timely fashion so that it can be incorporated into the Multidisciplinary Evaluation. All attempts to obtain the physical exam report should be documented by the evaluation site.

   The Multidisciplinary Evaluation will not be accepted as complete without the physical exam report. An IFSP meeting will not be held without a complete MDE.

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

4. Offer a family assessment as an option for exploring in more depth the family's resources, priorities, and concerns. If the family agrees, this report should be submitted as part of the core evaluation.

5. Schedule evaluations as soon as possible following receipt of referral in order to ensure compliance with the following:

   The evaluator shall complete screenings and evaluations within 30 calendar days of referral to NYCEIP. If the evaluator cannot comply with the 30-day time frame, the evaluator shall notify both the parent and the Initial Service Coordinator (ISC) prior to scheduling of the evaluation. Best practice in this instance would be to provide this notification within 48 hours to the ISC so that mandated time lines for the evaluation process can continue to be maintained by the ISC and the next evaluator chosen.

6. Ensure that the parent/guardian is present and has the opportunity to participate in all components of the Multidisciplinary Evaluation, whether it is performed at an EI facility, a child care site, or the child's home. If the evaluation takes place at a child care site, a staff member

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

who knows the child should be available as well.

7. **Individual evaluators should avoid making recommendations during the evaluation regarding frequency, duration and location of specific services, specific service providers, or eligibility for the Early Intervention Program.**

8. Include in the Summary of Multidisciplinary Evaluation/Screening as well as in each evaluation report a statement as to whether the parent/child care staff felt the evaluation gave a picture of the child's typical functioning.

E. WRITTEN REPORTS AND CONTENT

The evaluator shall provide the parent, the ISC, and the Regional Office with a written summary of the evaluation and a copy of the full evaluation, including any pertinent records related to the child's current health status and medical history gathered from other sources with the parent's written consent.

1. SUMMARY OF MULTIDISCIPLINARY EVALUATION/SCREENING - Each summary must include the following:

a. Description of child's current levels of functioning in cognitive, communication, physical (motor skills), social/ emotional, and adaptive domains.
b. The child's medical status.
c. A summary of family assessment.
d. Description of assessment process and conditions.
e. The child's responses and whether the family believes the responses were optimal.
f. An explanation of the scores or measures reported.
g. A statement of any specific transportation needs of the child.

The **Summary** must be **written by a member of the evaluation team or a representative who is an Early Intervention qualified personnel.** Pertinent medical information must be incorporated into this summary.

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

The written summary must be in parents' dominant language, unless it is clearly not feasible to do so.

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

2. MULTIDISCIPLINARY EVALUATION DATA ENTRY FORMS AND REPORTS

a. 10 NYCRR Section 69-4.8 states that no single procedure or instrument may be used as the sole criterion or indicator of eligibility.

b. The evaluation team must include two or more qualified personnel from different disciplines.

c. Components of the MDE and Summary must include the names and disciplines of those performing the evaluations and family assessment. Each report must also include the evaluator's original signature and license number (if a licensed professional).

d. Evaluations should be written in family friendly language. If a professional term must be utilized that is not readily apparent in meaning, an explanation should be inserted.

e. When evaluating a child who was born prematurely (less than 37 weeks gestation), the evaluator should adjust for prematurity and use **Corrected Age** when determining the existence of a developmental delay. A child's age should be adjusted for prematurity up to one year of age, unless the manual for a specific instrument gives other instructions.

f. It should be noted that it may be developmentally age appropriate for children under the age of three years to present with numerous articulation errors, phonological processes and unintelligibility. This is an important factor to keep in mind when determining eligibility.

g. Each evaluator should describe a child's strengths as well as areas of concern. However, if the child does demonstrate a delay, the area of deficit must be clearly described. When describing a child's inability or lack of a particular skill, the evaluator should make sure it is age expected and indicate when it is expected. **Skills a child is unable to perform should not be listed if they are skills expected above the child's age level.**

h. Physical therapy, occupational therapy and/or speech/language therapy services may only be authorized following an evaluation by an appropriately licensed professional as per their Practice Acts. However, those evaluations should not be performed unless the need for them is reflected in the core evaluation team's report.

i. **Individual evaluators should avoid making written recommendations in the evaluation report regarding frequency, duration and location of specific services, specific service providers, or eligibility for the Early Intervention Program.**

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

j. If a child does not meet eligibility criteria for the Early Intervention Program, the MDE should so indicate. A child might have delays that are not severe enough to qualify for eligibility. In such a case, the service coordinator should refer the family to the Health Outreach Unit of the NYC EIP for tracking, and/or to community resources or services through the family's medical coverage. If the family disagrees with this determination, the service coordinator should ensure that they are aware of their due process rights.

3. Attestation Statement from Evaluators

The following statement must be included at the end of all evaluation reports:

"I certify that I personally evaluated the above-named child, employing age-appropriate instruments and procedures as well as informed clinical opinion. I further certify that the findings contained in this report are an accurate representation of the child's level of functioning at the time of my assessment."

____ _____/_____/_____

Signature of Evaluator Date

__________________________ ____

Discipline License No. (If certified interventionist, do not indicate certificate number)

4. Assessment of the Child's Physical Health

The physical exam report must be attached to and relevant health information incorporated into the multidisciplinary evaluation. Pertinent medical information would include such information as the following:

a. Vision and hearing screening as performed by the pediatrician or other appropriate practitioner or the date on which they are scheduled to take place.

b. A history of ear infections or delayed language which may be an indication of a need for a referral for an audiological either through EI or the child's pediatrician.

c. Any diagnosed conditions determining eligibility (e.g., fetal alcohol syndrome, Prader-Willi Syndrome, Down Syndrome) which should be documented by a written statement from the professional who made the diagnosis.

d. Hemoglobin and blood lead level which should be part of the health assessment for every child at age one and repeated at age two. (If available, this information should be included in the report).

e. The child's immunization history.

NYC EARLY INTERVENTION PROGRAM

EVALUATION REQUIREMENTS UNDER THE EARLY INTERVENTION PROGRAM (Cont.)

F. SHARING OF EVALUATION RESULTS

Upon completion of the MDE, the evaluation results and eligibility of the child for services under the Early Intervention Program should be discussed with the parent by a qualified professional from the evaluation site, preferably by **a member** of the evaluation team.

According to the NYC Provider Agreement, written evaluations must be provided to the Regional Office, initial service coordinator, and parents, within 30 calendar days of referral to the NYC EIP.

G. ATTENDANCE AT THE IFSP MEETING

At least one person who has been directly involved in conducting the evaluation should **routinely** be a direct participant in the IFSP meeting. If none of the evaluators who directly assessed the child can attend, then a representative who is an Early Intervention qualified personnel and who is fully familiar with the evaluation reports and able to make appropriate recommendations should attend the IFSP meeting. He/she must have conferred with the entire evaluation team and be prepared to help families develop outcomes and outcome-oriented strategies for their child's IFSP. If the evaluator or above-described representative is unable to attend the IFSP meeting, arrangements must be made with the Regional Office in advance of the meeting for the evaluator's participation in a telephone conference, or the meeting will have to be re-scheduled.

H. FOLLOW-UP TO THE IFSP MEETING

1. The EIOD may request further information from the parent, the evaluator(s), the child's physician, or other specialist(s) whom the family has consulted.

2. The EIOD may request a supplemental evaluation by a specialist other than the provider of the original evaluation. The evaluator will be chosen from a list of appropriate specialists provided by the Department. The evaluation will be authorized by the EIOD with parental consent.

NYC EARLY INTERVENTION PROGRAM

CORE EVALUATION - DATA ENTRY FORM

INSTRUCTIONS: This form must be accompanied by Multidisciplinary Evaluation Data Entry form, Supplemental Evaluation Data Entry form (when applicable), Summary of Multidisciplinary Evaluation/Screening and evaluation report(s). Please print or type.

Child's EI ID #: ___________________________ DOB: _______/_______/_______

Name of Child: ____
Last. First Middle

EI Facility Name: _______________________________________ Phone#:(_____)_____________
Provider ID#: ____ Fax#:(_____)_______________
Contact Person: ____

Core Evaluation - Individuals Involved
Name: ___________________________________
Specialty: _________________________________
Instrument(s): ____________________________

[ ] Check if Bilingual Evaluation Performed
Language__________________________
Summary of Multidisciplinary Evaluation/Screening must be translated unless not feasible to do so.
Dates of Core: From____/____/____ To ____/____/____

Name: ___________________________________
Specialty: _________________________________
Instrument(s): ____________________________

Parent Interview completed by:
Name: ___________________________________
Specialty: _________________________________

Is physical exam report attached? [ ] Yes [ ] No The MDE is not accepted as complete without the physical exam report. An IFSP meeting will not be held without a complete MDE.

[ ] Family Assessment Offered & Refused [ ] Family Assessment Completed and Attached

Disciplines involved in Core Evaluation
[ ] Audiologist
[ ] Nurse
[ ] Nurse Practitioner
[ ] Nutritionist
[ ] Occupational Therapist
[ ] Pediatrician
[ ] Physical Therapist
[ ] Other Physician
[ ] Physician Assistant
[ ] Psychologist
[ ] Social Worker
[ ] Special Educator
[ ] Speech/Language Pathologist

(2) Method
P - Informed Clinical Opinion T - Standardized Test

(1) Developmental Status Codes

A - No Delay (development within acceptable ranges)
B - 2.0+ SD below the mean (sufficient alone for eligibility)
C - 1.5+SD below the mean (similar delay in another functional area needed to establish eligibility)
D - 12 month delay (sufficient alone for eligibility)
F - 33% or more delay (sufficient alone for eligibility)
G - 25% or more delay (similar delay in another functional area needed to establish eligibility)

EVALUATION SUMMARY

Functional Area	Developmental Status (1)	Method (2)
Adaptive		
Cognitive		
Communication		
Social/Emotional		
Physical		

DIAGNOSED CONDITION - from core. Transfer ICD 9 codes establishing eligibility to MDE data sheet.	ICD 9 Code

Reviewed by: ____ Date: _______/_______/_______

Data Entry: ____ Date: _______/_______/_______

NYC EARLY INTERVENTION PROGRAM
MULTIDISCIPLINARY EVALUATION DATA ENTRY FORM

Child's EI #: ____ **DOB:** ________/_______/_______

Child's Name: ____

Last First Middle

Date of MDE completion:_______/_______/________

[ ] NOT ELIGIBLE

1. Write V79.3 - "Not Eligible" and attach *Core Evaluation-Data Entry Form, Supplemental Evaluation Data Entry Form(s), and Summary of Multidisciplinary Evaluation/Screening*
2. Attach all evaluation reports.

DISCIPLINES INVOLVED IN MDE

Please check as applicable:

[ ] Audiologist
[ ] Nurse
[ ] Nurse Practitioner
[ ] Nutritionist
[ ] Occupational Therapist
[ ] Pediatrician
[ ] Physical Therapist
[ ] Other Physician
[ ] Physician Assistant
[ ] Psychologist
[ ] Social Worker
[ ] Special Educator
[ ] Speech Language Pathologist

[ ] ELIGIBLE - BASED ON DIAGNOSED CONDITION

Sufficient to determine eligibility. Submit the following to assist in developing service plan:
1. Indicate Diagnostic Condition in Part A. Attach documentation of diagnosis.
2. Attach *Core Evaluation - Data Entry Form*, *Supplemental Evaluation Data Entry Form(s)*, and *Summary of Multidisciplinary Evaluation/Screening*.
3. Attach all evaluation reports

[ ] ELIGIBLE - BASED ON DELAY

Submit the following to assist in developing service plan:
1. This page.
2. *Core Evaluation-Data Entry Form, Supplemental Evaluation-Data Entry Form(s)*, and *Summary of Multidisciplinary Evaluation/Screening.*
3. Attach all evaluation reports.

A. Diagnosed Physical and Mental Conditions With a High Probability of Developmental Delay. Complete this section only if child is eligible based on diagnosed condition. Attach documentation of diagnosis by physician or clinician.

[ ] 270.2 - Albinism
[ ] 759.89 - Angleman's
[ ] 743.45 - Aniridia
[ ] 728.3 - Arthrogryposis
[ ] 314.00 - Attention Deficit Disorder w/o Hyperactivity
[ ] 314.01 - Attention Deficit Disorder with Hyperactivity
[ ] 369.00 - Blindness, both eyes
[ ] 369.10 - Blindness one eye, low vision other eye
[ ] 749.00 - Cleft Palate
[ ] 759.7 - CHARGE Association
[ ] 389.00 - Conductive Hearing Loss - NOS
[ ] 742.3 - Congenital Hydrocephalus
[ ] 359.0 - Congenital Muscular Dystrophy
[ ] 348.8 - Cystic Periventricular Leukomalacia (CVPL)
[ ] 315.4 - Dyspraxia Syndrome
[ ] 758.0 - Down (Trisomy 21 or 22, G)
[ ] 758.2 - Edwards' (Trisomy 18 D 1)
[ ] 313.9 - Emotional Disturbance of Childhood (Unspecified)
[ ] 742.0 - Encephalocele
[ ] 760.71 - Fetal Alcohol
[ ] 759.83 - Fragile X
[ ] 299.00 - Infantile Autism active state
[ ] 343.9 - Infantile Cerebral Palsy - NOS
[ ] 345.60 - Infantile Spasms w/o intractable epilepsy
[ ] 345.61 - Infantile Spasms with intractable epilepsy
[ ] 772.1 - Intraventricular Hemorrhage (grade IV)
[ ] 765.01 -Less than 500 grams - Low birth weight
[ ] 765.02 - 500-749 grams - Low birth weight
[ ] 765.03 - 750-999 grams - Low birth weight
[ ] 755.58 - Lobster Claw (hand)
[ ] 369.20 - Low vision both eyes (moderate to severe)
[ ] 389.2 - Mixed conductive and sensorineural hearing loss
[ ] 742.4 - Multiple anomalies of brain - NOS
[ ] 377.23 - Optic nerve coloboma (bilateral), Acquired
[ ] 743.57 - Optic nerve coloboma (bilateral), Congenital
[ ] 359.8 - Other Myopathies
[ ] 758.1 - Pateau's (Trisomy 13 D 1)
[ ] 299.80 - Pervasive Developmental Disorder (PDD)
[ ] 755.4 - Phocomelia (absence of limb)
[ ] 759.81 - Prader-Willi
[ ] 309.81 - Prolonged Post Traumatic Stress Disorder
[ ] 742.2 - Reduction deformities of brain (Holoproencephaly/ Lissencephaly)
[ ] 362.21 - Retinopathy of prematurity (grades 4 & 5)
[ ] 389.10 - Sensorineural Hearing Loss - NOS
[ ] 741.00 - Spina Bifida with Hydrocephalus
[ ] 741.90 - Spina Bifida w/o Hydrocephalus
[ ] 952.9 - Spinal Cord Injury, NOS
[ ] 744.00 - Unspecified anomalies of ear with hearing impairment
[ ] 355.0 - Werdnig - Hoffman Syndrome (Infantile Spinal Muscular Dystrophy)
[ ] 774.7 - Kernicterus

B. Indicate Diagnostic Condition and ICD 9 Code(s) (from Core and Supplemental data entry forms) below if child is eligible due to delay or if diagnosis is not listed above.

1. ___________________________________ 2. ___________________________________ 3.__________________________
4.___________________________________

Reviewed by: ____________________________________Date: _____/_____/_____ Data Entry: __________________________

NYC EARLY INTERVENTION PROGRAM
SUPPLEMENTAL EVALUATION - DATA ENTRY FORM

Child's EI ID #: ___________________________ **DOB:**_______/_______/_______

Name of Child: ____

Last. First Middle

EI Facility Name:____ Phone #:(_____)______________

Provider ID#:____ Fax #:(_____)________________

Contact Person:____

Supplemental Evaluation

[ ] Bilingual Evaluation (3) Evaluation Type:_______
[ ] Physician [ ] Non-Physician
Dates: From:____/____/____ To:_____/_____/_____
Name:_______________________________________
Discipline:_______________________________________
Instrument Used:_______________________________
**Diag./ICD9 Code(s)

Functional Area	Developmental Status (1)	Method (2)

Supplemental Evaluation

[ ] Bilingual Evaluation (3) Evaluation Type:_______
[ ] Physician [ ] Non-Physician
Dates: From:____/____/____ To:_____/_____/_____
Name:_______________________________________
Discipline:_______________________________________
Instrument Used:_______________________________
**Diag./ICD9 Code(s)

Functional Area	Developmental Status (1)	Method (2)

Supplemental Evaluation

[ ] Bilingual Evaluation (3) Evaluation Type _______
[ ] Physician [ ] Non-Physician
Dates: From:____/____/____ To:_____/_____/____
Name:_______________________________________
Discipline:_______________________________________
Instrument Used:_______________________________
**Diag./ICD 9 Code(s)

Functional Area	Developmental Status (1)	Method (2)

Supplemental Evaluation

[ ] Bilingual Evaluation (3) Evaluation Type:_______
[ ] Physician [ ] Non-Physician
Dates: From:____/____/____ To:_____/_____/____
Name:_______________________________________
Discipline:_______________________________________
Instrument Used:_______________________________
**Diag./ICD 9 Code(s)

Functional Area	Developmental Status (1)	Method (2)

(1) Developmental Status Codes

**Transfer ICD 9 codes establishing eligibility to MDE data sheet

A - No Delay (development within acceptable ranges)
B - 2.0+ SD Below the mean (sufficient alone for eligibility)
C - 1.5+SD below the mean (similar delay in another functional area needed to establish eligibility)
D - 12 month delay (sufficient alone for eligibility)
F - 33% or more delay (sufficient alone for eligibility)
G - 25% or more delay (similar delay in another functional area needed to establish eligibility)

(2) Method of Determination

P - Informed Clinical Opinion T - Standardized Test

(3) Evaluation Type Code

A - Assistive Technology
B - Audiology
F - Nursing
G - Nutrition
H - Occupational Therapy
I - Physical Therapy
J - Psychological Services
L - Social Work
M - Special Instruction
N - Speech and Language
Q - Vision

Reviewed by: ____ Date: ________________

EIP Data Entry: ____ Date: _________________

NYC EARLY INTERVENTION PROGRAM

CONTENTS OF AN EVALUATION TO ADD NEW SERVICES TO A CHILD'S IFSP

The evaluation performed to add new services to a child's IFSP must include the situations, conditions or events requiring the additional evaluation. This evaluation must comply with the requirements described in the document "**Evaluation Requirements Under the Early Intervention Program".**

After the evaluation has been completed, the service coordinator and evaluator or evaluation site representative must convene a meeting with the parent(s) to prepare a proposed amended IFSP for submission to the EIOD. When appropriate, the EIOD may attend this meeting.

The proposed amended IFSP must indicate how a new service provider will coordinate with current interventionists.

The service coordinator must then ensure that the Regional Office receive the evaluation report, and a copy of the proposed amended IFSP which includes the:

a. Cover page;
b. "How The Child Is Doing" IFSP page with the area(s) evaluated completed;
c. Outcome/strategy page;
d. Consent for Services page;
e. Service Authorization form with the proposed additional services;
f. Copy of approved Request for Additional Evaluation form.

Also attached should be other appropriate documentation, such as outside evaluations and prescription for services when needed.

NYC EARLY INTERVENTION PROGRAM

SIX MONTH AND ANNUAL PROVIDER PROGRESS REPORT
PAGE ONE

Date of Report: / / ***Add additional page(s) if needed. Type or print legibly.***

Child's Name: ____
D.O.B._____/______/______
EI ID #: ___________ IFSP Period: From: _____/____/____ To: _____/_____/_____

Check As Appropriate: [ ] Six Month Update [ ] Annual Review Other: _________________

Please note: This form must be submitted with each Six Month Update and Annual Review.
Provider Agency Name: _____________________________________Prov. ID #: ____________

Name of Interventionist Completing Report: ____

Discipline: ____________________

1. What IFSP outcome(s) have you been addressing?

2. a) What strategies and techniques have you used to work towards these outcomes?
   b) What progress has been made?

3. a) How many times per week is the service authorized? _____________________
   b) Date you started working with this child: ________________________
   c) If there have been any gaps in service delivery of more than three consecutive scheduled visits please describe the length and the reason(s) for the gaps.

NYC EARLY INTERVENTION PROGRAM

SIX MONTH AND ANNUAL PROVIDER PROGRESS REPORT
PAGE TWO

Child's Name: ____ Date of Report: ____/____/____

4. What techniques have been taught to parents/caregivers and incorporated in the child's daily activities?

5. Based on ongoing assessment, what is the child's current level of functioning? For an Annual Review, state the child's current level of functioning in percentage of delay.

6. Recommendations for the next six (6) months. (Include suggested changes in outcomes, strategies/ techniques and activities).

I certify that I have received a copy of the child's IFSP and evaluation prior to starting services, and have provided the above services in accordance with the frequency and duration mandated in the IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: ____

License No.______________ **(If certified interventionist, do not indicate certificate number)**

INSTRUCTIONS FOR COMPLETION

SIX MONTH AND ANNUAL PROVIDER PROGRESS REPORT
PAGE ONE

Date of Report: _____/_____/_____ ***Add additional page(s) if needed. Type or print legibly.***

Child's Name: ____ D.O.B._____/______/______

EI ID #: _______________ IFSP Period: From: ____/_____/_____ To: _____/_____/_____

Check As Appropriate: [ ] Six Month Update [ ] Annual Review Other: ____________________

Please note: This form must be submitted with each Six Month Update and Annual Review.

Provider Agency Name: ____ Prov. ID #: ____________

Name of Interventionist Completing Report: ____

Discipline: ____________________

1. What IFSP outcome(s) have you been addressing? **Specifically address the outcomes as designated on the IFSP. If the outcomes were general and you have broken down the outcomes into appropriate developmental tasks, state as such. For example, speech outcomes may have been to use words to communicate so you may respond by saying, "to achieve the ability to use words, therapy has focused on increasing approximations and putting two syllables together". If initial outcomes have been achieved, state so, and identify new area of focus. Write this section as a narrative.**

2. a) What strategies and techniques have you used to work towards these outcomes? b) What progress has been made? **Be specific in identifying strategies. This will help define for parents how activities and interventions in your sessions are prompting specific developmental growth (e.g., "an interactive play approach using ………… has been used to address ……………………").**

3. a) How many times per week is the service authorized? _____________________
   b) Date you started working with this child: ____________________
   c) If there have been any gaps in service delivery of more than three consecutive scheduled visits, please describe the length and the reason(s) for the gaps. **If family or therapist has not been available for service delivery, or if there have been illnesses precluding service delivery, please indicate so and whether the sessions were made up. Indicate if more than one therapist is providing the service.**

INSTRUCTIONS FOR COMPLETION

SIX MONTH AND ANNUAL PROVIDER PROGRESS REPORT
PAGE TWO

Child's Name: ____ Date of Report: ____/____/____

4. What techniques have been taught to parents/caregivers and incorporated in the child's daily activities? **Identify ways in which information is shared with the family/day care provider/ babysitter. In addition, identify specific activities in which parents have implemented therapy suggestions.**

5. Based on ongoing assessment, what is the child's current level of functioning? For an Annual Review, state the child's current level of functioning in percentage of delay. **Use this area to comment on child's reaction to therapy and/or provide information or concerns. It is expected that clinicians will refer to developmental milestones, aspects of the clinical assessment and results of standardized or other testing as evidence to support the current percentage of delay and to enable comparison with previous levels of functioning. If services are to continue, this recommendation should be clearly supported.**

6. Recommendations for the next six (6) months. (Include suggested changes in outcomes, strategies/ techniques and activities).

I certify that I received a copy of the child's IFSP and evaluation prior to starting services, and have provided the above services in accordance with the frequency and duration mandated in the IFSP. Additionally, I have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: ____

License No.______________ **(If certified interventionist, do not indicate certificate number)**

NYC EARLY INTERVENTION PROGRAM

THIRD AND NINTH MONTH PROVIDER PROGRESS REPORT

Child's Name: ____ D.O.B._____/______/______
EI ID #: ______________________ IFSP Period: From: ____/____/____ To: _____/____/____

Check As Appropriate: [ ] Third Month [ ] Ninth Month

Provider Agency Name: ______________________________________ Prov. ID #: __________

Name of Interventionist Completing Report: ____

Discipline: _____________________

IFSP Service Type: ____

PROGRESS TO DATE: Include: a) status of IFSP outcomes (outcomes worked on and met); b) child's response to services; and c) progress

RECOMMENDATIONS FOR THE NEXT THREE (3) MONTHS. (Include suggested changes in outcomes, strategies/ techniques and activities).

I certify that I received a copy of the child's IFSP and evaluation prior to starting services, and have provided the above services in accordance with the frequency and duration mandated in the IFSP. Additionally, I have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: ____

License No.________________ **(If certified interventionist, do not indicate certificate number)**

NYC EARLY INTERVENTION PROGRAM

REQUESTS FOR AMENDMENT(S) TO CHANGE AN EXISTING IFSP SERVICE

The service coordinator must ensure that the Regional Office receives the following information when a change in an existing IFSP service plan is being requested:

1) Most current **Provider Progress Report** (third, sixth, ninth month, and annual).

2) **Request for a Change in Frequency, Method, or Location of Service Currently on an IFSP** form written by the service provider. This form must include the reason(s) why the request is being made and the reason(s) why current strategies, method, or location are not meeting the IFSP outcomes. For example, were there issues due to time of day, too many therapists back to back, changes in therapists, child health, or gaps in services? How will the requested change help to better meet the IFSP outcomes?

3) Any other documentation supportive of the requested change, including current physician prescription when appropriate.

Please note that an EIOD may require an independent evaluation for a request for change in service, particularly if the request is made within the first six months of initiation of the IFSP.

NYC EARLY INTERVENTION PROGRAM
REQUEST FOR A CHANGE IN FREQUENCY, METHOD OR LOCATION OF SERVICE CURRENTLY ON AN IFSP

Type or print legibly

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

EI ID #:__________________ IFSP Period: From:_____/_____/_____ To:_____/_____/_____

Provider Agency Name: _______________________________________Prov. ID #: ___________

Name of Person Completing Report:____________________________________

Discipline: ________________________________ Date: _______/_____/_____

Check as appropriate: Service Type:____________________________________

[ ] Request for increase in service: From :___________________To:________________

[} Request for a decrease in service: From:_________________To:_________________

[ ] Change in location/method of service: From: _____________________ To: _______________

[ ] Request for termination of service. Effective date: ______________________

Attach most current Provider Progress Report (3 mo., 6 mo., 9 mo., annual)

1. For increase or decrease in service: a) Why is the request being made? b) Why are the current plan and/or strategies not sufficient to meet IFSP outcomes? c) Have outcomes been met? d) Did this service start when authorized and has it been delivered as authorized on the IFSP?

2. For termination of service. Explain:

3. For change in location/method of service: a) Why is the request being made? b) Why can't the IFSP outcomes be met in the current location or by the current method? c) Has this service been delivered as authorized?

I certify that I have provided the above services in accordance with the frequency and duration mandated in the IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: ____

License No**.**_______________ **(If certified interventionist, do not indicate certificate number)**

INSTRUCTIONS FOR COMPLETION
REQUEST FOR A CHANGE IN FREQUENCY, METHOD OR LOCATION OF SERVICE CURRENTLY ON AN IFSP

Type or print legibly

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

EI ID #:__________________IFSP Period: From: _____/_____/_____ To: _____/_____/_____

Provider Agency Name: ____Prov. ID #: ___________

Name of Person Completing Report:_____________________________________

Discipline: __________________________________ Date: _______/_____/_____

Check as appropriate: Service Type:____

[ ] Request for increase in service: From :_____________________To:_________________

[ ] Request for a decrease in service: From: __________________ To:_________________

[ ] Change in location/method of service: From: __________________ To: _________________

[ ] Request for termination of service. Effective date:_______________________________

Attach most current Provider Progress Report (3 mo., 6 mo., 9 mo., annual)

1. For increase or decrease in service: a) Why is the request being made? b) Why are the current plan and/or strategies not sufficient to meet IFSP outcomes? c) Have the outcomes been met? d) Did this service start when authorized and has it been delivered as authorized on the IFSP?
Review the reason(s) for the request, and why current strategies are not meeting the IFSP outcomes. Are there issues due to factors such as time of day, too many therapists back to back, changes in therapists, child health, or gaps in services? How will an increase in the service(s) help to better meet the IFSP outcomes?

2. For termination of service. Explain: Review the progress that has been made, and the child's current developmental status.

3. For change in location/method of service: a) Why is the request being made? b) Why can't the IFSP outcomes be met in the current location or by the current method? c) Has this service been delivered as authorized?
Review the reason(s) for the request and why the IFSP outcomes cannot be met by the current location/method. How will a change in location/method of the service(s) help to better meet the IFSP outcomes?

I certify that I have provided the above services in accordance with the frequency and duration mandated in the IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: ____

License No.________________ **(If certified interventionist, do not indicate certificate number)**

NYC EARLY INTERVENTION PROGAM
IFSP CONSENT PAGE

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

EI ID #: _______________________________ Date: _____/_____/_____

- I have received a copy of **A Parent's Guide**. My rights as described in this guide have been explained to me and I understand them.
- I understand that I can request to review my child's file or request an amendment to the file.
- I understand that this is a family service plan and that my active involvement may result in better outcomes for my child and family.
- I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receive.
- I understand that if I have any questions or concerns at any time about the services in this IFSP, I should contact my service coordinator or the EIOD.
- I understand that services may increase, stay the same, be reduced, or terminate, depending upon the continuing needs and eligibility of my child.

____ _____/_____/_____
Signature Date

I (We) have participated in the development of this IFSP and agree to all aspects of this plan. I (we) give permission to the NYC Early Intervention Program to implement this plan.

____ _____/_____/_____
Signature Date

____ _____/_____/_____
Signature Date

I (We) do not agree with some aspects of this plan. I (We) understand that I (we) have due process rights that are described in the **Parent's Guide** and that have been explained at this meeting. This is what I (we) do not agree with:

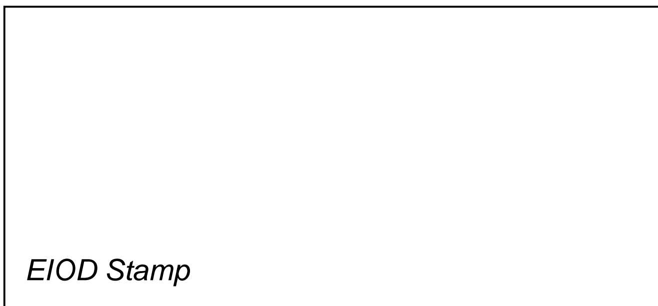
____ _____/_____/_____
Signature Date

____ _____/_____/_____
Signature Date

Ongoing Service Coordinator: ________________________________Tel. #: ______________________

Service Coordination Agency/ Tel.#: ____

EIOD: ____Telephone number: ______________



EIOD Stamp

NYC EARLY INTERVENTION PROGRAM
IFSP ATTESTATION PAGE

Child's Name:____

EI ID #:_________________________________ Date of IFSP:_____/_____/_____

EVALUATION REPRESENTATIVE: I certify that I am qualified personnel as defined in the New York State Early Intervention Regulations, and that I am representing the Multidisciplinary Evaluation Team for the above-named child. I further certify that I have personally evaluated this child and/or have read the complete multidisciplinary evaluation, am knowledgeable about the clinical needs of this child and family, and am able to make appropriate recommendations for services during the IFSP meeting.

Signature: _____________________________________ Date: ____/_____/_____

EARLY INTERVENTION OFFICIAL DESIGNEE (EIOD). I certify that the services that I have authorized in this IFSP are based upon the review of the documentation provided by the evaluators and the discussion that took place at the IFSP meeting as documented in the IFSP.

Signature: _____________________________________ Date:_____/_____/_____

Please note: The Early Intervention Official Designee may be contacted by the parent, service provider or service coordinator at any time after this meeting if there are any concerns about the implementation of this plan.

This page must be signed at the initial IFSP meeting by the evaluation site representative and the EIOD and attached to the completed IFSP.

NYC EARLY INTERVENTION PROGRAM

SUMMARY OF MULTIDISCIPLINARY EVALUATION/SCREENING

Please check one: Evaluation Screening

Child's EI ID Number: ___________________ Date of Eval/Screening:_____/_____/_____
Child's Name:____ DOB:_____/____/____

SIGNATURE OF PERSON COMPLETING SUMMARY: I certify that the determination of eligibility and the summary of multidisciplinary evaluation are based upon an interview with the above-named child's parent (or other guardian if there is no available parent), a general assessment of the child's level of functioning in each of the five developmental domains, as well as an in-depth assessment in the specific domain(s) in which there is a suspected delay. I further certify that to the best of my knowledge, age-appropriate instruments and procedures and informed clinical opinion were employed in such assessments.

____ Date: _____/_____/________

<u>Summary of Evaluation:</u>

I. Description of child's current levels of functioning in cognitive, communication, physical (motor skills), social/ emotional, and adaptive domains.
II. The child's medical status. (Please attach recent physical).
III. Summary of family assessment.
IV. Description of assessment process and conditions.
V. The child's responses and whether the family believes the responses were optimal.
VI. An explanation of the scores or measures reported.
VII. Nature of child/family's transportation needs.

If evaluation was conducted bilingually, this summary must be translated and attached to this form (unless it is clearly not feasible to do so).