

**Kentucky Early Intervention Program**

# Policy & Procedure Manual

**2021**



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## **Introduction**

Kentucky's Early Intervention System is a statewide, comprehensive, coordinated, multidisciplinary, interagency system designed to provide early intervention services for infants and toddlers with disabilities and their families. This system is authorized by PL 108-446, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), Part C.

The U.S. Department of Education, Office of Special Education Programs (OSEP) is responsible for oversight of Part C programs. OSEP monitors programs through the State Performance Plan (SPP) and Annual Performance Report (APR).

The Cabinet for Health and Family Services (CHFS), Department of Public Health (DPH), Division of Maternal and Child Health (MCH), Early Childhood Development (ECD) Branch is the lead agency for the Kentucky Early Intervention System (KEIS).

This manual provides the policy and procedures for the implementation of the state and federal statutes and regulations.

Points of Entry (POE) staff, agency administrators, and early intervention service providers are responsible for complying with the information contained in this manual, in addition to the specifications and deliverables in their respective contracts.

# Definitions

**Ability to Pay:** a family's financial ability to help with the cost of early intervention services.

**Advocate:** a person requested by the family to help the family decide on services the child may need and understand the rights provided by law.

**Amendment or Requested Review:** changes made to the current Individualized Family Service Plan (IFSP) or early intervention record.

**Annual Performance Report (APR):** a yearly report submitted to the US Department of Education, Office of Special Education (OSEP) that describes the state's progress towards performance targets for each performance indicator identified by OSEP. The State Interagency Coordinating Council is required to certify the APP or submit a separate progress report.

**Assessment:** the ongoing procedures used by appropriately qualified service providers throughout a child's period of eligibility in First Steps to identify:

- the child's unique strengths and needs;
- the services appropriate to meet those needs;
- the resources, priorities, and concerns of the family; and
- the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

Initial assessment, conducted before the child's first Individualized Family Service Plan (IFSP) meeting, includes the assessment of the child and family.

**Assistive Technology Device:** any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, used to increase, maintain or improve the functional capabilities of a child with a disability and is necessary to implement the Individualized Family Service Plan (IFSP). The term does not include a surgically implanted medical device, including a cochlear implant or the optimization (mapping), maintenance, or replacement of that device.

**Assistive Technology Service:** a service that directly assists the child with a disability in the selection, acquisition, or use of an assistive technology device; and includes the evaluation of the needs of the child with a disability including a functional evaluation of the child in the child's customary environment.

**Child Abuse Prevention and Treatment Act Reauthorization Act of 2010 (CAPTA); reauthorized in the Victims of Child Abuse Act Reauthorization Act of 2018:** key piece of legislation that guides child protection. 42 U.S.C. 5106 a (b)(2)(B)(xxi)

**Child Find:** a system to identify, locate and evaluate all infants and toddlers with disabilities who are eligible for early intervention services, determine the children who are receiving services, and coordinate the effort with other state agencies and departments.

**Confidentiality:** the nondisclosure of personally identifying information about the child and family, per the applicable provisions of the Individuals with Disability Education and Improvement Act of 2004 (IDEA), Family Education Rights and Privacy Act (FERPA), and Health Insurance Portability and Accountability Act (HIPAA) regulations.

**Consent:** the parent or guardian, after being fully informed in their native language or other familiar mode of communication, of all information relevant to the activity for which consent is sought, agrees in writing to the carrying out of the activity. Consent is voluntary and may be withdrawn at any time.

**Consultative Model:** a partnership model of service delivery wherein parents and/or other primary caregivers and service providers work collaboratively to meet a child's developmental needs, address parent concerns, and achieve success by promoting the competencies of all parties.

**Developmental Delay:** a lag that occurs when a child has not reached an expected milestone of development in the domains of cognitive development, physical development, including vision and hearing, communication development, social or emotional development, and adaptive (self-help skills) development. The eligibility criterion for developmental delay is:

Two (2) standard deviations below the mean in one (1) domain of development or skill area; or, one and one-half (1 1/2) standard deviations below the mean in two (2) domains of development or skill areas.

**Destruction:** the physical destruction of the child's early intervention record or ensuring that personal identifiers are removed from a record so that the record is no longer personally identifiable.

**Direct Supervision:** the continuous, on-site observation and guidance of a First Steps provider by another First Steps provider while implementing activities with children and families.

**District Child Evaluation Specialist (DCES):** an individual housed at the Point of Entry (POE) who ensures that referrals to First Steps are appropriate, oversees administration of high-quality evaluations and assessments, and provides leadership/guidance to IFSP teams in synthesizing assessment information that results in effective IFSPs.

**Due Process:** the formal procedures to resolve parental complaints about the identification, evaluation, or placement of their child or the provision of appropriate early intervention service(s) to the child or family.

**Early Intervention Record:** all records, electronic and hard copy regarding a child that are collected, maintained, or used in First Steps.

**Early Intervention Services:** services for infants and toddlers with disabilities and their families delivered according to an Individualized Family Service Plan (IFSP) developed by the child's multidisciplinary team to meet the developmental needs of eligible children and provided by entities receiving public funds using qualified personnel. The IFSP is developed and the services provided in collaboration with the families and to the maximum extent appropriate, in natural environments, including home and community settings in which infants and toddlers without disabilities would participate. This definition also includes the descriptions of each discipline for early intervention services found in 34 CFR 303.12.

**Established Risk Condition:** a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

**Evaluation:** the procedures to determine eligibility for First Steps. Activities include gathering information about the child and family, review of relevant health records, child assessments and tests to identify the current level of developmental functioning, and a family assessment of concerns, priorities, and resources.

**Family Centered:** practices that are driven by a family's priorities and choices; that support the family's role in recognition as the constant in a child's life; that complement a family's natural activity settings and daily routines, and that support, respect, encourage and enhance the strengths, competence, and confidence of the family.

**Family assessment:** a voluntary process designed to identify the family's resources, priorities, and concerns, and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability. This assessment must be conducted in the native language of the family member being assessed, be based on information obtained through both an assessment tool and interview with those family members who elect to participate in the assessment.

**Family Education Rights and Privacy Act (FERPA):** a federal law that describes the maintenance and sharing of personally identifiable information in education records. The early intervention record is an education record and as such, must be maintained in compliance with FERPA. 34 CFR Part 99.

**Free Appropriate Public Education (FAPE):** an entitlement protected by law ensuring that a child with a disability is afforded an education designed to meet the child's educational needs at no cost to the family and provided under public supervision. FAPE is provided to eligible children, beginning at age three (3), through public schools.

**Health Insurance Portability and Accountability Act (HIPAA):** a federal law created in 1996 to help secure families with health insurance. Title II of HIPAA, the Administrative Simplification (AS) provisions address the security and privacy of health data, whether electronic or paper. The U.S. Department of Health and Human Services (DOHHS) provides oversight of HIPAA. Some provisions of HIPAA apply to the business transactions between the State Lead Agency (SLA) and early intervention providers: 45 CFR Parts 160, 162, and 164.

**Homeless Child:** as defined by the McKinney-Vento Homeless Assistance Act (42 USC §11434a) those children who lack a fixed, regular, and adequate nighttime residence”.

**Inability to pay:** a family who is not able to help defray the cost of early intervention services. Families who have an income at or below 200% of poverty have an inability to pay.

**Indirect Supervision:** the regular, periodic, off-site guidance of a professional providing authorized early intervention services by another professional with children and families. This includes review of activity plans and reports, review of service logs, and other methods of assessing practice.

**Individualized Family Service Plan (IFSP):** a written plan that guides the provision of early intervention services to a child eligible under Part C of the IDEA and the child's family. A team that includes the family must develop the IFSP, uses evaluation and assessment information as the basis, and contain all required components.

**Individuals with Disabilities Education Improvement Act of 2004 (IDEA):** the public law that established the right to a free, appropriate, public education for children and youth with disabilities, originally known as the Education of the Handicapped Act (PL 94-142). Provisions for services to infants and toddlers (Part C) and preschoolers (Section 619) were included in the reauthorization in 1986 (PL 99-457).

**Kentucky Early Childhood Data System (KEDS):** a web-based assessment data collection system to provide data for analysis to determine the degree with which Kentucky's children are meeting major outcomes as required by Office of Special Education Programs (OSEP) in the U.S. Department of Education and state early learning standards.

**Medically Fragile:** a child who has significant medical conditions that require modifications to early intervention services and/or assessment. A physician or an advanced registered nurse practitioner must make the determination of medically fragile.

**Multidisciplinary Team:** the child-specific group including the parent(s) or guardian(s) of the child and individuals representing at least two (2) applicable disciplines responsible for determining the services needed by the infant or toddler with disabilities and the child's family. One team member must be a service coordinator.

**Native Language:** the language or mode of communication typically used by the child or parent(s).

**Natural Environments:** daily activities and settings, such as the home and community, in which the same age peers who have no disability normally participate.

**Office of Special Education Programs (OSEP):** the federal office within the U.S. Department of Education responsible for the general supervision of the Individuals with Disabilities Education Improvement Act of 2004.

**Parent:**

- (1) A natural or adoptive parent of a child;
- (2) A foster parent, if the birth parent rights have been terminated by judicial order or the birth parent, has given consent for the foster parent to co-parent for the purposes of educational decisions;
- (3) A guardian (but not the state if the child is a ward of the State);
- (4) An individual acting in the place of a natural or adoptive parent, including a grandparent, stepparent, or other relative with whom the child lives or an individual who is legally responsible for the child's welfare; or
- (5) An individual assigned to be an educational surrogate parent.

**Period of Eligibility:** the time from referral to First Steps termination of services due to failure to meet initial program eligibility requirements; attainment of age three (3); documented refusal of service by parent or legal/guardian inclusive of disappearance; or change of residence to another state.

**Personally Identifiable Information (PII):** as defined in Office of Management and Budget (OMB) Memorandum M-07-1616 refers to information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. According to 34 CFR 99.3 the term includes but is not limited to:

- (1) The student's name;
- (2) The name of the student's parent or other family members;
- (3) The address of the student or student's family;
- (4) A personal identifier, such as the student's social security number, student number, or biometric record;
- (5) Other indirect identifiers, such as the student's date of birth, place of birth, and mother's maiden name;
- (6) Other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty; or
- (7) Information requested by a person who the educational agency or institution reasonably believes knows the identity of the student to whom the education record relates  
(Authority: 20 U.S.C. 1232g).

**Protected Health Information (PHI):** under the HIPAA Privacy Rule, protected health information (PHI) refers to individually identifiable health information. Individually identifiable health information is that which can be linked to a particular person. Specifically, this information can relate to:

- (1) The individual's past, present, or future physical or mental health or condition,
- (2) The provision of health care to the individual, or
- (3) The past, present, or future payment for the provision of health care to the individual.  
Common identifiers of health information include names, social security numbers, addresses, and birth dates.

**Point of Entry (POE):** the entity responsible for implementation of the Kentucky Early Intervention System within the Area Development District (ADD) of the state, serving as the Local Lead Agency (LLA) for Kentucky's Part C Early Intervention System.

**Prematurity:** a gestational age, at birth, of less than thirty-seven (37) weeks.

**Primary Referral Source:** those in the community who have the greatest opportunity, by virtue of their work, their relationship to children of this age, or their special knowledge to refer a child to First Steps.

**Primary Service Provider/Primary Coach (PSP/Primary Coach):** one (1) professional selected by the IFSP team who serves as the team lead and provides regular support to the family.

**Provider Action:** action(s) or decision(s) by First Steps staff, and action(s) or decision(s) made by early intervention service providers relating to the identification, evaluation, placement of the child or the provisions of appropriate early intervention services.

**Qualified Service Provider:** an entity including but not limited to an individual, program, department, or agency, responsible for the delivery of early intervention services to eligible infants and toddlers with disabilities and their families, who have met the highest minimum standards of state-approved or recognized certification, licensing,



registration and other comparable requirements that apply to the area in which they are providing early intervention services. Qualifications are in the Kentucky Administrative Regulations at 902 KAR 30:150.

**Record Review Team:** a group of early intervention experts representing each discipline of early intervention providers who review complex cases for eligibility and service provision and make recommendations to IFSP teams.

**Referral:** notification to the POE of a child identified between birth and three (3) years of age who is a Kentucky resident or homeless within the boundaries of the Commonwealth and is suspected of having an Established Risk diagnosis or a developmental delay.

**Routines-Based Interview™:** a methodology for conducting the required family assessment developed by Dr. R.A McWilliam.

**State Lead Agency (SLA):** the designated staff in the Department for Public Health who are responsible for implementing the First Steps Program in accordance with 34 CFR 303 Part C of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) and KRS 200.650 to 200.676.

**State Performance Plan (SPP):** a multi-year plan developed by the state that describes the state's performance according to specific performance indicators identified by the US Department of Education, Office of Special Education. Improvement activities are included in the plan. Yearly progress reports are required.

**Surrogate Parent:** an individual appointed to make educational decisions on the child's behalf and has no interests that would conflict with the interests of the child. When a child has no parent or anyone who "acts like a parent", an appointment of an educational surrogate occurs.

**Technology-assisted Observation and Teaming Support System (TOTS):** the First Steps statewide online integrated database and management system. TOTS contain the child's early intervention record and serves as the centralized billing and monitoring system.

**Transdisciplinary Team:** professionals from various disciplines working together cooperatively by educating each other in the skills and practices of their disciplines, demonstrating a commitment to work together across traditional discipline boundaries being consistent with the training and expertise of the individual team members.

**Ward of the State:** a child who has been committed to the Cabinet for Health and Family Services or the Department of Juvenile Justice through a legal process, whether the commitment is voluntary or non-voluntary and the biological or adoptive parental rights have been terminated.

# **Chapter 1: Accessing First Steps**

The Point of Entry (POE) serves as the Local Lead Agency (LLA) for Kentucky's Early Intervention System (KEIS) and assists the State Lead Agency (SLA) to effectively implement the requirements of Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Each Area Development District (ADD) has a POE designated within its boundaries. POEs are under the direct line of supervision of the SLA. The POE/LLA is responsible for the following activities:

- (1) Local public awareness and child find;
- (2) Intake, including developmental screening;
- (3) Coordination of the multidisciplinary evaluation and assessment;
- (4) Determine eligibility;
- (5) Service coordination;
- (6) Individualized Family Service Plan (IFSP) development and implementation;
- (7) Facilitation of smooth transitions within and from KEIS program;
- (8) Provide general quality assurance activities related to program performance in the district; and
- (9) Implementation of the State Performance Plan (SPP) actions that support achievement of the indicator targets on the local level.

## **1.1 Operations of POE**

The POE/LLA office is open and accessible to parents, early intervention providers, and community stakeholders Monday through Friday for no less than an eight (8) hour period between the hours of 7:30am and 6:00pm, respective of their time zone, with the exception of generally observed holidays, closures due to inclement weather, or other unforeseen circumstances.

Staff at the POE includes at a minimum, the manager, District Child Evaluation Specialist (DCES), Service Coordinators (SC), and support staff.

The POE agrees to act in accordance with all state and federal statutes and administrative rules applicable to the provision of KEIS services.

The POE shall:

- (1) Act on all referrals, determining their appropriateness and refer to other entities when necessary within five (5) working days;
- (2) Complete initial visits to families;
- (3) Coordinate the evaluation process for eligibility determination, assessment, and initial IFSP development within forty-five (45) calendar days from receipt of the referral;
- (4) Maintain a complete record on all children served. All children in early intervention have a hybrid record. Some of the child and family's information is entered on the Technology-assisted Observation and Teaming Support System (TOTS) and some are maintained in a hard copy file. The hard copy file includes but is not limited to: *IFSP Signature Page (FS-15)*; *Record of Access Form (FS-27)*; *Surrogate Parent Identification of Need (FS-23A)* and subsequent surrogate forms (as needed); medical and health records, screening, evaluation, and assessment protocols and score sheets; notifications of meetings; and all other notices and consents;
- (5) Collect and provide child and family-specific data to the SLA via TOTS, as well as submit billing information to the SLA;
- (6) Ensure provision of early intervention services in natural environments;
- (7) Ensure office access for parents and other KEIS stakeholders;
- (8) Provide a mechanism to receive referrals twenty-four (24) hours per day, seven (7) days per week (i.e. phone, fax, e-mail, online referral portal, and mail). Enter all referrals into the online data management system (TOTS) within seventy-two (72) hours of receipt of the referral;
- (9) Establish and maintain secure email accounts for POE staff;
- (10) Ensure that each employee/subcontractor maintains a functional e-mail account;
- (11) Establish and maintain reliable internet access;
- (12) Ensure that all agency employees and subcontractors will abide by the security requirements for the online data management system;

- (13) Assign all early intervention providers who conduct assessments in the district with Kentucky Early Childhood Data System (KEDS) logon credentials and assign the appropriate caseload for assessment entry;
- (14) Abide by the POE agency's emergency operations protocol (i.e. inclement weather, fire, natural disasters, etc.);
- (15) Agree to comply with and abide by all current and future applicable federal laws and regulations, including, but not limited to: IDEA, Health Insurance Portability and Accountability Act (HIPAA) and Family Education Rights and Privacy Act (FERPA);
- (16) Agree to comply with and abide by all current and future applicable state laws and regulations, including but not limited to: the KEIS, policy and procedures and guidelines governing early intervention service providers, including but not limited to, the KEIS Provider Code of Ethical Conduct;
- (17) Maintain an office location that is non-stigmatizing with adequate accessible space and facilities to store permanent child records, house staff, hold meetings, and conduct child evaluations;
- (18) Purchase and maintain equipment to adequately meet the needs of the POE;
- (19) Participate in monitoring by the U.S. Department of Education Office of Special Education Programs (OSEP), the Department for Public Health (DPH), the Department of Medicaid Services (DMS), or other potential auditors, data collection and reporting obligations, record or chart audits, complaint investigations, district performance monitoring, and consumer satisfaction surveys;
- (20) Provide qualified personnel to fulfill the required staffing positions;
- (21) Employ a dedicated full-time Program Manager who under normal circumstances shall not carry a service coordination caseload;
- (22) Employ, supervise, and support a sufficient number of qualified service coordination staff to implement all requirements of the Part C Early Intervention System;
- (23) Employ, supervise and support sufficient clerical staff for providing clerical support to the KEIS POE manager and service coordination staff;
- (24) Employ, supervise and support a sufficient number of staff to perform the functions of qualified child evaluation specialists;
- (25) Require a notice upon termination of employment;
- (26) Notify DPH upon receipt of a resignation or termination letter for all POE Managers, DCESs and SCs;
- (27) Provide a toll-free telephone number and a local telephone number dedicated for the POE office hotline that shall be accessible twenty-four (24) hours per day;
- (28) Maintain records documenting that contract deliverables are met;
- (29) Ensure all child, agency, and staff related information required shall be submitted on TOTS under the timelines as outlined;
- (30) Provide transition services to all eligible children in accordance with KEIS regulations, policies, and procedures; and
- (31) Develop and implement activities that shall keep district performance at the highest level or above the state performance indicator targets as outlined in the SPP and reported in the Annual Performance Report (APR).

## **1.2 Role of POE Manager**

Each POE has a dedicated manager as the lead position for the POE.

The POE manager shall:

- (1) Provide administrative oversight of the POE;
- (2) Participate in the hiring of all POE staff;
- (3) Maintain sufficient service coordination staff to ensure appropriate caseloads;
- (4) Ensure that families are assigned a single SC;
- (5) Ensure that all POE staff participates in regular opportunities for peer-to-peer collaboration and support;
- (6) Immediately notify the SLA of vacancies for any of the positions funded by the POE contract;
- (7) Train and supervise all SCs, DCES, and clerical staff according to program standards and requirements;
- (8) Monitor and analyze contract performance, including regular assessment of the accuracy of contract performance data;
- (9) Review the performance of all SCs using the KEIS Performance Standards as outlined in the POE contract;
- (10) Participate in activities to recruit early intervention providers to ensure all needs of KEIS children within the POE district are met;
- (11) Monitor and analyze service coordination documentation and data entry;

- (12) Ensure all billable POE activities are billed through the TOTS system;
- (13) Monitor and review the IFSP for eligible children on an ongoing basis to ensure that children's IFSP meet their developmental needs and ensure implementation of the IFSP with timely and appropriate service in compliance with State Regulations;
- (14) Coordinate Child Find and Public Awareness activities and address concerns regarding KEIS participation in the POE district;
- (15) Work with primary referral sources within the POE district to ensure receipt of valid referrals;
- (16) Identify and work to address barriers to referral and enrollment of children who may be eligible for the KEIS Program;
- (17) Develop and submit all required SLA reports;
- (18) Establish and maintain relationships with KEIS service providers, agencies, local health departments, local maternal and child health partners, infant and maternal mental health resources, local social service agencies, local and other referring pediatricians and pediatric subspecialists, local public and private education agencies, local child care providers, and other KEIS stakeholders;
- (19) Provide general quality assurance activities related to program performance in the POE district to include reviewing and improving district performance data, monitoring and resolving disputes or complaints at the district level and carrying out activities needed to improve district performance;
- (20) Work with SLA staff to investigate and resolve complaints in the District;
- (21) Notify providers who do not complete progress monitoring reports within timelines to ensure compliance with regulations, and report such to the SLA if the delays continue;
- (22) Participate in meetings with SLA as requested;
- (23) Develop and maintain a resource guide for families of children who do not meet KEIS eligibility criteria;
- (24) Ensure that a KEIS staff person is available at the POE office during regular state working hours; and
- (25) Participate in training as outlined by the SLA.

### **1.3 Role of District Child Evaluation Specialists (DCES)**

The DCES works to enhance the quality and appropriateness of First Steps services. Each POE has at least one (1) DCES.

The DCES shall:

- (1) Ensure there is a completed developmental screening for children referred to KEIS for suspicion of a developmental delay using a Cabinet-approved screening protocol;
- (2) Determine the disciplines needed for eligibility determination and, in collaboration with the SC, coordinate the multidisciplinary evaluation and any further assessment when needed;
- (3) Complete Five Area Assessments (5AA) using a Cabinet-approved, criteria-referenced instrument with children who have a diagnosed established risk (ER) condition;
- (4) Conduct initial evaluations as specified in the DPH/POE contract;
- (5) Ensure a health assessment is entered on TOTS;
- (6) Synthesize all information gathered on a child and determine eligibility;
- (7) Provide input to the development of initial IFSPs by attending the IFSP meeting in person or by consulting with the assigned SC to review evaluation and family assessment results;
- (8) Review all protocols and written evaluation reports from contracted primary level evaluators to ensure quality;
- (9) Facilitate the Record Review process for the district;
- (10) Be subject to periodic and ongoing review by representatives from the KEIS program to ensure their work demonstrates knowledge of child development and adherence to KEIS program standards;
- (11) Seek technical assistance when needed from the Record Review team;
- (12) Assist the SLA, POE Manager, and other POE staff in ensuring the provision of quality services in the district within the required timelines; and
- (13) Participate in training as outlined by the SLA.

### **1.4 Role of Service Coordinator (SC)**

Service coordination is the primary service provided through the POE. Service coordination means the activities carried out by an individual to assist and enable the child and the child's family to receive the rights, procedural safeguards and services authorized under the state's early intervention system. Each eligible child and the child's family must be provided with one (1) SC.

The SC shall:

- (1) Assist parents of infants and toddlers with significant developmental delays in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families;
- (2) Coordinate the provision of early intervention services and other services that the child needs or is currently provided;
- (3) Coordinate evaluations and assessments;
- (4) Facilitate and participate in the development, review and evaluation of IFSPs;
- (5) Conduct referral and other activities to assist families in identifying available KEIS providers;
- (6) Coordinate, facilitate and monitor the delivery of services required to ensure that service provision is timely;
- (7) Conduct follow-up activities to determine the provision of appropriate Part C services;
- (8) Inform families of their rights and procedural safeguards;
- (9) Coordinate the funding sources for services;
- (10) Facilitate the development of a transition plan to preschool, school, or if appropriate, to other services;
- (11) Explain to families in detail all requirements of the KEIS system of payments, including all provisions for the use of public insurance, private insurance and family participation fees;
- (12) Understand the use of KEIS funds as the payor of last resort; and
- (13) Participate in training as outlined by the SLA.

#### **1.4 (1) Service Coordinator Responsibilities**

SCs must document all face-to-face meetings and phone calls as billable service activities in a service log. All non-billable service activities (i.e. emails, text messages, voice mails, faxes, mailed correspondence, etc.) must be documented in a communication log on TOTS. All documentation must occur within ten (10) calendar days of service. This includes all contacts with families, early intervention providers, community partners, and other resources.

Documentation shall include:

- (a) the date of contact;
- (b) amount of time spent;
- (c) reason for contact;
- (d) type of contact whether by telephone or face-to-face;
- (e) result of contact; and
- (f) plan for further action.

See the "Quick Reference- POE Responsibilities" document in the Appendix for further reference.

#### **1.5 Role of Administrative Staff**

Administrative staff assist POE staff to ensure that things run smoothly at the POE office.

The Administrative Staff shall:

- (1) Provide administrative support to the POE Manager, service coordination staff, and DCES including, but not limited to, answering phones, sending and receiving faxes, copying, mailing, filing, and other KEIS duties as assigned; and
- (2) Participate in training as outlined by the SLA.

## **Chapter 2: Public Awareness/Child Find**

Federal law requires that all infants and toddlers who are potentially eligible for early intervention services under Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) be identified and evaluated. Public Awareness materials developed by the State Lead Agency (SLA) are designed to inform parents with infants and toddlers birth to three (3) with risk factors associated with learning or developmental complications on the availability of early intervention services. Other supplemental materials developed by the Point of Entry (POE) also inform parents on the availability of early intervention services. The POE works with the primary referral sources in their geographic area to develop procedures for disseminating public awareness materials and other information in such a way as to reach parents of children with suspected or confirmed disabilities or delays. POE efforts specifically target parents with infants and toddlers suspected of having a developmental delay on the availability of early intervention services.

Primary referral sources identified in law are those agencies that have major efforts to locate and identify children and that have frequent contact with families. Primary referral sources include but are not limited to:

- (1) Local school districts special education (Part B of IDEA) programs;
- (2) Managed care agencies, including Early and Periodic Screenings, Diagnosis and Treatment (EPSDT) programs;
- (3) Early Head Start and Head Start;
- (4) Homeless shelters;
- (5) Supplemental Security Income (SSI) programs;
- (6) Local Department for Community Based Services (DCBS);
- (7) Programs authorized through the Developmental Disabilities Assistance and Bill of Rights Act;
- (8) Child care programs;
- (9) Programs providing services under the Family Violence Prevention and Services Act;
- (10) Office for Children with Special Health Care Needs (OCSHCN), including the Early Hearing Detection and Intervention (EHDI) program;
- (11) The Kentucky Children's Health Insurance Program (K-CHIP);
- (12) Hospitals and physicians; and
- (13) Programs through the Department for Public Health (DPH).

Federal regulations require that primary referral sources refer a child as soon as possible but no later than seven (7) days after identification of the child. Children who are subjects of a substantiated case of abuse or neglect and children identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure must be referred to First Steps.

A general-purpose referral form, *Referral Form (FS-1A)*, is included in the forms section of this manual. This referral form is distributed to the primary referral sources throughout the state. There is a specific referral form for use with the DCBS. The *DCBS Referral Form (FS-1B)* requests information that is relevant for children under the care and custody of DCBS.

Referrals to the POE can also be made through the online referral portal at:

<https://www.kytots.org/tots/ReferralPortal.aspx> The *Referral Portal Letter (FS-19)* is used to assist primary referral sources in obtaining a login for the portal and instructions on how to make the referral.

All POEs are required to complete a Child Find Plan. Child Find is a system to identify, locate and evaluate all infants and toddlers with disabilities who are eligible for early intervention services, determine which children are receiving services and coordinate the efforts with other state agencies and departments. The *Child Find Plan (FS-28)* must be submitted to the SLA for approval no later than August 1 each year. Results of the planned activities are submitted to the SLA no later than May 1 of the subsequent year.

## **Chapter 3: Procedural Safeguards**

The procedural safeguards required by Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) are intended to protect the interests of families with infants and toddlers with developmental delays or disabilities and of the early intervention system. Procedural safeguards are the checks and balances of the system, not separate from the system. Rights and safeguards help ensure that an Individualized Family Service Plan (IFSP) is developed with families that address their priorities and concerns. For the early intervention system, rights and safeguards ensure quality and equity. For families and the system, procedural safeguards provide the protection of an impartial system for complaint resolution.

Early intervention system personnel are legally obligated to explain procedural safeguards to families and to support an active adherence to and understanding of these safeguards throughout the early intervention system.

In order for families to be fully informed of their rights and safeguards, they must understand the early intervention system and their role as partners and decision-makers in the early intervention process. They should be advised that the intent of Part C of IDEA is to enhance families' abilities to meet the special needs of their infants and toddlers by strengthening their authority and encouraging their participation in meeting those needs (Hurth & Goff, 2002).

### **3.1 Family Rights**

#### **3.1 (1) Native Language**

All families have the right to information in their native language. Native language is defined as the language normally used by the parents of the child. For evaluations and assessments, providers use the child's native language. If the individual is deaf, hard of hearing, blind, visually impaired, deaf-blind, or is an individual who has no written language, the provider must use the mode of communication that is normally used by the individual (Braille, sign language, or oral communication). For early intervention services, the preferred language of the family may be used.

#### **3.1 (2) An Evaluation**

All children and families referred to the early intervention program have the right to a timely, comprehensive and multidisciplinary evaluation to assist in eligibility determination. No one criterion determines eligibility. The evaluation of the child must occur prior to eligibility determination and conducted by a multidisciplinary team of two (2) or more qualified professionals who examine the child's medical history, development and current abilities. If the child is eligible for services, the child has the right to ongoing assessments of the child's strengths, skill levels, progress and needs. The family has the right to a family assessment of their resources, priorities and concerns. This family assessment is voluntary.

#### **3.1 (3) An Individualized Family Service Plan (IFSP)**

Within forty-five (45) calendar days of the referral, each eligible child must have a written IFSP for providing early intervention services that includes the concerns, priorities and resources for the child and family. The IFSP is valid for a year and reviewed at least every six (6) months. It includes the measurable results or outcomes for the child and family, how progress will be measured, when services will begin and for how long, methods of payment, and transition at various times throughout the plan.

#### **3.1 (4) Educational Surrogate Parent (Representation of Children)**

A parent or someone who is acting as a parent represents all children. In cases where the parent is not responsive or cannot be identified, an educational surrogate parent is appointed and afforded all rights allowed by Part C of IDEA. The educational surrogate can make decisions about the early intervention services for the child. The person appointed as the educational surrogate cannot be a contracted early intervention provider, an employee of the Point of Entry (POE), anyone with a state agency that is involved in the care of the child or someone with personal or professional interest that conflicts with the interests of the child. Additionally, the educational surrogate shall have knowledge and skills to ensure

adequate representation of the child. More information about an Educational Surrogate is in Chapter Five (5) of this manual.

### **3.1 (5) Parent Consent**

Written parental consent must be obtained before:

- (a) conducting a screening, evaluation or assessment;
- (b) initiating the provision of early intervention services;
- (c) using private insurance for payment of early intervention services;
- (d) increasing the frequency, length, duration or intensity of any early intervention service; and
- (e) disclosing personally identifiable information.

### **3.1 (6) Consent without Jeopardy**

Parents may choose to refuse consent for any particular service without jeopardizing other services. They may revoke consent at any time, without affecting other early intervention services.

### **3.1 (7) Privacy-Confidentiality**

The law provides for the protection of family privacy at all times. Written consent must be obtained before personally identifiable information is:

- (a) disclosed to anyone other than officials of participating agencies collecting or using the information under Kentucky's Early Intervention System (KEIS); or
- (b) to be used for any other purpose than meeting the requirements under IDEA.

The Family Educational Rights and Privacy Act (FERPA), Section 99.31 specifies when information can be released from records to participating agencies without parental consent. Release of information is further defined in Chapter twelve (12) of this manual.

### **3.1 (8) Prior Notice for Services**

Parents must receive prior written notice at least five (5) working days before there is an initiation of change to the identification, evaluation or placement of a child or the provision of early intervention services to the child and family. This notice must inform the parent of the action(s) being proposed or refused and the reason(s) for the action(s). The family must receive their procedural safeguards with the notice. Notices must be written in a way that is understandable to the general public. If English is not the native language of the family, the family has the right to receive information in their native language, unless it is clearly impossible to do so. If a family uses another method of communication, such as sign language or Braille, they have the right to receive information in that method.

### **3.1 (9) Information on Early Intervention Records**

Parents receive written notice of records collected and maintained by KEIS that includes their rights regarding their child's records. Additionally, this Notice includes a description of the types of records collected and maintained, as well as the policy for storage, destruction, disclosure to third parties and required length of retention.

### **3.1 (10) Review Records**

Parents have the right to inspect or review all early intervention records pertaining to their child. This includes all records maintained on the Technology-assisted Observation and Teaming Support System (TOTS) and in the hard copy file.

Parents may request amendments to the records in writing. The POE forwards the request to the State Lead Agency (SLA). If justified, the SLA will amend the record and notify the parent in writing of the change. If the SLA disagrees or refuses to amend the record, the parents may request a hearing to challenge the information contained in the file. If, as a result of the hearing, the information is found to be inaccurate, misleading or otherwise in violation of the privacy or other rights of the child, the SLA will change the information accordingly and inform the parents in writing.



### **3.1 (11) Mediation**

Parents may use mediation to resolve concerns before going to a due process hearing. This is voluntary and does not take away the right to a due process hearing. Mediation services are at no cost to the family. Both parties who will be participating in the mediation agree to a trained mediator selected from a list maintained by the Administrative Hearings Branch of the Cabinet for Health and Family Services (CHFS). The mediation session will be scheduled at a location and time mutually agreed upon by the parties. No more than three (3) people can accompany each party to the session unless both parties mutually agree to allow more. Attorneys are not allowed to participate or attend the mediation session. A lay advocate may accompany parents.

All discussions held during the mediation are confidential and cannot be used later as evidence in a due process hearing or civil action. Mediation shall be completed within thirty (30) working days of the receipt by the department of the written request for mediation. Mediation is requested by submitting the *Mediation/Due Process Request (FS-21)*.

### **3.1 (12) Administrative Appeal (Due Process or Individualized Child Complaint Resolution)**

Parents have the right to resolve, through a procedure called due process, concerns about their child's identification (eligibility), evaluation, placement or the provision of early intervention services. A request for a due process hearing may arise from the proposal or refusal of a service provider to initiate or change the identification, evaluation, placement or provision of early intervention services.

To initiate a due process hearing, a written request with a statement of the concerns must be submitted on the *Mediation/Due Process Request (FS-21)* to the Administrative Hearings Branch of the CHFS. Parents are offered the opportunity to use mediation to resolve concerns before going to a due process hearing. Should the family decide that they do not want mediation services, a due process hearing will be held to review their concerns. The due process hearing will be held at a time and place that is reasonably convenient to the family. The family will be notified if a hearing is warranted within fifteen (15) calendar days of receipt of the written request for a due process hearing. If so, the hearing will be held.

An officer named by the Secretary of the Cabinet will conduct the hearing. This hearing officer shall be knowledgeable of services for infants and toddlers and shall not be an employee of any state agency or service providers responsible for providing early intervention services to the child. There shall not be any personal or professional conflict of interest that would affect the hearing officer's objectivity in making a decision.

At the hearing, parents may be accompanied and advised by counsel and by individuals with special knowledge or training in early intervention services for children with disabilities. Parents may present evidence and confront, cross-examine and compel the attendance of witnesses. At the hearing, parents may prohibit the introduction of evidence that has not been disclosed to them at least five (5) calendar days prior to the hearing. A record of the proceedings will be maintained. A written or verbatim transcription of the proceedings may be obtained.

The hearing officer will listen to the presentation of the parties involved, examine relevant information and reach a timely resolution. Both parties will receive a copy of this decision in writing. If parents disagree with the final decision, they have the right to bring civil action. This action may be brought in a state or federal district court.

During these proceedings, unless otherwise agreed to by the parents and the agency, the child will continue to receive the early intervention services that were being provided at the time the request for due process hearing was made.

### **3.2 Complaints to the SLA**

Any individual may file a complaint if they feel that a lead agency, public agency or early intervention provider has violated the requirements of Part C of IDEA (by submitting the *Complaint Form (FS-20)*). The party filing the complaint must also forward a copy of the complaint to the entity or individual that the allegations involve.

The complaint must be in writing and include:

- (1) A statement that the SLA, POE or early intervention provider has violated a requirement of state or federal law;
- (2) The facts on which the statement is based; and
- (3) The signature and contact information of the complainant.

If the complaint alleges violations regarding a specific child, the following must be included:

- (1) The name and address of the child;
- (2) The name of the early intervention provider(s) serving the child (if applicable);
- (3) A description of the problem concerning the child, including facts relating to the problem;
- (4) Proposed resolution of the problem; and
- (5) The complaint must allege a violation that occurred not more than one (1) year prior to the date that the complaint was received.

The complaint is investigated and resolved within sixty (60) calendar days. A written decision addressing each allegation with finding of fact conclusions and the reasons for the final decision will be sent to the party filing the complaint as well as any entity or individual named in the allegations.

**Procedural Safeguards: Parent Prior Written Notice and Consent Requirements**

Initial IFSP					
Procedural Safeguards Associated with Initial IFSP	Prior Written Notice Required		Written Consent Required		First Steps Form
	YES	NO	YES	NO	
Surrogate Parent Identification of Need		✓		✓	FS-23A
Notice for Use of Medicaid (if applicable)	✓			✓	FS-12B
Notice & Consent for Use of Private Insurance	✓		✓		FS-12A
Notice of Confidentiality, Privacy Practices & Records	✓			✓	FS-29
Transition Notice & Consent	✓			✓	FS-11
Notice of Referral to LEA/KDE ( <i>for children 2 years, 10 1/2 months or older only</i> )	✓		✓		FS-3
Notice & Consent for Release of Child Outcome Data to the Kentucky Center for Statistics (KYSTATS)	✓		✓		FS-6
Initial Screening, Evaluation & Assessment (includes Record Review if necessary for eligibility determination)	✓		✓		FS-8
Initial Discipline Specific Assessment (conducted as part of the initial evaluation for eligibility)	✓		✓		FS-8
Determination of Ineligibility/refusal to develop an IFSP	✓			✓	FS-9
Initial early intervention service	✓		✓		FS-15

**Procedural Safeguards: Parent Prior Written Notice and Consent Requirements**

Six Month and Requested Review IFSP					
Procedural Safeguards associated with Six (6) Month IFSP Review Meeting or Requested Review IFSP Meeting	Prior Written Notice Required		Written Consent Required		First Steps Form
	YES	NO	YES	NO	
Revision of Outcome (only if no change to early intervention services)		✓		✓	
Add new early intervention service	✓		✓		FS-9 FS-15 FS-12A (if insurance is payor source)
Increase frequency, length, duration, intensity, and/or method of early intervention service	✓		✓		FS-9 FS-15 FS-12A (if insurance is payor source)
Decrease frequency, length, duration, intensity, and/or method of early intervention service (includes ending an early intervention service)	✓			✓	FS-9
Intensive Level Evaluation (if not conducted as part of initial evaluation)	✓		✓		FS-30
Record Review (for service exception)	✓		✓		FS-30

**Procedural Safeguards: Parent Prior Written Notice and Consent Requirements**

Annual IFSP					
Procedural Safeguard Associated with Annual IFSP	Prior Written Notice Required		Written Consent Required		First Steps Form
	YES	NO	YES	NO	
Notice of Action for Annual Eligibility Determination (60 days prior to annual IFSP date)	✓			✓	FS-18
New or Revised Outcome	✓			✓	FS-18
Notice for Use of Medicaid (if applicable)	✓			✓	FS-12B
Notice & Consent for Use of Private Insurance (if insurance is payor source for any service)	✓		✓		FS-12A
Notice of Confidentiality, Privacy Practices & Records	✓			✓	FS-29
Notice of Referral to LEA/KDE ( <i>for children 2 years, 10 1/2 months or older only</i> )	✓			✓	FS-3
Transition Notice & Consent (if appropriate)	✓			✓	FS-11
Notice & Consent for Release of Child Outcome Data to the Kentucky Center for Statistics (KYSTATS)	✓		✓		FS-6
Discipline Specific Assessment (if needed for redetermination of eligibility)	✓		✓		FS-7
Intensive Level Evaluation (if needed for redetermination of eligibility)	✓		✓		FS-30
Record Review	✓		✓		FS-30
Determination of ineligibility/refusal to develop an IFSP	✓			✓	FS-9

## **Chapter 4: Kentucky's System of Payments**

Early intervention services are costly and depend upon a variety of funding sources for support. The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires that Part C be the payor of last resort and requires that Part C funds only be used for early intervention services that an eligible child needs but is not currently entitled to under any other federal, state, local or private source. Kentucky's Early Intervention System (KEIS) uses a variety of public and private resources to support the costs for early intervention services.

These resources include:

- (1) Family Share participation fee;
- (2) Public health insurance (Medicaid);
- (3) Private health insurance;
- (4) State KEIS funds; and
- (5) Federal Part C funds.

Parents are a part of the team who determine what early intervention services are needed to address the outcomes on the Individualized Family Service Plan (IFSP) and the needs of the child. Service Coordinators (SCs) are responsible for obtaining and updating financial information from the parent and ensuring that funding sources for each early intervention service are identified. Certain services are at no cost to families.

These core services provided at no cost to families include:

- (1) Screening (child find activities);
- (2) Service coordination;
- (3) Evaluation and assessment;
- (4) IFSP development; and
- (5) Implementation of procedural safeguards.

### **4.1 Notice of System of Payments**

KEIS is required by law to provide a *Notice of System of Payments (FS-48)* to all families referred for early intervention services. Point of Entry (POE) staff are required to provide the *FS-48* during the child's enrollment and annually between April 25 and May 5 once the Federal Poverty Guidelines are updated.

### **4.2 Ability to Pay**

All families enrolled in KEIS are assessed for ability to pay. Ability to pay is the determination of a family's financial ability to help with the cost of early intervention services.

During the process of determining ability to pay, families are informed of their right to refuse any service, their right to have the Family Share cost assessed and their right to refuse consent for billing private insurance. Additionally, families are informed of the core services provided at no cost to them.

Inability to pay is the determination that a family is not able to help defray the cost of early intervention services. Placement on the sliding fee scale at \$0 indicates an inability to pay.

Families can request a review of their ability to pay due to a change in income or increased expenses due to the illness or hospitalization of the KEIS enrolled child. Depending upon the results of the review, the Family Share participation fee may be lowered, suspended or waived. Families must complete the *Family Share Extraordinary Family Expenses Worksheet (FS-24)* which is submitted to the State Lead Agency (SLA).

### **4.3 Financial Verification**

One of the duties of the SC is to explain the financial responsibilities in KEIS and to collect financial information when conducting intake activities. This information determines the family's ability to pay. Family documentation of income and allowable expenses occur upon entry, Six (6) Month Review, Annual Review and at other times when requested by the family. The SC determines the members of the family. For the purposes of determining ability to pay "family" means a basic social unit consisting of parent(s) and their children living together in a household (unborn children cannot be counted as a member of the household until they are born).

The SC collects the family income information in one (1) or more of the following ways:

- (1) A total of family income is verified by the most recent U.S. Income Tax Return for the Adjusted Gross Income of each member identified in the family. If the U.S. Income Tax Return cannot be produced, the federal taxable gross column on the last four (4) consecutive or last two (2) bi-monthly pay stubs of each identified family member who has income will be used to calculate and verify the sum total of the family income;
- (2) If the identified members have income that does not require tax returns, then it cannot be counted as income and does not have to be recognized (Social Security Income (SSI), child support, etc.);
- (3) If the child has a Kentucky Medical Card or Kentucky Children's Health Insurance Program (KCHIP), the information reported to these agencies can be used to verify the family's income; and/or
- (4) The employer shall provide a notarized letter of income verification when a pay stub or tax return cannot be produced.

Any of the identified family members may have their income verified by the Family Share Administrator (FSA) at the SLA by completing the *Financial Assessment Verification (FS-13)* instead of verification by the SC. Failure or refusal to submit family income for verification will result in a maximum Family Share participation fee.

#### **4.4 Family Share Participation Fee**

Family Share is one (1) category within the KEIS' system of payments. The monthly participation fee is required as payment from families identified with the ability to pay. Based on the family's size, family income and use of a sliding fee scale; KEIS calculates the payment amount and compares it to the annual Federal Poverty Guidelines. The amount of the fee is not related to the number or frequency of services received by the family. This monthly participation fee begins the same month early intervention services start and continues until the month of the last session. Monthly invoices for Family Share participation fees are generated based upon the early intervention services billing data.

##### **4.4 (1) Calculation of Family Share**

Using the total number of identified family members and the sum total of the verified earned income of the identified family members, the SC calculates the applicable monthly payment fee using the current sliding fee scale that is located in the *Notice of System of Payments (FS-48)*. The participation fee ranges from \$0 to \$400 per month.

On the Current Family Financial Support page on the Technology-assisted Observation and Teaming Support System (TOTS), the SC enters the family size and income. For families temporarily living with friends or relatives, the family size and income is based upon the family size and income that is reported on federal tax forms of the parents.

If the financial information is updated at any time during the duration of the IFSP, the SC must notify the SLA of the TOTS identification number, the change, and the effective date of the change by using the general mailbox: [chfs.firststeps@ky.gov](mailto:chfs.firststeps@ky.gov). When the SC makes the changes in TOTS, the system will automatically update the family share fee calculation based on the date entered, which may be different from the effective date. The FSA ensures the assessment of an appropriate amount.

##### **4.4 (2) Family Share and Multiple Children in KEIS**

Families will pay the participation fee based on one (1) child only, regardless of the number of siblings enrolled.

##### **4.4 (3) Family Share and Medicaid (public insurance)**

Per the contract between KEIS and Medicaid, families whose children have Medicaid are not charged a monthly participation fee. Financial verification must be completed as discussed in section 4.3.

When the child's Medicaid coverage ends or lapses, a monthly participation fee will be charged to the family based upon the information gathered through financial verification. The fee will be charged for the period of time the child has no Medicaid coverage.

#### **4.4 (4) Split Household Family Share Calculation**

To determine the monthly participation fee in a case of a split household (i.e. divorce, separation, unmarried), determine which parent claimed the child on the most recent tax filing. The monthly participation fee is based on the income and household size listed on the tax filing.

If the parent who claimed the child on the most recent tax filing refuses to participate in KEIS and there is no access to their tax filing information, the parent participating in KEIS must provide his/her own tax information. The monthly participation fee is based on the income listed on the tax filing. The household size is the size listed on the tax filing plus the child enrolled in KEIS.

#### **4.4 (5) Family Share Calculation for a Child in Foster Care**

Children who are verified as wards of the state shall be entered as family size of one (1) and income of \$0 on the Current Family Financial Support page on TOTS. Children in foster care and whose parents have not had parental rights terminated shall be entered as family size of one (1) and income of \$0 on the TOTS Current Family Financial Support page.

#### **4.4 (6) Family Share and Families on Active Military Duty at Fort Campbell or Fort Knox**

Families who are on active duty assigned to Fort Campbell or Fort Knox and are on the waiting list for base housing may have monthly participation fees waived. The SC completes the *Family Share Temporary Suspension or Waiver Request (FS-25)* and attaches the official letter from the base documenting that the family is on the waiting list for housing. This information is sent through secure email to CHFS.firststeps@ky.gov. Fees may be waived for three (3) consecutive calendar months. At the end of that period, if the family continues to be on the waiting list, the form and letter are resubmitted to the SLA for approval.

#### **4.4 (7) Family Share and Consent to Bill Insurance**

Families with both a monthly participation fee and private health insurance may choose to waive the participation fee as long as the consent to bill insurance is active. If the parent withdraws consent to bill insurance or experiences a loss of coverage, the Family Share participation fee will be reinstated.

Ability to pay must be assessed before consent can be given to bill insurance. If a parent refuses to verify family income, a \$400 monthly participation fee will be assessed to the family, regardless of the consent to bill private insurance.

#### **4.4 (8) Family Hardship Review**

Family Share is not intended to place undue hardship on the family. If the family reports that they are unable to pay their identified monthly participation fee, then consideration is given to either reducing or eliminating the fee. The SC completes one of the following:

- (a) A *Family Share Temporary Suspension or Waiver Request (FS-25)* and submits to the SLA through secure email to CHFS.firststeps@ky.gov. Eligibility for suspension is in increments up to three (3) consecutive calendar months. This request is available for families experiencing:
  1. illness or hospitalization by the participating child;
  2. loss of employment that significantly reduces the family income; or
  3. effects of natural disasters (flood, tornado, ice storm, etc.) that significantly impact family income; or
- (b) A *Family Share Extraordinary Family Expenses Worksheet (FS-24)*. Eligibility for suspension is in increments up to three (3) consecutive calendar months.

In the event of bankruptcy, the parent must submit verification from the United States Bankruptcy Court to the SLA.

### **4.5 Use of Medicaid for Payment of Early Intervention Services**

#### **4.5 (1) Children Covered by Medicaid Only**

Families with a child who is potentially eligible for Medicaid are encouraged to apply for this public insurance; however, families cannot be required to enroll in Medicaid in order to receive early intervention

services. SCs must check that the Medicaid coverage is current and encourage families to re-apply for Medicaid when eligibility expires. The SC must also verify if the child is covered by both Medicaid and private health insurance.

Families whose child has Medicaid coverage, including KCHIP, must be given notice that Medicaid will be billed as a payor source for their child's services. Provide the family a copy of the *Notice for Use of Medicaid (FS-12B)*. SCs must explain the following information to the family:

- (a) KEIS cannot require the family to enroll or re-apply for Medicaid in order to receive early intervention services;
- (b) the use of Medicaid for early intervention services will not result in:
  - 1. a decrease in the available lifetime coverage or any other insured benefits for the child;
  - 2. costs to a parent for a service that is otherwise covered by Medicaid;
  - 3. an increase in premiums or discontinuation of public benefits or insurance for the child; or
  - 4. loss of eligibility for the child or that child's parent for home and community-based waivers based on aggregate health-related expenditures; and
- (c) there are no costs to the family for co-payments or deductibles for services billed to Medicaid.

#### **4.5 (2) Children Covered by Private Insurance and Medicaid (Dually-Covered Child)**

Medicaid requires that private insurance be billed first when a child has both private insurance and Medicaid. Under IDEA, parents have the right to deny consent for billing private insurance. When a parent of a dually covered child refuses to allow private insurance to be billed, Medicaid cannot be billed. Therefore, KEIS will use other funding sources to pay for early intervention services. Income verification must be conducted and all information for private insurance and Medicaid must be entered on the Current Family Financial Support page on TOTS. The SC must enter "First Steps" as the Payor 1 on all authorizations on the IFSP Planned Service Information page.

#### **4.5 (3) Family Loses Medicaid Coverage**

There may be instances when a family loses Medicaid coverage during the IFSP. The SC will contact the family to verify the lapse of coverage and enter the lapsed period on the Current Family Financial Support page on TOTS under "Medicaid and Insurance" in the "Medicaid Ineligible Period" boxes. The family's ability to pay is reassessed at this time using the *Financial Assessment Verification (FS-13)*. If it is determined the family has an ability to pay, the Family Share participation fee is assessed.

If the family now has private insurance, the SC will obtain the new information and consent to bill insurance using the *FS-12A*. The SC will enter the new private insurance information on the Current Family Financial Support page and under Household Information, "Not Billable Due to:" check "Insurance Use". The SC must complete a Requested Review IFSP to edit planned services to reflect the change in "Payor Source" and mark "Permit Insurance".

If the family does not consent for KEIS to bill private insurance, they must pay a Family Share participation fee. The SC must document the private insurance information on the Current Family Financial Support page on TOTS and ensure that IFSP Planned Service Information page reflects "First Steps" as "Payor 1".

**Note:** The SC must document all changes to insurance in a communication or service log on TOTS.

#### **4.6 Use of Private Insurance for Payment of Early Intervention Services**

SCs must review the benefits of using private insurance for early intervention services with families. Benefits include that the claims may be applied to annual deductibles and KEIS covers the co-pays. The parent must consent to the use of private insurance by completing the *Notice & Consent for Use of Private Insurance (FS-12A)* during intake, annually, when a new early intervention service is added and when there is an increase in frequency, length, duration, or intensity of early intervention services.

The SC will collect all the necessary private insurance information from the family (including secondary insurance if applicable). The SC must enter on TOTS the policyholder's demographic information on the Parent/Guardian



Information page and enter the private insurance information on the Current Family Financial Support page under the "Primary Insurance" section. This information must be accurate.

There is no penalty for refusing consent for the billing of insurance.

**4.6 (1) Family Consents to Billing for Specific Early Intervention Services**

Depending on the family's insurance policy, the family may be limited in their coverage for benefits. If a child or family member is seeking services outside of the KEIS program, and choose to use their benefits for these services, they can deny consent for KEIS to bill their private insurance for specific services. In this instance, a family consents to bill for part of the IFSP services, but not all. The parent must consent to the use of private insurance by completing the *Notice & Consent for Use of Private Insurance (FS-12A)* which documents the services they consent to bill for early intervention services and which services they do not consent to bill to private insurance. The SC must enter the private insurance information on the Current Family Financial Support page on TOTS and select "not billable due to: insurance use" under the "Household Information". The SC must ensure that planned services reflect the appropriate payor source for each early intervention services that is authorized.

**4.6 (2) Family Receives Payment from Private Insurance**

When a family consents to billing private insurance and receives a payment for the KEIS services, they must submit that payment to the provider who rendered the service. The family can provide the insurance check to the provider or they can write a personal check for the same amount that insurance provided. The provider must submit to the SLA a copy of the detailed Explanation of Benefits (EOB) and a copy of the insurance check or personal check that was provided within one (1) year of the date of service in order for the claim to be processed.

If the parent keeps the insurance payment and does not pay the provider, the provider must take action to collect the payment. The provider must send the parent a request for payment invoice listing the amount owed for services via certified mail giving a ten (10) calendar day deadline to make payment or arrangements for payment. After the deadline, the provider must submit all documents (invoice, request, certified mail receipt, copies of EOB, etc.) to the SLA and requests payments to be processed. The SLA will approve payment to the provider and will take the necessary actions to recoup the payment from the family.

**4.6 (3) Provider Receives Payment from Private Insurance**

When the provider receives a payment directly from insurance for the KEIS services, the provider must submit to the SLA a copy of the detailed EOB and a copy of the insurance check. These documents must be submitted within one (1) year of the date of service and approved in order for the claim to be processed.

**4.6 (4) Archiving Private Insurance on TOTS**

SCs will collect and enter all the necessary private insurance information on the Current Family Financial Support page on TOTS under the "Primary Insurance" section. There may be instances when the SC will need to archive the family's insurance information on TOTS. The SC must follow the procedures below:

<b>If the family initially consents to bill insurance:</b>	<ul style="list-style-type: none"><li>• SC will leave the private insurance information in the Current Family Financial Support page on TOTS, under the "Primary Insurance" section;</li><li>• At the bottom of the Current Family Financial Support page on TOTS, under the "Household Information" section for "Family Share", the SC will select "Not Billable Due to: Insurance Use";</li><li>• On the IFSP Planned Service Information page on TOTS, the SC will select "Permit Insurance" on the provider's authorization for services; and</li><li>• SC will select "Private Insurance" as "Payor 1" on the provider's authorization for services.</li></ul>
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<p><b>If the family initially declines consent to bill insurance:</b></p>	<ul style="list-style-type: none"> <li>• On the Current Family Financial Support page, the SC will select the “Archive Primary Insurance” button. When this is selected, the “Primary Insurance” section of the page will become blank and a pop-up box will appear stating that the primary insurance has been archived. Select “ok”;</li> <li>• SC must select the yellow “save” button in the “Primary Insurance” section to finalize archiving the insurance information;</li> <li>• SC will not select anything under the “Household Information” section for “Family Share”; and</li> <li>• On the IFSP Planned Service Information page on TOTS, the SC will select “First Steps” as “Payor 1” on the provider’s authorization for services.</li> </ul>
<p><b>If the family initially declines consent to bill insurance and later consents:</b></p>	<ul style="list-style-type: none"> <li>• The archived private insurance information will be located at the bottom of the “Primary Insurance” section on the Current Family Financial Support page on TOTS. This information cannot be retrieved from the archive, therefore, the SC must verify and re-enter the primary insurance information;</li> <li>• At the bottom of the Current Family Financial Support page, under the “Household Information” section for “Family Share”, the SC will select “Not billable Due to: Insurance Use”;</li> <li>• The SC will need to complete a Requested Review or if it is a naturally occurring IFSP, edit the plan;</li> <li>• On the IFSP Planned Service Information page, the SC will select “Permit Insurance” on the provider’s authorization for services; and</li> <li>• SC will select “Private Insurance” as “Payor 1” on the provider’s authorization for services.</li> </ul>
<p><b>If the family initially gives consent to bill insurance and later revokes the consent:</b></p>	<ul style="list-style-type: none"> <li>• The private insurance information will be listed in the “Primary Insurance” section on the Current Family Financial Support page on TOTS. The SC will select the “Archive Primary Insurance” button. When this is selected, the “Primary Insurance” section of the page will become blank and a pop-up box will appear stating that the primary insurance has been archived. Select “ok”;</li> <li>• SC must select the yellow “save” button in the “Primary Insurance” section to finalize archiving the insurance information;</li> <li>• At the bottom of the Current Family Financial Support page on TOTS, under the “Household Information” section for “Family Share”, the SC will select “Not Billable Due to: Not Applicable”. This action will remove the selection from “Insurance Use”;</li> <li>• The SC will need to complete a Requested Review or if it is a naturally occurring IFSP, edit the plan;</li> <li>• On the IFSP Planned Service Information page, the SC will select “First Steps” as “Payor 1” on the provider’s authorization for services.</li> </ul>

**4.6 (5) Family Loses Private Insurance Coverage**

There may be instances when a family loses private insurance coverage during the IFSP. The SC will contact the family to verify the lapse of coverage. Reassess the family’s ability to pay at this time using the *Financial Assessment Verification (FS-13)*.

The SC will obtain the new insurance policy information if applicable and consent to bill insurance using the *FS-12A*. The SC archives the lapsed insurance information on the Current Family Financial Support page on TOTS and enters the new private insurance information.

If there will be a gap in coverage with the new insurance and it is determined the family has an ability to pay, the Family Share participation fee may be suspended for up to three (3) months while the new insurance policy is activated. If the new insurance policy is not activated within three (3) months, the family will be assessed the applicable Family Share participation fee for the next invoice billing period.

The SC must notify the SLA of the gap in coverage by completing the *Family Share Temporary Suspension or Waiver Request (FS-25)* and send by secure email to CHFS.firststeps@ky.gov.

If the family does not consent to bill or does not have new private insurance coverage, the SC will reassess the family's ability to pay using the *Financial Assessment Verification (FS-13)*. If the family has an ability to pay, the Family Share participation fee is assessed. The SC must archive the lapsed insurance information on the Current Family Financial Support page on TOTS and complete a Requested Review IFSP to edit planned services to reflect the change in "Payor Source" and unselect "Permit Insurance" box.

**Note:** The SC must document all changes to insurance in a communication or service log on TOTS.

## **Chapter 5: Referral**

Children referred to the Point of Entry (POE) are processed through intake. Referrals may be written, verbal, or sent through the online referral portal. Referrals may originate from anyone concerned about a child's development including the parent. In the case that the parent did not self-refer, POE staff confirms that the parent knows about the referral.

Referrals accepted include children who are under the age of three (3) years, residents of Kentucky and live within the POE geographic region or is homeless and located within the boundaries of the Commonwealth of Kentucky and meet at least one (1) of the following criteria:

- (1) Child is suspected to have an Established Risk (ER) condition or a significant developmental delay; or
- (2) Child is the subject of a substantiated case of child abuse or neglect; or
- (3) Child is identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

Federal law requires the Department for Community Based Services (DCBS) to refer children to the Kentucky Early Intervention System (KEIS) who have had any of the following life experiences:

- (1) Child was or is exposed to drugs;
- (2) Child tested positive for drugs at birth;
- (3) Child was or is exposed to violence in the home; or
- (4) Child is a substantiated victim of abuse or neglect.

The Child Abuse Prevention and Treatment Reauthorization Act of 2010 (CAPTA) is the primary federal legislation addressing child abuse and neglect that provides a definition of child abuse and neglect and authorizes federal funding to states in support of prevention, identification, assessment, investigation and treatment activities. The Victims of Child Abuse Act Reauthorization Act 2018 amended CAPTA. Under the recent reauthorization of this law, states are mandated to report the annual number of children under the age of three (3) who are substantiated as abused or neglected that were eligible for referral, and actually referred, for early intervention services under Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

IDEA requires states participating in Part C to accept the referral for any child under the age of three (3) who is involved in a substantiated case of child abuse or neglect or identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

If a referral is received that does not meet the criteria above for acceptance, the POE must record the referral. The *Unable to Process Referral Letter (FS-36)* must be sent to the referral source explaining that the referral cannot be accepted. If the parent is aware of the referral, a *Notice of Action (FS-9)* must be sent to the parent.

If the referral was through the referral portal, a file is automatically created in TOTS. The POE documents the referral cannot be accepted, the reason, and closes the file. For all other referrals that cannot be accepted, the POE must record the referral somewhere outside of TOTS. The POE may choose their own method of recording (electronic spreadsheet, handwritten log, etc.). The record must include the date the referral was received, the child's name and date of birth, the referral source, and why the referral was not accepted. This record must be maintained permanently.

If the family currently resides outside of Kentucky, but plans to move to Kentucky soon, the referral still cannot be officially accepted until the family permanently resides in Kentucky. However, if the family is participating in early intervention services in their current state and would like to go ahead and get things started with KEIS, they may send the POE medical records, hearing evaluations, IFSP documentation, evaluations, etc. As time permits, the POE may review this information to let the family know if KEIS will need to do additional evaluations once the family officially moves.

### **5.1 Receipt of Referral**

- (1) Each POE shall have staff designated to process all referrals. POE staff shall attempt to contact the parent by phone within five (5) working days of receipt of the referral.

If the DCBS caseworker is the referral source but does not provide information regarding the child's status (parental rights intact; parental rights terminated; child in relative placement; child in foster care), POE staff shall send the *Referral Information Request for Caseworker (FS-23D)* to the referring caseworker. If they do not respond within ten (10) calendar days notify the DCBS Regional Contact. They may have access to the information, or they will ensure the caseworker responds. If the caseworker or supervisor does not respond, ask the foster parent for the contact information. If the foster parent doesn't know how to reach the family and DCBS still cannot be reached, the file is closed by entering the "Exit/Close Date" on the Transition/Exit Information page on the Technology-assisted Observation and Teaming Support System (TOTS). Select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

If the POE staff is unable to contact the parent by phone, mail the *Unable to Contact Referral Letter (FS-4)* to the parent. If the parent does not respond within five (5) working days of the date of the letter, the file is closed. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

If the POE staff is able to contact the parent by phone, verify the family is aware of the referral, provide an overview of the KEIS program and determine if the family is interested in moving forward with the referral.

If the parent is not interested in participating in KEIS, the POE staff must send the parent a *Notice of Action (FS-9)* stating the "action refused" is "evaluation of child for eligibility" and "reason for action(s)" is "parent declined services". This provides the family with written notice as required by Federal law. After the five (5) working day notice, document refusal of services on the Transition/Exit Information page on TOTS by entering the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu. A note with the reason for case closure can also be added to the "Note" section at the bottom of the Transition/Exit Information page.

If the parent is interested in proceeding with the referral POE staff must obtain the following information:

Age of child	Must be under three (3) years of age
Prematurity status	Gestational age (or # of weeks born early) determined by parent or referral source report
Location/address of residence	Must be within Kentucky boundaries
Preferred language	Must identify if an interpreter is needed
Possible Established Risk Condition	Identification of the possible condition
Parent(s) name and/or guardian	Verify that person meets the definition of a parent by completing the <i>Surrogate Parent Identification of Need (FS-23A)</i> . Only the individual who is legally authorized to make educational decisions can sign consents for screening and initial evaluation
Telephone number	If no telephone number, identify alternative way to contact family
Financial Status	Private insurance and Medicaid coverage must be ascertained at this point but the insurance policy or Medicaid number may be entered later if referral source does not have this information

- (2) Prior to adding a child to TOTS, POE staff check TOTS for a current record by selecting Search/Add Child on the POE home page. Search "All Across State" using either the child's name or date of birth.

If a record is found on TOTS:  
 (a) verify same child; and

(b) check for inactive or active status:

1. if the case is active, document on the Communication Log page that a referral was received and any relevant information from the new referral;
2. if the case is active in another POE district, the POE staff will contact that POE office to request a transfer of the record;
3. if the case is inactive, POE staff will reactivate the record by removing the "Exit/Close Date" and "Exit/Close Reason" on the Transition/Exit Information Page on TOTS and select "Save"; or
4. if the child's record is inactive in another POE district, the POE staff will contact that POE office to request a transfer of the record.

**\*Note:** If an inactive child has no prior IFSPs documented on TOTS, and has evaluations or assessment reports, the Service Coordinator (SC) must copy and paste those reports into the Communication Log page on TOTS in order to maintain these records. The sections of evaluations populate to the Individualized Family Service Plan (IFSP), so if no IFSP is in place and a new evaluation is entered, the previous report will be overwritten. The Communication Log has limited character space, so the reports may need to be entered into more than one log.

If no record is found on TOTS, select "Add New Child", and complete the Demographic Information, Referral Information and Parent/Guardian Information pages on TOTS.

CAPTA referrals are documented on the Demographic Information page by selecting "yes" on item twelve (12) "Does this child have an open case with DCBS/DPP?" Once "yes" is selected, POE staff must select "There is a substantiated case of abuse or neglect on this child (CAPTA referral)" from the drop-down menu.

(3) Once the referral information is entered on TOTS, an authorization for a SC must be created to move forward through the referral process. One (1) authorization for "Initial Service Coordinator" is entered on the IFSP Planned Service Information page on TOTS as the following:

- (a) "Start Date": date the SC takes the referral;
- (b) "End Date": date of the forty-five (45) day deadline;
- (c) "Intensity": Individual;
- (d) "Setting": Other (SC Office/etc.);
- (e) "Frequency": 1 X Biannually
- (f) "Length": 25 hours; and
- (g) "Note": enter a note to state services will be provided through a combination of face-to-face and phone contacts in order to keep from having to enter two separate authorizations for the SC.

#### **5.1 (1) Late Referrals to the POE**

Late referrals are those referrals for children whose third birthday is in forty-five (45) days or less. First Steps does not accept referrals for children forty-five (45) or less days from the third birthday. These are children with the age range of two years, ten and one-half months (2 yrs., 10.5 mo.) to three (3) years of age. The POE is unable to determine eligibility and develop an IFSP within timelines prior to aging out at age three (3).

State and federal regulations require Part C notify both the State Education Agency (Kentucky Department of Education (KDE)) and Local Education Agency (LEA) of referrals of children who are potentially eligible for special education and related services (Part B of IDEA). Parent consent is required to make the referral to the KDE and LEA for children not enrolled in KEIS services.

The POE must notify the parent in writing that due to the child's age at time of referral, there will be no evaluation to determine KEIS eligibility by using the *Notice of Referral to LEA/KDE (FS-3)*. With consent, the POE must send a copy of the FS-3 to KDE and the LEA of the potentially eligible child. The POE may also share other community resources with the parent.

Late referral procedures:

- (a) open a record on TOTS (complete the following pages: Demographic Information, Referral Information, Parent/Guardian Information, Communication Log and Transition/Exit Information);

- (b) mail a copy of the *Notice of Referral to LEA/KDE (FS-3)* explaining why the POE is not evaluating the child to the parent;
- (c) fax the *Notice of Referral to LEA/KDE (FS-3)* to the designated LEA and KDE if parent consents; and
- (d) close the case on the Transition/ Exit Information page by entering the "Exit/Close Date" and selecting "Part B Eligibility Not Determined-Late Referral" as the "Exit Close Reason".

### **5.1 (2) Determining who has Educational Decision-Making Authority**

Under IDEA, the lead agency (POE) must establish who has the legal authority to make educational decisions for all children referred for services. IDEA states that public agencies must ensure that a person selected as a surrogate parent is not an employee of the lead agency or any other public agency or early intervention provider that provides early intervention services, education, care or other services to the child or any family member of the child.

All children must have a completed *Surrogate Parent Identification of Need (FS-23A)* at the time of referral. The child's status and need for an educational surrogate must be appropriately documented on the Demographic Information page on TOTS. Items twelve (12) "Does this child have open case with DCBS/DPP," thirteen (13) "Is child currently in home or out of home?" and fourteen (14) "Child requires an educational surrogate parent?" must be completed for all children. If there is a restriction of parental rights item eleven (11) "Parent Restriction of Rights:" and "Reason Right Restricted" must be completed as well. Any restriction due to custody, commitment, or guardianship must be noted in this box with the copies of the appropriate court orders in the child's hard copy file. POE staff can refer to the "Quick Reference Guide- Educational Decision-Making Rights Decision Tree" and the "Quick Reference Guide- Surrogate Parents" in the appendix for further assistance in completing the *Surrogate Parent Identification of Need (FS-23A)*.

If it is determined a surrogate parent is needed, the POE must follow the steps outlined in Section 5.1 (2) (c).

### **5.1 (2) (a) Children Involved with the Department for Community Based Services (DCBS) and Division of Protection and Permanency (DPP)**

The assigned DCBS caseworker is not legally authorized to make Part C educational decisions (give consent) or serve as a surrogate parent for a child in the custody of the Cabinet for Health and Family Services (CHFS). If the parent or guardian would like the DCBS caseworker to attend IFSP meetings and/or receive copies of IFSPs, the SC must obtain consent on the *Consent to Release/Obtain Information (FS-10)*. The FS-10 is not necessary if there is an open, active child abuse or neglect investigation. The SC must obtain a signed and dated letter or form from DCBS verifying there is an open, active child abuse/neglect investigation. Maintain the letter/form in the child's hard copy file and document receipt of it on the Communication Log page on TOTS. If at any time the DCBS caseworker asks for information after the receipt date of the letter/form, the SC must verbally confirm and document on the Communication Log page on TOTS that the child abuse or neglect investigation remains active.

#### **5.1 (2) (a) 1. Children in Foster Care when Birth Parent Rights Have Been Terminated**

When parental rights have been terminated and the child is a ward of the state and residing in a state appointed foster home, the SC must attempt to obtain a copy of the court order and place it in the hard copy record. The SC must review the court order to determine if educational rights were granted to the foster parent. If the court order does not specifically name the foster parent as the authority to make educational decisions, the foster parent shall be appointed as the surrogate parent following the steps outlined in Section 5.1 (2) (c).

#### **5.1 (2) (a) 2. Children in Foster Care when Birth Parent Rights Have Not Been Terminated**

The DCBS worker may recommend to the birth parent(s) to give written consent for the foster parent to serve as a co-parent. This would allow the foster parent to provide

educational decisions in the event that the birth parent is not available to give consent for services or cannot attend IFSP meetings. This helps ensure no disruption of the child's educational needs while the child is in out of home care. The POE staff must ensure that the birth parent has the opportunity to provide consent for actions that require parental consent, invited to all meetings, and encouraged to participate in the educational process.

If the birth parent agrees to allow the foster parent to co-parent in regards to educational decisions for the child, they complete a DCBS *DPP-330 Educational Advocacy Request Form*. The DCBS caseworker must provide a copy of the *DPP-330* prior to the first action requiring parental consent. Maintain the copy in the child's early intervention record. A *DPP-330* signed by the DCBS worker is not valid and cannot be used by the POE to allow the foster parent to give consent for services. A *DPP-330* that lists an agency (i.e. Benchmark Services) and not the individual who the parent has agreed to co-parent is not valid and cannot be used by the POE.

If a *DPP-330* is not available but the DCBS worker is able to provide a last known address or phone number for the biological parent, POE staff must make at least two (2) attempts to contact the parent. If POE staff is able to make contact with the parent they shall provide an overview of the First Steps program and ask if the parent is interested in moving forward with the referral.

If the parent is interested in moving forward with the referral but is not available to give consent or attend meetings, POE staff shall mail the *Parent Designation of Educational Decision-Making (FS-23C)* and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure to the address provided by the parent. If this form is not returned to the POE by the return date listed on the form (ten (10) calendar days from the date sent), POE staff can move forward with surrogate parent appointment process outlined in Section 5.1 (2) (c).

If the parent states they do not want their child to receive services, the POE must honor the refusal of KEIS services and close the record. On the Transition/Exit Information Page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.

Document all correspondence regarding this process on TOTS.

#### **5.1 (2) (b) Children Not Involved with the DCBS/DPP**

Children may be under the care of someone other than the birth parent, with parent rights intact and no involvement of DCBS. The POE must first determine if the caregiver has any written statement from the parent or has court documents that give the caregiver authority for educational decisions. A copy of the statement must be placed in the child's record. An educational surrogate parent is not required.

However, if the caregiver does not have a statement of educational decision-making authority, the POE must attempt to locate the parent. POE staff must document at least two (2) attempts to contact the parent. If POE staff is able to make contact with the parent, they shall provide an overview of the KEIS program and ask if the parent is interested in moving forward with the referral. POE staff shall mail the *Parent Designation of Educational Decision-Making (FS-23C)* and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure to the address provided by the parent. If the *FS-23C* is not returned to the POE by the return date listed on the form (ten (10) calendar days from the date sent), POE staff can move forward with surrogate parent appointment process outlined in Section 5.1 (2) (c). If the parent states they do not want their child to receive early intervention services, the POE must honor the refusal of services and close the record. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.



### **5.1 (2) (c) Surrogate Parent Assignment**

Once determined that an educational surrogate parent is needed, the POE staff shall send the *Educational Surrogate Assigned Request (FS-23B)* to the potential surrogate parent. The POE sends the signed form by fax or secure email to the SLA for review and appointment. Document sending the form on the Communication Log page on TOTS. If approved, the SLA will return the signed form to the POE by fax or secured email. If not approved, the SLA will discuss the reasons for not approving the request with the appropriate POE staff and will hold the request if additional information is needed. Once obtained, the POE shall notify the SLA staff person holding the request that additional information is documented on the Communication Log page on TOTS. SLA staff will review the file, provide signed appointment as appropriate and document the appointment on the Communication Log page on TOTS.

Change in the caregiver for a child with an appointed surrogate requires a new *Educational Surrogate Assigned Request (FS-23B)* before obtaining consent for further action.

**Note:** POE staff are encouraged to send the *FS-23C* to the biological parent and the *FS-23B* to the foster parent at the same time to expedite the process. The POE staff should explain to the foster parent that if the biological parent returns the *FS-23C*, then the *FS-23B* is not valid. If the biological parent does not respond within the timeframe given (ten (10) calendar days from the date sent), the POE can proceed with assigning the educational surrogate.

**Note:** From this point forward all references to “parent” throughout this manual shall refer to either the biological parent or an individual appointed as an educational surrogate parent.

### **5.1 (3) Language Access: Native Language**

The CHFS requires all programs within the Cabinet to ensure language access services for individuals with Limited English Proficiency (LEP) to have meaningful participation in the programs offered by CHFS. In KEIS, this can be accomplished by the SC or early intervention provider having the skills to communicate effectively with the family or through the use of a CHFS qualified language interpreter. Language access services must be provided as needed for all services provided in KEIS without unreasonable delay and at no cost to the family. KEIS is responsible for providing qualified interpreting services for only those services provided or funded through KEIS. The Office for Children with Special Health Care Needs (OCSHCN) serves as the fiscal agent for language access services in early intervention.

#### **5.1 (3) (a) Procedures for Ensuring Language Access**

Every POE office should display an “*I Speak*” *Language Selection Card*, used to indicate the language spoken. In addition, all POE staff who conduct home visits should carry “*I Speak*” *Language Selection Cards* to use with the family to determine what language is the primary language for communication and if different, what language is used for learning.

##### **5.1 (3) (a) 1. Language Access for Contacts with Families by POE Staff**

All interpreting services will be provided through use of a CHFS qualified interpreter who is under contract with the OCSHCN.

- a. Interpreting services are at no cost to the family. Families should be given a copy of the *Know Your Rights* brochure.
- b. Information regarding the need for and type of interpreter is documented on TOTS. The POE staff indicate this on the Demographic Information page by choosing the appropriate language for items number eight (8) “Language Used at Home” and number nine (9) “Preferred Language/Instruction”. Documentation of the language used for learning must be accurate to ensure meaningful access to services.
- c. All children who have “Interpreter is needed” checked in item number eight (8) must have an interpreter. Documentation must be accurate.

- d. If the child and family require interpreting services and the SC or early intervention provider is not bilingual, an interpreter is assigned by the POE staff before any early intervention service begins. This may be at the point of referral for some children.
- e. POE staff must choose an interpreter from the list of OCSHCN contracted interpreters. An interpreter without a valid contract with the OCSHCN cannot be paid.
- f. Once the need for language access by an interpreter is established, POE staff will contact an interpreter to schedule services. The interpreter then notifies the designated contact at OCSHCN.
- g. If a family refuses a specific interpreter, OCSHCN staff will attempt to find a replacement; however, there is no guarantee of a replacement interpreter.
- h. If there is no interpreter that speaks the native language of the family or child that provides services through OCSHCN, POE staff may utilize INTERPRETALK to translate contacts with the family.

**5.1 (3) (a) 2. Waiving Rights to an Interpreter**

POE staff do not ask families to use other family members or friends for interpreting. If the person with LEP declines free interpreting services and asks to use a relative or friend, staff must document the declination in the child's file. The parent must sign the *Waiver of Interpreter Services (FS-34)* and the decision is recorded on TOTS on the Demographic Information page, number eight (8) "Language Used at Home" and "Interpreter is waived" must be selected. A copy of the *Waiver of Interpreter Services (FS-34)* is given to the family with the signed original maintained in the child's hard copy file. The waiver of interpreter services may be rescinded at any time. The evaluation and/or assessment of the child must be conducted in the native language of the child. Parents cannot decline an interpreter for the purpose of completing evaluations and/or assessments.

**5.1 (3) (a) 3. Language Access for Contacts with Families by Providers**

Early intervention providers, as independent contractors for KEIS, are responsible for providing language access for all children and families they serve. The SLA will cover the cost of interpreter services for early intervention providers at this time. This is not an obligation of the SLA.

The provider must coordinate the need for an interpreter with the SC to ensure the use of an approved interpreter. The provider shall not use an interpreter who is not Cabinet-approved. If there is no interpreter that speaks the native language of the family or child that provides services through OCSHCN, providers may utilize INTERPRETALK to translate contacts with the family.

**5.1 (3) (a) 4. Documenting Language Access on TOTS**

POE staff and early intervention providers must document that interpretation was provided by choosing one (1) of the options on the Service Log Information page.

- a. In the drop-down menu under "Interpreter", the first three (3) choices indicate specific situations. POE Staff and early intervention provider must only choose one (1) of these if it applies to the date of service being entered:
  - i. No show by Interpreter;
  - ii. Provider/SC as Interpreter; or
  - iii. SC without Interpreter needed.
- b. The fourth option on the drop-down list begins the listing of Interpreters. When the interpreter was present for the delivery of the service, select the correct Interpreter from the list.
- c. Immediately notify the interpreter assigned to the family of cancellation of appointments.

**5.1 (4) Communication with the Referral Source**

All information obtained by the POE staff during the referral process is confidential under the Family Education Rights and Privacy Act (FERPA) and IDEA. There must be signed parental consent to share or release any information about the referral.

The POE must obtain consent from the parent to share child specific information with the referral source, if that source provides ongoing services to the child and is important to the continuity of the child's care. Should the parent refuse to provide consent to the POE, no information can be shared. It is the responsibility of the referral source to seek consent from the parent and provide a copy of the signed consent for release of information to the POE.

The *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* includes a provision to share results of the initial screening, evaluation and assessment with the referral source. Once the parent gives consent, POE staff sends the *Parent Consent to Share Information Referral Letter (FS-40)* and the information permitted by the parent to the referral source. The *Consent to Release/Obtain Information (FS-10)* form is used to obtain consent to release ongoing information.

All children should have a consent to share information with their primary care physician. POE staff needs to inform parents of the benefits of sharing information so that the care of the child is comprehensive and not duplicative.

It is recommended that if a child is involved with DCBS, the POE attempt to obtain consent on the *FS-10* to share information with DCBS. If the child is in foster care, it is also recommended that the POE attempt to obtain consent from the foster parent to share information with the Department of Disability Determination Services (DDS). The POE should explain to the foster parent that the state may have applied for disability for the child. This consent will expedite the process in the event of disability determination.

## **5.2 Screening**

Provide all families referred to KEIS and interested in screening or evaluation a screening packet that contains at a minimum the following:

- (1) *Screening Cover Letter (FS-44)*;
- (2) *Notice of Confidentiality, Privacy Practices and Records (FS-29)*;
- (3) *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*;
- (4) *Notice of System of Payments (FS-48)*;
- (5) *Notice for Use of Medicaid (FS-12B)* (if applicable);
- (6) *Consent to Release/Obtain Information (FS-10)*;
- (7) Parents' Rights in Kentucky's Early Intervention System: First Steps brochure;
- (8) Helping Children Develop and Succeed...One Step at a Time brochure; and
- (9) Screening, Evaluation & Assessment brochure.

**\*Note:** Parents have the right to decline the screening and request an evaluation (by giving consent to the evaluation). In these instances, the child is assigned a SC who will proceed with intake activities necessary to facilitate the evaluation.

### **5.2 (1) Using Screening Results from Primary Referral Sources**

POEs may use screening results from primary referral sources based on a published screening tool. The POE staff reviews the screening information and checks that it is complete. Checklists created by the primary referral source are not acceptable. The POE must have a copy of the screening results (scores) for each domain. It is recommended that the POE obtain a copy of the completed protocol. Screening information accepted from other sources must include:

- (a) Date of screening: the screening must be current within thirty (30) days;
- (b) Name of individual administering the instrument; and
- (c) Results of the screening in each domain measured by the instrument.

The POE without parental consent may accept screening results from outside sources if the screening is complete. However, if the results indicate need for specialized screening (such as the Screening Tool for

Autism in Toddlers and Young Children (STAT)) or need for an evaluation, consent for these actions are required.

If the POE has to score a screening received from an outside source, obtain consent on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*.

If the POE does not accept the screening conducted by an outside source, they must screen the child following the procedures outlined in this chapter.

### **5.2 (2) Screening for Children Referred due to an Established Risk (ER) Condition**

Children referred due to a suspected ER condition are not automatically screened by the POE. POE staff shall contact the parent and obtain consent on the *FS-10* to request the child's medical records and send the *Health Information for Eligibility (FS-22)* to the child's physician to confirm the ER condition.

POE staff should allow at least five (5) working days for the return of the *FS-22*. The POE will contact the physician's office to encourage timely return of the form. Emphasize that this information will facilitate the timely determination of eligibility for early intervention services.

Upon verification of the ER condition, do not administer a screening instrument. Assign a SC to the referral and the District Child Evaluation Specialist (DCES) or when appropriate a specialized contracted evaluator to conduct a Cabinet-approved Five Area Assessment (5AA). Enter the diagnosis as part of the health assessment on the Evaluation and Assessment Information page on TOTS.

Should the child not have an ER condition, the POE proceeds with screening using the procedures for a child suspected of a developmental delay.

### **5.2 (3) Screening for Children Suspected of a Developmental Delay**

All children referred due to concerns of developmental delay are screened using the Ages and Stages Questionnaires, Third Edition (ASQ-3) and the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE-2), appropriate for the age of the child (adjusted for prematurity as applicable).

Obtain written parental consent at least five (5) working days before conducting any screening. Use the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* to obtain consent. The date of the parent's signature is the first day of the notice.

#### **5.2 (3) (a) Screening by Mail**

If screening is completed by mail a *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* is sent with the appropriate screening protocol for the child's age. The additional required documents are included in the screening packet (see section 5.2). POE staff may not contact the family to complete and score the protocol until receipt of the signed consent. Should a family mail the completed protocol to the POE without including the signed consent, the protocol cannot be scored until the written consent is obtained.

Written consent must be obtained no later than ten (10) calendar days from the date mailed. If the consent has not been returned by the tenth day, the POE closes the file. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

#### **5.2 (3) (b) Screening in Person**

If the parent comes to the POE office to complete the screening process, the parent must sign the *FS-8*. POE staff gives the parent the choice to complete the screening or wait the five (5) working days from consent. POE staff must clearly document in a service log or communication log on TOTS that the parent chose how to proceed. If screening indicates the need for further evaluation, the child moves forward to evaluation. The parent can be given the choice to complete the evaluation at that time or wait the five (5) working days from the consent if the child

is present. The POE staff must also document this in a service log or communication log on TOTS.

There are instances when POE staff will complete screening with the parent in the home or community settings other than the POE office. The *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* must be mailed to the parent prior to the scheduled visit in order for the POE staff to complete the screening at the visit. If the *FS-8* is not mailed prior to the scheduled visit, it is completed at the visit and the parent is given the choice to complete the screening or wait the five (5) working days from consent. POE staff must clearly document in a service log or communication log on TOTS that the parent chose how to proceed.

**5.2 (4) Screening of Children too Young for Administration of Screening Protocol**

With written parent consent as documented on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*, children who are less than one (1) month of chronological age shall be assigned a SC and move forward to evaluation. If the parent did not consent to an evaluation, inform them that the child is too young to be screened and without consent, no further action can be taken by the POE.

Children who are less than one (1) month of corrected age shall be referred to a Neonatal Follow-up Program (NFP) with parent consent on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*. The NFP will complete the screening process for the child and may administer a developmental evaluation as appropriate.

**5.2 (5) Screening for Children Referred by DCBS**

All children referred from DCBS or foster parent must be screened with both the ASQ-3 and the ASQ:SE-2 appropriate for the age of the child.

**5.2 (6) Screening Children Suspected of Autism Spectrum Disorders (ASD)**

Children who present with a constellation of concerns that raise suspicions of having an ASD shall, with parental consent, have a secondary screening completed using the Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F) and the STAT. Document the results of these screeners on TOTS on the Screening Information page under number ten (10) M-CHAT and number eleven (11) STAT.

**\*Note:** The *FS-8* completed at intake covers consent for the M-CHAT-R/F and STAT. The M-CHAT-R/F may be administered by the SC or DCES. The STAT must be completed by the DCES.

Results from the M-CHAT-R/F and STAT can assist in determining need for a diagnosis of an ASD which may influence eligibility and subsequent IFSP development. See section 6.9 (1) (a) Children Suspected of Having Autism for further details.

**5.2 (7) Screening Results of ASQ-3 and ASQ:SE-2 and Follow-Up Action**

Once the screening instruments are scored, take one (1) of the actions below:

ASQ-3 Results	ASQ:SE-2 Results	Next Action
All in the "no concern" area	"no risk"	Provide the parent with: <ul style="list-style-type: none"> <li>• <i>Family Letter for Screen Passed (FS-2)</i></li> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents' Rights in Kentucky's Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting "Screening Passed" from the "Exit/Close Reason" drop-down menu</li> </ul>

		<p>If parent requests and consents to an evaluation:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul>
All in the “no concern” area	“at risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>
Results in both the “no concern” and only one (1) in the “monitoring” area	“no risk”	<p>Provide the parent with:</p> <ul style="list-style-type: none"> <li>• <i>Family Letter for Monitoring Area (FS-35)</i></li> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Screening Passed” from the “Exit/Close Reason” drop-down menu</li> </ul> <p>If parent requests and consents to an evaluation:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul>
Results in both the “no concern” and only one (1) in the “monitoring” area	“at risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>
Two (2) or more in the “monitoring” area	“no risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>

Two (2) or more in the “monitoring” area	“at risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>
At least one (1) in “refer for evaluation” area	“no risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>
At least one (1) in the “refer for evaluation” area	“at risk”	<p>Move to evaluation with parental consent:</p> <ul style="list-style-type: none"> <li>• Document results on the Screening Information page</li> <li>• SC moves forward with an evaluation</li> </ul> <p>Parent did not consent to an evaluation:</p> <ul style="list-style-type: none"> <li>• <i>Notice of Action (FS-9)</i></li> <li>• <u>Parents’ Rights in Kentucky’s Early Intervention System: First Steps brochure</u></li> <li>• List of local resources &amp; developmentally appropriate activities</li> <li>• Document results on the Screening Information page</li> <li>• Close case (after five (5) working days from <i>FS-9</i>) on the Transition/Exit Information page by entering a date and selecting “Parent Withdraw” from the “Exit/Close Reason” drop-down menu</li> </ul>

**5.2 (8) Use of Professional Judgment at Screening**

A child whose screening scores do not indicate the need for an evaluation may be referred for an evaluation when:

- (a) parental concerns in a specific area of development are confirmed by further in-depth questioning of the parent;
- (b) documentation of developmental concerns that were not flagged by the screening instrument; or
- (c) documentation of behavior patterns, family history of hearing loss not reported during completion of the health screen, family history of a social-emotional disorder (i.e. older sibling who has autism) or atypical behavior not addressed by the screening instrument.

**5.3 Intake**

The SC schedules the intake meeting and sends the *Initial Home Visit Confirmation Letter (FS-5)* to conduct intake activities with the parent, which includes, at a minimum, the following actions:

- (1) A description of services available through KEIS including the following:
  - a. information about the evaluation and assessment at no cost to the family;
  - b. IFSP development;
  - c. the coaching model of service delivery;

- d. natural environments;
  - e. financial requirements related to Family Share, use of private insurance and Medicaid;
  - f. evidence-based early intervention services;
  - g. the forty-five (45) day timeline; and
  - h. service options that may be available upon exit.
- (2) If child is screened by another source, the parent must give written consent for the evaluation by signing the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*. The notice must be provided at least five (5) working days before the evaluation can take place.
  - (3) An explanation of the parent's rights under Part C of the IDEA, including a description of Procedural Safeguards and options for Dispute Resolution, with a copy of the Family Rights Handbook provided to the family.
  - (4) A review of the IDEA confidentiality rights using the *Notice of Confidentiality, Privacy Practices and Records (FS-29)* and provide the parent with a copy of the form.
  - (5) The completion of the *Consent to Release/Obtain Information (FS-10)* by the parent or guardian. This form should be used to gather existing medical or developmental records, screening or evaluation reports, diagnosis information and other information. SCs are encouraged to obtain consent for the following agencies:
    - a. Early Hearing Detection and Intervention (EHDI) program;
    - b. OCSHCN;
    - c. DCBS;
    - d. Early Head Start;
    - e. Health Access Nurturing Development Services (HANDS);
    - f. KY Birth Surveillance Registry (KBSR);
    - g. Local School District;
    - h. Primary Care Physician; and
    - i. DDS (children in foster care, listed as "other").

Consents must be appropriately marked on the Referral Information page on TOTS in section eleven (11).

- (6) Provide an explanation and obtain consent to share child outcomes data with the Kentucky Center for Statistics (KYStats) using the *Notice & Consent for Release of Child Outcomes Data to the Kentucky Center for Statistics (KYStats) (FS-6)*. The consent for the data share is listed as "Longitudinal Data System" under item twelve (12) on the Referral Information page on TOTS. The parent's choice must be marked either "yes" or "no" under item twelve (12) "Consents Mailed".
- (7) Provide parents with a *Transition Notice & Consent (FS-11)* and document their willingness for, or refusal of, participation of the transition process. If parent refuses transition, check the box that states "Family Refuses Participation in Transition Process" located at the top of the Transition/Exit Information page on TOTS.

**\*Note:** All actions above must be documented in a service log. The documentation must be specific to the child and family.

#### **5.4 Re-referrals**

Only users with a District Administrator (DA) logon can implement procedures to re-activate a closed TOTS record. To re-activate a file:

- (1) POE staff selects the "Search Child" button on the TOTS home page and enters the child's name. When the record appears at the bottom of the screen, POE staff selects "detail" beside the child's name to view the record;
- (2) Go to the Transition/Exit Information page, scroll to the bottom to "Exit/Close Information". Remove the "Exit/Close Date" and the "Exit/Close Reason" and save the page. Once saved, the date the case was reopened, the original exit date and the original exit reason will automatically save in the "Note" section; and
- (3) On the Referral Information page, select the "ReReferral" button at the top of the screen. This will move all previous referral information to the "Referral History" at the bottom of the screen and will allow entry of the new referral information.

There are many factors to consider when a child has exited the program and then re-referred. The actions of the POE staff will depend largely on the phase the child was in at the time of exit.



**\*Note:** If the parent or surrogate parent has changed since the previous referral new consents must be obtained for future actions.

#### **5.4 (1) Pending Consents**

Cases in this phase were closed because the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* was not obtained within the ten (10) calendar day timeframe.

- (a) The correctly completed *FS-8* is valid if the information is returned within thirty (30) calendar days from the date of case closure. POE staff will reactivate the TOTS file, leave the original "Referral Date" and document in the communication log that there was a delay in receiving the screening protocol and consent from the parent. POE staff shall review the ASQ screening protocols to determine if new screening protocols are needed based on the current age of the child and rescreen as appropriate (a new consent is not needed). If an IFSP is developed, the "IFSP Delay Reason" on the Individualized Family Service Plan page on TOTS will be "Child/Family/Guardian Unavailable".
- (b) If the screening protocols and *FS-8* are returned beyond thirty (30) calendar days from the date of case closure, the consent is no longer valid. POE staff will reactivate the TOTS file and enter the new referral date and information. A new ASQ-3 and ASQ:SE-2 screening protocol and *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* must be sent to the parent to complete and return to the POE. POE staff should document in the communication log that this is a re-referral and new screening protocols and *FS-8* have been sent to the parent.

#### **5.4 (2) Screening Completed and Awaiting Evaluation**

Cases in this phase were closed because an initial evaluation was not completed. Children in this phase have a completed *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* on file and have been screened.

- (a) If the child is re-referred within thirty (30) calendar days from the date of exit, the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* on file is considered valid and the child is not re-screened. POE staff will reactivate the TOTS file, leave the original "Referral Date" and document in the communication log that a new consent and screening is not needed for the re-referral. If an IFSP is developed, the "IFSP Delay Reason" on the Individualized Family Service Plan page on TOTS will be "Child/Family/Guardian Unavailable".
- (b) If the child is re-referred beyond thirty (30) calendar days from the date of exit, a new *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* and ASQ screening protocols are needed. POE staff will reactivate the TOTS file and enter the new referral date and information. POE staff document in the communication log that this is a re-referral and new screening protocols and *FS-8* have been sent to the parent.

#### **5.4 (3) Evaluation Conducted and Awaiting Eligibility**

Cases in this phase were closed because eligibility was not determined. Children in this phase have had an initial evaluation completed.

- (a) The initial evaluation shall be considered valid if the child is under age one (1) and the re-referral is within three (3) months of the date of the initial evaluation or if the child is over the age one (1) and the re-referral is within six (6) months of the date of the initial evaluation. POE staff will reactivate the file and leave the original "Referral Date" and document in the communication log that a new evaluation is not needed. If the *Consent to Release/Obtain Information (FS-10)* on file is valid, POE staff shall obtain updated medical records as applicable and move forward with eligibility determination. If the evaluation is still valid the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* is valid for past actions, but not future actions. POE staff will send a *Notice of Action & Consent for Assessment (FS-7)* to the parent. Once consent is received from the parent, the SC shall schedule a home visit to conduct the initial family assessment. If an IFSP is developed, the "IFSP Delay Reason" on the Individualized Family Service Plan page on TOTS will be "Child/Family/Guardian Unavailable."
- (b) The initial evaluation shall not be considered valid if the child is under the age one (1) and the re-referral is beyond three (3) months of the date of the initial evaluation or if the child is over the age one (1) and the re-referral is beyond six (6) months of the date of the initial evaluation. POE staff will reactivate the TOTS file, enter the new referral information and send a new *Notice of Action &*

*Consent for Screening, Evaluation and Assessment (FS-8)* and ASQ screening protocols to the parent.

**\*Note:** The *FS-10* is considered valid for one year from the date that the parent signed consent or the child's third birthday, whichever comes first.

#### **5.4 (4) Evaluation Conducted and Found Ineligible**

Cases in this phase were closed because the child was evaluated and found ineligible. The file must be reopened to reflect the new referral.

##### Initial Evaluation Is Valid

The initial evaluation shall be considered valid if the child is under age one (1) and the re-referral is within three (3) months of the date of the initial evaluation or if the child is over the age one (1) and the re-referral is within six (6) months of the date of the initial evaluation.

POE staff contacts the parent to discuss the re-referral and determine if there are any new developmental concerns or new diagnosis. Discussion should include potential significant events that may have occurred since the original referral (such as severe illness, head trauma, etc.).

Developmental concerns have not changed from the original referral:

The POE staff informs the parent that the initial evaluation is still valid and re-evaluation cannot be conducted at this time. POE staff explains to the parent that KEIS eligibility is based on significant developmental delay and a child may present with mild delays that do not meet Kentucky's eligibility criteria. POE staff informs the parent that a re-referral can be made before the child turns three (3):

- (a) if a new developmental concern arises; or
- (b) when the previous evaluation is no longer valid.

POE staff document the discussion in the child's record on TOTS, send the *Notice of Action (FS-9)* to the parent, and close the file. No *Notice of Record Destruction (FS-32)* is needed as the referral is being declined.

Re-referral presents new developmental concerns from original referral:

POE staff discusses the new developmental concerns with the parent and moves forward with re-evaluation. Because the initial evaluation is still valid, a different standardized norm-referenced tool must be completed for re-evaluation.

##### Initial Evaluation Is Invalid

The initial evaluation shall not be considered valid if the child is under the age one (1) and the re-referral is beyond three (3) months of the date of the initial evaluation or if the child is over the age one (1) and the re-referral is beyond six (6) months of the date of the initial evaluation. POE staff will reactivate the TOTS file, enter the new referral information and send a new Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8) and ASQ screening protocols to the parent.

#### **5.4 (5) Determined Eligible and Awaiting Initial IFSP**

Cases in this phase were closed because an IFSP was not developed. Children in this phase have been determined eligible for early intervention services. POE staff will determine if the evaluation is still valid at time of re-referral based upon the timeline indicated in 5.4 (3).

If the evaluation is valid, POE staff will reactivate the TOTS file, leave the original "Referral Date" and document in the communication log that eligibility is still valid. If an IFSP is developed, the "IFSP Delay Reason" on the Individualized Family Service Plan page on TOTS will be "Child/Family/Guardian Unavailable".

- (a) The family assessment shall be considered valid if the child is under age one (1) and the re-referral is within three (3) months of the date of the initial family assessment or if the child is over the age one (1) and the re-referral is within six (6) months of the date of the initial family assessment. It is best

practice to review the prior listed “Concerns, Supports, Possible Outcomes and Priorities” as well as “Family Routines” before scheduling the initial IFSP meeting.

- (b) The family assessment shall not be considered valid if the child is under the age one (1) and the re-referral is beyond three (3) months of the date of the initial family assessment or if the child is over the age one (1) and the re-referral is beyond six (6) months of the date of the initial family assessment. POE staff will send a *Notice of Action & Consent for Assessment (FS-7)* to the parent. Once consent is received from the parent the SC shall schedule a home visit to conduct a new family assessment.
- (c) If no family assessment was conducted prior to discharge, POE staff will send a *Notice of Action & Consent for Assessment (FS-7)* to the parent. Once consent is received from the parent the SC shall schedule a home visit to conduct the initial family assessment.

If the evaluation is not valid at the time of re-referral, POE staff will reactivate the TOTS file, enter the new referral information and send a new *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* and ASQ screening protocols to the parent. If the *Consent/Release of Information (FS-10)* on file is still valid that release can be used to obtain updated medical information.

#### **5.4 (5) IFSP**

Re-referrals can occur when a case has been closed and there was an IFSP developed previously.

##### **5.4 (5) (a) IFSP In Process (Outcomes Not Met At Time Of Exit)**

Children in this phase had an IFSP developed, but did not meet the outcomes at the time of exit. If the case has been closed for less than thirty (30) calendar days, a new IFSP is not needed. The IFSP that was in place at the time of exit is still valid. POE staff will reactivate the file and enter a Requested Review IFSP to reflect the new start date for services the end date for the IFSP does not change.

If the case was closed for more than thirty (30) calendar days a new IFSP will be needed and the procedures outline below must be followed:

1. If the IFSP was an initial IFSP at the time of discharge POE staff shall determine if the initial evaluation results are still valid based on the procedures outlined in Section 5.4 (3).
  - a. If the initial evaluation is still valid, POE staff will create a Requested Review IFSP to show the new start and end date for services and IFSP services continue.
  - b. If the initial evaluation is no longer valid, POE staff will process the case as if it is a new referral and re-determine eligibility.

**\*Note:** The very first IFSP is always considered the initial IFSP. When a new IFSP is developed following eligibility determination, that IFSP must be labeled as an Annual IFSP. This will allow TOTS to accurately track the timeline for future IFSPs.

2. If the IFSP was a Six (6) Month Review at the time of discharge, POE staff will process the case as if it is a new referral and re-determine eligibility.
3. If the IFSP was an Annual IFSP at the time of discharge POE staff shall determine if the results of the annual 5AA are still valid.
  - a. If the annual 5AA was conducted within ninety (90) calendar days, it is considered valid. A Requested Review IFSP is created to show the new start and end date for services and IFSP services continue.
  - b. If the annual 5AA was conducted more than ninety (90) calendar days, it is no longer valid. POE staff will process the case as if it is a new referral and re-determine eligibility.

##### **5.4 (5) (b) IFSP In Process (Outcomes Met At Time Of Exit)**

Children in this phase had an IFSP developed and met the outcomes at time of exit. POE staff will process the case as if it is a new referral and re-determine eligibility.

IFSP Phase	# Of Days Absent From Services	POE Actions
<b>Initial</b>	If the child is absent from services for less than thirty (30) calendar days	The file is made active again, a Requested Review is entered to show the new start date for services and IFSP services continue
	If the child is absent from services for more than thirty (30) calendar days	Determine if the initial evaluation is still valid based on the procedures outlined in section 5.4 (3): <ul style="list-style-type: none"> <li>• If initial evaluation is valid reactivate the file, enter a Requested Review to show the new start date for service and IFSP services continue</li> <li>• If initial evaluation is no longer valid, POE staff will process the case as if it is a new referral and re-determine eligibility</li> </ul>
<b>Six (6) Month Review</b>	If the child is absent from services for less than thirty (30) calendar days	The file is made active again, a Requested Review is entered to show the new start date for services and IFSP services continue
	If the child is absent from services for more than thirty (30) calendar days	POE staff will process the case as if it is a new referral and re-determine eligibility
<b>Annual</b>	If the child is absent from services for less than thirty (30) calendar days	The file is made active again, a Requested Review is entered to show the new start date for services and IFSP services continue
	If the child is absent from services for more than thirty (30) calendar days	Determine if the annual 5AA is still valid <ul style="list-style-type: none"> <li>• If the annual 5AA was completed within ninety (90) calendar days, reactivate the file and enter a Requested Review to show the new start date for services and IFSP services continue</li> <li>• If the annual 5AA was completed more than ninety (90) calendar days from the date of re-referral, POE staff will process the case as if it is a new referral and re-determine eligibility</li> </ul>

## **Chapter 6: Evaluation & Eligibility**

Eligibility for early intervention services is determined for every child referred to Kentucky's Early Intervention System (KEIS) through an evaluation. Evaluation as defined by Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) means the procedures used by qualified personnel to determine a child's initial and continuing eligibility. Procedures include formal testing, observations, review of relevant health records and other records pertinent to the child's developmental status, comparison to eligibility criteria and final determination of eligibility.

KEIS uses a two (2) level evaluation system that consists of Initial Evaluation and Secondary Level Evaluations.

### **6.1 Nondiscrimination in Eligibility Determination**

All activities conducted as part of eligibility determination must be unbiased, non-judgmental, comprehensive and individualized according to the presenting needs of the child and family and their individual ethnic and cultural beliefs. Any standardized instrument or test employed to evaluate or assess children and families must be free from racial or cultural bias. No single procedure is the sole criterion for determining a child's eligibility for early intervention services.

### **6.2 Language Access: Native Language**

All child evaluations and assessments must be administered in the native language of the child as defined in the definitions section of this manual. The only time this does not apply is when it is clearly not feasible to conduct either the evaluations or assessments in the native language. The family assessment must be conducted in the preferred language of the parent or other mode of communication.

### **6.3 Timelines**

A determination of eligibility must occur within forty-five (45) calendar days of the initial referral to the Point of Entry (POE) and early enough to allow for the development of an Individualized Family Service Plan (IFSP) for an eligible child before the end of the timeline. Document the results of the eligibility determination on the Eligibility Information Page on the Technology-assisted Observation and Teaming Support System (TOTS).

When a determination of eligibility does not occur within forty-five (45) calendar days of the initial referral, the circumstances that caused the delay must be documented on the Communication Log page on TOTS. If the child was determined eligible, the reason must also be documented on the Individualized Family Service Plan page in the "IFSP Delay Reason" dropdown box.

### **6.4 Written Consent**

Written parental consent must be obtained at least five (5) working days before conducting any initial evaluation or assessment. Consent is obtained on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*.

#### **6.4 (1) Issues with Parent Consent for Evaluation**

##### **6.4 (1) (a) Parent Consented to Screening Only, Not Evaluation**

If the parent consents to screening only on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*, the POE staff complete the appropriate screening action and provide the parent with the results. If the POE staff recommends evaluation, they must explain to the parent that the child will not be considered for eligibility without the evaluation.

1. If the parent chooses to move forward to evaluation, consent must be obtained on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*.
2. If the parent chooses not to move forward with evaluation, the POE staff informs the parent that they may contact the POE if they decide to pursue eligibility in the future. A *Notice of Action (FS-9)* is completed and given to the parent along with a copy of Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. The record is closed by entering the "Exit/Close Date" and "Exit/Close Reason" on the Transition/Exit Information Page on TOTS. The reason for exit is marked as "Parent Withdraw".

#### **6.4 (1) (b) Child Not Made Available**

If the parent gives consent for the evaluation on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* for evaluation, the POE staff or contracted evaluator must make at least three (3) attempts to schedule the evaluation. These attempts are documented on the Communication Log page on TOTS. After three (3) attempts, the POE staff sends a *Notice of Action (FS-9)* that indicates no evaluation will be conducted because the parent has not made the child available. A copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure is included with this notice. Close the child's record on TOTS by entering the "Exit/Close Date" and "Exit/Close Reason" on the Transition/Exit Information Page on TOTS. The reason for exit is marked as "Attempts to Contact Unsuccessful".

#### **6.4 (1) (c) Parent Gives Consent to Evaluation but Does Not Follow Through with Medical Component**

The medical component is necessary in order to determine the appropriate procedures for an initial evaluation. The medical component is satisfied by either a review of recent, relevant health records or a physical examination by a physician or ARNP (See Section 6.8 for details regarding the medical component). Parents who refuse to give consent for the POE to obtain the health records or who refuse to take the child for a physical examination are refusing the evaluation. The POE staff sends a *Notice of Action (FS-9)* indicating that the parent has not followed-through with the required actions for the medical component of the evaluation. A copy of Parent's Rights in Kentucky's Early Intervention System: First Steps brochure is included with this notice. Close the child's record on TOTS by entering the "Exit/Close Date" and "Exit/Close Reason" on the Transition/Exit Information Screen on TOTS. The reason for exit is marked as "Parent Withdraw".

There are instances where the medical component cannot be obtained due to the parent's religious exemption for medical care. This must be documented in the "Health Assessment" on the Evaluation/Assessment Information page. Also note this on the Pregnancy, Birth and Health Information page on TOTS. With proper documentation, the POE can move forward with evaluation.

#### **6.5 Hearing Status**

Prior to the administration of the child evaluation, the child's hearing status shall be determined through screening or evaluation.

There are two (2) types of hearing screens: a verbal assessment screen and an instrument screen using an audiology screener designed for detection of hearing. This type of screening is commonly conducted with an Otoacoustic Emissions (OAE) device. All live births in Kentucky are screened prior to discharge from the birthing hospital by the Early Hearing Detection & Intervention/Newborn Hearing Screening Program (EHDI) housed within the Office for Children with Special Health Care Needs (OCSHCN). Audiology evaluations are provide in KEIS by the OCSHCN as needed or if the parent chooses, a private audiologist.

All children referred to KEIS have a verbal risk assessment performed for suspected hearing impairment prior to the evaluation. The risk assessment is located on the Pregnancy, Birth and Health Information Page on TOTS, consist of the following questions:

Under the "Health Information", questions five (5) through nine (9):

"Has the child experienced:

5. Bacterial Meningitis;
6. Family History of Early Onset Hearing Loss;
7. Severe Head Trauma;
8. Prolonged Otitis Media and/or Middle Ear Fluid Greater Than two (2) Months; and
9. Syndromes Associated With Hearing Loss (Flag all for audiological screen)."

Under the "Birth Information", question number one (1), three (3) and five (5):

"1. Birth Weight (if less than 1500 grams);

3. Gestational Age (if less than 34 weeks);
5. Special Considerations (Flag for audiological screen for Bilirubin, Birth Defects, and Congenital Infection)."

Document the completion of the verbal risk assessment on TOTS.

**\*Note:** Children whose parents report a history of frequent ear problems (infections, fluid build-up) resolved through medical interventions should be marked as a "no" on question eight (8) on the Pregnancy, Birth and Health Information page on TOTS. If the ear problems persist after medical intervention, then the answer to question eight (8) should be "yes".

#### **6.5 (1) Required Hearing Screening**

It is mandatory for a child to have a hearing screening with a device (OAE or other) if the following apply:

- (a) A child who has failed a verbal risk assessment by having a positive answer to any of the following questions on the TOTS Pregnancy, Birth and Health Information Page:
  1. Items five (5) through nine (9) under the "Health Information"; and
  2. Number one (1), three (3) and five (5) under Birth Information; or
- (b) A child who did not fail the verbal risk assessment, but parent voices concern.

**\*Note:** It is best practice to conduct an OAE when a child is referred only for communication delay.

If prematurity (gestational age) is the only item flagged on the verbal risk assessment and the parent has no concerns, the newborn hearing screening may serve as the hearing screening with a device as long as the child has not experienced a serious illness or injury that may affect hearing since that screening occurred.

The POE may conduct hearing screenings depending upon the POE's resources (availability of OAE machines and trained staff). A hearing evaluation may be conducted by the OCSHCN. If a hearing screening or evaluation is required, ensure that the parent gives the POE and OCSHCN the ability to share information on the hearing results by signing a *Consent to Release/Obtain Information (FS-10)*.

This process is to ensure identification of a hearing impairment before the administration of evaluation and assessment and the provision of early intervention services.

#### **6.5 (2) Procedures for Hearing Screens Conducted by the POE**

The POE should make every effort to conduct the OAE screening for the child. To provide adequate hearing screens for children, POE's should:

- (a) Attempt to screen a child in as quiet an environment as possible. (It is often helpful for a parent or someone the child knows to be present and assist with keeping the child quietly entertained).
- (b) Visually inspect the child's ear before screening with the OAE. This is to check for any excess wax or other debris present in the ear canal, as well as to detect if there are any structural abnormalities of the ear itself.
- (c) Carefully conduct the OAE screening according to the training provided by the OCSHCN/EHDI staffs.
- (d) Results for each ear are recorded on the *Otoacoustic Emissions (OAE) Screen Reporting Form (FS-38)* and are sent to the OCSHCN/EHDI. The results are documented on the Screening Information Page on TOTS under number twelve (12), "Scores/Results of other screeners". POE staff document the hearing screening in a communication log or service log on TOTS and include any required action.

##### **6.5 (2) (a) Procedures for Children who Cannot be Screened with the OAE Machine**

If the POE cannot screen the child with the OAE machine document the attempt in a service or communication log on TOTS and refer the child to the OCSHCN or if the parent chooses, a private audiologist.

##### **6.5 (2) (b) Procedures for Children who Pass Hearing Screens**

For children who pass the hearing screening, the results are documented on the Screening Information Page on TOTS under number twelve (12), "Scores/Results of other screeners". The

results are also entered on the Evaluation/Assessment Information Page on TOTS as a Hearing Assessment. The findings are captured on the *Otoacoustic Emissions (OAE) Screen Reporting Form (FS-38)* and sent to the OCSHCN so that the results can be accurately matched to the newborn record. Enter a service log or communication log. Children who pass hearing screens conducted by the POE continue to the next step towards evaluation if there are other developmental concerns that support the evaluation.

### **6.5 (2) (c) Procedures for Children who Fail Hearing Screens**

If the hearing screening is conducted by POE staff and the child does not pass in one (1) or both ears, the screening results are documented on the Screening Information Page on TOTS under number twelve (12), "Scores/Results of other screeners". The results are also documented on the *Otoacoustic Emissions (OAE) Screen Reporting Form (FS-38)* and a referral to the OCSHCN is made or if the parent chooses, a private audiologist. POE staff must document this in a service log or communication log on TOTS. The hearing evaluation must be conducted before continuing the next steps toward eligibility determination.

**\*Note:** All *Otoacoustic Emissions (OAE) Screen Reporting Form (FS-38)*, regardless of results, must be mailed or faxed to the OCSHCN.

### **6.5 (3) Referrals from KEIS to OCSHCN**

The OCSHCN will provide the necessary audiological evaluation.

Procedures to refer child to the OCSHCN:

- (a) Complete Demographic Information page and Pregnancy, Birth and Health Information pages on TOTS;
- (b) Complete the *Otoacoustic Emissions (OAE) Screen Reporting Form (FS-38)*;
- (c) Ensure that the parent receives prior notice and gives consent for the referral to OCSHCN to conduct the hearing evaluation on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*;
- (d) Complete the *Consent to Release/Obtain Information (FS-10)* for the OCSHCN and EHDI so that hearing information may be shared;
- (e) Complete the *Referral Form to OCSHCN (FS-37A)*;
- (f) Fax the *FS-37A*, *FS-10* and *FS-38* to the OCSHCN office;
- (g) Assist the family by calling the local OCSHCN office to set-up an appointment or instruct the family to call to make an appointment as soon as possible;
- (h) Issue an authorization for the "Audiology Assessment" on the IFSP Planned Service Information page on TOTS with OCSHCN as Payor 1; and
- (i) Document on TOTS on the communication or service log that the referral to the OCSHCN has been made.

**\*Note:** Following the Title V rules, the OCSHCN will bill Medicaid or the family's private insurance, even if the parent has declined the use of insurance in KEIS.

Once the OCSHCN completes the evaluation, the audiologist will enter the results on the Evaluation/Assessment Information page on TOTS and will enter a service log for the activity. It is crucial that the SC enter the authorization on IFSP Planned Service Information page timely and accurately. If the date of service is beyond the end date of the authorization, the report can be entered but not the service logs. The dates that authorized service begin and end should be included on the faxed *Referral Form to OCSHCN (FS-37A)*.

**\*Note:** If a child fails the hearing evaluation conducted by OCSHCN, a referral is made by EHDI to Kentucky Hands and Voices. Kentucky Hands and Voices is a non-profit, parent-driven organization dedicated to supporting families of children who are deaf or hard of hearing. For more information about Kentucky Hands and Voices and their services, please visit: <https://kyhandsandvoices.org/>.

### **6.5 (3) (a) Results of the Hearing Evaluation are Inconclusive**



There may be instances where the hearing evaluation results are inconclusive. The OCSHCN audiologist will document the results by completing a "Hearing" assessment on the Evaluation/Assessment Information page on TOTS that states the hearing results were inconclusive and follow-up is recommended. If hearing cannot be verified, POE staff must document in the communication log that based on the hearing results further evaluation and assessment of the child is placed on hold until the hearing can be verified. A new "Audiology Assessment" authorization may be warranted dependent upon the dates of the previous authorization.

Once verified, the OSCHCN audiologist will edit the previous "Hearing" assessment and update with the conclusive results. Once the hearing has been confirmed, the POE staff move forward to evaluation and assessment of the child.

#### **6.5 (3) (b) Results are Conclusive but Follow-Up is Recommended**

There may be instances where the hearing evaluation results are conclusive but the OCSHCN audiologist recommends follow-up with the child's pediatrician or Ear, Nose and Throat physician (ENT) due to the need for some type of medical follow-up. The SC can assist in coordinating these services; however, KEIS will not pay for the follow-up.

1. If results are conclusive that the child passed the hearing evaluation, POE staff move forward to evaluation and assessment to determine eligibility for early intervention services.
2. If results are conclusive that the child passed the hearing evaluation in one ear, POE staff move forward to evaluation and assessment to determine eligibility for early intervention services.
3. If results are conclusive and the child meets the definition of an ER condition (twenty-five (25) decibels (dB) or greater in the better ear) for hearing, a Five Area Assessment (5AA) is conducted by a contracted primary level evaluator or District Child Evaluation Specialist (DCES) who is a speech pathologist if available.
4. If results are conclusive that the child failed the hearing evaluation but results may be due to medical issues (fluid build-up, tubes, infection), POE staff inform the parents that the POE is unable to evaluate and assess the child for eligibility until medical follow-up is complete. POE staff will close the case and provide the parent with a *Notice of Action (FS-9)*, indicating that the POE refuses to evaluate the child due to hearing status and provide the parent with the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. After the five (5) working day notice, on the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu. The parent will need to re-refer the child once the medical follow-up is complete. Once the re-referral is made, the POE staff will determine hearing status and proceed as appropriate.

#### **6.5 (3) (c) Scheduling Difficulties with Hearing Evaluations**

In the event that a hearing evaluation with the OSCHCN cannot be scheduled in a timely manner, POE staff enters documentation in the communication log on TOTS that includes the date of the scheduled evaluation and reason for delay (no earlier appointments available, parent unable to schedule, etc.). Further evaluation and assessment of the child will be delayed until the hearing evaluation is complete.

#### **6.5 (3) (d) Parent Declines Referral to the OCSHCN**

If the parent does not want a referral made to the OCSHCN, inform the parent of the need to ascertain the child's hearing status prior to evaluation and assessment so that results are accurate and valid. The parent may prefer to follow-up with an audiologist or physician of their choosing, however, KEIS is not responsible for the payment of the follow-up services. The POE staff must complete the *Consent to Release/Obtain Information (FS-10)* for the records that provide information on the child's hearing status from the outside provider. Further evaluation and assessment of the child will be delayed until follow-up by the parent is completed and the POE obtains the results.

In cases where the parent is unable to schedule and complete the follow-up on the child's hearing in a timely manner, the POE staff must document the delay of the forty-five (45) day timeline on TOTS in the communication log. This documentation must clearly state the anticipated date of the appointment and other relevant information.

Should the delay be more than ten calendar (10) days, the POE staff discusses with the parent the need to close the case and reopen the case after the follow-up is completed. The parent needs to understand that without valid hearing results, the child cannot be further evaluated and eligibility cannot be determined. Provide the parent with a *Notice of Action (FS-9)*, indicating that the POE refuses to evaluate the child due to the lack of confirmed hearing status. Also provide the parent with the [Parent's Rights in Kentucky's Early Intervention System: First Steps](#) brochure. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.

#### **6.5 (4) Referrals from OCSHCN to KEIS**

OCSHCN is required to refer all infants with hearing loss to KEIS within forty-eight (48) hours of identification per KRS 211.647 (6).

##### **6.5 (4) (a) Referrals for Children with Established Risk (ER) Condition**

Significant hearing loss is an ER condition and defined as twenty-five (25) decibels (dB) or greater in the better ear.

The OCSHCN will send the results of the hearing evaluation and may also send the *Consent to Release & Obtain Information OCSHCN (FS-37B)* when making the referral. POE staff must have consent on file in order to discuss child information with the OCSHCN. The *Consent to Release/Obtain Information (FS-10)* or the *Consent to Release & Obtain Information OCSHCN (FS-37B)* signed by the parent must be on file prior to the referral so that the status of the child can be discussed by both programs and recent audiology assessment information can be shared. Consent must be appropriately marked on the Referral Information page on TOTS for item number eleven (11); "Parents have consented for the following agencies to receive child specific data" by checking both "Office for Children with Special Health Care Needs" and "Early Detection and Intervention/Newborn Hearing Screening Program."

The OCSHCN can complete the *Health Information for Eligibility (FS-22)* if there is appropriate staff that can sign the form (physician or Advanced Practice Registered Nurse (APRN)).

Children referred by OCSHCN with a confirmed ER condition will need to have a 5AA conducted by an Initial Evaluator or DCES who is a speech pathologist, if available. If consent was obtained on the FS-37B, a copy of the IFSP must be sent to the OCSHCN once it is finalized.

##### **6.5 (4) (b) Referrals for Children Suspected for Developmental Delay**

If the hearing loss does not meet the criteria for an ER condition but the OCSHCN/EHDI staff believes that the child has developmental delay or has evidence of a hearing loss; the child will be referred to the POE for developmental screening. The child may move forward to evaluation and assessment based upon the results of the screening.

The OCSHCN will send the results of the hearing evaluation and may also send the *Consent to Release & Obtain Information OCSHCN (FS-37B)* when making the referral. POE staff must have consent on file in order to discuss child information with the OCSHCN. The *Consent to Release/Obtain Information (FS-10)* or the *Consent to Release & Obtain Information OCSHCN (FS-37B)* signed by the parent must be on file prior to the referral so that the status of the child can be discussed by both programs and recent audiology assessment information can be shared. Consent must be appropriately marked on the Referral Information page on TOTS for item number eleven (11); "Parents have consented for the following agencies to receive child specific data" by checking both "Office for Children with Special Health Care Needs" and "Early Detection and Intervention/Newborn Hearing Screening Program."

If eligibility is determined and an IFSP is created, a copy of the finalized IFSP must be sent to the OCSHCN if consent was obtained on the FS-37B

### **6.5 (5) Children enrolled in OCSHCN Services Prior to Entry in KEIS**

Children are sometimes referred by KEIS to the OCSHCN for audiology services when they are already being followed in the otolaryngology clinic. SCs must verify if a child is already receiving services from the OCSHCN to prevent authorizing services that the child is already receiving. Part C regulations require that OCSHCN financial resources be used before Part C funds. This means that OCSHCN pays for the services it typically provides. KEIS cannot replace existing services but rather, coordinate with those services. KEIS funds support those children who are not entitled to or covered by Medicaid, Title V or private insurance. Parents of children referred to the OCSHCN by KEIS who are not currently enrolled in OCSHCN are not charged fees by OCSHCN.

SCs must have consent on file in order to discuss child information with the OCSHCN. The *Consent to Release/Obtain Information (FS-10)* or the *Consent to Release & Obtain Information OCSHCN (FS-37B)* signed by the parent must be on file prior to the referral so that the status of the child can be discussed by both programs and recent audiology assessment information can be shared. Consent must be appropriately marked on the Referral Information page on TOTS for item number eleven (11); “Parents have consented for the following agencies to receive child specific data” by checking both “Office for Children with Special Health Care Needs” and “Early Detection and Intervention/Newborn Hearing Screening Program.”

### **6.6 Determination of Vision Status**

Prior to evaluation, the POE must ascertain the child’s vision status from medical records and the Ages and Stages Questionnaires, Third Edition (ASQ-III) results (if applicable).

The ASQ-III includes an open-ended question about the parent’s concerns with vision. Record the parent’s response to the question in the “Summary of question 1-9 from the score sheet” on the Screening Information page on TOTS. If no vision concerns were noted on the ASQ-III, but concerns with vision were raised during screening, these concerns should be entered in the “Note” section of the Screening Information page on TOTS.

The POE staff must review the child’s medical records for vision concerns noted by the physician. The *Health Information for Eligibility (FS-22)* includes a space for the physician to indicate any concerns with vision. Vision concerns noted in medical records should be entered on the Pregnancy, Birth and Health Information page on TOTS in the “Health Comments” section. A “Vision” assessment must also be entered by POE staff on the Evaluation/Assessment Information page on TOTS.

Once the child’s vision status is determined, the POE can move forward with the evaluation/assessment. The child’s vision status must be taken into consideration when determining who conducts the initial evaluation.

### **6.7 Children with Dual Hearing and Vision Loss**

If a child presents with both a hearing and vision impairment, a referral to the Kentucky Deaf-Blind Project is made. A dual sensory impairment is sometimes referred to as deaf-blindness. This does not always mean that an individual has no vision or no hearing. It means that an individual has challenges with both vision and hearing. Many times the challenges are actual vision and hearing losses. Often times the challenges exist because a person is having difficulty processing the information they see and hear.

The following is a list of conditions with a high probability of dual hearing and vision loss:

- (1) Prematurity
- (2) Direct Trauma to the Eye and Ear
- (3) Severe Head Injury
- (4) Intraventricular Hemorrhage (IVH)
- (5) Asphyxia
- (6) Periventricular Leukomalacia (PVL)
- (7) Tumors

- (8) Post Hemorrhagic Hydrocephalus (PHH)
- (9) Meningitis
- (10) Encephalitis
- (11) Syphilis
- (12) Toxoplasmosis
- (13) Rubella
- (14) Herpes
- (15) Cytomegalovirus (CMV)
- (16) Down Syndrome
- (17) Trisomy 13
- (18) Usher Syndrome
- (19) Alstrom Syndrome
- (20) Charge Syndrome
- (21) Goldenhar Syndrome

If the child has one (1) of the conditions above or the parent has both hearing and vision concerns for their child, discuss these concerns to determine if a referral to Kentucky Deaf-Blind Project is needed. If the parent consents to a referral, complete the *Consent to Release/Obtain Information (FS-10)*. Log into <https://education.uky.edu/kydbp/referral/> and complete the referral online.

**\*Note:** For more information about the Kentucky Deaf-Blind Project and their services, please visit <https://education.uky.edu/kydbp/>.

### **6.8 Initial Evaluation**

The purpose of evaluation is to confirm the existence of a significant developmental delay. The initial evaluation is conducted when eligibility for KEIS is determined the first time the child is referred. A child can only have one (1) initial evaluation even if the child has withdrawn and is re-referred to KEIS multiple times.

#### **6.8 (1) Initial Evaluation for a Child with Suspected Developmental Delay**

In Kentucky, scores obtained from an initial evaluation determine a significant developmental delay. A norm-referenced, standardized instrument is conducted that provides a standard deviation score in the full domain for each of the five (5) areas. The recommended evaluation tool is the most current version of the *Bayley Scales of Infant and Toddler Development*. The results of this norm-referenced assessment are used for comparison to Kentucky's eligibility criteria for documentation of the significance of a developmental delay.

In order to meet Kentucky's definition of a significant developmental delay the child must obtain a score that indicates a delay of:

- (a) Two (2) standard deviations or more in at least one (1) developmental domain; or
- (b) One and a half (1.5) standard deviations in at least two (2) developmental domains.

The initial evaluation is performed using two (2) types of instruments that address the five (5) developmental domains of cognition, communication (includes receptive and expressive), physical development (includes gross and fine motor), social and emotional development and adaptive (self-help) skills development. One instrument is the norm-referenced, standardized evaluation and the other is a Cabinet-approved criterion-referenced assessment (5AA). The evaluation must be conducted within the forty-five (45) calendar day timeline for IFSP development.

The Cabinet-approved 5AA instruments are:

- (a) *Hawaii Early Learning Profile (HELP)*;
- (b) *The Carolina Curriculum for Infants and Toddlers with Special Needs (CCITSN)*; and
- (c) *Assessment, Evaluation, and Programming System for Infants and Children (AEPS)*.

#### **6.8 (1) (a) Choosing an Evaluator**

A DCES or contracted primary level evaluator provides the initial evaluation. The choice of an evaluator is dependent upon the presenting concerns of the child. Prior to choosing an evaluator,

the DCES must review the referral reason(s), concerns of the parent, and ASQ results to determine if the concerns are global or domain-specific. If concerns are global, any evaluator may be chosen to administer the initial evaluation. If concerns are domain-specific, the area of expertise or discipline of study of the possible evaluator should be matched to the areas of concern for the child. For example, a child presenting with concerns in speech should be evaluated by a speech pathologist because the speech pathologist is a specialist that has the expertise to administer both a multi-domain instrument as well as discipline-specific instruments to ascertain the existence of a significant developmental delay in the area of speech.

When concerns are domain-specific, the specialist chosen to be the evaluator will bring a discipline-specific norm-referenced instrument with them to the initial evaluation. After administering the first norm-referenced instrument and the 5AA, the evaluator will use their professional judgement to determine if a discipline-specific assessment is warranted. If so, the second assessment will be administered during the same visit and will be included in the flat fee for the PLE/5AA.

If it is not possible to have the appropriate specialist as the primary level evaluator, no discipline-specific assessment is authorized.

### **6.8 (1) (b) Authorizing the Initial Evaluation**

The initial evaluation informs the Initial IFSP. TOTS will generate a “Pending” IFSP once the Demographic Information and Referral Information pages are completed. The IFSP Planned Service Information page can then be completed to authorize the initial evaluation.

To authorize the initial evaluation:

1. On the IFSP Planned Service Information page on TOTS, enter a “Start Date” and “End Date” for the evaluation (it is recommended to authorize the evaluation up to day twenty-five (25) of the forty-five (45) day timeline);
2. Select Primary Level Evaluation under “Service Name”;
3. Select the appropriate agency and provider from the drop down menu under “Provider” (do not mark this provider as the Primary Service Provider);
4. Select Assessment as “Method of Delivery”;
5. All other sections of the authorizations will default; and
6. Select “Save”.

### **6.8 (1) (c) Completion of the Initial Evaluation**

Once the evaluator (DCES or contracted evaluator) completes the initial evaluation, the following must be completed in this order:

1. Enter the results of the 5AA in the Kentucky Early Childhood Data System (KEDS) and ensure the results have been “verified” within five (5) working days;
2. Enter the full evaluation and 5AA report in the Evaluation/Assessment Information page on TOTS within five (5) working days;
3. Mail a copy of the completed evaluation report to the parent and document on TOTS within five (5) working days;
4. Enter a service log for the completed evaluation within ten (10) calendar days;
5. Submit the completed protocol to the POE; and
6. Bill for the service on the Account Payable page on TOTS within sixty (60) calendar days.

**\*Note:** The DCES or contracted evaluator must ensure the above steps are completed in the exact order listed before payment will be approved by the SLA. The provider must also ensure that the completed protocol is submitted to the POE to be maintained in the child’s hard copy file.

It is not the role of the evaluator to inform a parent that their child is “eligible” or “not eligible” after completion of the evaluation and assessment. Determining eligibility on the results of the testing violates the prohibition of basing eligibility on a sole criterion. General information about how the child performed on specific items or performed on the instrument overall may be shared. Inform

the parent that the results are only part of the information needed to determine eligibility and that they will receive a copy of the evaluation report.

### **6.8 (2) Initial Evaluation for a Child with an ER Condition**

Children with an ER condition receive only the 5AA for the initial evaluation.

#### **6.8 (2) (a) Choosing an Evaluator**

The DCES is responsible for conducting the 5AA for children with a confirmed ER condition. If the DCES does not have the expertise necessary to address the primary issue presented by the child a referral to a contracted evaluator can be made. The evaluator's ability to assess the area of concern in-depth, using a variety of discipline-specific testing instruments and methods should be considered. The DCES must document the referral on the Communication Log page on TOTS.

##### **6.8 (2) (a) 1. Child with an ER Condition of Hearing Loss**

Children with an ER condition of hearing loss will have a 5AA completed by a Speech Language Pathologist (SLP) or a Teacher of Deaf and Hard of Hearing (TDHH). Preference is given to a TDHH, if available.

##### **6.8 (2) (a) 2. Child with an ER Condition of Visual Impairment**

Children with an ER condition of visual impairments will have a 5AA completed by a Teacher of the Visually Impaired (TVI) who is an approved evaluator, if available. The availability of the TVI cannot delay the forty-five (45) calendar day timeline for eligibility determination and IFSP development.

#### **6.8 (2) (b) Authorizing the 5AA**

The initial evaluation informs the Initial IFSP. TOTS will generate a "Pending" IFSP once the Demographic Information and Referral Information pages are completed. The IFSP Planned Service Information page can then be completed to authorize the 5AA.

To authorize the 5AA:

1. On the IFSP Planned Service Information page on TOTS, enter a "Start Date" and "End Date" for the assessment (it is recommended to authorize the evaluation up to day twenty-five (25) of the forty-five (45) day timeline);
2. Select Five Area Assessment under "Service Name";
3. Select the appropriate agency and provider from the drop down menu under "Provider" (do not mark this provider as the Primary Service Provider);
4. Select Assessment as "Method of Delivery";
5. All other sections of the authorizations will default; and
6. Select "Save".

#### **6.8 (2) (c) Completion of the 5AA**

Once the DCES or contracted evaluator completes the 5AA, the following must be completed in this order:

1. Enter the results of the 5AA in KEDS and ensure the results have been "verified" within five (5) working days;
2. Enter the full evaluation and 5AA report in the Evaluation/Assessment Information page on TOTS within five (5) working days;
3. Mail a copy of the completed evaluation report to the parent and document on TOTS within five (5) working days;
4. Enter a service log for the completed evaluation within ten (10) calendar days;
5. Submit the completed protocol to the POE; and
6. Bill for the service on the Account Payable page on TOTS within sixty (60) calendar days.

**\*Note:** The DCES or contracted evaluator must ensure the above steps are completed in the exact order listed before payment will be approved by the SLA. The provider must also ensure that the completed protocol is submitted to the POE to be maintained in the child's hard copy file.

It is not the role of the evaluator to inform a parent that their child is “eligible” or “not eligible” after the completion of the assessment. Determining eligibility on the results of the testing violates the prohibition of basing eligibility on a sole criterion. General information about how the child performed on specific items or performed on the instrument overall may be shared. Inform the parent that the results are only part of the information needed to determine eligibility and that they will receive a copy of the assessment report.

### **6.8 (3) Initial Evaluation for a Child Born Premature**

For a child with a corrected age less than six (6) months, an approved Intensive Level Evaluation (ILE) team or an approved Neonatal Follow-Up Program (NFP) conducts the initial evaluation.

**\*Note:** This policy only applies to premature children. If the child is not premature and is less than six (6) months old, the DCES or a contracted evaluator may conduct the evaluation.

Either the DCES or a contracted evaluator under the following conditions can perform an initial evaluation of a child with a corrected age of four (4) to six (6) months:

- (a) The ILE team or NFP is unable to conduct the evaluation within thirty-five (35) calendar days of the referral to KEIS. Documentation of the attempt to schedule an evaluation must include the date of contact, name of person at the respective team with whom the SC spoke and date of possible evaluation which clearly is at least thirty-five (35) calendar days from date of referral to KEIS. Documentation should be noted in the SC’s service log on TOTS;
- (b) The DCES or contracted evaluator is trained on appropriate instrumentation for this age child (i.e., the *Bayley Scales of Infant and Toddler Development*); and
- (c) The DCES or contracted evaluator has experience assessing this age child.

**\*Note:** All three (3) criteria must be met before the DCES or contracted evaluator is allowed to complete the evaluation on a child with corrected age of four (4) to six (6) months.

### **6.8 (3) (a) Children Followed by a NFP**

Two (2) types of children participate in NFPs: those who are born before thirty-seven (37) weeks gestation and those who are born full-term but who have certain health conditions that warrant close monitoring by professionals with expertise in the development of very young children. These children often have unique developmental concerns and growth trajectories. Children must meet criteria set by the NFP for acceptance in follow-up clinics. Staff at the University of Kentucky and the University of Louisville NFPs are experts in determining the existence of a developmental delay in these infants.

Routine follow-up consists of developmental screening, examination and teaching family appropriate exercises and developmental activities. If a referral to KEIS is considered, additional testing will be conducted using instruments such as the *Bayley Scales of Infant and Toddler Development*.

#### **6.8 (3) (a) 1. Evaluation/Assessment Referrals to the NFP**

All evaluation and assessment referrals to a NFP must have the following information included with the referral: Italicized questions are included in the *Neonatal Follow-Up Program (NFP) Referral (FS-39)*.

- a. *Is child currently being seen by a Neonatal Follow-Up Program?* If yes, provide name of program and date of last visit. With parent consent, contact the NFP to find out results of last visit, recommendations, and date of next appointment. (This is important to prevent any duplicate testing or invalidation of testing.) Also, inform the NFP of any issue or concern that has arisen since the child’s last appointment. The NFP may decide to bring the child in earlier, depending upon the concern;
- b. *Child’s date of birth, demographic information including parent name;* and

- c. Birth information from the Pregnancy, Birth and Health page on TOTS complete and accurate (*birth weight*, birth length, *gestational age*, multi-birth status, special considerations and comments).

### **6.8 (3) (a) 2. Referrals from the NFP to KEIS**

When the family begins working with the NFP, the parent is informed of the KEIS program as a possibility in the future and is provided the Helping Children Develop and Succeed...One Step at a Time brochure.

At the point that the NFP team determines a referral is needed, the parent is provided the following:

- a. *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*; and
- b. A copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure.

The NFP staff person faxes the referral to the appropriate POE. The following documents may be included with the referral:

- a. Completed *Referral Form (FS-1A)*;
- b. Copy of the signed Release of Information allowing the transmission of information from the NFP to KEIS; and
- c. The signed *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*.

The designated POE staff enters the referral information into TOTS on the Referral Information, Demographic Information and Parent/Guardian Information pages and authorizes the evaluation or assessment on the IFSP Planned Service Information page on TOTS. Authorize the evaluation or assessment up to day twenty-five (25) of the forty-five (45) day timeline.

The NFP team is responsible for entering the evaluation or assessment results in KEDS and then on TOTS. POE staff are responsible for contacting the parent and completing the intake process.

**\*Note:** KEIS will not create an authorization for the evaluation or assessment without the signed consent of the parent on the *FS-8* form. POE staff can still accept the referral without a copy of the NFP's consent form, but cannot share information with them until/unless the parent gives consent on the *FS-10*.

**\*Note:** If the NFP makes a referral with a partially completed assessment, the POE accepts the referral. The POE will proceed with the referral, but cannot utilize the partial testing to assist in determining eligibility. Before administration of the evaluation or assessment, the POE will need to review the requirements for administering the testing protocol that was used by the NFP to determine if a different testing tool is needed.

### **6.8 (3) (a) 3. Ongoing Collaboration**

A person from the NFP is to be included as a member of the IFSP team. Authorize the person designated as the team member by the NFP program on the IFSP Planned Service Information page on TOTS as collateral for the entire period of the IFSP. Having ongoing access to the TOTS record will enable the NFP team to better understand the early intervention services and progress for the child as well as give them opportunity to enter information from the NFP follow-up visits that is relevant to the child's IFSP team.

SCs must document all services that a child is receiving—whether or not KEIS is the payor. For example, if a child is receiving speech or physical therapy from a clinic outside of KEIS (paid by Medicaid or private insurance), this needs to be cited as an "Other Services" on the Individualized Family Service Plan page on TOTS. For this particular



population, it is imperative that all team members understand the comprehensiveness of services. This practice will enhance the ongoing collaboration and coordination between the NFP and KEIS.

#### **6.8 (4) Use of Transferred Records for Evaluation**

With parent consent for an evaluation, the POE staff review the early intervention records and/or evaluation records transferred from a developmental evaluator outside of the KEIS. The parent must give consent on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* for the POE staff to review the materials. The outside evaluation and assessment information may be used for eligibility determination if the records meet the following evaluation timelines:

- (a) Children under twelve (12) months of age, the evaluation was conducted within three (3) months of the referral; or
- (b) Children over twelve (12) months of age and under three (3) years of age, the evaluation occurred within six (6) months of the referral.

The DCES or SC also review the evaluation to determine if it meets the Kentucky testing requirements; for example, there is a recently conducted *Bayley Scales of Infant and Toddler Development* but there is no 5AA available. The SC would need to authorize the 5AA to be completed.

#### **6.9 Medical Component of Evaluation- Health Assessment**

There must be confirmation of an ER condition and verification of vision and hearing status before conducting an evaluation or assessment. The POE documents the receipt of medical records on the Communication Log page on TOTS. Enter the "Health" assessment into TOTS on the Evaluation/Assessment Information page before eligibility determination. Place the health information in the child's hard copy file maintained by the POE.

The child's medical and health history and results of the most recent physical examination comprise the medical component of the initial evaluation. Every child must have documentation of the following information for use in eligibility determination:

- (1) General health status including the date of last well-child checkup;
- (2) Consistency of regular medical care (i.e., well-child checkups, immunizations, etc.);
- (3) Physician concerns about development including hearing and vision status;
- (4) Chronic conditions;
- (5) Verification or identification of ER condition (the appropriate ICD code/condition must be selected to document the eligible condition); and
- (6) Identification of medical fragility and any needed assessment accommodations.

The *Health Information for Eligibility (FS-22)* provides this information for the purposes of evaluation. A physician or nurse practitioner completes the form. To facilitate the timely receipt of medical information, the POE may use the fiscal agent's Health Insurance Portability and Accountability Act (HIPAA) compliant Release of Information when requesting medical information.

The POE needs to watch the timeline carefully while waiting for medical information. Alerting the parent to the importance of getting this information may facilitate timely response from the physician's office. However, if the POE does not receive the required information by the thirty-fifth (35<sup>th</sup>) day from the referral date, notify the parent that required medical information has not been received and that eligibility cannot be determined. Provide the parent a *Notice of Action (FS-9)* indicating that the case will be closed in five (5) working days because eligibility could not be determined without the required medical information. Include a copy of [Parent's Rights in Kentucky's Early Intervention System: First Steps](#) brochure with this notice. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.

Should the POE receive the medical information before the case is closed, the case may move forward. The parent must be informed that if child is determined eligible, the family assessment and IFSP development will be completed. Due to the delay in receiving the medical information from the physician, the IFSP timelines for completion may not be met. This is documented on TOTS in a communication log.

Should the POE receive the medical information after the case is closed, please refer to section 5.4 to determine appropriate re-referral action to be taken.

## **6.10 Eligibility Determination**

### **6.10 (1) Eligibility by Significant Developmental Delay**

The DCES determines eligibility for children referred on the suspicion of a developmental delay by comparing the results of the norm-referenced assessment to the eligibility criteria, reviewing the 5AA results, reviewing the relevant medical and health records and considering the input of the parent. Once eligibility status is determined, POE staff contacts the parent by phone to discuss the eligibility determination. Documentation of eligibility (eligible or ineligible) is entered on the Eligibility Information page on TOTS.

If the child is found to be eligible, the DCES must:

- (a) Check the "Eligible" box under the "Developmental Evaluation" section of the Eligibility Information page on TOTS;
- (b) Complete the "Eligibility Decision Justification" box explaining the reason the child is eligible for services;
- (c) Select the "Part C Eligible Decision" reason as "Eligible";
- (d) Enter a date for the "Determination Date"; and
- (e) Notify the parent of determination and document the notification on TOTS.

The SC will proceed with the family assessment and development of the IFSP for children who are eligible.

If child is ineligible:

Provide the parent of children determined not eligible for early intervention services a *Notice of Action (FS-9)* that indicates that the POE is refusing to develop an IFSP because the child is not eligible accompanied by a copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. This is documented in a communication log on TOTS.

On the sixth (6<sup>th</sup>) working day from the date the *FS-9* was sent, the DCES must:

- (a) Complete the "Eligibility Decision Justification" box on the Eligibility Information page on TOTS explaining the reason the child is not eligible for services;
- (b) Select the "Part C Eligible Decision" reason as "Ineligible";
- (c) Enter the date eligibility was determined for the "Determination Date"; and
- (d) Notify the parent of determination and document the notification on TOTS.

Once ineligible is marked on the Eligibility Information page and saved, the file is immediately inactive. The "Determination Date" will default as the "Exit/Close Date" on the Transition/Exit Information page on TOTS and "Ineligible for Part C" will show as the "Exit/Close Reason".

### **6.10 (1) (a) Children Suspected of Having Autism**

Children suspected of autism spectrum disorder either due to parent concerns or results of the initial evaluation who have not already been referred for medical evaluation undergo additional autism specific screening by the POE. It is preferred that both the Modified Checklist for Autism in Toddlers, Revised, with Follow- Up (M-CHAT-R/F) and the Screening Tool for Autism in Toddlers and Young Children (STAT) be completed. If only one is completed, the STAT is preferred given its better psychometric properties. In cases where the STAT findings are felt to be invalid or the STAT is unable to be administered, the MCHAT-R/F can be completed. The M-CHAT-R/F may be administered by the SC or DCES. The STAT must be completed by the DCES.

If the results of the autism screeners indicate a risk and the parents choose to proceed with further evaluation, the POE refers the child for a record review at the University of Louisville for an Intensive Level Evaluation (ILE) as part of eligibility determination. The parent consented to this secondary evaluation when they signed the Notice of Action & Consent for Screening,

Evaluation and Assessment (FS-8). The POE completes and submits the Record Review Cover Letter & Request (FS-16). Following approval by the record review team, an authorization for an ILE is entered for ten (10) calendar days on the IFSP Planned Service Information page on TOTS.

The Norton Children's Development Center (formerly Weisskopf Center) team schedules and enters the ILE results into TOTS within ten (10) business days of referral. Exceptions are communicated to the DCES/SC. Once the results have been determined the POE continues with eligibility determination.

No shows and same-day cancellations will not be rescheduled. The DCES should continue with eligibility based on developmental delay if they have enough information from the primary level evaluation and available records to do so.

If the parent chooses an evaluation date outside of the ten (10) business day window, Norton Children's Development Center will notify the DCES or SC. The SC will update planned services if the ILE will be completed within one (1) month of referral to Norton. If IFSP development is late due to this delay, it is considered a family delay.

If the ILE appointment cannot be completed within one (1) month, the parent has the option to:

- (a) Proceed with eligibility based on developmental delay if the data from the primary level evaluation and available records supports this determination. The IFSP team can discuss if an ILE is warranted at the next review meeting; or
- (b) Close the file, no ILE is scheduled, and the family will not receive early intervention services. The parent can re-refer the child to KEIS any time before the child turns three (3).

#### **6.10 (2) Eligibility by ER Condition**

A child with a confirmed ER condition is eligible for KEIS services. The DCES must determine if early intervention services are needed. The DCES reviews the results of the 5AA, the relevant medical and health records and considers the input of the parent. Some children with an ER condition may not have delays at the time of eligibility. Keep in mind that the child's physician may have ordered clinical therapy to address the child's medical needs. Early intervention is not a substitute for clinical therapy. The provision of early intervention services must be necessitated by the developmental status of the child. It is a violation of some disciplines' code of ethics to provide services to children who do not have a need.

If the DCES determines the child is not currently in need of ongoing early intervention services, the parent has two options: service coordination for monitoring purposes or closing the chart. The DCES must document this decision in the Communication Log page on TOTS.

If the parent chooses service coordination only, the SC will contact the parent on a monthly basis for monitoring purposes. Monitoring the child involves periodic screening along with periodic checks with the parent to learn their perceptions of the child's growth and development. There is no specific screener required; however, if the child has moved into the next age bracket of the ASQ, it is recommended to complete this tool. SCs may link the family to support groups or other sources of information about their child's condition as appropriate.

The DCES must:

- (a) Check the "Eligible" box under the "Established Risk Condition and/or Other Health Conditions" section of the Eligibility Information page on TOTS;
- (b) Complete the "Eligibility Decision Justification" box explaining the reason the child is eligible for services;
- (c) Select the "Part C Eligible Decision" reason as "Eligible";
- (d) Enter a date for the "Determination Date"; and
- (e) Notify the parent of determination and document the notification on TOTS.

If the parent decides they would like to receive early intervention services, the SC will proceed with the family assessment and creation of the IFSP.

If the parent chooses to close the chart, the DCES must:

- (a) Complete the Eligibility Information page on TOTS by marking “Eligible” by “Established Risk Condition and/or Other Health Conditions”, entering the “Eligibility Decision Justification” and “Determination Date”;
- (b) Provide the parent with a *Notice of Action (FS-9)* and document in the Communication Log that it was given; and
- (c) On the sixth (6<sup>th</sup>) working day from the date the *FS-9* was sent, complete the Transition/Exit Information page by entering the “Exit/Close Date” and “Exit/Close Reason”. The reason for exit will be “Parent Withdraw”.

### **6.10 (3) Eligibility by Informed Clinical Opinion**

Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. For example, a physical therapist must make judgments about muscle tone abnormality based on the therapist’s training and experience with other children. Likewise, a psychologist may note in observing a child playing that she performs tasks in adaptive ways not permitted during the administration of a standardized cognitive assessment. (Shackelford, J. *Informed Clinical Opinion*; NECTAC Notes, #10, May 2002).

The Record Review team may determine eligibility for children whose initial evaluation results are inconclusive and POE staff are unable to make a clear eligibility decision. For example, if a child is more significantly delayed in gross motor than fine motor or more significantly delayed in receptive communication than expressive communication, the total scores for the motor or communication domains may not show a significant developmental delay. The Record Review team can use their clinical expertise to determine if the child is eligible for our services.

The Record Review team will complete a comprehensive review of all records collected on the child. They use their knowledge of child development to decide if the child is eligible by a diagnosis or by informed clinical opinion. Informed clinical opinion means that a child is deemed eligible based upon the synthesis of the child’s information and the expert’s experience and knowledge of typical and atypical development without definitive test scores.

The Record Review team may request a discipline-specific assessment be conducted if one was not done at the time of the initial evaluation or they may conduct an ILE if there is not enough information to make an informed clinical opinion. An ILE includes additional testing by specific team members chosen based on expertise needed to address the child’s developmental concerns. The team reviews the testing results along with medical testing from genetics, neurology, nutrition, etc. to render a diagnosis or rule out a possible diagnosis.

Parents consented to this secondary evaluation when they signed the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*. The DCES must work with the SC to complete the *Record Review Cover Letter & Request (FS-16)* and submit it to Record Review. The Record Review Information page on TOTS must also be completed. The TOTS record for the child must be up to date with all intake information: referral, health and evaluation. Record Review has ten (10) calendar days from the date the request was received to finalize eligibility.

**\*Note:** The teams at the University of Kentucky and the University of Louisville NFPs are also qualified to determine eligibility based on informed clinical opinion when the POE is unable to make this determination for a child evaluated by the NFP.

### **6.10 (3) (a) Parent requests ILE after eligibility has been determined**

If the parent requests an ILE after eligibility has been determined the POE must proceed as normal (i.e. family assessment, IFSP development, etc.). The parent would receive a *Notice of*

*Action (FS-9) refusing the ILE. After enough data has been collected to determine the need for an ILE (recommended best practice is three (3) months of service), a State Lead Agency Approval Request for Intensive Level Evaluation (FS-31) may be submitted. Please see 8.18 Intensive Level Evaluation (ILE) Request for Children with an IFSP for procedures.*

### **6.11 Annual Redetermination of Eligibility**

All children with an active IFSP must be re-determined eligible prior to the Annual IFSP meeting. The SC is responsible for ensuring that eligibility determination is conducted and properly documented in the child's record. The Annual IFSP meeting cannot be held until continuing eligibility is confirmed and the family assessment has been completed.

Annual redetermination parallels initial eligibility in many ways and includes the following:

- (1) Administration of an assessment instrument (5AA);
- (2) A review of the child's relevant medical history;
- (3) The identification of the child's level of functioning in each developmental domain;
- (4) Review of vision and hearing status;
- (5) A review and synthesis of information from medical, educational and other records, including service logs and Progress Reports; and
- (6) Review of information from other sources such as family members, care-givers, etc.

Eligibility based solely on the results of the 5AA is not permissible.

Timing the determination of continuing eligibility with the timelines of the Annual IFSP for eligible children is critical. The Annual 5AA must be administered no more than sixty (60) and no later than thirty (30) calendar days prior to the Annual IFSP date in order for eligibility to be determined. An updated health (including pertinent diagnoses), hearing and vision assessment must be completed on the Evaluation/Assessment Information page on TOTS.

Prior to the end of the current IFSP the SC must ensure:

- (1) The *Notice of Action for Annual Eligibility Determination (FS-18)* is sent to the family at least sixty (60) calendar days before the end of the current IFSP;
- (2) Parent signature on an updated *Consent to Release/Obtain Information (FS-10)* is obtained to request updated medical or educational records; and
- (3) Updated medical records are requested timely.

**\*Note:** Many children receive outpatient therapy services during their enrollment in KEIS. It is best practice to send a request for those outpatient records as part of the redetermination of eligibility process.

Once the Annual 5AA is completed, the SC must:

- (1) Prepopulate a requested review IFSP for the evaluator to enter the assessment report;
- (2) Ensure a new "Health" assessment that summarizes the updated medical information is completed on the Evaluation/Assessment Information page on TOTS; and
- (3) Ensure updated "Hearing" and "Vision" assessments are completed on the Evaluation/Assessment Information page on TOTS.

A child has continuing eligibility in two (2) ways:

- (1) **Significant Developmental Delay:** The overwhelming majority of children in KEIS experience developmental progress. The POE must decide that the progress a child has made over the last year indicates that the child is functioning within the range of typical development. The Annual 5AA must list the functional age range in months that the child achieved for each developmental domain. The comments section of the report is used to more specifically document the child's functioning. It is accepted practice to consider a child to be within the range of typical development when the child has acquired developmental skills within three (3) months of their chronological age. The POE has to ensure that continuing eligibility is not based on slight or temporary delays or on the quality of the child's performance of a developmental skill. Eligibility cannot be based on the fear of regression.

The annual 5AA must document an ongoing significant delay in one (1) or more of the developmental domains. The delay should be significant enough to impair demonstration of age-appropriate skills, be based on the knowledge of the individual child's rate of growth (documented in the Progress Report and the Response to Intervention in the service logs) and opportunity to use the skill. Redeterminations of eligibility are not to address concerns that are medical in nature.

- (2) ER condition: The child continues to have an ER condition or has been diagnosed with an ER condition since the initial determination of eligibility. The diagnosis must be documented in an updated "Health" assessment on the Evaluation/Assessment Information page on TOTS.

#### **6.11 (1) Child Determined Eligible at Annual Redetermination of Eligibility**

To record the annual redetermination of eligibility, POE staff must:

- (a) Prepopulate a Requested Review IFSP;
- (b) Mark the reason for continued eligibility, as appropriate, on the Eligibility Information page;
- (c) Complete the "Eligibility Decision Justification" box explaining the reason for continued eligibility; and
- (d) Enter a new date for the "Determination Date".

Children who are eligible will move forward towards the Annual IFSP meeting. Prior to the Annual IFSP meeting, the SC must conduct the family assessment. After the family assessment is completed, the IFSP team is able to hold the Annual IFSP meeting to create a new IFSP.

#### **6.11 (2) Child Determined Not Eligible at Annual Redetermination of Eligibility**

If a child is determined ineligible for KEIS, the SC calls the early intervention providers on the plan to notify them of the decision and ensure that they will complete their Discharge Reports and enter all documentation on TOTS because the record will soon be inactive.

The SC will contact the parent to notify them of the decision and that current early intervention services will stop. The parent is given the option to receive one final service from each provider on their current plan if they choose. Provide the parent a *Notice of Action (FS-9)*, indicating that the POE refuses to develop an IFSP because the child is not eligible, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. This action is documented in a communication log.

On the sixth (6<sup>th</sup>) working day from the date the *FS-9* was sent, the SC will:

- (a) Prepopulate a Requested Review IFSP;
- (b) Complete the "Eligibility Decision Justification" box on the Eligibility Information page on TOTS explaining the reason the child is no longer eligible for service;
- (c) Enter a new date for the "Determination Date"; and
- (d) Change the "Part C Eligible Decision" reason from "Eligible" to "Ineligible".

Once ineligible is marked as a choice on the Eligibility Information page, the file is immediately made inactive. The "Determination Date" will default as the "Exit/Close Date" on the Transition/Exit Information page on TOTS and "IFSP Goals Met" will show as the "Exit/Close Reason".

# Chapter 7: Assessment

Assessment serves multiple purposes in the Kentucky Early Intervention System (KEIS) program: to provide a snapshot of present strengths and needs of the child and family, to provide information for individualized intervention planning and to provide a method for monitoring and reporting developmental progress. Federal regulations define assessment as the ongoing procedures used to identify the child's unique strengths and needs and the early intervention service(s) appropriate to meet those needs throughout the child's eligibility in Part C.

All children in KEIS receive a Five Area Assessment (5AA) upon entry to the program, annually, and at exit. Some children may also receive a discipline-specific assessment in addition to the 5AA to provide information that leads to changes or modifications to interventions. The 5AA serves a dual purpose. First, it provides information on the current functional abilities of the child. Secondly, the item specific data is the measurement unit for reporting progress to the U.S. Department of Education, Office of Special Education Programs (OSEP). 5AA data is reported in the State Performance Plan (SPP) Indicator three (3), Child Outcomes for Part C.

The Cabinet-approved criterion-referenced instruments for the 5AA are:

- (1) *Hawaii Early Learning Profile (HELP)*;
- (2) *The Carolina Curriculum for Infants and Toddlers with Special Needs (CCITSN)*; and
- (3) *Assessment, Evaluation, and Programming System for Infants and Children (AEPS)*.

The family assessment reflects the family's resources, priorities and concerns, and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child. The Routines Based Interview™ (RBI™) is the assessment tool used in KEIS to complete the family assessment.

## 7.1 Five Area Assessment (5AA)

### 7.1 (1) Initial 5AA

For a child referred due to a suspicion of a developmental delay, the initial 5AA is conducted as part of the initial evaluation. For children referred due to an Established Risk (ER) condition, the initial 5AA is to be conducted by a District Child Evaluation Specialist (DCES), unless a contracted evaluator is more appropriate.

Point of Entry (POE) staff obtains a physician's or nurse practitioner's (ARNP) written approval to complete an assessment for a child who is medically fragile using the *Health Information for Eligibility (FS-22)* form. The approval is specific to the modifications needed to accommodate the child's medical status.

All attempts to schedule the assessment with the parent must be documented on the Technology-assisted Observation and Teaming Support System (TOTS).

The results of the 5AA form the foundation of the Individualized Family Service Plan (IFSP) for eligible children. The present level of performance describes the skills and abilities the child has in each developmental domain.

Kentucky Early Childhood Data System (KEDS) is the collection portal for assessment data analyzed for the SPP Indicator three (3), Child Outcomes. Kentucky reports on three child outcomes:

- (a) The percentage of children who have positive social-emotional skills (including social relationships);
- (b) The percentage of children who acquire and use knowledge and skills (including early language/communication and early literacy); and
- (c) The percentage of children who use appropriate behaviors to meet their needs.

The item level data from the criterion-referenced instrument is entered into KEDS by the evaluator who conducted the assessment for all children (eligible or not).

To authorize the initial evaluation for children referred for developmental delay, POE staff will:

- (a) Enter a “Start Date” and “End Date” for the evaluation (it is recommended to authorize the evaluation up to day twenty-five (25) of the forty-five (45) day timeline) on the IFSP Planned Service page on TOTS;
- (b) Select “Primary Level Evaluation” under “Service Name”;
- (c) Select the appropriate agency and provider from the drop down menu under “Provider” (do not mark this provider as the Primary Service Provider);
- (d) Select “Assessment” as “Method of Delivery”;
- (e) Select the appropriate “Setting”;
- (f) All other sections of the authorization will default; and
- (g) Select “Save”.

To authorize the 5AA for children referred due to an ER condition, POE staff will:

- (a) Enter a “Start Date” and “End Date” for the assessment (it is recommended to authorize the evaluation up to day twenty-five (25) of the forty-five (45) day timeline) on the IFSP Planned Service page on TOTS
- (b) Select “Five Area Assessment” under “Service Name”;
- (c) Select the appropriate agency and provider from the drop down menu under “Provider” (do not mark this provider as the Primary Service Provider);
- (d) Select “Assessment” as “Method of Delivery”;
- (e) Select the appropriate “Setting”;
- (f) All other sections of the authorizations will default; and
- (g) Select “Save”.

#### **7.1 (1) (a) Completion of the Initial 5AA**

Once the DCES or contracted evaluator completes the 5AA, the following must be completed in this order:

1. Enter the results of the 5AA in the Kentucky Early Childhood Data System (KEDS) and ensure the results have been “verified” within five (5) working days;
2. Enter the full evaluation and 5AA report in the Evaluation/Assessment Information page on TOTS within five (5) working days;
3. Mail a copy of the completed evaluation report to the parent and document on TOTS within five (5) working days;
4. Enter a service log for the completed evaluation within ten (10) calendar days;
5. Submit the completed protocol to the POE; and
6. Bill for the service on the Account Payable page on TOTS within sixty (60) calendar days.

**\*Note:** The DCES or contracted evaluator must ensure the above steps are completed in the exact order listed before payment will be approved by the State Lead Agency (SLA). The provider must also ensure that the completed protocol is submitted to the POE to be maintained in the child’s hard copy file.

It is not the role of the evaluator to inform a parent that their child is “eligible” or “not eligible” after the completion of the assessment. Determining eligibility on the results of the testing violates the prohibition of basing eligibility on a sole criterion. General information about how the child performed on specific items or performed on the instrument overall may be shared. Inform the parent that the results are only part of the information needed to determine eligibility and that they will receive a copy of the assessment report.

#### **7.1 (2) Annual Five Area Assessment (5AA)**

During the Six (6) Month Review IFSP meeting, the IFSP team should discuss the need for an annual review of the IFSP, which includes an annual 5AA. This 5AA provides information for the annual determination of eligibility for the child. This assessment data also provides progress update towards achievement of the Federal Child Outcomes targets. Each annual assessment must be completed using one (1) of the Cabinet-approved criterion-referenced instruments. The annual 5AA must be completed no earlier than sixty (60) and no later than thirty (30) calendar days prior to the Annual IFSP start date. The Annual 5AA must be completed prior to the IFSP meeting.



To authorize the annual 5AA:

- (a) Enter a "Start Date" of sixty (60) calendar days prior to the Annual IFSP and an "End Date" of thirty (30) calendar days prior to the Annual IFSP for the assessment on the IFSP Planned Service page on TOTS;
- (b) Select "Five Area Assessment" under "Service Name";
- (c) Select the appropriate agency and provider from the drop down menu under "Provider" (do not mark this provider as the Primary Service Provider);
- (d) Select "Assessment" as "Method of Delivery";
- (e) Select the appropriate "Setting";
- (f) All other sections of the authorizations will default; and
- (g) Select "Save".

**\*Note:** The annual 5AA is a separate authorization from the provider's ongoing services. Therefore, the annual 5AA does not replace ongoing services. These are separate authorizations resulting in separate visits. If the Primary Service Provider (PSP)/Primary Coach) is unable to conduct the annual 5AA, the DCES should be authorized to complete the assessment. If the DCES cannot conduct the 5AA, then another provider on the IFSP team may be authorized to complete the assessment.

**\*Note:** The DCES will conduct the annual 5AA for children who receive service coordination as the only service provided by KEIS. This includes entering item level data into KEDS.

#### **7.1 (2) (a) Completion of the Annual 5AA**

Once the DCES or contracted evaluator completes the 5AA, the following must be completed in this order:

1. Enter the results of the 5AA in the Kentucky Early Childhood Data System (KEDS) and ensure the results have been "verified" within five (5) working days;
2. Enter the full evaluation and 5AA report in the Evaluation/Assessment Information page on TOTS within five (5) working days;
3. Mail a copy of the completed evaluation report to the parent and document on TOTS within five (5) working days;
4. Enter a service log for the completed evaluation within ten (10) calendar days;
5. Submit the completed protocol to the POE; and
6. Bill for the service on the Account Payable page on TOTS within sixty (60) calendar days.

**\*Note:** The DCES or contracted evaluator must ensure the above steps are completed in the exact order listed before payment will be approved by the SLA. The provider must also ensure that the completed protocol is submitted to the POE to be maintained in the child's hard copy file.

It is not the role of the evaluator to inform a parent that their child is "eligible" or "not eligible" after the completion of the assessment. Determining eligibility on the results of the testing violates the prohibition of basing eligibility on a sole criterion. General information about how the child performed on specific items or performed on the instrument overall may be shared. Inform the parent that the results are only part of the information needed to determine eligibility and that they will receive a copy of the assessment report.

#### **7.1 (3) Exit Assessment**

An exit assessment must be completed within thirty (30) calendar days prior to the child's third birthday. The assessment used for the annual redetermination of eligibility may be used to meet this requirement if the assessment was completed less than ninety (90) days from the date of the child's third birthday.

It is critical that this exit assessment be conducted in a timely manner so that if a child is transitioning to the public school, the assessment results are available to the school for use in determining eligibility and developing an Individualized Education Plan (IEP). The exit assessment should be authorized on the naturally occurring IFSP that is closest to the child's third birthday.

To authorize an exit assessment:

- (a) Enter a "Start Date" that is thirty (30) calendar days prior to the child's third birthday and an "End Date" of the day before the child's third birthday on the IFSP Planned Service page on TOTS;
- (b) Select "Five Area Assessment" under "Service Name";
- (c) Select the appropriate agency and provider from the drop down menu under "Provider" (do not mark this provider as the Primary Service Provider);
- (d) Select "Assessment" as "Method of Delivery";
- (e) Select the appropriate "Setting";
- (f) All other sections of the authorizations will default; and
- (g) Select "Save".

**\*Note:** Exit assessments are not completed for children who have received less than six (6) months of early intervention services based on the date of the initial IFSP.

**\*Note:** The exit 5AA is a separate authorization from the provider's ongoing services. Therefore, the exit 5AA is not conducted instead of providing ongoing services. They are separate authorizations resulting in separate visits. If the PSP/Primary Coach is unable to conduct the annual 5AA, the DCES should be authorized to complete the assessment. If the DCES cannot conduct the 5AA, then another provider on the IFSP team may be authorized to complete the assessment.

**\*Note:** The DCES will conduct the exit 5AA for children who receive service coordination as the only service provided by First Steps. This includes entering item level data into KEDS.

#### **7.1 (3) (a) Completion of the Exit 5AA**

Once the DCES or contracted evaluator completes the 5AA, the following must be completed in this order:

1. Enter the results of the 5AA in the Kentucky Early Childhood Data System (KEDS) and ensure the results have been "verified" within five (5) working days;
2. Enter the full evaluation and 5AA report in the Evaluation/Assessment Information page on TOTS within five (5) working days;
3. Mail a copy of the completed evaluation report to the parent and document on TOTS within five (5) working days;
4. Enter a service log for the completed evaluation within ten (10) calendar days;
5. Submit the completed protocol to the POE; and
6. Bill for the service on the Account Payable page on TOTS within sixty (60) calendar days.

**\*Note:** The DCES or contracted evaluator must ensure the above steps are completed in the exact order listed before payment will be approved by the SLA. The provider must also ensure that the completed protocol is submitted to the POE to be maintained in the child's hard copy file.

#### **7.1 (4) Rescheduled Assessment**

If delays in completing the assessment occur, the assessor documents the reason(s) for the delay in the communication log on TOTS and notifies the Service Coordinator (SC).

Procedures:

- (a) The SC must follow-up with the parent concerning the delay;
- (b) Pre-populate a Requested Review IFSP on the Individualized Family Service Plan page by selecting "prepopulate Next Draft IFSP";
- (c) Enter an "IFSP Meeting Date";
- (d) Select "Requested Review" as the "IFSP Type";
- (e) Enter the reason for the Requested Review in the "IFSP Meeting Note";
- (f) Select "Save Draft";
- (g) On the IFSP Planned Service Information page on TOTS, enter a new authorization for the 5AA. Enter the "Start Date" and "End Date" with the revised timelines;
- (h) Select "Five Area Assessment" under "Service Name";

- (i) Select appropriate agency and provider from the drop down menu under “Provider” (do not mark this provider as the Primary Service Provider);
- (j) Enter “Assessment” as “Method of Delivery”;
- (k) Select the appropriate “Setting”;
- (l) All other sections of the authorization will default;
- (m) Select “Save”;
- (n) Finalize the Requested Review IFSP on the Individualized Family Service Plan page by selecting “Save Final” (this action does not require that the family receive a copy of the IFSP noting the addition of the assessment);
- (o) The assessment is conducted and the provider notifies the SC that the assessment has been completed;
- (p) A Requested Review IFSP is pre-populated by following the steps above (b-f) so the assessment can be entered into TOTS;
- (q) The provider must enter the assessment in KEDS and TOTS, send the parent an assessment report and document in TOTS that the report was sent no later than five (5) working days after the assessment; and
- (r) Finalize the IFSP by selecting “Save Final” on the Individualized Family Service Plan page on TOTS.

**\*Note:** Do not request for the SLA to unlock the IFSP to change authorization dates. The SC should complete a new authorization for the assessment on the IFSP Planned Service Information page on TOTS with the dates that the parent will be available.

## **7.2 Ongoing Assessment**

Each early intervention service provider conducts ongoing assessments as they provide services. Assessment is an integral part of service delivery. This type of assessment is the foundation for determining if the interventions are effective or if there is a need to change the interventions. This process includes ecologically valid and appropriate assessment methods such as observations, parent interviews and reports, and behavioral checklists and inventories. Service log documentation describes the child’s progress based on the ongoing assessment. Progress is also documented on the Progress Report page by each provider (including the PSP/Primary Coach) every six (6) months. The Progress Report summarizes the on-going progress monitoring data that the provider has been collecting for the IFSP outcomes for which they are responsible. The provider must enter the “Progress Report” on TOTS at least five (5) working days prior to the IFSP meeting and send a copy to the family. The provider must document on TOTS that the report was sent to the family.

## **7.3 Discipline-Specific Assessment**

Discipline-specific assessments may be conducted for a variety of reasons listed below. These assessments are limited to no more than three (3) per discipline per child during the child’s participation in KEIS.

An assessment that is completed as part of the provider’s scope of practice per licensure requirements is considered to be part of the provider’s therapeutic intervention and is not authorized as a discipline-specific assessment. The *Notice of Action & Consent for Assessment (FS-7)* is not required for this type of assessment; however, the provider may request a written consent from the parent for their own records.

**\*Note:** The discipline-specific assessments must be a standardized norm-referenced instrument. A 5AA will not be accepted as a discipline-specific assessment.

### **7.3 (1) Discipline-Specific Assessment as Part of the Initial Evaluation**

When concerns are domain-specific and a specialist is available to conduct the initial evaluation, a discipline-specific norm-referenced instrument may be administered. The evaluator will bring the instrument with them to the initial evaluation. After administering the first norm-referenced instrument and the 5AA, the evaluator will use their professional judgement to determine if a discipline-specific assessment is warranted. If so, the second assessment will be administered during the same visit and will be included in the flat fee for the PLE/5AA.

If it is not possible to have the appropriate specialist as the primary level evaluator, no discipline-specific assessment is authorized.

### **7.3 (2) Discipline-Specific Assessment for Children with an Active IFSP**

There may be situations when a concern emerges as the child ages or as the IFSP team becomes more familiar with the child over the course of implementing the IFSP. The IFSP team must be comprehensive in its planning and thoughtful about the assessments and services identified for the child and family.

When there is a concern that cannot be appropriately addressed by the current IFSP providers, a norm-referenced discipline-specific assessment may be authorized. The SC must consult with the DCES and IFSP team about the need for a discipline-specific assessment. This consultation should occur before the team meeting. A face-to-face team meeting is not required to obtain the discipline-specific assessment; however, there must be a simultaneous conversation documented of the discussion about the need for the assessment.

Documentation of the team discussion must include the IFSP teams reason(s) for the additional assessment; whether a current provider on the IFSP team can assess the area of concern; and the circumstances relating to the child's ability and family's capacity to address the child's developmental needs that warrant the subsequent assessment.

The SC must provide prior written notice and obtain written consent for the discipline-specific assessment using the *Notice of Action & Consent for Assessment (FS-7)*. The discipline-specific assessment cannot be conducted for five (5) working days after the date of notice.

Entering a discipline-specific assessment:

- (a) Pre-populate a Requested Review IFSP on the Individualized Family Service Plan page by selecting "Prepopulate Next Draft IFSP";
- (b) Enter an "IFSP Meeting Date";
- (c) Select "Requested Review" as the "IFSP Type";
- (d) Enter the reason for the Requested Review in the "IFSP Meeting Note";
- (e) Select "Save Draft";
- (f) On the IFSP Planned Service Information page on TOTS, enter a "Start Date" and "End Date" (it is recommended that a ten calendar day timeline is authorized);
- (g) Select the appropriate discipline's assessment under "Service Name" (For example, "Physical Therapy Assessment", "Occupational Therapy Assessment");
- (h) Select appropriate agency and provider from the drop down menu under "Provider" (do not mark this provider as the Primary Service Provider);
- (i) Enter "Assessment" as "Method of Delivery";
- (j) Select the appropriate "Setting";
- (k) All other sections of the authorization will default;
- (l) Select "Save";
- (m) Finalize the Requested Review IFSP on the Individualized Family Service Plan page by selecting "Save Final" (this action does not require that the family receive a copy of the IFSP noting the addition of the assessment);
- (n) The assessment is conducted and the provider notifies the SC that the assessment has been completed;
- (o) A Requested Review IFSP is pre-populated by following the steps above (a-e) so the assessment can be entered into TOTS;
- (p) The provider must enter the assessment in TOTS, send the parent an assessment report and document in TOTS that the report was sent no later than five (5) working days after the assessment; and
- (q) Finalize the IFSP by selecting "Save Final" on the Individualized Family Service Plan page on TOTS.

**\*Note:** Assessment authorizations do not affect the limits set for ongoing services.

Assessments conducted close to the natural Six (6) Month Review or Annual IFSP do not require additional authorizations. The team will discuss the results as part of that IFSP meeting. If, however, the assessment is conducted more than three (3) months from the next natural IFSP meeting, enter any

necessary collateral authorizations for the IFSP team meeting to discuss results of the assessment and revise the IFSP as needed.

### **7.3 (3) Rescheduled Assessments**

If delays in completing the discipline-specific assessment occur due to the illness of the child or by the request of the parent, the assessor documents the reason(s) for the delay in the Communication Log on TOTS and notifies the SC.

Procedures:

- (a) The SC must follow-up with the family concerning the delay;
- (b) Pre-populate a Requested Review IFSP on the Individualized Family Service Plan page by selecting "Prepopulate Next Draft IFSP";
- (c) Enter an "IFSP Meeting Date";
- (d) Select "Requested Review" as the "IFSP Type";
- (e) Enter the reason for the Requested Review in the "IFSP Meeting Note";
- (f) Select "Save Draft";
- (g) On the IFSP Planned Service Information page on TOTS, enter a new authorization for the 5AA. Enter the "Start Date" and "End Date" with the revised timelines;
- (h) Select the appropriate discipline's assessment under "Service Name" (For example, "Physical Therapy Assessment", "Occupational Therapy Assessment");
- (i) Select appropriate agency and provider from the drop down menu under "Provider" (do not mark this provider as the Primary Service Provider);
- (j) Enter "Assessment" as "Method of Delivery";
- (k) Select the appropriate "Setting";
- (l) All other sections of the authorization will default;
- (m) Select "Save";
- (n) Finalize the Requested Review IFSP on the Individualized Family Service Plan page by selecting "Save Final" (this action does not require that the family receive a copy of the IFSP noting the addition of the assessment);
- (o) The assessment is conducted and the provider notifies the SC that the assessment has been completed;
- (p) A Requested Review IFSP is pre-populated by following the steps above (b-f) so the assessment can be entered into TOTS;
- (q) The provider must enter the assessment in TOTS, send the parent an assessment report and document in TOTS that the report was sent no later than five (5) working days after the assessment; and
- (r) Finalize the IFSP by selecting "Save Final" on the Individualized Family Service Plan page on TOTS.

**\*Note:** Do not request to unlock the IFSP to change authorization dates.

### **7.4 Assessment Reports**

All formal, direct assessments must have a written report completed within five (5) working days of the completion of the assessment. The assessment results must be entered into TOTS which generates the written report. A 5AA conducted at entry, at annual redetermination of eligibility or at exit, must first be entered in KEDS. The entry of item level data from the 5AA into KEDS is necessary for payment approval.

The report includes the following:

- (1) A description of the assessment instrument used;
- (2) A description of assessment activities;
- (3) Identifying information including:
  - (a) The child's TOTS identification number;
  - (b) The name of the child;
  - (c) The child's age at time of assessment;
  - (d) The name of the service provider and discipline;
  - (e) The date of the assessment;
  - (f) The setting of the assessment;

- (g) The state of the child's health during the assessment, including a statement concerning vision and hearing status;
  - (h) The parent's assessment of the child's performance in comparison to abilities demonstrated by the child in more familiar circumstances;
  - (i) The medical diagnosis if the child has an ER condition; and
  - (j) Individuals present at the assessment; and
- (4) A profile of the child's level of performance, in a narrative form which shall indicate:
- (a) Child's unique strengths, needs;
  - (b) Skills achieved since last report; and
  - (c) Current and emerging skills, including skills performed independently and with assistance.

Reports must **NOT** include:

- (1) Statements of eligibility or recommendations for eligibility;
- (2) Recommendations for record review;
- (3) Recommendations for specific early intervention services, including method, frequency and intensity;
- (4) Recommendations for services from a specific professional discipline;
- (5) Recommendations for specific programs; or
- (6) Business solicitations.

The IFSP team is the only authorized entity to identify the early intervention services to be provided.

### **7.5 Family Assessment**

Federal law and regulation require the identification of resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child. KEIS is rooted in the belief that family-centered early intervention builds on and promotes the strengths and competencies present in all families. The family assessment is the starting point for discovering the family's resources, priorities and concerns for their child and family, as they relate to the child's development. This information is translated into outcome statements that drive the IFSP team's actions to address the unique needs of the child. The RBI™ is conducted with the family of an eligible child by the SC to gather this information.

At the IFSP meeting, the team discusses the results of the family assessment to aid in developing IFSP outcomes. The family assessment is conducted prior to the Initial and Annual IFSP meetings and is updated prior to the Six (6) Month Review.

The RBI™ is a semi-structured interview designed to:

- (1) Establish a positive relationship with the family;
- (2) Obtain a rich description of child and family functioning; and
- (3) Result in a list of proposed outcomes (child and family) chosen by the parent.

The interview assesses:

- (1) The child's engagement, independence, and social relationships (EISR) within everyday routines;
- (2) The family's satisfaction with home routines; and
- (3) When appropriate the childcare teacher's perception of the goodness of fit of classroom routines with the child's interests and abilities.

The RBI™ can be used to obtain a description of the child's functioning in cognitive, motor, adaptive, communication and social skills; however, it does not result in a developmental score.

#### **7.5 (1) Functional Outcomes**

Because families vary in resources, priorities, concerns and culture, the RBI™ helps to individualize early intervention services. The RBI™ will result in a list of child and family proposed outcomes generated by the interviewee. Informal outcomes become formalized at the IFSP meeting.

Functional outcomes point to the direction for collaboration between family members and early intervention providers in order to reach a family's desired outcomes. Too often, IFSPs focus only on child outcomes and do not address family supports from early intervention providers and other community

resources (Jung & Baird, 2003; Boone *et al*, 1998; McWilliam *et al*, 1998). Identifying functional outcomes with families is the cornerstone for developing the IFSP document since the outcomes specify what should happen for the family and child as a result of their participation in early intervention.

The IFSP is not an education-only document for the child. It should aim to address outcomes targeted at family as well as child needs. Not all families will have or want family concerns or outcomes listed on the IFSP. However, when family concerns related to care and raising of the child with special needs have been identified and discussed, every effort should be made to identify possible resources to address them and list outcomes desired to resolve the concern.

Child level outcomes must include the following criteria when finalized on the IFSP:

- (a) Behavior (one (1) behavior per outcome);
- (b) Criteria (must be family friendly and measurable); and
- (c) Routine (minimum of one (1) routine per outcome).

Family level outcomes must include the following criteria when finalized on the IFSP:

- (a) Behavior (activity to address); and
- (b) Criteria (typically a frequency or date).

### **7.5 (2) Initial Family Assessment**

Consent for the family assessment is obtained on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*. The SC schedules the RBI™ with the parent once eligibility is established. Once the RBI™ is scheduled, the SC sends the parent a *Family Assessment Preparation Letter (FS-47)*, places a copy in the child's hard copy chart, and documents on TOTS that it was sent.

If the child is in childcare for fifteen (15) hours per week or more, the SC should also schedule a meeting with the childcare worker to supplement the parent's RBI™. The SC should focus the interview on the child's participation in the routines that occur in the childcare setting. Parents must consent to this meeting by signing the *Consent to Release/Obtain Information (FS-10)*. This meeting can be held in conjunction with the parent or separate. If the interviews are held at separate times, the childcare worker must be interviewed first so the parent will have access to the information provided by the childcare worker to aid in IFSP outcome selection.

**\*Note:** If limited on time during the Initial IFSP phase, the interview with the childcare worker can be completed prior to the six (6) month family assessment.

The SC may conduct the RBI™ using the "Quick Reference Guide-Family Assessment". The SC guides the parent through a detailed description of their daily routines as well as a satisfaction rating for each routine. The parent generates proposed outcomes to be discussed at the IFSP meeting. The SC will discuss possible service selection with the parent based on the proposed outcomes.

Within five (5) working days of the date of the RBI™, the SC will enter the information onto the Family Assessment Information page on TOTS. The SC will select "Family Assessment Report" to generate a copy to send to the parent. The SC will document on TOTS that the report was sent.

The information entered into the Family Assessment report carries forward to the "Family Statement" on the Individualized Family Service Plan Information page on TOTS. This information becomes a component of the IFSP.

#### **7.5 (2) (a) Parent Declines Initial Family Assessment**

Parents have the right to decline the family assessment without any jeopardy to the services of the child. If a parent declines the family assessment, it must be recorded on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* or the *Notice of Action and Consent for Assessment (FS-7)*. Verbal denial is not acceptable.

On the Family Assessment Information page on TOTS, the SC must:

1. Enter an "Interview or Decline Date";
2. Enter the SC in "Interviewed By";
3. Enter the parent's name in "Person(s) Interviewed"; and
4. Check "Yes" for "Parent/Guardian Declined to Participate in the Family Assessment".

If the parent declines the family assessment, the Family Assessment Information page on TOTS will be disabled and no additional information may be entered. Items one (1) through five (5) cannot be completed, as they are official questions of the Routines-Based Interview™. The "Family Statement" portion of the IFSP will state that the family declined the parent interview.

### **7.5 (3) Annual IFSP Family Assessment**

SCs should begin preparing for the annual redetermination of eligibility and the Annual IFSP at least sixty (60) calendar days prior to the Annual IFSP meeting.

#### **7.5 (3) (a) Child Determined Eligible at Annual Redetermination of Eligibility**

A new family assessment must be conducted prior to the Annual IFSP meeting for all eligible children at least fifteen (15) calendar days and no earlier than twenty-five (25) calendar days prior to the Annual IFSP meeting. The SC will schedule the RBI™ with the parent (and childcare worker when appropriate); send a *Family Assessment Preparation Letter (FS-47)*, place a copy in the child's hard copy chart, and document on TOTS that it was sent.

**\*Note:** A *Notice of Action & Consent for Assessment (FS-7)* must be obtained before the annual family assessment if the parent has declined the previous family assessment. See chart at the end of this section for clarification.

The SC may conduct the RBI™ using the "Quick Reference Guide-Family Assessment". The SC will guide the parent through a detailed description of their daily routines focusing on the engagement, independence and social relationships (EISR) of the child. Proposed outcomes are generated by the parent and discussed at the Annual IFSP meeting. The SC discusses possible service selection with the parent based on the proposed outcomes.

To Enter the Annual Family Assessment on TOTS:

- (a) Select "Prepopulate Next Draft IFSP";
- (b) Enter a "IFSP Meeting Date";
- (c) Select "Requested Review" as the "IFSP Type";
- (d) Enter the reason for the Requested Review in the "IFSP Meeting Note";
- (e) Select "Save Draft";
- (f) On the Family Assessment Information page, enter the new "Interview or Decline Date";
- (g) Enter the SC in "Interviewed By";
- (h) Enter the parent's name in "Person(s) Interviewed";
- (i) Enter the updated information in items one (1) through five (5);
- (j) Select "Save"; and
- (k) Finalize the IFSP by selecting "Save Final" on the Individualized Family Service Plan page on TOTS.

Within five (5) working days of the date of the RBI™, the SC will enter the information onto the Family Assessment Information page on TOTS and send the parent a Family Assessment Report. The SC will document on TOTS that the report was sent to the parent.

#### **7.5 (3) (b) Parent Declines Annual Family Assessment**

If the parent declines the annual family assessment, the *Notice of Action & Consent for Assessment (FS-7)* must be completed and placed in the child's hard copy file. Verbal denial is not acceptable.

To enter the declined family assessment:

1. Select "Prepopulate Next Draft IFSP";



2. Enter a "IFSP Meeting Date";
3. Select "Requested Review" as the "IFSP Type";
4. Enter the reason for the Requested Review in the "IFSP Meeting Note";
5. Select "Save Draft";
6. On the Family Assessment Information page, enter the new "Interview or Decline Date";
7. Enter the SC in "Interviewed By";
8. Enter the parent's name in "Person(s) Interviewed";
9. Delete any information in boxes 1-5, "Main Concerns, Family Worries, Family Desired Changes, Formal and Informal Supports and Family Priorities" (this section should not be completed if the family declined the family assessment);
10. Check "Yes" for "Parent/Guardian Declined to Participate in the Family Assessment"; and
11. Finalize the IFSP by selecting "Save Final" on the Individualized Family Service Plan page on TOTS.

**7.5 (3) (c) Child Determined Not Eligible at Annual Redetermination of Eligibility**

If the child is determined to be ineligible for services at annual redetermination of eligibility, the annual family assessment will not be conducted by the SC.

**7.5 (4) Six (6) Month Update of the Family Assessment**

SCs must begin preparing for the Six (6) Month Review at least forty-five (45) calendar days and no later than thirty (30) calendar days prior to the date of the meeting. The family assessment must be updated prior to the Six (6) Month Review IFSP meeting. The purpose of updating the family assessment information is to evaluate the outcomes and services the family is currently receiving and determine the need for changes. The SC will schedule the RBI™ update with the parent (and childcare worker when appropriate). Once the RBI™ update is scheduled, a *Family Assessment Preparation Letter (FS-47)* is sent to the parent. The SC will document on TOTS that the letter was sent and place a copy in the child's hard copy chart.

**\*Note:** The update of the family assessment may be conducted by telephone if the parent agrees.

The SC will update the information from the initial/annual RBI™ rather than completing a full family assessment interview. Notes from the initial/annual RBI™ can be used to document the updated information. The SC will record any changes to the family's routines and concerns.

At the six (6) month update, SC must discuss:

- (a) Progress on current outcomes;
- (b) New concerns since the previous family assessment;
- (c) Previous concerns that are no longer a concern for the parent;
- (d) Update on routines that were a concern previously for the parent;
- (e) Any additional information that may not have been discussed during the previous family assessment;
- (f) Proposed outcomes/changes for the upcoming IFSP; and
- (g) Possible changes to early intervention services based on the proposed outcomes.

To enter the six (6) month update of the family assessment on TOTS:

- (a) Select "Prepopulate Next Draft IFSP";
- (b) Enter a "IFSP Meeting Date";
- (c) Select "Requested Review" as the "IFSP Type";
- (d) Enter the reason for the Requested Review in the "IFSP Meeting Note";
- (e) Select "Save Draft";
- (f) On the Family Assessment Information page, enter the new "Interview or Decline Date";
- (g) Enter the SC in "Interviewed By";
- (h) Enter the parent's name in "Person(s) Interviewed";
- (i) Enter the updated information in items one (1) through five (5);
- (j) Select "Save"; and
- (k) Finalize the IFSP by selecting "Save Final" on the Individualized Family Service Plan page on TOTS.

Within five (5) working days of the updated RBI™, the SC will enter the information onto the Family Assessment Information page on TOTS. The SC will select “Family Assessment Report” to generate a copy to send to the parent. The SC will document on TOTS that the report was sent.

If there are no updates to the six (6) month family assessment and proposed outcomes, the SC will not generate a report of the family assessment unless requested by the parent.

**7.5 (4) (a) Parent Declined Previous Family Assessment**

If the parent declined the previous family assessment, then there is no update that can be completed. Under this circumstance, the SC must attempt to complete a full family assessment with the parent. A *Notice of Action & Consent for Assessment (FS-7)* must be completed to document the parent’s decision.

**7.5 (4) (b) Parent Declines Six (6) Month Update of the Family Assessment**

If the parent completed the previous family assessment and declines the six (6) month family assessment, the *Notice of Action & Consent for Assessment (FS-7)* must be completed and placed in the child’s hard copy file. Verbal denial is not acceptable.

To enter the declined six (6) month update of the family assessment:

1. Select “Prepopulate Next Draft IFSP”;
2. Enter a “IFSP Meeting Date”;
3. Select “Requested Review” as the “IFSP Type”;
4. Enter the reason for the Requested Review in the “IFSP Meeting Note”;
5. Select “Save Draft”;
6. On the Family Assessment Information page, enter the new “Interview or Decline Date”;
7. Enter the SC in “Interviewed By”;
8. Enter the parent’s name in “Person(s) Interviewed”;
9. Delete any information in boxes 1-5, “Main Concerns, Family Worries, Family Desired Changes, Formal and Informal Supports and Family Priorities” (this section should not be completed if the family declined the family assessment);
10. Check “Yes” for “Parent/Guardian Declined to Participate in the Family Assessment”; and
11. Finalize the IFSP by selecting “Save Final” on the Individualized Family Service Plan page on TOTS.

**When to complete Notice of Action and Consent for family assessments:**

<b>Initial Family Assessment</b>	<b>Six (6) Month Family Assessment</b>	<b>Annual Family Assessment</b>
Agreed to complete- complete FS-8	Agreed to complete (covered by FS-8)	Agreed to complete (covered by FS-8)
Agreed to complete- complete FS-8	Agreed to complete (covered by FS-8)	Declined- complete FS-7
Agreed to complete- complete FS-8	Declined- complete FS-7	Declined (covered by FS-7)
Agreed to complete- complete FS-8	Declined- complete FS-7	Agreed to complete- complete FS-7
Declined- complete FS-8	Agreed to complete- complete FS-7	Agreed to complete (covered by FS-7)
Declined- complete FS-8	Agreed to complete- complete FS-7	Declined- complete FS-7
Declined- complete FS-8	Declined (covered by FS-8)	Declined (covered by FS-8)
Declined- complete FS-8	Declined (covered by FS-8)	Agreed to complete- complete FS-7

## **Chapter 8: IFSP Development & Implementation**

The purpose of the Kentucky Early Intervention System's (KEIS) supports and services are to increase the child's participation in family and community activities. The supports and services also encourage the family in using learning opportunities throughout the day to enhance their child's development. Consideration of family routines, activities and natural settings are critical. Supports and services occur in the context of and are integrated into the normal daily activities, routines and environments of each child and family.

KEIS uses a Primary Service Provider (PSP)/Primary Coach model of service delivery. This means that one (1) early intervention provider, selected by the Individualized Family Service Plan (IFSP) team, visits with the child and family the majority of the time. Supports and services fit into the family's life and build effectively on the resources and supports already in place.

The team works together to develop an IFSP that identifies measurable outcomes that can be reasonably achieved within a year. A review of the progress towards the outcomes occurs every six (6) months.

Family members are active, participating members of this team. Infants and toddlers are uniquely dependent on their families for their survival and nurturance. This dependence necessitates a family-centered approach to early intervention. Early intervention systems honor the racial, ethnic, cultural and socioeconomic diversity of families served.

Parents teach their children everyday – they are the primary agent of change in their child's development and the experts on their child and family. Early intervention service providers work with families by adding their specialized skills and knowledge to identify and use learning opportunities already found in the daily routines of the family to address the IFSP outcomes. To the greatest extent possible, the supports used to implement the outcome should be those found in natural environments (e.g., family members, childcare providers, neighbors) instead of, or in addition to, those provided by KEIS. Activities are to enhance what the family is already doing—not add additional burdens to their lives.

Materials used to expand the child's engagement with the environment are those that the child typically has access to, including when the early intervention providers leave. Therapeutic equipment or materials that are used only when the provider is visiting do not have a lasting effect on the child.

The measurable outcomes in the IFSP indicate the functional skills that the child will learn to enhance development. Basic skills are those that can be embedded into natural routines and activities in which the child and family participate (e.g., expressing wants and needs, initiating social interactions, grasping/holding objects, holding head up, feeding self, and demonstrating cause-effect relationships). The interventions for each outcome statement should reflect the specific natural routines and activities in which the skills can be embedded (e.g., expressing wants and needs can be taught during mealtime, such as when a child wants a drink or another bite of food).

The family, through an ecological assessment, looks at many different environments (e.g. home, community, play), to identify the priority routines and activities.

### **8.1 The Purpose of the IFSP**

The IFSP is a process documented in writing. The IFSP guides the family and early intervention providers in meeting the developmental needs of a young child from birth to age three (3) with significant developmental delays or an Established Risk (ER) condition. It is a contract between the family and the state's early intervention system that carries the full rights and safeguards of federal and state law. The IFSP identifies the outcomes for the child and family and the early intervention services that will be provided to help the child and family achieve the identified outcomes.

Early intervention services are chosen based on the priorities of the family. Families participate in an assessment of their concerns, resources and priorities related to the child's development. The family chooses the outcomes

and priorities that they want to address through the IFSP services. Decisions about early intervention services, service intensity and frequency are based on the functional outcomes.

Early intervention services are determined by a team that includes the family as an integral part. Specific early intervention services are selected to address the outcomes that the IFSP team develops. Physicians or other professionals may provide recommendations for services which are considered by the IFSP team; however, services are selected based on the family's priorities. As a family-centered system, KEIS upholds the priorities of the family, even when the professionals have different priorities for the child.

The match between the IFSP outcomes and the ability of the provider(s) to support and assist the family in accomplishing those outcomes is the critical factor when choosing service providers to partner with each family. Once chosen, the IFSP team must consider the following factors in determining frequency and intensity of service:

- (1) The complexity of the priority outcomes for the child;
- (2) The nature and complexity of the child's needs;
- (3) The confidence of the family in the knowledge and skills required to address their child's needs;
- (4) The complexity of the family's needs;
- (5) The extent of their social support network; and
- (6) The nature of the intervention strategies.

One (1) provider is the PSP/Primary Coach who meets with the family most often and relies on assistance from the other team members when addressing the IFSP outcomes. The IFSP may include authorized co-treatment visits by team members. The purpose of the co-treatment visits is to expand the activities being taught to the parents as the child progresses. At times, the co-treatment visits may be needed for problem-solving issues that are impeding the child's successful learning. The number of co-treatment visits listed on the IFSP is individualized based on the child and family's needs and the progress towards achievement of IFSP outcomes. This number counts toward the maximum service unit allotment for the planned period.

## **8.2 Required Components of the IFSP**

- (1) Description of the child's present level of functioning in the domains of physical development, cognitive development, communication development, social and emotional development and adaptive (self-help) development based on the child's evaluation and assessment(s);
- (2) Description of underlying factors that may affect the child's development, including the ER condition and what motivates the child;
- (3) With family agreement, a statement of the family's resources, priorities and concerns related to enhancing the child's development;
- (4) Statement of the measurable results or outcomes expected to be achieved for the child and family and the criteria, procedures and timelines used to determine progress and need for revisions or modifications to outcomes or services:
  - (a) Measurable results/criteria: How will the family and the team members know whether the outcome is achieved, when to decrease or eliminate services or to address the target for longer or in a new way? How long or how often must the child do the action or activity before knowing that the outcome is achieved?
  - (b) Procedures: How will the family and team measure the progress? This can be informal methods such as observation by the family or formal methods such as checklists, assessment probes, etc. Any procedure conducted by the family needs to be something they are comfortable with and can easily implement; and
  - (c) Target Date: When is it expected that the outcome will be achieved?
- (5) At least one (1) measurable transition outcome that addresses any upcoming changes relevant to the child and family or, if the child is two (2) years or older, the steps and services to be taken to support an effective transition of the child to preschool or other appropriate services. This shall include:
  - (a) Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition;
  - (b) Activities to be used to help prepare the child for changes in the service delivery;
  - (c) Specific steps that will help the child adjust to and function in the new setting; and
  - (d) Identification of transition service and other activities the IFSP team determines are necessary to support the transition of the child.

- (6) Specific peer-reviewed early intervention services necessary to meet the unique needs of the child and family to achieve the outcomes, including the frequency, intensity, length, duration, location, method of delivering services, natural environment in which early intervention services are to be provided, and payment arrangements;
  - (a) Frequency means number of days or sessions to be provided;
  - (b) Intensity means group or individual services;
  - (c) Length means amount of time the service provided during each session;
  - (d) Duration means point at which service will no longer be provided;
  - (e) Location means actual place(s) service will be provided (justification must be documented if the location is not a natural environment); and
  - (f) Method means how a service is provided.
- (7) Start dates of services. Early intervention services start after five (5) working days from date of parent consent;
- (8) Other services needed by the child and family that are not early intervention services; and
- (9) Names of the Service Coordinator (SC), PSP/Primary Coach and other IFSP team members.

### **8.3 Required IFSP Team Membership and Meeting Frequency**

IFSP meetings are a group discussion of the child's progress towards achievement of outcomes, successes in functional skill attainment, identification of issues interfering with progress and needed revisions to the IFSP. It is a simultaneous conversation. The core members required at every IFSP meeting are the parent and SC. Early intervention providers are paid for face-to-face IFSP meetings through a collateral authorization.

Participation in an IFSP meeting via telephone conference call is permitted; however, this must be simultaneous conversation. Early intervention providers are not issued an authorization for telephone meetings and may not submit a claim for payment.

- (1) **Initial IFSP:** The initial IFSP team consists of the parent of the child, the SC and the individual who conducted the initial evaluation. Individuals involved in conducting evaluations and assessments may participate in IFSP meetings in person, by report or by having a knowledgeable representative attend. If a representative attends, this person must be an enrolled KEIS provider. Other team members that may be included are advocates or other family members invited by the parent and potential early intervention service providers as appropriate. The initial IFSP meeting must be held as a face-to-face meeting.
- (2) **Six (6)-Month and Requested Review:** Core team membership remains the same as the initial IFSP. Early intervention providers are expected to participate in the IFSP meetings held subsequent to the initial IFSP. These meetings may be held face-to-face or by phone conference according to guidelines (see 8.11 and 8.12).
- (3) **Annual IFSP:** Core team membership remains the same as the initial IFSP. Early intervention providers are expected to participate in the IFSP meetings held subsequent to the initial IFSP. Individuals involved in conducting evaluations and assessments may participate in IFSP meetings in person, by report or by having a knowledgeable representative attend. If a representative attends, this person must be an enrolled KEIS provider. The District Child Evaluation Specialist (DCES) attends the annual IFSP meeting if service coordination is the only ongoing service the child is receiving. The annual IFSP meeting must be held as a face-to-face meeting.

### **8.4 Preparing for the IFSP Meeting**

All IFSP meetings are to be scheduled at times and locations that are convenient for the parent. Preparations for the meeting include:

- (1) Scheduling the meeting and complete the Scheduling Tool on the Technology-assisted Observation and Teaming Support System (TOTS);
- (2) Providing the parent the *IFSP Meeting Notice (FS-14)* at least seven (7) calendar days in advance of the meeting date;
- (3) Notifying all IFSP team members of the meeting at least seven (7) calendar days in advance of the meeting date. This can be done by sending an electronic message to the providers when adding the meeting to the Scheduling Tool; and
- (4) Authorizing collateral services for each early intervention IFSP provider on the IFSP Planned Service Information Page on TOTS. Enter the "Start Date" of the authorization which is the entry date of the

authorization. The “End Date” should be the projected IFSP meeting date. Enter the “Length” as zero. The authorization enables the early intervention provider the ability to review the child’s record before the IFSP meeting. The authorization must be edited to reflect the correct “State Date”, “End Date” and “Length” of the IFSP meeting before the IFSP is finalized.

The SC reviews TOTS to ensure any needed assessment reports are completed and provided to the parent before the meeting. A meeting agenda, *IFSP Meeting Reminders*, is a guide for all IFSP meeting participants.

### **8.5 IFSP Meeting Facilitation**

IFSP meetings must be conducted in settings and at times that are convenient for the parent and in the native language or other mode of communication used by the parent, unless it is clearly not feasible to do so. The SC facilitates IFSP meetings, which includes, at a minimum, the following (these steps should be documented in the SC’s service log and IFSP note box):

- (1) Introduction of all IFSP team members;
- (2) A review of the purpose of the IFSP meeting;
- (3) An explanation of family rights and procedural safeguards, with a copy of the *Family Rights Handbook* given to the parent unless they decline the copy because they already have one (1);
- (4) A review of the evaluation and assessment results linked to the child’s growth and development explained in such a way as to ensure that parents can share this information to others;
- (5) A review of the eligibility determination;
- (6) A review of the parent’s concerns, priorities, resources, routines and other family information pertinent to program planning;
- (7) A discussion of measurable outcomes developed by the family according to the priorities identified through the family assessment. \* **Note:** Every IFSP includes at least one (1) transition outcome;
- (8) A discussion and justification of the early intervention services, that are necessary to meet the unique needs of the child and the family for achieving the outcomes identified by the IFSP team;
- (9) A discussion and justification of the frequency, intensity, duration, length, method of delivering services and service delivery settings;
- (10) A discussion regarding transition from early intervention and the points at which efforts will begin to focus on that process, specific transition planning activities depending on the child’s age at the time of the IFSP meeting or the parent’s concerns related to transition;
- (11) A review of medical needs and other services and resources outside of KEIS which the parent utilizes or could utilize (but not paid by KEIS);
- (12) A review of financial matters and resources including Family Share participation fees and private and public insurance (including obtaining consents for billing private insurance as appropriate);
- (13) A discussion and justification of the selection of the PSP/Primary Coach; and
- (14) Completion of the *IFSP Signature Page (FS-15)*. The parent will need to mark their level of consent for services and sign the form. All other meeting participants sign the form if present. If a provider participates by phone or by report, the SC will add their name to the signature page and mark their method of participation.

#### **8.5 (1) Billing for a Collateral Service**

In order for an early intervention provider to bill a collateral service for attending an IFSP meeting, the provider, SC and parent must all be physically present at the meeting.

A provider is not able to bill for collateral services if:

- (a) the meeting is held by phone;
- (b) they participate by report only;
- (c) they participate as a representative of an “other” service on the IFSP;
- (d) the SC is not physically present at the meeting; or
- (e) the parent is not physically present at the meeting.

### **8.6 Selection of Early Intervention Services**

The SC leads the identification of possible early intervention services by reviewing each priority outcome with the IFSP team. Discussion centers on the type of service needed to address the concern. The discussion must be framed with the understanding that early intervention services are provided through a PSP/Primary Coach. Other early intervention providers support the PSP/Primary Coach through consultation and meet with the child and

family on an infrequent basis. Discussion and selection of the PSP/Primary Coach and other early intervention services must be documented on TOTS in the service log and in the IFSP note box.

**Factors to consider in the selection process:**

- (1) Family priorities and concerns that are expressed as outcomes;
- (2) Child's ability to engage meaningfully with the environment;
- (3) Child's ability and needs for appropriate social engagement; and
- (4) Child's developmental needs as documented through the assessments.

**\*Note-** It is a rare occurrence that two (2) Developmental Interventionists (DI) would be authorized on the same IFSP. If an IFSP team believes that it is necessary, they must submit a justification to the State Lead Agency (SLA) seeking approval.

**8.6 (1) Using the Provider Matrix for Selecting Early Intervention Providers**

After identifying the IFSP outcomes that the parent has prioritized and the discussion of what type of early intervention service is needed, the SC searches the TOTS Provider Matrix for appropriate, available early interventionists to work with the family.

SCs identify the provider(s) that match the concerns and priorities of the family such as:

- (a) Provider's experience with specific types of disabilities;
- (b) Provider's availability;
- (c) Provider's additional training in an intervention methodology or strategy; and
- (d) Provider's networking status if child has private insurance.

To search for a provider using the TOTS Provider Matrix:

- (a) Select "Provider Matrix" from the Management Tool section on the "Home Page" on TOTS;
- (b) Select a "County", "Service" (discipline), "Service" (insurance) and/or "Availability";
- (c) Select "Available for Referral";
- (d) Enter the security code shown and select "Search";
- (e) All available providers based on the selected criteria will appear at the bottom of the page; and
- (f) Select "Detail" to view the "Provider Information Detail" page.

**8.6 (2) Making Referrals to Early Intervention Providers**

It is important that the SC makes a referral early enough in the process to allow providers time to check their availability. The SC needs to find out the parent's needs such as: can they receive services during the morning, afternoon or evening? Is there a day that works better than others?

Referrals offered to a provider must be done in such a manner to prevent discrimination based on the financial resources of the parent.

All providers sign an agreement that states:

- (a) Agree to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84 and 90. The Cabinet shall make no payment to providers of service who discriminate on the basis of race, color, national origin, sex, disability, religion, or age in the provision of services;
- (b) Agree to serve all geographic areas of the counties indicated on the appropriate provider enrollment form, unless the Cabinet grants a waiver from this requirement; and
- (c) Agree to accept KEIS client referrals without discrimination, including but not limited to children with public or private insurance coverage.

To prevent opportunities for discrimination, referrals to a provider must be offered "blind"; that is, offered to the potential provider based only on minimal information that does not violate anti-discrimination laws. For example, "Provider or Agency X, we have a child who needs a speech pathologist. Do you accept this referral?"

The SC can share this information to facilitate finding a provider:

- (a) County; and

- (b) Time or day restrictions if applicable: parent can only receive services in the evening, on Wednesday mornings, etc. There is no need to share this type of information if the parent states “any time will work”.

### **8.6 (3) No Provider Available**

There may be instances when the IFSP team has identified the need for a specific early intervention service; however, no provider is able to provide services when the child and family are available. In these situations, the SC must complete an *Early Intervention Service Availability Notice (FS-45)*. The SC marks the service that is not available and the reason why. The SC must also create a plan for how to obtain the service for the child and family. If the service is being provided in a clinical setting, mileage may be paid by KEIS. Services received in a clinical setting should be temporary and the SC must continue to try to find a provider to serve the child and family in their natural environment. The parent and SLA are provided a copy of the completed *FS-45* form. Documentation of the situation, including the efforts by the SC to find a provider, must be entered in a service log.

If the SC is able to find an early intervention provider who is able to serve the child and family in the natural environment during the existing IFSP, the SC will conduct a requested review meeting to add the new provider to the IFSP. The SC should also update the existing *Early Intervention Service Availability Notice (FS-45)* form notifying the SLA that the service has been obtained.

If the SC is unable to find an early intervention provider during the existing IFSP, at each subsequent IFSP meeting, the availability of early intervention providers should be reassessed to determine if an early intervention provider is available or if the need is ongoing. If a provider is found, the existing *FS-45* form must be updated with the date that the service was obtained. If an early intervention service is still unavailable, a new *FS-45* form should be completed with the parent and submitted to the SLA.

Should compensatory services be necessary due to the inability of the system to provide adequate early intervention as defined by Individuals with Disabilities Education Improvement Act of 2004 (IDEA), the SLA will work with the Point of Entry (POE) Manager and SC to authorize such services.

### **8.6 (4) Parent Request for Services that are not Early Intervention Services**

A parent may request KEIS to pay for services that are not in agreement with the team or are services that do not meet the standards and definitions for early intervention. This includes services that are for medical follow-up and services that are not peer-reviewed or developmentally appropriate. If the parent request such services, the SC will provide the parent with a *Notice of Action (FS-9)* declining the services the parent requested and review the parent’s rights using the [Parent’s Rights in Kentucky’s Early Intervention System: First Steps](#) brochure. Services such as these may be listed on the IFSP as “other services”. The SC is responsible to assist the parent in accessing the “Other Services” on the IFSP.

### **8.6 (5) Request for Services in Another District**

When a child lives in one (1) district and the parent requests that services be provided in another district (due to custody orders or childcare), the POE Managers for each district need to discuss the request. The managers must decide which POE is the appropriate one (1) responsible for the case based upon the access to the parent and child. Once the decision has been made, the appropriate POE will follow-up with the parent to proceed with the process.

### **8.6 (6) Out of State Service Request**

Parents who live near the borders of Kentucky may request services be delivered to a site (typically a childcare environment) that is outside Kentucky. KEIS providers are not required to provide services out-of-state. The SC will need to investigate if there are early intervention providers available who can legally work in the other state. If there are no providers who can work out-of-state, the SC and parent need to find a location in Kentucky where services can be provided.

If the parent continues to request the provision of services in the other state and no KEIS provider can legally meet this request, provide the parent a *Notice of Action (FS-9)* indicating that the POE is refusing to provide services to an out-of-state location.



### **8.6 (7) Physicians Orders for Therapy**

Physicians often order physical, occupational and speech therapy. Nutrition services may also be ordered or recommended. When ordering these services, physicians are doing so based on their clinical knowledge and judgment of need for medical treatment. Medical treatment is not the same as early intervention services provided by KEIS.

Early intervention is rooted in clinical experiences of the providers; however, there are significant differences between early intervention provided through KEIS and clinical or medical therapies.

Early intervention is provided in the settings where the child interacts on a daily basis- the home, the child care classroom, the backyard, the park, the grocery store, etc. Emphasis is on using the naturally found toys, equipment and furniture of those settings to teach the parent how to extend their child's learning throughout the routines of the family. Focus is on the whole child rather than specific developmental skills or deficits. Learning for this age group requires frequent repetition and practice. Embedding early intervention into the daily life of the child and family provides the frequency needed for learning.

Clinical or medical therapies are provided to remediate a chronic or acute issue by direct, hands-on interventions with the child. These services are prescribed based on the context of medical treatment. Type of service is determined by one (1) person with the therapist usually determining the frequency and intensity of service based upon clinical standards of care. Focus is typically on one (1) concern and not a holistic approach. Depending upon the type of therapy, specialized equipment is necessary for treatment. Some therapists will suggest a home program of exercises to supplement the clinical visit; however, the expectation is that the goals for therapy are attained through the clinical visits.

The purpose of the medical therapy is to:

- (a) remediate a medical issue;
- (b) provide medical follow-up; and/or
- (c) provide a specific medical treatment protocol.

Before adding the ordered services to the IFSP as part of the ongoing early intervention services, the IFSP team has to decide if the reason for the medical therapy fits within the philosophy and purpose of early intervention. If the service needed requires that the infant or toddler be manipulated specifically by the therapist in order to achieve treatment goals, then it may not be an early intervention service. KEIS targets the adult caregiver as the focus of coaching and teaching embedded interventions. Determining that the ordered service is not an early intervention service provided by KEIS does not mean that the child goes without the service. If the child and family receive the ordered medical therapy, it would be listed on the IFSP as an "Other Service" that the child needs but KEIS is not responsible to provide.

Physician ordered services cannot be added to the ongoing services for the reason that parent wants services in the home instead of going to the clinic or that the parent does not have the resources to provide the service.

### **8.7 Timelines and Timely Services**

Initial IFSPs must be developed within forty-five (45) calendar days of the referral. All services authorized on the initial IFSP and any new services on subsequent IFSPs must begin after five (5) working days and no later than thirty (30) calendar days of the date the parent gives consent for the services. The date of consent is the date the IFSP was signed.

### **8.8 Parental Notice of Action and Consent for Early Intervention Services**

The initial written notice for early intervention services is part of the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)*. The parent gives written consent for early intervention services by signing the IFSP. No early intervention service may be provided without written parent consent.

If a parent chooses not to receive a service included on the IFSP, they may decline that service without jeopardizing other early intervention services. The refusal of the service must be documented on the IFSP

signature page as well as in the “IFSP Meeting Note” box on the Individualized Family Service Plan page on TOTS. If the parent decides that they do want the early intervention service that they initially declined, an additional face-to-face requested review meeting is required.

If a parent provides written consent for services on the IFSP signature page, but subsequently refuses an early intervention service, the SC must complete a requested review to amend the existing IFSP. Since this is a decrease in early intervention services, a face-to-face IFSP meeting is not required. The SC sends the parent the *Notice of Action (FS-9)* along with a copy of the Parent’s Rights in Kentucky’s Early Intervention System: First Steps brochure.

### **8.9 Financial Resources**

The parent’s financial resources must be verified prior to the Initial, Six (6) Month Review and Annual IFSP meetings using the *Financial Assessment Verification (FS-13)*. Completion of the form must be documented in a communication log or service log. A new *Financial Assessment Verification (FS-13)* is required any time there is a change to the parent’s financial status. The Current Family Financial Support page on TOTS must be updated each time a *FS-13* is completed.

Parents must be asked if they consent for use of private insurance to pay for the initial provision of early intervention services and each time services increase in frequency, length, duration or intensity. The *Notice & Consent for Use of Private Insurance (FS-12A)* is used for this purpose.

The *Notice for Use of Medicaid (FS-12B)* must be provided annually to parents who use Medicaid for early intervention services.

### **8.10 Initial IFSP**

A proposed date and time for the initial IFSP meeting should be discussed with the parent during the intake meeting to adhere to the forty-five (45) day timeline. Once the child is determined eligible for early intervention services, the SC should confirm the proposed date and time with the parent or reschedule the meeting if necessary.

The IFSP is documented on the Individualized Family Service Plan page on TOTS, including a list of IFSP team members and method of participation. Some data is entered by the SC and some information is pulled to the IFSP from various screens that other individuals have completed. TOTS is designed to export the current IFSP to Word for printing.

The IFSP on TOTS cannot be changed once it is saved (finalized or locked). It is very important that the SC carefully reviews the IFSP **before** finalizing. However, corrections or other modifications to the IFSP can be made on the items that the user has access to on the Individualized Family Service Plan page as it is entered. The items or sections that are pulled to the IFSP screen from other screens must be edited from the screen of origination.

To enter the initial IFSP:

- (1) **IFSP Meeting Date**- format is of mm/dd/yyyy.
- (2) **IFSP Delay Reason**- For initial IFSP’s only, if the IFSP date is not within forty-five (45) days of referral, a delay reason must be chosen. In order to determine the cause for delay, the SC should consider the initial incident that may have resulted in the delay. The SC will need to review the delayed IFSP with the POE Manager to ensure the proper delay reason is selected and clearly documented. The delay reason of “Other” should only be selected when no other delay reason is appropriate.  
\***Note:** When entering an initial IFSP on a re-referral, TOTS will give an error message that a delay reason is needed to save the plan as final, even when the IFSP is not delayed. The SC must select “Save Draft” and go to the Referral Information page on TOTS and select “Save”. This will allow the SC to save the initial IFSP without a delay reason. Another option is to have a user with District Administrator (DA) profile, such as a POE Manager, save the IFSP without selecting a delay reason.
- (3) **IFSP Type**- Select “Initial”.
- (4) **Official Transition Plan?**- If the IFSP is also the official transition conference the SC will select “yes”.

- (5) **Informed Parental Consent**– Consists of four (4) yes or no questions. TOTS defaults to “yes” for these questions. However, these questions must be reviewed at every IFSP and documented accordingly.
- (6) **Family Statement**– “Parent Interview Date”, “Main Concerns”, “Formal and Informal Supports”, “Family Worries”, “Desired Changes” and “Family Priority” are pulled from the Family Assessment Information page.
- (7) **Identification of Natural Environments**- Enter where the early intervention services will take place.  
\*Note: When daycare is listed as the natural environment, the name of the daycare should be entered.
- (8) **Other Services**- Enter all other services that the child and family need to achieve the IFSP outcomes but are not funded by KEIS.
- (9) **IFSP Participants**- Select the role of each individual who contributed to the IFSP development.
- (10) **IFSP Participants Detail**- List the persons who signed the signature page, their disciplines, date of signature, and how attended (in person, by report, by phone). Be sure to list the name of the provider if they participated by report.
- (11) **IFSP Meeting Note**- This is a record of the discussion and reasons for decisions made by the IFSP team. See section 8.5 for all required components that must be documented in this note.) If a new IFSP is created, the SC must delete old information from the note box. The note must contain information relevant to the current IFSP only.
- (12) **Child’s Development Levels**- This is populated from the Evaluation/Assessment Information page.
- (13) **Outcome**- This is populated from the Outcome Strategy and Activities Information page.
- (14) **Planned Services**- This is populated from the IFSP Planned Service Information page. When a subsequent IFSP is created, the planned services that are on the current IFSP carry forward to the pending IFSP and must be deleted or updated to reflect changes to the new IFSP. The edits or modifications are made on the IFSP Planned Service Information page. Any previous authorizations that are no longer needed for the new IFSP must be deleted; they are archived with the previous IFSP and may still be reviewed.

When entering the planned service, these definitions apply:

- (a) **Method of Delivery**- how a service is provided. Choices are modeling, assessment, coached caregiver, provide resources, co-treatment and meeting. Only one (1) method may be chosen on Planned Services; this should be the primary method that the provider will use to address the outcome. On-going co-treatments must be entered as separate authorizations;
- (b) **Intensity**- group or individual sessions; and
- (c) **Setting**- the location of the early intervention service. These settings are tied to the provider’s rate of pay. Choices are:
  1. family/guardian home (natural environment)- this is a private residence where the child lives;
  2. day care provider home (natural environment)- this is a private residence where the child receives care while the parent is unable to provide care;
  3. day care center (natural environment)- this is a facility where the child attends with other children who are typically developing while parent is unable to provide care (this does not include Prescribed Pediatric Extended Care (PPEC));
  4. early intervention center/independent clinic (not natural environment)- this is a special purpose facility where specialized care or services are provided to children (this includes PPECs);
  5. early childhood center (natural environment)- this is a facility where the child attends with other children who are typically developing for learning and social experiences;
  6. community (natural environment)- these are settings found in the community like libraries, parks, restaurants, grocery stores, churches, etc.;
  7. hospital (not natural environment)-associated clinic- this is a special purpose facility, under the administration of a hospital, where specialized care or services are provided to children; and
  8. other (not natural environment)- these are settings that do not fit the definitions of setting listed above such as POE offices, service provider office, parent’s work setting.

- (15) **Note**- This note box does not print on the IFSP. Add details that a reader of the IFSP document should know but did not fit in the “IFSP Meeting Note” box.

### **8.10 (1) IFSP Development for Children with ER Conditions with Age Appropriate Developmental Functioning**

If the child has no developmental delays as indicated by the initial evaluation, the IFSP team needs to discuss with the parent what the options are for services in KEIS. The child is eligible for early intervention, due to the confirmation of the medical condition, but the child’s development is age

appropriate and may only require monitoring of developmental progress through assessment. The SC can assist with linkages to other services to address developmental supports or informational needs of the family. The individual who conducted the initial evaluation is designated as the PSP/Primary Coach on an IFSP that does not include early intervention services. The DCES conducts the annual Five Area Assessment (5AA) for these children.

If developmental concerns arise during the IFSP plan, the SC will consult with the DCES regarding appropriate steps to address the concerns.

The parent may request KEIS to provide ongoing services when their child has an ER condition and is functioning within age appropriate levels as evidenced by the assessment. If the parent requests such services, the SC is to provide the parent with a *Notice of Action (FS-9)* indicating refusal of a service due to the child's age-appropriate functioning and reviews the parent's rights using the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure.

Should the parent access therapy services outside of KEIS, these may be listed on the IFSP as "Other Services". The SC is responsible to assist the parent in accessing the "Other Services" on the IFSP.

### **8.10 (2) Finalizing the IFSP**

The SC must finalize the IFSP on TOTS and provide the parent a printed copy within five (5) working days of the date of the meeting. A hard copy IFSP must also be sent to those individuals outside KEIS that the parent consented to receive a copy within five (5) working days. This should be clearly documented in the communication log. KEIS providers view the IFSP on TOTS. Finalizing the IFSP is also known as "locking" the IFSP.

The IFSP is a contract between the parent and KEIS. Any change to the document without the knowledge of the parent renders the plan null and void. Parents must be notified every time the IFSP is unlocked and given the reason for unlocking. Documentation of this must be in the service log and "IFSP Meeting Note".

There should be minimal need to unlock an IFSP for corrections. The best way to correct an error is to always review content before saving or finalizing a plan. Prior to saving the plan, the SC reviews all IFSP pages to ensure the information is correct. Errors in planned services can be corrected at this time. Once the SC is satisfied that all information is correct, the plan is saved as final and a copy of the plan printed and mailed to the parent. This is documented in the communication log.

#### **8.10 (2) (a) Unlocking Plans to Correct Errors**

If, after a copy of the plan has been mailed to the parent, it is discovered that the plan contains an error, the SC must contact the parent to explain that the plan they have received contains an error (be sure to explain what the error is) and that it needs to be corrected in the on-line data management system. This conversation should be documented in both the SC service log for the call and in the IFSP meeting note section.

If the correction results in a change to planned services the IFSP cannot be unlocked. A Requested Review IFSP will need to be created. If the change results in an increase in the frequency, length, intensity or duration of a service, written parental consent is required and a face-to-face IFSP meeting must be scheduled.

The SC may request by email that the SLA unlock the IFSP. The POE Manager should be copied on this request. SLA staff will review the request to unlock the plan. If the SLA staff agrees to unlock the plan, the SC and POE Manager will be notified that the plan is unlocked for correction. If the SLA staff does not agree to unlock the plan, the SC and POE Manager are notified of this decision. The error can then be corrected by the SC, a new copy mailed to the parent and the plan saved as final. This is documented in the communication log.

### **8.10 (3) Implementing the IFSP**

The IFSP is a legal contract between KEIS and the parent. Once the parent has given written consent, the IFSP is implemented. The early intervention provider must wait five (5) working days before starting the initial service to ensure that the parent receives prior written notice. Initial services must begin before the thirtieth (30<sup>th</sup>) calendar day in order to be considered timely. While the initial IFSP outcomes are written for one (1) year, authorizations for services are limited to no more than six (6) months in length. A review of the IFSP must be conducted every six (6) months or more frequently if conditions warrant, or if the parent requests a review.

### **8.11 Six (6) Month Review**

IFSPs are written for one (1) year; however, they are reviewed every six (6) months. The purpose of the six (6) month review is to determine the degree to which progress toward achieving the results or outcomes identified in the IFSP is being made and whether modification or revision of the results, outcomes or early intervention services is necessary.

The potential date of the six (6) month IFSP should be determined during the initial IFSP meeting and documented in the SC's service log for the IFSP meeting. SCs should begin preparing for the six (6) month review at least forty-five (45) calendar days and no later than thirty (30) calendar days before the date of the meeting.

Preparations for the meeting include:

- (1) Contacting the parent to confirm the potential IFSP meeting date and schedule a time to update the family assessment. During this call the SC should discuss with the parent their satisfaction with the early intervention services;
- (2) Updating the family assessment no later than ten (10) calendar days prior to the meeting. POE staff shall provide a written report of the family assessment to the parent within five (5) working days of the parent interview;
- (3) Reviewing the updated family assessment and service logs to determine need for possible revisions;
- (4) Notifying all IFSP team members of the meeting at least seven (7) calendar days in advance by sending the family an *IFSP Meeting Notice (FS-14)* and scheduling the meeting in the TOTS Scheduling Tool page. Each team member will then receive an electronic notice of the meeting; and
- (5) Ensuring all providers enter progress reports on TOTS on the Progress Report page and mail a copy of the report to the parent at least five (5) working days before the meeting.

### **8.11 (1) Six (6) Month Review by Telephone Conference**

The six (6) month review may be conducted by a simultaneous telephone conference call if parents agree to this format. The meeting may be held by phone if:

- (a) there is not a proposed change that would require an increase in frequency, length, duration or intensity of early intervention services;
- (b) there is not a proposed change in the method of delivering services;
- (c) there is not a proposed change in service delivery settings;
- (d) there is not a proposed change to add a new service;
- (e) there is not a proposed change to add or modify IFSP outcomes; or
- (f) there is a proposed change to decrease or delete an existing service or outcome.

**\*Note:** A decrease in an existing IFSP service does not require parental consent. However, the SC must provide the parent a copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure with the *Notice of Action (FS-9)* that describes the decrease in service.

On the conference call, if the team determines that a change to the current IFSP is necessary the discussion should be tabled and a face-to-face meeting needs to be held. Current early intervention services may continue. A new meeting notice is not required.

If the IFSP will continue with no changes to the outcomes or services, a new *IFSP Signature Page (FS-15)* is not needed. The unchanged services will continue without interruption. The SC sends a copy of the finalized IFSP to the parent within five (5) working days.

The annual redetermination of eligibility must be discussed during the six (6) month review IFSP meeting. The parent should be notified that as part of the redetermination of eligibility an annual 5AA will be completed. This conversation must be documented as part of the IFSP meeting note. This assessment should be authorized as part of six (6) month IFSP planned service authorizations. The start date for the assessment should be at least sixty (60) calendar days and no more than thirty (30) calendar days before the end of the six (6) month review IFSP. During the six (6) month review meeting the IFSP team should schedule a tentative date for the annual review meeting.

### **8.11 (2) Six (6) Month Review Held Face-to-Face**

The six (6) month review meeting must be held as a face-to-face meeting if:

- (a) there are proposed changes that would require an increase in the frequency, length, duration or intensity of early intervention services;
- (b) there are proposed changes in the method of delivering services;
- (c) there are proposed changes in service delivery settings;
- (d) there is a proposed change to add a new service; or
- (e) there is a proposed change to add or modify IFSP outcomes.

The SC will document the IFSP meeting and issue authorizations for ongoing services by:

- (a) pre-populating an IFSP;
- (b) making any necessary changes to the IFSP;
- (c) entering authorizations on IFSP Planned Service page; and
- (d) finalizing the IFSP.

If the IFSP will continue with no changes to the outcomes or services, a new *IFSP Signature Page (FS-15)* is not needed. The unchanged services will continue without interruption. The SC sends a copy of the finalized IFSP to the parent within five (5) working days.

If changes are made to the IFSP at the six (6) month review meeting, the SC must provide the parent a copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure with the *Notice of Action (FS-9)* that describes the proposed changes to the IFSP. The parent will sign a new *IFSP Signature Page (FS-15)* while at this meeting. The parent has the opportunity to indicate consent for services (including any new service) or any declination of a service on the signature page of the IFSP. The SC sends a copy of the signature page with the finalized IFSP to the parent within five (5) working days. The early intervention provider must wait five (5) working days before starting the changed service to ensure that the parent receives prior written notice. Any new early intervention service must begin before the thirtieth (30<sup>th</sup>) calendar day in order to be considered timely.

The annual redetermination of eligibility must be discussed during the six (6) month review IFSP meeting. The parent should be notified that as part of the redetermination of eligibility an annual 5AA will be completed. This conversation must be documented as part of the IFSP meeting note. This assessment should be authorized as part of six (6) month IFSP planned service authorizations. The start date for the assessment should be at least sixty (60) calendar days and no more than thirty (30) calendar days before the end of the six (6) month review IFSP. During the six (6) month review meeting the IFSP team should schedule a tentative date for the annual review meeting.

### **8.11 (3) Editing Outcomes**

During the six (6) month IFSP, the SC will review the outcomes on the current IFSP. The progress of each outcome will be discussed with the team. There may be instances when outcomes are met, need to be modified or the parent may choose to discontinue the outcome. Once the outcome has been reviewed the SC must determine if the outcome is one of the following:

- (a) achieved;
- (b) continued;
- (c) continued with changes; or
- (d) discontinued.

### **8.11 (3) (a) Outcome Has Been Achieved**

On the Outcome Strategy and Activities Information page on TOTS, the SC will:

1. Select the "Edit" button for the outcome to be reviewed;
2. Enter "Date Reviewed" with the date of the IFSP meeting;
3. Select "Achieved" as the "Outcome Status"; and
4. Select "Save".

**\*Note:** Achieved outcomes must remain on the IFSP until the next natural IFSP. At the next natural IFSP, the outcome must be deleted.

### **8.11 (3) (b) Outcome Is Continued**

On the Outcome Strategy and Activities Information page on TOTS, the SC will:

1. Select the "Edit" button for the outcome to be reviewed;
2. Enter "Date Reviewed" with the date of the IFSP meeting;
3. Select "Continued" as the "Outcome Status"; and
4. Select "Save".

### **8.11 (3) (c) Outcome Is Continued With Changes**

On the Outcome Strategy and Activities Information page on TOTS, the SC will:

1. Select the "Edit" button for the outcome to be reviewed;
2. Edit the outcome in the "Outcome" box;
3. Edit procedures for the outcome as needed in the "Procedure" box;
4. Enter "Date Reviewed" with the date of the IFSP meeting;
5. Select "Continued With Changes" as the "Outcome Status";
6. Document the justification for the change to the outcome in the "Outcome Review" box; and
7. Select "Save".

### **8.11 (3) (d) Outcome Is Discontinued**

On the Outcome Strategy and Activities Information page on TOTS, the SC will:

1. Select the "Edit" button for the outcome to be reviewed;
2. Enter "Date Reviewed" with the date of the IFSP meeting;
3. Select "Discontinued" as the "Outcome Status"; and
4. Select "Save".

**\*Note:** Discontinued outcomes must remain on the IFSP until the next natural IFSP. At the next natural IFSP, the outcome must be deleted.

### **8.11 (4) Editing Planned Services**

IFSPs are written for one (1) year, however they are reviewed every six (6) months. In order to ensure the IFSP spans the full year, the new authorization "Start Date" must be the day after the previous authorization's "End Date" on IFSP Planned Service Information page on TOTS. For example, if the authorization on the Initial IFSP ended on 06/15/2022 the "Start Date" on the new authorization would be 06/16/2022.

### **8.12 Requested Review**

A revision to an existing IFSP may occur when requested by the parent only or by the parent and an IFSP team member and when an early intervention service is changed.

There must be child or parent specific data that supports the need to revise the IFSP. Revisions must be a result of data collection describing the variety of strategies that have been implemented by the early intervention provider(s) and parent and the results from the ongoing assessments by the early intervention provider(s). The data must be recent and collected by a qualified professional.

It is recommended that a reasonable timeline (approximately three (3) months) be reached before IFSP teams consider adding a new service or increasing the frequency and intensity of an existing service. This allows for

adequate data collection to determine if changes are warranted. The IFSP team may need to consider different strategies to implement rather than increasing early intervention services.

When there is a revision to an existing IFSP, the SC will:

- (1) Schedule a Requested Review meeting; and
- (2) Notify all IFSP team members of the meeting at least seven (7) calendar days in advance by sending the parent an *IFSP Meeting Notice (FS-14)* and scheduling the meeting in the TOTS Scheduling Tool page. Each team member will then receive an electronic notice of the meeting.

**\*Note:** See section 8.11 (1) and 8.11 (2) for how the meeting should be held (face-to-face or by phone).

To document the requested review, the SC will:

- (1) Pre-populate an IFSP;
- (2) Make any necessary changes;
- (3) Enter authorizations on IFSP Planned Service Information page ("End Date" for all services will remain the same); and
- (4) Finalize the IFSP.

**\*Note:** See section 8.11 (3) for procedures on how to edit outcomes.

Unchanged services are to continue without interruption; new services must begin after five (5) working days and no later than thirty (30) calendar days from date of IFSP meeting.

A *Notice of Action (FS-9)* must be provided to the parent when there are changes to existing IFSP services or when the POE staff refuses to implement an action. A copy of the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure must be sent with the *Notice of Action (FS-9)*.

### **8.13 Annual Evaluation of the IFSP**

The timelines for the annual evaluation of the IFSP must be carefully observed to ensure that the current IFSP does not lapse or terminate prior to the development of a new IFSP, should the child remain eligible (see Chapter 6, for additional information on annual redetermination of eligibility).

SC should begin preparing for the annual IFSP:

- (1) At least sixty (60) calendar days prior to the annual IFSP date by sending the parent a *Notice of Action for Annual Eligibility Determination (FS-18)*;
- (2) Ensure that the annual 5AA is conducted no earlier than sixty (60) and no later than thirty (30) calendar days prior to the annual IFSP date; and
- (3) Conduct the family assessment at least fifteen (15) and no earlier than twenty-five (25) calendar days prior to the date of the meeting. The SC must provide the parent with a copy of the family assessment within five (5) working days of the date of the assessment.

All IFSP team providers must enter progress reports on TOTS in the Progress Report page and mail a copy of the report to the parent at least five (5) working days before the meeting.

The annual evaluation of the IFSP includes the requirement that current assessments and other information be used to:

- (1) Develop new outcomes that help to identify what early intervention services are needed; and
- (2) Determine what services will be provided.

The SC notifies all IFSP team members of the meeting at least seven (7) calendar days in advance by sending the parent the *IFSP Meeting Notice (FS-14)* and scheduling the meeting on the Scheduling Tool page on TOTS. Each team member will then receive an electronic notice of the meeting.

Unchanged services are to continue without interruption. New services or services that have changed (increase in frequency, intensity and length) are to begin at least five (5) working days after the parent provides written consent on the IFSP signature page and no later than thirty (30) calendar days from date of IFSP meeting. Prior



written notice (five (5) working days) is required because changes have been made in the written contractual obligation determined by the IFSP.

In order to ensure the IFSP spans the full year, the new authorization "Start Date" must be the day after the previous authorization's "End Date" on IFSP Planned Service Information page on TOTS. For example, if the authorization on the six (6) month review IFSP ended on 06/15/2022 the "Start Date" on the new authorization would be 06/16/2022.

#### **8.14 Lapsed IFSP**

SCs must make every effort to hold all six (6) month and annual IFSP meetings in a timely manner. When the six (6) month or annual review meeting does not take place prior to the end date of the authorized planned services, the SC reviews the case with the POE Manager and/or the DCES to determine the cause of the delay and the most appropriate next step. Parents must be informed fully of the cause for the delayed meeting and the impact such a delay may have on services to the child. If the plan lapses due to reasons other than parent initiated reasons and the child does not receive the IFSP services as written on the IFSP, the child may be eligible for compensatory services.

If the plan lapsed due to parent initiated reasons, no compensatory services will be provided. Parent initiated reasons include frequent or persistent rescheduling of the IFSP meeting, no notification of need to cancel scheduled IFSP meeting, or illness of a family member or child.

#### **8.15 IFSP Extensions**

IFSP extensions are not allowed. The SC will follow the procedures based on the next naturally occurring IFSP.

If the child is close to turning three (3) and aging out of the program and the parent declines to move forward to develop an IFSP, the POE must ensure that all transition activities have been completed and will close the case. The exit reason on the Transition/Exit Information page on TOTS will reflect one of the following:

- (1) "Part B Eligible";
- (2) "Not Eligible for Part B-Exit to Other Program";
- (3) "Not Eligible for Part B-Exit with No Referrals"; or
- (4) "Part B Eligibility Not Determined-Other".

#### **8.16 Hearing Concerns for Children with IFSP**

There may be instances when a hearing concern arises after a child has an active IFSP. The concerns may be expressed by the parent or early intervention provider. The SC must ensure that the parent receives prior notice and gives consent for the Hearing Screening/Evaluation on the *Notice of Action & Consent for Assessment (FS-7)*. The POE should follow procedures to conduct the Otoacoustic Emissions (OAE) screening to determine the need for further hearing evaluation. If the child passes the OAE screening, the results are documented on TOTS and no further action is required. If the child does not pass the OAE screening, a referral for hearing evaluation to the Office for Children with Special Health Care Needs (OCSHCN) may be made.

To make a referral to OCSHCN, the SC will:

- (1) Update "Demographic Information" page and "Pregnancy, Birth and Health Information" page on TOTS;
- (2) Complete the *Consent to Release/Obtain Information (FS-10)* for the OCSHCN so that hearing information may be shared between KEIS and the OCSHCN;
- (3) Complete the *Referral Form to OCSHCN (FS-37A)*;
- (4) Fax the *FS-37A* and *FS-10* to the OCSHCN office;
- (5) Assist the parent by calling the local OCSHCN office to set-up an appointment or instruct the parent to call to make an appointment;
- (6) Pre-populate a requested review IFSP;
- (7) Issue an authorization for the screen/evaluation on the IFSP Planned Service Information page on TOTS;
- (8) Finalize the IFSP;
- (9) Document on TOTS that the referral to the OCSHCN has been made (once the OCSHCN completes the evaluation they will notify the SC);
- (10) Pre-populate a requested review IFSP to allow the report to be entered by the OCSHCN; and
- (11) Once the report has been entered by the OCSHCN, finalize the IFSP.

**\*Note:** If a referral is being made to OCSHCN at the at the six (6) month or annual IFSP, a Requested Review IFSP is not necessary. The authorization would be added to the naturally occurring IFSP.

**\*Note:** The OCSHCN will bill Medicaid or the family's private insurance, even if the parent has declined the use of insurance in KEIS.

### **8.17 Autism Concerns for Children with IFSP**

There may be instances when concerns for autism spectrum disorder (ASD) arise after a child has an active IFSP. The concerns may be expressed by the parent or early intervention provider. The SC must ensure that the child has not already been referred for a medical evaluation for ASD concern, the parent receives prior notice and gives consent for the autism screenings (M-CHAT-R/F, STAT) on the *Notice of Action & Consent for Assessment (FS-7)*. The POE should follow procedures to conduct the screening to determine the need for further evaluation. The M-CHAT-R/F may be administered by the SC or DCES. The STAT must be completed by the DCES. If the child passes the screening, the results are documented on TOTS and no further action is required. If the child does not pass the screening, a referral for an Intensive Level Evaluation (ILE) may be made.

### **8.18 Intensive Level Evaluation (ILE) Request for Children with an IFSP**

The purpose of an ILE in cases where a child has an IFSP is to gain in-depth clarifying information so that the IFSP team can develop effective interventions and services in a timely manner. The information needed cannot be provided through the available 5AA, initial evaluation, ongoing assessment of progress, and/or any appropriate discipline-specific assessments. The results of the ILE must have direct impact on the IFSP.

After enough data has been collected to determine the need for an ILE (recommended best practice is three (3) months of service), a *State Lead Agency Approval Request for Intensive Level Evaluation (FS-31)* may be submitted. ILEs may be approved when the following issues arise and there is clear documentation that:

- (1) The child is not responding as expected to intervention, despite attempts by the early intervention providers to change interventions;
- (2) The child is suspected of having an ER condition that requires significant change to the intensity, frequency, and methodology of IFSP services;
- (3) The child's progress appears to be impeded with no clear reason for the lack of progress and the IFSP team suspects that additional information will impact the IFSP services and interventions;
- (4) The child's ongoing assessment information is contradictory and the IFSP team seeks guidance to develop appropriate interventions; and/or
- (5) Documentation supports that the IFSP has been implemented with fidelity by all team members, including the parent and the child continues to show a lack of progress.

Requests for an ILE will not be approved for the following issues:

- (1) Child has available or IFSP team seeks medical sub-specialty evaluation (i.e., developmental pediatrics, genetics, neurology, etc.) available. An ILE adds little additional information to the information already available to the IFSP team;
- (2) Eligibility for special education services (Part B) through the local district. While information from KEIS is valuable for the district to use as they process a referral, it is not KEIS' responsibility to conduct additional testing to establish eligibility for future educational placement for the schools. No ILE submitted ninety (90) days prior to the third birthday will be approved;
- (3) Parental desire to obtain a medical diagnosis for future services once the child exits KEIS. ILEs are approved for the impact the information has on current IFSP services—not future services that parents may seek. SCs may assist parents in accessing appropriate resources to obtain this information; or
- (4) Requests do not include current quantitative and/or qualitative data to support the need for the ILE. Data must be specific and consistent with service log documentation and clearly support the position of the IFSP team. Even with coaching as the service delivery method, providers continually assess progress so that the coaching stays relevant for the child's needs and family priority. While working with the family, all providers on the IFSP team must be keeping data on child progress, watching the child for response, and asking the family questions regarding the child's response. Data included should document that the coaching is working to improve the child's participation in daily routines. Data can be observational assessment probes, developmental data (e.g., expressive vocabulary, independent steps, attention span), or reported frequency of

concern area. Documentation must also include the impact of family priority on daily routines (e.g., social-communication skill impact on play, mealtime, bath time, bedtime routines). General statements, vague descriptions and lack of quantitative data are unacceptable. All data included above must be documented in TOTS as updated progress reports. If a progress report has not been entered within three (3) months of the request for ILE, providers must enter an updated progress report to provide most recent on-going progress monitoring data for the child.

**\*Note:** For children with language or speech as the only concern, there must be a current audiology evaluation that definitively identifies level of hearing. An OAE is not sufficient for this purpose.

The need for an ILE should first be discussed with the DCES. If the decision is to submit a request, the SC provides the parent with a *Notice of Action & Consent for Secondary Level Evaluation (FS-30)*, describing that an ILE is for in-depth assessment of the child's developmental status. The parent must give written consent for the ILE as the initial consent for evaluation does not apply to an ILE conducted after eligibility is established.

The TOTS record for the child must be up to date with all information: referral, health, evaluation, family assessment, IFSP screens, plus all service and communication logs. The DCES must review to ensure that all of the required components for an ILE are present and that the request for the ILE is appropriate.

To request an ILE for a child in ongoing services, the *Request for Intensive Level Evaluation (FS-31)* must be completed and faxed to the SLA. Once SLA approval is obtained, the SC must complete the *Record Review Cover Letter & Request (FS-16)* and submit to the designated Record Review Team. The SC must also follow up with the parent to notify them that the ILE has been approved.

If the ILE is not approved by the SLA, the SC must provide the parent with a *Notice of Action (FS-9)* and document in a communication log on TOTS.

The ILE team schedules and enters the ILE results into TOTS within ten (10) business days of referral. Exceptions are communicated to the SC. No shows and same-day cancellations will not be rescheduled. The IFSP team then reconvenes to discuss the findings and revise the IFSP.

### **8.19 Early Intervention Services**

Early intervention services must be provided in the natural environment to the maximum extent appropriate. The federal definition of a natural environment in early intervention is "settings that are natural or typical for a same-aged infant or toddler without a disability, may include the home or community settings". The intent of this law is to include the places children and families spend time, the things they do, the toys they use in play, and the interactions they have throughout the day with the people they spend time with and know best. Removing a child to a one-on-one setting in daycare and/or bringing a toy bag do not meet the intent of this law and thereby does not meet the definition of a natural environment. Natural environments are the places where very young children engage in learning opportunities that promote and enhance their development. Services and supports should encourage opportunities for the development of relationships with children without disabilities and with a variety of adults in the community. These opportunities should also provide typically developing children with the opportunity for positive interactions and relationships with infants and toddlers with disabilities.

Early intervention service providers, particularly the SC, help the family understand the importance of using natural environments and offer assistance to identify natural supports and incorporate those into the delivery of all early intervention services.

Examples of natural environments are:

- (1) Family/Guardian Home;
- (2) Day Care Provider Home;
- (3) Day Care Center (must include typically developing children);
- (4) Early Childhood (EC) Center; or
- (5) Community (library, park, restaurant, etc.).

The natural environment must be documented on the Individualized Family Service Plan page under "Identification of Natural Environments".

In addition, services must be provided in the child's native language. The Cabinet for Health and Family Services (CHFS) requires all programs within the Cabinet to ensure language access services for individuals with Limited English Proficiency (LEP) to have meaningful participation in the programs offered by the CHFS. In KEIS, this can be accomplished by the early intervention provider having the skills to communicate effectively with the family or through the use of a CHFS qualified language interpreter. Language access services must be provided as needed for all services provided in KEIS. Qualified interpretation services must be provided without unreasonable delay and at no cost to the family. KEIS is responsible for providing qualified interpreting services for only those services provided or funded through KEIS. The OCSHCN serves as the fiscal agent for language access services in early intervention.

The provider must coordinate the need for an interpreter with the SC to ensure an approved interpreter is chosen. The provider shall not use an interpreter who is not Cabinet-approved. If there is not an interpreter that speaks the native language of the family or child that provides services through OCSHCN, providers may utilize INTERPRETALK to translate contacts with the family.

### **8.19 (1) Non-natural Environments**

Early intervention service decisions are team decisions; therefore, justification for a service decision that establishes services outside the practice of the principles of natural environments cannot be based alone on parent choice. While the parent provides significant input regarding the provision of appropriate early intervention services, ultimate responsibility for determining what services are appropriate for a particular infant or toddler, including the location and approach of such services, rests with the IFSP team as a whole. The state bears no responsibility for early intervention services that are selected exclusively by the parent, outside of the IFSP team, or those services that are selected outside the bounds of natural environments without clear justification for the choice.

Examples of non-natural environments are:

- (a) Early Intervention (EI) Center/Independent Clinic;
- (b) Hospital Associated Clinic; or
- (c) Other (SC office, parent place of business, school, etc.).

If the early intervention service cannot currently be provided in a natural environment, the SC can temporarily authorize early intervention services in a non-natural environment. The SC should continue to attempt to secure early intervention services in a natural environment. The SC shall document the reason on the IFSP Planned Service Information page in the "Justify for non-natural env." box. Documentation must include:

- (a) Why the IFSP outcomes cannot be achieved satisfactorily in a natural environment;
- (b) How the service provided in this location or using this approach/materials will carry over to support the child's ability to function in the natural environment; and
- (c) A time line when the service is expected to be delivered in a natural environment.

### **8.19 (1) (a) Delivery of Early Intervention Services in a Prescribed Pediatric Extended Care (PPEC) Facility**

PPEC facilities are not natural environments. PPECs are licensed medical facilities that provide necessary specialized care to children who meet the state definition:

"Infants and children considered for admission to the PPEC facility shall be those with complex medical conditions requiring continual care, including but not limited to, supplemental oxygen, ventilator dependence, cystic fibrosis, apnea, spinal cord injury and malignancy, etc. The care provided to these children is specialized child care due to the nature of their medical conditions."

Early intervention services provided in a PPEC must be justified and temporary. Early intervention services provided in a PPEC should be a last resort until a natural environment is secured. The setting choice on TOTS for this location is EI Center/Independent Clinic. SCs must ensure that

providers understand that the payment rate for services at the PPEC is lower than the natural environment rate for services.

### **8.20 Early Intervention Visits**

The hours allotted for service coordination, service assessment and collateral are not included in the hours allowed for early intervention services for the child and family.

IFSP teams need to discuss the distribution of intervention hours with consideration for the implementation of the PSP/Coaching model and the individual needs of the family and child. Other resources or services that the family may be using should also be considered before identifying that an early intervention service is required. For example, it may be appropriate to have more intervention in the beginning of the plan to address critical prerequisite skills or to capitalize on the child's readiness for the skill. Service visits may then become less frequent in response to the child's progress. Other configurations may also be discussed that meet the needs of the family.

If the child needs only one (1) early intervention service, the team can plan for up to twenty-four (24) total hours of intervention for a six (6) month plan. If the child needs more than one (1) early intervention service, the team can plan for up to thirty-six (36) total hours of intervention. Early intervention, services must be limited to one (1) hour per day per discipline per child.

In order to bill for the whole visit, the parent must be an active participant and the child must be awake for the entire session. If a child is sleeping when the early intervention provider arrives and the parent is able to wake the child and get them to engage, the provider may stay and complete the visit. If the provider and parent agree, the provider may stay late to make-up the time that the child was asleep. If this is not possible, the provider should bill for the nearest fifteen (15) minutes down that the child was awake. If the child falls asleep during the session, the visit should end. The provider should bill for the nearest fifteen (15) minutes down that the child was awake. A provider cannot make-up a partial session.

If the child is consistently remaining asleep or falling asleep during scheduled session times, there are two options:

- (1) The provider should discuss with the parent to determine if a different time would be better for the sessions; or
- (2) The IFSP team may meet to discuss decreasing the length of sessions. If the length of sessions is decreased, it may be appropriate to increase the number of sessions.

When early intervention providers see siblings at the same time, they must divide the total time by the number of siblings to determine the amount of time to bill per child.

Personal health and safety is a priority. When a provider or POE staff feel unsafe during an early intervention visit devise a plan to exit the situation. The provider and SC should discuss the situation and determine the best course of action. The SLA may be contacted for additional guidance. See the "Home Visiting Safety Tips" document in the appendix for further reference.

#### **8.20 (1) Co-Treatment**

Co-treatment is when more than one (1) early interventionist provides services for a child and family at the same time. Since KEIS utilizes both the PSP/Primary Coach and the Coaching Models of service delivery, co-treatments are encouraged when more than one (1) provider is on an IFSP. This enables the PSP/Primary Coach the ability to follow-up with the parent and child when the supplemental service is not there. Co-treatments must be entered on TOTS as separate authorizations. An occasional unexpected co-treatment session does not warrant a separate authorization on the IFSP Planned Service Information page; however, the justification for the co-treatment must be documented in the service log.

Payment for co-treatments is limited to three (3) disciplines providing services concurrently. TOTS billing must reflect the same date and time of service for all providers co-treating.

If the child has private insurance as payor 1, each provider must bill insurance according to the requirements of the insurance plan.

### **8.20 (2) Working with Assistants**

KEIS permits two types of assistants to provide early intervention services: Physical Therapy Assistant (PTA) and Occupational Therapy Assistant (OTA). Both must be licensed by the respective board for the profession and work under an enrolled KEIS provider of that discipline. The state regulations for physical therapy (PT) and occupational therapy (OT) delineate the required supervision of assistants.

#### **8.20 (2) (a) PT and PTA**

Physical therapy license regulations require that the supervising PT conduct an evaluation of each child and develop a Plan of Care. The PTA may work with the child and family after the initial evaluation and Plan of Care are completed by the supervising PT. The supervising PT must be available by telecommunication while the PTA is working. PTAs may assist in the collection of assessment data.

PT regulations require reassessment of the child by the supervising PT every thirty (30) calendar days following the last evaluation or subsequent reassessment. The PTA does not need to be present for the reassessment of the child by the supervising PT.

To authorize a PTA on an IFSP, the supervising PT must be authorized at a minimum of one (1) visit per month. Any authorization of the supervising PT less than one (1) visit per month will disqualify the use of a PTA on the IFSP.

If PT is the primary service on an IFSP and there is a PTA on the plan, both the PT and PTA must be marked as PSP/Primary Coach on planned services. This is done with the understanding that the PTA cannot conduct the annual or exit 5AA.

#### **8.20 (2) (b) OT and OTA**

Occupational therapy license regulations require that the supervising OTs provide proper child evaluation and identify and document a Plan of Care. The OTA may work with the child and family after the evaluation and Plan of Care are completed. OTAs are permitted to contribute to the evaluation process by collecting data, administering structured tests, and reporting observations. OTAs are not permitted to independently evaluate a child.

In KEIS, the IFSP team will determine the frequency and length of the service necessary for the child and family to achieve the IFSP outcomes. The total frequency of the service shall be divided between the supervising OT and the assistant. At a minimum, the supervising OT is authorized for two (2) early intervention sessions in the six (6) month plan period. The supervisor must see the child for the initial IFSP service. During the initial early intervention visit the supervising OT shall complete an evaluation of the child and develop a specific Plan of Care to be implemented during the plan period. The initial early intervention visit can be a co-treatment session with the supervisor and assistant. The supervising OT shall see the child at the end of the plan period to complete the progress report. The assistant may contribute to the development of the progress report.

If OT is the primary service on an IFSP and there is an OTA on the plan, both the OT and OTA must be marked as PSP/Primary Coach on planned services. This is done with the understanding that the OTA cannot conduct the annual or exit 5AA.

### **8.20 (3) Working with Student Interns**

#### **8.20 (3) (a) Early Intervention Provider Working with Student Interns**

Any student completing an internship with an enrolled KEIS early intervention provider must submit a Signature on File (RF-23) and Code of Ethical Conduct to the SLA. The student must complete the Record Keeping and Confidentiality training before beginning the placement. The supervising service provider must verify with the SLA that all requirements have been met prior to the first service. Failure to complete all requirements makes the internship null and void.

#### Requirements for KEIS Early Intervention Provider

During the internship, the early intervention provider must provide direct, one-to-one supervision of student-implemented early intervention services at all times. A student is not allowed to provide services without the presence of the supervising early intervention provider.

Prior to the first encounter with the family, including IFSP meetings, service sessions, assessments, etc., the early intervention provider must obtain written consent from the parent for the student to assist with early intervention. As with all early intervention services, prior written notice is required. In Kentucky, prior notice is five (5) working days. The notice and consent form must be developed by the agency, which shall include:

1. A statement that the early intervention provider proposes to have a named student intern participate in future services with the child and family;
2. Consent for the named student to provide early intervention under supervision;
3. A statement that the named student will maintain confidentiality regarding all aspects of the placement (i.e., discussions with the service provider; intervention sessions with the child; family and other adults; written notes or service summaries);
4. Consent to audio or video record sessions, if required by the placement;
5. Consent for the University supervisor to observe, if required by the internship; and
6. A statement that consent is voluntary and may be revoked at any time.

**\*Note:** "Named student" means the specific student must be named on the notice and consent and is only valid for that student.

Once the signed notice and consent is received, the early intervention provider must maintain the original hard copy of the form in the child's record. The provider must submit a copy of the notice and consent to the POE. Documentation of the notice and consent activities (contact with parent, date mailed, date returned, etc.) must be entered in the Communication Log in TOTS.

The early intervention provider must work with the student to develop an internship schedule and assist the student in planning and implementing the early intervention sessions. The provider may share assessment information, the IFSP, service logs or other documentation that may assist the student in familiarizing themselves with the child and family. The student may view the child's record under the provider's TOTS credentials with the provider present.

During the early intervention sessions, the supervising early intervention provider must be present at all times. At no time is a student allowed to work with the child and family independently.

Following the early intervention session, the student may assist the provider in documenting the details of the session. At no time during the internship shall the student have unrestricted access to the child's record in TOTS. The student may view the file under the provider's TOTS credentials with the provider present and may enter service log details as part of one-to-one supervision. If the intern enters the service log, it must include who entered the note and state the supervising provider's approval of the entry. Any written documentation completed by the student must be reviewed and signed by the supervising early intervention provider. The service log must reflect the student intern as a participant in the early intervention session.

#### Requirements for the Student

During the internship, the student must maintain confidentiality in compliance with the IDEA; the Family Education Rights and Privacy Act (FERPA); and the Health Insurance Portability and Accountability Act (HIPAA) in both written and/or verbal communication throughout the placement.

Before working with the family, the student must verify that the supervising early intervention provider received a signed notice and consent from the parent.

The student must ensure that the supervising early intervention provider is present during each session at all times. If at any time the early intervention provider leaves the student alone with a child and/or family, the student must end the session immediately.

The student must be present for all scheduled early intervention visits, unless an emergency arises. In the case of an emergency, the student must notify the supervising early intervention provider as soon as possible. The student will work with the supervising early intervention provider to make-up any lost time.

The student may implement early intervention strategies with the assistance of and under the supervision of the early intervention provider. The student shall participate in feedback sessions with the supervising early intervention provider and/or the university supervisor as required by the university.

Following the early intervention session, the student may assist the provider in documenting the details of the session. At no time during the internship shall the student have unrestricted access to the child's record in TOTS. The student may view the file under the provider's TOTS credentials with the provider present and may enter service log details as part of one-to-one supervision. If the intern enters the service log, it must include who entered the note and state the supervising provider's approval of the entry. Any written documentation completed by the student must be reviewed and signed by the supervising early intervention provider. The service log must reflect the student intern as a participant in the early intervention session.

**\*Note:** An Interim SLP is an individual working in their clinical fellowship year. These therapists do have an interim license; therefore, they are not treated as assistants or interns in KEIS. An Interim SLP may fully enroll in KEIS as a provider.

### **8.20 (3) (b) POE Staff Working with Student Intern**

Any student completing an internship with a POE office must be added to the POE contract as administrative staff. The POE will complete the appropriate addendum paperwork along with a Signature on File (RF-23) and a Code of Ethical Conduct signed by the student. These forms must be submitted to the SLA by mail as the SLA must have original signatures.

Once the paperwork is complete, the SLA will create a TOTS and Adobe account for the student. The student will have thirty (30) calendar days to complete all required trainings. Failure of the student to complete the required training within the specified timeline will render the field or practicum placement null and void.

#### **Requirements for POE Staff**

During the internship, the POE must provide direct supervision of student implemented activities. The POE must work with the student to develop an internship schedule. The student may assist the POE with various activities such as entering referrals into TOTS, hard copy filing, answering phones, attending home visits, etc.

If the student accompanies the POE on a home visit, the POE must obtain written consent from the parent for the student to attend the home visit. As with all early intervention services, prior written notice is required. In Kentucky, prior notice is five (5) working days. The notice and consent form must be developed by the POE, which shall include:

1. A statement that the POE proposes to have a named student intern participate in future services with the child and family;
2. Consent for the named student to attend home visits under supervision;
3. A statement that the named student will maintain confidentiality regarding all aspects of the placement (i.e., discussions with the IFSP team; IFSP meetings, family assessments, child assessments, written notes or service summaries, etc.);
4. Consent to audio or video record visits, if required by the placement;
5. Consent for the University supervisor to observe, if required by the internship; and



6. A statement that consent is voluntary and may be revoked at any time.

**\*Note:** "Named student" means the specific student must be named on the notice and consent and is only valid for that student.

Following the home visit, the student may assist POE staff in documenting the details of the visit. The student may view the file under the POE staff's TOTS credentials with the POE staff present and may enter service log details as part of one-to-one supervision. If the intern enters the service log, it must include who entered the note and state the supervising POE staff's approval of the entry. Any written documentation completed by the student must be reviewed and signed by the supervising POE staff. The service log must reflect the student as a participant of the visit.

Once the internship is over, the POE must submit an addendum to the SLA to have the student removed from the POE contract.

#### Requirements for the Student

The student must maintain confidentiality in compliance with the IDEA; the FERPA; and the HIPAA in both written and/or verbal communication throughout the placement.

Before working with the family, the student must verify that the POE received a signed notice and consent from the parent.

The student must ensure that the supervising POE staff is present during each visit at all times. If at any time the POE staff leaves the student alone with a child and/or family, the student must end the visit immediately.

The student shall be present for all scheduled internship activities, unless an emergency arises. In the case of an emergency, the student must notify the supervising POE as soon as possible. The student will work with the supervising POE to make-up any lost time.

#### **8.20 (4) Family Temporarily Out of State or Country**

A family may take a vacation or trip to a location out of state or out of the country. The trip may be planned or unplanned. If the absence from early intervention services is less than sixty (60) calendar days, the child's case can remain open. While the family is unavailable for early intervention services, the SC must contact the parent every thirty (30) calendar days to ensure that the parent wants to continue early intervention services. The SC must notify the providers when services will resume. The SC must document the contacts with the parent and providers on TOTS.

#### **8.20 (5) Missed Visits**

A missed visit is a visit that the provider had prior knowledge that the family, or provider, would not be able to keep the scheduled appointment. Missed visits should not be routine occurrences and a provider should make every effort to avoid missing service sessions. Missed visits must be offered as make-up sessions to the parent since the IFSP is a binding document. A provider can reschedule a missed visit based upon the guidelines stated below:

- (a) If a weekly or monthly service session cannot be rescheduled within seven (7) calendar days of the original scheduled date, it should be considered a missed visit;
- (b) Never provide a make-up visit on the same date that a regular session has been scheduled if the total amount of time will exceed one (1) hour of service for the day. Do not split the total amount of time of the missed session across several subsequent visits;
- (c) If it is necessary for a provider to miss a number of service visits due to an extended vacation, prolonged illness or injury, etc., the parent should be given the option of selecting another equally qualified provider to fill in during the absence or go without the service for the length of the expected absence;
- (d) Always document in TOTS on the service log the date of the missed visit, the reason for the missed visit and if the visit was rescheduled based on the above guidelines; and

(e) Always bill for a make-up session based upon the actual date of service, not the date of the missed visit.

Should a parent not want to make-up a missed visit, the provider must document this in the communication log.

### **8.20 (6) No Show Visits**

A no show is a visit that was attempted but the parent did not answer the door when the provider arrived. The parent did not give any prior warning or notice of unavailability. There are times when no show visits are unintentional by the parent (emergency situations). Providers may use their own judgment if a make-up visit is offered to the parent. Make-up visits for no shows are optional.

A provider may request to be removed from the IFSP team if habitual no show visits (two (2) or more consecutive visits) occur by a parent. The SC will need to follow-up with the parent to determine the reason for the habitual no show visits and how to best resolve the issue. If a make-up session is provided, it is billed based upon the actual date of service, not the date of the no show visit.

### **8.20 (7) Compensatory Services**

Compensatory services are early intervention services that are awarded to children and families to make-up for early intervention services that were lost due to KEIS failure to provide all services documented in the IFSP. Compensatory services may be awarded when:

- (a) an appropriate service provider is unavailable as documented on the *Early Intervention Service Availability Notice (FS-45)*; or
- (b) the service provider is unable to provide all early intervention services during the existing IFSP.

The parent should inform the POE that they would like compensatory services in writing. It does not have to be a formal complaint. The POE should forward written request to the SLA. The SLA will determine if compensatory services are allowed and if so, how many service visits will be awarded. The SLA will inform the POE of the decision and how to proceed. If compensatory services are awarded, they would be in addition to any ongoing early intervention services already authorized on the existing IFSP. Compensatory services may occur beyond the child's third birthday, depending on when the make-up sessions are awarded. The parent can determine how many of the awarded compensatory services they would like to receive.

### **8.20 (8) Service Limitations**

To act in the best interest of the child and family, providers must implement the PSP/Coaching model, use a professional approach to decision-making, use a proactive approach to service decisions about frequency and intensity, and adapt the planning process to incorporate the required limitations.

In KEIS, the IFSP team must plan services according to the following service hours: if the child needs only one (1) early intervention service, the team can plan for up to twenty-four (24) total hours of intervention for a six (6) month plan; or if the child needs more than one (1) early intervention service, the team can plan for up to thirty-six (36) total hours of intervention.

#### **8.20 (8) (a) Requests for Exception to Service Limitations**

IFSP teams may determine, based upon the unique needs of the child and family, that additional hours are needed to effectively implement the IFSP. The request for additional hours of early intervention services must be a result of the team's documented efforts to utilize all resources available to the family and be in compliance with the payor of last resort provisions of KEIS. IFSP teams may not request services that are not provided by KEIS and are the responsibility of another funding source. KEIS funding will not be used to provide services when a parent chooses to not use the resources available to them outside of KEIS. The team must first clearly identify the reasons for the additional hours of service based upon at least one (1) of the following factors:

1. **Lack of progress:** The child is making little or no progress which is documented on TOTS.

Required documentation to substantiate lack of progress:

- a. Current progress notes that includes data specific to the lack of progress;

- b. Assessment results; and
  - c. Anecdotal notes or observation notes that include data specific to the lack of progress. This is documented in the progress summary on the Progress Report page.
2. **Critical point of instruction:** The child is making progress and with added visits the parent will learn new techniques to move the child to the next level of skills and directly address the priorities of the family and an IFSP outcome. The service increase is expected to be short term and the request for additional hours clearly indicates the need for the additional hours for a period of three (3) months or less. This shows responsiveness to an immediate need. The team will decide on the duration of services and will review any ongoing need when the authorization expires. Documentation must support the critical point of instruction and demonstrate the positive impact of the additional units.
  3. **PSP/Coaching models are implemented:** The IFSP team is implementing the PSP/Coaching model with coaching of the parent as the main service delivery methodology. The documentation is clear that additional hours are necessary to provide the intensity of coaching necessary for implementing the IFSP. The intensity of coaching is determined by the rate of progress demonstrated by the child with increased intensity required when faster progress noted. The distribution of hours should clearly indicate that one (1) provider has been assigned the majority of hours as the PSP/Primary Coach.
  4. **Regression:** The child has regressed in his or her skill development and additional intervention is needed to address the concern. Developmental regression in children is never normal; however, situational skill regression can occur following a period of missed intervention or a reaction to a trauma such as divorce, family death, etc. For example, the provider has not been able to see the child because of hospitalization or long-term illness and the child has regressed due to lack of instruction during that period. The regression has to be more than what is expected when instruction is suspended for a period of time. Consideration for additional hours is based on the use of the “missed” hours before any additional hours are authorized.

The parent must be provided notice and give written consent for the request for service exception by completing the *Notice of Action & Consent for Secondary Level Evaluation (FS-30)*.

Requests for an exception to the service limitations are sent to the Record Review Team. To request consideration of additional hours:

1. The IFSP team must complete the *Record Review Cover Letter & Request (FS-16)* and the *Service Exception Supporting Documentation Form (FS-17)*;
2. Review the request with the DCES;
3. Complete the Record Review page on TOTS; and
4. Submit the completed forms (*FS-16 and FS-17*) to the Record Review Team. Where available, the request must include citation of the peer reviewed research that supports the request. If not available, clinical data must be used to demonstrate the efficacy of interventions utilized to meet the IFSP outcomes.

Within ten (10) calendar days of submitting the request, the Record Review Team will enter recommendations on the Record Review Information page on TOTS. A notification is generated on the SC's announcement page.

**\*Note:** If service limitations are approved by Record Review, they are only valid for the life of the current IFSP. A new request for service limitations must be submitted if the IFSP team determines they are needed at the next naturally occurring IFSP.

### **8.20 (8) (a) 1. Appeal of Record Review Recommendations**

If the IFSP team does not agree with the recommendations from the Record Review Team, an appeal to the SLA may be made. The appeal must be submitted to the attention of the Part C Coordinator. The IFSP team must submit a letter, which clearly states the reasons for disagreement with the recommendations from the Record Review

Team. Additional information may be included but if the Record Review Team did not have access to the newly submitted information, it will not be considered.

Should the IFSP team disagree with the findings of the SLA; the team must reconvene and include a representative of both the Record Review Team and the SLA. If the IFSP team, at the end of this meeting, determines that the services are still needed, an authorization will be issued for the duration of the IFSP plan period.

### **8.20 (9) Group Services**

Group instruction in KEIS refers to a learning environment where multiple children are receiving early intervention services in the same room and interacting with one (1) or more instructors and with multiple peers. Group instruction has a common focus and intervention intent that is needed for the specific group of children enrolled in the group setting.

Parents often enroll their children in group settings such as preschool or childcare. Frequently, early intervention services are provided individually to a child at that group location. The IFSP services are not an integrated component of the group setting—the child’s participation in the group program is coincidental (in other words, the child just happens to be there). The purpose for the child attending the program is not related to the IFSP.

Group instruction is not typically required to achieve early intervention outcomes; however, when considered necessary, the IFSP team may decide to identify group instruction for the child’s services.

The IFSP team must fully discuss the reasons that support the decision to provide an early intervention service through group instruction. Additionally, when considering group instruction for service delivery, the IFSP should answer the following questions:

- (a) Does the child require interaction with peers in order to benefit from the early intervention services provided? Keep in mind the egocentric nature of infants and toddlers. Solitary and parallel play is typical for this age group. Spontaneous peer interactions are limited and, if peer interactions are needed as part of the early intervention service, then adult mediation or facilitation may be required for the full instructional benefit to be achieved.
- (b) Is the child being placed in this group in order to achieve the outcomes identified on the IFSP? Is the purpose of the group specific to children with disabilities or other special needs? Will the time spent in “group” impact the outcome? If “group” instruction is required to achieve the outcome, how will this be achieved when the child is not in “group”? How will the family replicate group instruction if this is the methodology that the child must have to achieve the IFSP outcomes?
- (c) Is group instruction a viable teaching methodology for the age and developmental level of the child? Will the child benefit from less individual instruction/attention that occurs when providing group instruction? What enhancement to learning will this methodology produce that individual instruction cannot provide? The child’s ability to focus on the appropriate model or adult while facing the distractions of other children is critical to ensure effective group instruction.

The decision to provide group instruction is a deliberate decision that supports the specific instructional methodology necessary to teach this child and family. It is not a decision based upon the belief that a child will generally benefit from the group. Typically, all children will gain some level of incidental benefit when in a group learning environment. Early intervention services are comprised of specially designed strategies that are not gained through the typical curriculum of a child care or preschool environment. Group instruction has clear learning objectives that are regularly assessed to validate the effectiveness of the instruction.

It is unacceptable to identify group instruction for the following reasons:

- (a) To provide general benefit;
- (b) To prepare for preschool;
- (c) To provide opportunity for play with peers when communication and social skills are developmentally appropriate for peer interaction; or
- (d) To provide convenience for providers.

Justification for the decision for group services must be documented in the "IFSP Meeting Note" box on the Individualized Family Service Plan page on TOTS.

When a child is authorized for group services, the child must receive the group instruction for the full time authorized for group. Individual services such as OT or Speech cannot be provided during the group instruction time. If a provider delivers individual services during the group session, the group session time must be adjusted to reflect the lack of group instruction while the child was seen individually.

If two (2) providers (individual discipline and group leader of different discipline) are working with the child in order to ensure the child's engagement and participation in the group, this must be indicated as co-treatment. Documentation must support that both early interventionists were addressing the same outcome and skills in a coordinated and planned approach.

#### **8.20 (9) (a) Limitations for Group Services**

1. Group service is not included in the twenty-four (24) or thirty-six (36) hours of early intervention per six (6) months.
2. Children are not eligible for both group and individual services to address the same developmental domain currently on the IFSP (for example: a child cannot be enrolled in group services to address communication concerns and have speech therapy services).
3. A group provider must be approved by the Department for Public Health (DPH) and can practice without direct supervision.
4. The ratio of staff to children in group early intervention is limited to a maximum of three (3) children per professional and paraprofessional per group.
5. Group is limited to an additional forty-eight (48) hours during a six (6) month plan.

#### **8.20 (10) Respite**

Respite services may be provided to the parent for the purpose of providing relief from the care of the child in order to strengthen the parent's ability to attend to the child's developmental needs. The need for respite must be clearly associated with the child who is receiving IFSP services and is required due to the stress on the parent created by the enrolled child. Respite services are not provided due to multiple children in the home or a need for babysitting.

Respite is subject to the following limitations:

- (a) Payment shall be limited to no more than eight (8) hours of respite per month;
- (b) Respite hours are not allowed to accumulate beyond each month; and
- (c) Respite is limited to families in crisis, or strong potential for crisis without the provision of respite.

If an IFSP team determines that respite services are required for a family, the SC notifies the SLA by emailing the child's TOTS identification number to [chfs.firststeps@ky.gov](mailto:chfs.firststeps@ky.gov) with "Respite Request" as the subject. Respite services are documented on the Individualized Family Service Plan page in the "Other Services" box. Respite is not authorized as a planned service.

#### **8.20 (11) Travel Reimbursement**

Travel reimbursement may be a service provided to the parent for the purpose of accessing early intervention services not available in the child's home or other natural environments. Travel reimbursement is limited to covering the cost of transporting the child to appointments and services with an enrolled early intervention provider when services cannot be provided in a natural environment.

If a parent is in need of travel reimbursement, the SC notifies the SLA by emailing the child's TOTS identification number to [chfs.firststeps@ky.gov](mailto:chfs.firststeps@ky.gov) with "Travel Reimbursement Request" as the subject. Travel reimbursement is documented on the Individualized Family Service Plan page in the "Other Services" box. Travel reimbursement is not authorized as a planned service.

## Chapter 9: Assistive Technology

Assistive technology (AT) services and devices are a type of early intervention service as defined by Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Federal and state regulations implementing Part C of IDEA provide for AT devices when these devices are necessary to increase, maintain, or improve the functional capabilities of an infant or toddler in one (1) or more of the following areas of development:

- (1) Motor;
- (2) Communication;
- (3) Cognitive;
- (4) Social-emotional; and
- (5) Adaptive.

The federal definition of AT device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an infant or toddler with a disability. The term does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance or replacement of that device.

The federal definition of AT service is a service that directly assists a child with a disability in the selection, acquisition or use of an AT device. AT services include:

- (1) The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment (natural environment);
- (2) Purchasing, leasing, or otherwise providing for the acquisition of AT devices by children with disabilities;
- (3) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices;
- (4) Coordinating and using other therapies, interventions, or services with AT devices, such as those associated with existing education and rehabilitation plans and programs;
- (5) Training or technical assistance for a child with disabilities or, if appropriate, the child's family; and
- (6) Training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to, or are otherwise substantially involved in, the major life functions of individuals with disabilities (34 CFR Sec. 303.13 (B)(i)).

AT devices can range from items considered low technology to those considered high technology. Low technology devices are items that rely on mechanical principles and can be purchased or made using simple hand tools and easy to find materials. High technology devices include sophisticated equipment and may involve electronics.

**\*Note:** A listing of commonly approved AT devices can be found on the First Steps to Assistive Technology Facebook Group under the file section in a document called *KEIS AT Equipment List*. Since this is a closed group, you must request to join and be approved by the Administrator.

The Individualized Family Service Plan (IFSP) team determines whether AT is necessary to increase, maintain, or improve the functional capabilities of a child, based on an AT assessment completed by an AT provider, or by a provider on the child's team qualified to make that recommendation. Please refer to the *KEIS AT Equipment List* which outlines what each discipline can request. AT devices appropriate for the Kentucky Early Intervention System (KEIS) must be usable by the child and parent independently to meet a developmentally appropriate outcome. Devices are not to be used solely as a therapy tool by an early intervention provider.

### **9.1 AT Process**

The AT provider or other early intervention provider on the child's team makes recommendations as to the AT device needed. If an assessment was authorized and completed related to this process it must be entered in the child's Technology-assisted Observation and Teaming Support System (TOTS) record on the Evaluation/Assessment Information page by the provider. The IFSP team determines whether this is an item that can be rented, and whether rental is a reasonable option for the child. An informed decision is made whether to rent or purchase. IFSP teams are required to utilize short-term rentals or a documented trial of an item to be sure

it is appropriate for a child before purchasing. Refer to 9.4 (2) (d) for further explanation regarding ownership of purchased items.

## **9.2 Notice and Consent for AT**

The first time a parent agrees to obtain AT, the Service Coordinator (SC) must provide the parent a *Notice of Action (FS-9)* and obtain parental consent on the *IFSP Signature Page (FS-15)* that includes the AT. If at any time the parent requests AT that the IFSP team determines is not necessary, then the SC must complete a *Notice of Action (FS-9)* that indicates the reason for denying the parent's request for AT.

If a device is not the initial AT request, but is a replacement or additional device, the SC must complete a *Notice of Action (FS-9)* for a change in IFSP for the device; however, no consent is required.

A provider may use his or her own AT device on a short-term, trial manner in order to determine if it might be appropriate for a child (e.g., trying it out). This does not require an IFSP team decision. Merely trying a device would not trigger a change in the IFSP and does not require *Notice of Action (FS-9)*. The provider notes any discussion with the SC or parent regarding this trial on TOTS.

## **9.3 AT Evaluations**

Children are evaluated for AT in their typical, daily setting rather than in a specialized clinic. This is so the evaluator can base recommendations on the child's functioning in the setting that he or she is most comfortable. This also provides the evaluator the opportunity to see the physical layout of the environment, which may influence recommendations.

Speech therapists, occupational therapists, physical therapists and developmental interventionists who are working with a child on an ongoing basis, are required to continually assess the needs and progress of the child. A therapist may recommend an AT device based upon the documentation of the continual assessment of the child. No authorization is required for this type of AT evaluation.

In-depth evaluations in the natural environment or at an AT Center may be appropriate for some children due to the complexity of needs. An authorization on the IFSP Planned Service Information page on TOTS is required for an AT evaluation.

## **9.4 AT Device Procurement Procedures**

### **9.4 (1) Rental**

- (a) The requesting provider enters an AT justification in the Communication Log stating the specific AT device requested and how the device is linked to the child's outcomes.  
**\*Note:** Rentals must be initiated prior to sixty (60) calendar days of the child aging out.
- (b) SC searches for availability on the Kentucky Assistive Technology Locator website ([www.katsnet.at4all.com](http://www.katsnet.at4all.com)) then contacts the appropriate AT Center to request the device, inquire about the cost of the device and how long it can be rented.
- (c) Once the SC locates an AT Center that has the requested device available for rent, AT Center staff will place a hold on the device. The SC will complete the AT Device page on TOTS, ensuring the estimated cost is listed, and authorize the AT Center on IFSP Planned Service Information page on TOTS. Each device requested must be entered separately.

On the IFSP Planned Service Information page, the SC:

1. Enters the outcome number(s) addressed in "Outcome # (s)";
2. Enters the "Start Date" and "End Date" (date of the approval and plan end date);
3. Ensures that "Accept Service" is checked;
4. Ensures that "Permit Insurance" is not checked for rentals;
5. "Service Name", selects "Assistive Technology Device";
6. "AT Device", chooses one (1) device for each authorization;
7. "Provider", selects the appropriate "Agency" and "Provider";
8. "Method of Delivery", selects "Provide Resource";
9. "Intensity", selects "Individual";

10. "Setting", selects "Family/Guardian Home";
  11. "Frequency", adds frequency number and selects "biannually" (how many months the item will be on loan for the planned period);
  12. "Length", enters one (1) HR;
  13. "Payor", for rentals, chooses "First Steps" as Payor One (1); and
  14. "Note", briefly states the maximum total liability based on the rental price X term.
- (d) Once the AT device has been authorized on IFSP Planned Service Information page, TOTS will send an individual message to the AT Center through the announcement feature. The AT Center will complete a service log noting the AT device and cost of the first month's rental. Subsequently, the AT Center will enter a service log each month of the authorized rental within ten (10) calendar days of the original service day.
  - (e) The AT Center will complete the Account Payable Information page on TOTS each month of the loan.
  - (f) State Lead Agency (SLA) staff will approve or disapprove the loan amount.
  - (g) Once the SLA makes a billing approval decision, TOTS will send a message to the AT Center through the announcement feature, which will include the child's name and other details. The AT Center will also find the device listed as approved or disapproved on the child's Account Payable Information page and on their own agency invoice report.
  - (h) If approved, the AT Center will inform the SC the AT device is ready for pick up or make arrangements for shipping to the Point of Entry (POE) office.  
**\*Note:** AT providers who deliver the AT device prior to the SLA approval, risk the item not being approved for payment.
  - (i) The SC will notify the early intervention provider that the device is ready and ensure that the child receives the device on a timely basis. If the device is delivered by the SC, the parent will be instructed to not use the device until the early intervention provider is present and can train them on how to use it. This is especially important for any type of gait trainer, stander or adaptive seating system. If the early intervention provider chooses to deliver the AT device to the parent, training will occur during that visit and no wait time is necessary.
  - (j) The SC will enter the "Date of Delivery" on the AT Device page on TOTS.
  - (k) The SC is responsible for explaining to the family that:
    1. The AT device is rented from an AT Center contracted with KEIS;
    2. KEIS pays for the monthly rental fees in accordance with the schedule listed below; and
    3. By signing the loan agreement provided by the AT Center, the parent is responsible for the equipment, all accessories and when the device will need to be returned.
  - (l) The SC and early intervention provider are responsible for documenting continued use of AT devices. SC should document in subsequent IFSP's and when items are no longer in use. The provider documents ongoing use in their service logs to aide in future purchase requests.

**9.4 (1) (a) Rental Fees and Lengths**

The purpose of renting an AT device is for short-term use for a child whose needs will change quickly and for trial periods to determine if the device is appropriate before purchasing. Rental fees must not exceed the cost of the item. If rental fees are within \$25 of the purchase cost of the item, then a request for the purchase of the AT device must be made on the AT Device page on TOTS.

Loaned AT devices should be evaluated on a regular basis to ensure the device is being used to avoid unnecessary rental fees. If the IFSP team determines the device will be needed beyond the maximum rental, a purchase request must be submitted after a two (2) month successful trial.

**9.4 (1) (a) 1. Fees**

Items valued up to \$100	\$10 per month
Items valued between \$101-\$250	\$25 per month
Items valued between \$251-\$500	\$35 per month
Items valued between \$501-\$1,000	\$50 per month
Items valued between \$1,001-\$2,500	\$75 per month
Items valued between \$2,501-\$5,000	\$100 per month



#### **9.4 (1) (a) 2. Length of Rentals**

Recommended lengths for trial use vary based on the cost of the device.

Under \$100	1-4 month loan
\$100 - \$500	1-8 month loan
\$500 & up	1-10 month loan

#### **9.4 (1) (b) Items Not Approved for Rental**

1. Software;
2. Bath chairs;
3. Eating utensils; and
4. Weighted vests or blankets.

#### **9.4 (1) (c) Return of Rented AT Devices**

It is the SC's responsibility to pick up the AT device when; the loan period is over, the device is no longer in use or the child exits KEIS, whichever is sooner.

1. The SC will complete the AT Device page on TOTS to indicate the final "Disposition" of the device; and
2. The SC will document the return date and circumstances on the AT Device page on TOTS and in the service log.

If the SC is not able to recover the rental device or accessories, per the loan agreement from the AT Center signed by the parent, the parent will be billed by the AT Center for the listed value for the unreturned equipment.

**\*Note:** The AT Center and the POE must communicate about the return of an AT device to ensure that the correct AT device is delivered or picked-up by the courier service.

#### **9.4 (2) Purchase of the AT Device**

KEIS will not consider purchase of AT device(s) regardless of cost during the ninety (90) days prior to the child's third birthday. Other payor sources must be exhausted prior to purchase of the device(s) with KEIS funds. Please refer to The Buck Starts Here – A Guide to Assistive Technology Funding in Kentucky ([http://www.katsnet.org/docs/The\\_Buck\\_Starts\\_Here\\_2013.pdf](http://www.katsnet.org/docs/The_Buck_Starts_Here_2013.pdf)).

To request purchase of an AT device:

- (a) The SC informs the requesting provider that they must enter an AT justification in the communication log stating the specific device requested and how the device is linked to IFSP outcomes;
- (b) The SC contacts the AT Center to determine the estimated price of each device and enters this on the AT Device page on TOTS;
- (c) The SC seeks funding through all other possible sources, including the child's private insurance or Medicaid and agencies that offer on-going grant opportunities, such as civic organizations, community groups, churches, and clubs;
- (d) If the SC finds that there is another payor source, this is documented in the SC's service log and the family and provider are notified. The item is ordered by either the SC or the physician. In some cases the provider will place the order. There is no planned service entry for a device in this circumstance. The AT device information is included on the IFSP page under item number six (6), "Other Services";
- (e) Before determining that KEIS is the only payor available, the SC must document two (2) alternative funding denials in the service log in addition to the private insurance denial. Documentation must be specific and include who they spoke with, agency name and reason for denial. Gait trainers, standers and adapted seating are considered durable medical equipment (DME) and would typically be purchased through private insurance or Medicaid. If initially denied, the AT Review Team suggests that it be resubmitted or appealed if time permits. Medicaid or Medicaid Managed Care Organizations shall not be included as funding denials;
- (f) If the SC finds that KEIS is the only payor available, then the SC documents the device on AT Device page on TOTS. Each device requested must be entered separately;
- (g) If a single item costs less than \$100, the SC completes the screen and the planned services;

- (h) Authorized AT Center submits a service log for approval of purchase cost, shipping and additional administrative fees;
- (i) SLA will approve or disapprove the purchase of the device; and
- (j) If approved, the AT Center will purchase the device and coordinate delivery or pick-up with the POE.

#### **9.4 (2) (a) Purchases over \$100**

If any single device costs over \$100, it must be approved by the AT Review Team prior to purchase. When the SC saves the request date and other information on the AT Device page on TOTS, TOTS supplies the child's information for monitoring to the SLA under a link entitled "AT Requests Awaiting Approval". The SC will be prompted to forward the *Assistive Technology Purchase Request (FS-42A)* and the *Assistive Technology Purchase (FS-42B)* to the requesting provider for completion and submission. The AT Review Team will review the case within ten (10) working days of receipt of the completed request. When the SLA chooses "Approve" or "Reject", TOTS will send an individual message directly from TOTS to the SC notifying them of the committee's decision. The AT Review Team will also notify the SC and the AT Center of the team's decision and any pertinent information needed to proceed.

#### **9.4 (2) (b) Purchase Approved**

If the SC receives notification that the purchase is approved, the AT Center will be authorized on planned services.

The SC will:

1. Enter the outcome number(s) addressed in "Outcome # (s)";
2. Enter "Start Date" and "End Date" (date of the approval and plan end date);
3. Ensure that "Accept Service" is checked;
4. Do not check "Permit Insurance";
5. "Service Name", select AT Device;
6. "AT Device": User chooses one (1) device for each authorization;
7. "Provider", select the appropriate Agency and Provider;
8. "Method of Delivery", select Provide Resource;
9. "Intensity", select Individual;
10. "Setting", select Family/Guardian Home;
11. "Frequency", enter one (1) time biannually;
12. "Length", enter one (1) HR; and
13. "Payor": for purchases, always choose First Steps as Payor One (1).

Once the AT device has been authorized on planned services, TOTS will notify the AT Center through the announcement feature. The AT Center will complete a service log for each AT device authorization, which will display the device name. There may be multiple AT device authorizations. The AT Center will complete the billing on the Accounts Payable Information page with the total cost for each device plus administrative fees. SLA staff will review the request and approve or disapprove the purchase amount on the Account Payable Information page.

The AT Center will find the payment listed as approved or disapproved on the child's record and on their Agency Invoice Report. Once the SLA makes the billing approval decision, TOTS will notify the AT Center. If approved, the AT Center will order the item and deliver or ship to the SC when received.

**\*Note:** AT Centers who order devices prior to the SLA approval, risk the device not being approved for payment.

The SC arranges for delivery to the parent by the requesting provider who will show the parent how to use it. The SC enters the date of delivery on the AT Device page on TOTS. If applicable, the SC is responsible for informing the parent that AT devices purchased with state general fund dollars are the property of KEIS and must be returned or purchased at a depreciated cost when the child turns three (3). Refer to 9.4 (2) (d).

The SC is responsible for documenting the continued use of AT devices on their service logs and subsequent IFSP's, and for documenting when items are no longer in use. If the item was purchased by KEIS, the SC will follow procedures for the return of a purchased AT device.

**9.4 (2) (c) Purchase Not Approved**

If the purchase is NOT approved, the SC will notify the parent and other team members of this decision, and alternative strategies will be discussed. If the IFSP team does not agree, a written appeal may be made to the Part C Coordinator clearly stating the reasons for disagreement.

**9.4 (2) (d) Return of Purchased AT Devices**

It is the SC's responsibility, as part of transition planning, to discuss options with the parent when the item is no longer in use, or when the child exits KEIS, whichever is sooner. There are five (5) choices to document disposal of items:

1. If the child has Medicaid, the device remains with the child and parent.
2. Return to the POE Office: SC will return the device to the POE Office, which may reuse, refurbish or destroy. In this case the SC must pick up the item when the child exits KEIS or when the item is no longer in use, whichever is sooner. If the item is reused, it must be by a child currently enrolled in KEIS.
3. Purchased by Family/School at depreciated cost: The SC is notified of the intent to purchase the device. The SC then contacts the SLA of the intent to work with the buyer to complete the purchase.
4. Lost/Destroyed: Parent lost device or it was destroyed.
5. Not Returnable Due to Sanitary Reasons (example: bath chair, feeding utensils).

The SC documents the return date and circumstances on the AT Device page on TOTS, in the service log, on any future IFSP or the Transition/Exit Information page.

**\*Note:** The AT Center and the POE must communicate about the return of an AT device to ensure that the correct AT device is delivered or picked-up by the courier service.

## Chapter 10: Transition

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires that certain steps be taken when a child transitions out of Part C services at age three (3). The transition process begins at the initial Individualized Family Service Plan (IFSP) and is addressed throughout the Kentucky Early Intervention System (KEIS) process and at each IFSP team meeting.

IDEA requires each state to have policies and procedures to ensure a smooth transition for toddlers receiving early intervention services to preschool or other appropriate services, including a description of how KEIS will notify the Local Education Agency (LEA) that the child will shortly reach the age of eligibility for preschool services under Part B.

IDEA also requires the lead agency to convene a conference, with the approval of the parents, which includes the IFSP team and the LEA at least ninety (90) days before the child turns three (3) to discuss any special education services that the child may be eligible to receive from the LEA. The conference may be held as early as nine (9) months before the third birthday.

These federal policies also require the Kentucky Department of Education (KDE) to ensure that:

- (1) Children served under Part C who are eligible for Part B preschool programs experience a smooth and effective transition to those preschool programs by the child's third birthday;
- (2) An Individualized Education Program (IEP) with appropriate content has been developed and implemented for the child; and
- (3) Each LEA participates in transition planning conferences arranged by KEIS.

For those children and families experiencing a transition into or within KEIS:

- (1) The Service Coordinator (SC) must identify the specific nature of the transition with the family through the family assessment process and then discuss this with the other team members; and
- (2) The IFSP team must discuss how services will be provided (or what modifications are needed) to facilitate a smooth transition and to ensure that there will be no unnecessary disruption in services for the eligible child and family. The discussion leads to at least one (1) transition outcome, which is documented in the IFSP.

In addition to the actual transition that all newly referred children and families experience, some other examples of transitions include:

- (1) Significant family or child changes:
  - (a) impending birth of a new child;
  - (b) family relocation or job change;
  - (c) enrollment or change in childcare;
  - (d) unemployment;
  - (e) divorce or marriage; or
  - (f) long term illness of a child; and
- (2) Terminating one (1) or more services and the child is continuing in KEIS.

### **10.1 Notification of Directory Information to KDE and LEA**

IDEA Part C regulations require that the Part C lead agency... "notify the local educational agency for the area in which the child resides that the child will shortly reach the age of eligibility for preschool services under Part B of the act..."

The interagency agreement between the State Lead Agency (SLA) and the KDE requires that the SLA notifies the KDE of any children ages two (2) or above. The KDE sends the list of children who are potentially eligible for special education services to the appropriate LEA. It is important that all options, including a referral to the local school for Part B special education services, be considered and discussed with the family.

The *Transition Notice & Consent (FS-11)* must be completed at intake and reviewed with the parent at each IFSP meeting.

Parents are informed of the release of directory information to the KDE and the LEA once the child nears age two (2) or when they enroll after age two (2). Children who are older than two (2) when enrolled in KEIS will be included in the next quarterly list provided to KDE. Parental consent is not required for KEIS to release directory information; however, if a parent does not want directory information released to KDE and the LEA, Section 1 of the *Transition Notice & Consent (FS-11)* must be completed.

If the parent completes and signs Section 1 of the *FS-11*, the SC must uncheck item #2 "Is child potentially eligible for Part B?" on the Transition/Exit Information page on the Technology-assisted Observation and Teaming Support System (TOTS). If Item #2 is not unchecked, the directory information will be sent to the KDE and LEA.

### **10.2 Parent Elects to Opt-Out of Transition Process**

SCs must fully inform the parent of the purpose of the transition conference so that the parent can make an informed decision about services after the child exits the program. The parent has the right to:

- (1) Participate in the transition conference and provide consent to invite the local school system;
- (2) Participate in the transition conference and deny consent to invite the local school system; or
- (3) Not participate in the transition process (Opt-Out).

The SC must make changes to TOTS depending upon how the parent completed the *Transition Notice & Consent (FS-11)* form:

- (1) If the parent completes Section 2.A, the SC completes #4, "Date Parent Consent to Convene Transition Conference" on the Transition/Exit Information page on TOTS. Completion of the *FS-11* must also be documented in a service log.
- (2) If the parent completes Section 2.B, the SC completes #4, "Date Parent Consent to Convene Transition Conference" on the Transition/Exit Information page on TOTS. Completion of the *FS-11* must also be documented in a service log.
- (3) If the parent completes Section 2.C, the SC must check the box at the top of the Transition/Exit Information page on TOTS, "Family Refuses Participation in Transition Process". Once this box is checked, the transition information on this page will be disabled. Completion of the *FS-11* must also be documented in a service log.

### **10.3 Scheduling the Transition Conference**

Transition steps must be developed that identify appropriate options for the child and family including private preschool, Head Start, Early Head Start, child care, or other community early childhood programs.

The SC's responsibility is to schedule and convene a transition conference between the child's two year, three month (2 yr., 3 mo.) age and two year, nine month (2 yr., 9 mo.) age in order to meet the timelines for Part B eligibility determination and IEP development. This should be part of the periodic IFSP meeting. On the Transition/Exit Information page, item #3, "Transition Conference Shall be Held Between" indicates the timeframe when the transition conference must occur.

SCs should begin scheduling the transition conference early enough (at least one (1) month before the desired meeting date) so that the LEA representative can be present. Notification to the school district personnel must be provided at least two (2) weeks before the meeting, if possible.

If the LEA does not participate in the conference, the SC must still hold a transition conference at least ninety (90) days (and at the discretion of all parties, nine (9) months) prior to the child's third birthday and have invited the LEA representative to the conference. The transition conference is waived only if the parent has opted-out of the transition process as documented on the *Transition Notice & Consent (FS-11)*.

The SC must send an *IFSP Meeting Notice (FS-14)* at least seven (7) calendar days prior to the meeting to the parent, LEA representative, and any other community agency representative that the parent wishes to invite. Early intervention providers are notified of the meeting by a message sent through the TOTS Scheduling Tool. The SC must ensure that the parent signs the *Consent to Release/Obtain Information (FS-10)* so information can be shared with the LEA.

IDEA, Part B states "By the third birthday of such a child, an Individualized Education Program (IEP) ...has been developed and is being implemented for the child." Because of the requirements to provide a Free Appropriate

Public Education (FAPE), LEAs must have the evaluation completed and IEP implemented by the child's third birthday. The LEA must provide the team with all available service delivery options for the child. The LEA must also obtain parent consent and conduct a multidisciplinary evaluation of the child to determine eligibility for Part B services.

**\*Note:** It is the LEA's responsibility to attend the transition conference. The conference must be held no later than ninety (90) calendar days prior to the child's third birthday, even if the LEA is unable to attend.

#### **10.4 Conducting a Transition Conference**

The purpose of the transition conference is to discuss and develop steps for the upcoming transition of the child from Part C. The discussion must include a plan for exiting Part C and a review of the child's options upon their third birthday.

Other community partners such as community preschool agency representatives, Head Start, community or private childcare agencies, etc. may be invited to the transition conference. This is their opportunity to describe the services provided by their agency and answer any questions the parent may have.

SCs are responsible to ensure that parents are provided the following information during the transition conference:

- (1) A description of the Part B eligibility definitions;
- (2) Part B's timelines and process for consenting to an evaluation and conducting eligibility determinations; and
- (3) The availability of special education and related services.

This requirement is accomplished by the provision of this information by the LEA representative or by giving the parent the *KEIS Transition: Part B Special Education Fact Sheet (FS-49)*.

#### **10.5 Documenting the Transition Steps**

The naturally occurring IFSP meeting that includes the transition conference must be documented following the procedures outlined in Chapter 8. The procedures below indicate how to identify this meeting as the official transition conference.

The SC must:

- (1) Complete the Individualized Family Service Plan page on TOTS by documenting that the meeting is the official transition plan by selecting "Yes" under item #2 "Official Transition Plan?" Once the transition box is marked, the information that is entered into the "IFSP Meeting Note" box will transfer to the Transition/Exit Information page on #9, "Transition Meeting Note";
- (2) Document the discussions that have taken place with the family regarding transition from KEIS in item #9, "IFSP Meeting Note" box; Documentation must include the following:
  - (a) Procedures the team will use to prepare the child for the upcoming transition:
    1. Discussions about the steps and services necessary to prepare the child and parents for changes in service delivery;
    2. Discussions with parents regarding future placements and other matters related to the child's transition; and
    3. Discussions with parents regarding community programs available following transition from Part C;
  - (b) Program options identified by the team. Possible options include but are not limited to:
    1. Part B;
    2. Head Start/Early Head Start;
    3. Child Care;
    4. Medicaid EPSDT services; and/or
    5. Other community resources; and
- (3) Complete #1-8 of the Transition/Exit Information page. The SC is responsible to ensure that all elements identified throughout the transition conference are properly implemented.

### **10.6 Admissions and Release Committee (ARC) and IEP Participation by IFSP Team Members**

Part B regulations require the LEA to invite a representative of the Part C program to the IEP meeting if the parent requests their attendance. Many LEAs hold two (2) ARC meetings; the first ARC is to discuss the referral and plan the Part B evaluation and the second ARC meeting is to develop the IEP.

The SC must make every effort to participate in the ARC meetings if invited by the LEA at the request of the parent. The SC documents attendance or inability to attend in a service log or communication log on TOTS.

The Primary Service Provider (PSP)/Primary Coach may attend one (1) ARC meeting at the expense of KEIS. The IFSP team needs to determine which meeting is most appropriate for the PSP/Primary Coach to attend at KEIS cost. If the PSP/Primary Coach is unable to attend, another early intervention provider on the IFSP team may be authorized on the IFSP Planned Service Information page on TOTS to attend the ARC meeting.

### **10.7 Exit IFSP Meeting**

To support a smooth transition from KEIS, an exit IFSP meeting may be held. Discussions at this meeting should focus on the results of the exit Five Area Assessment (5AA), review of the current developmental status, review of the progress the child and parent has achieved, and review of the supports and services available after age three (3). This meeting is optional and provides closure to the parent as they exit KEIS.

Once the Exit IFSP has been scheduled, the SC must send participants an *IFSP Meeting Notice (FS-14)* at least seven (7) calendar days prior to the meeting. This is documented in the communication log on TOTS.

The SC must ensure:

- (1) The exit 5AA has been conducted, that the report is entered on TOTS and that a copy has been provided to the parent; and
- (2) Providers have completed discharge summaries and mailed a copy to the parent at least five (5) working days prior to the meeting.

# **Chapter 11: Case Closure & Transfers**

## **11.1 Record Closure Before Age Three (3)**

There are numerous reasons why a case would need to be closed prior to the child's third birthday. These reasons can occur at different stages in the process. Examples of child exiting prior to age three (3) include:

- (1) All outcomes are met and the child is no longer eligible (age-appropriate);
- (2) Parent declines services or withdraws;
- (3) Child is deceased; or
- (4) Family or child moves out of state or country.

If the child experiences early transition from the Kentucky Early Intervention System (KEIS) and the Individualized Family Service Plan (IFSP) team is aware of this transition, an exit Five Area Assessment (5AA) must be completed prior to the child's exit and case closure at the Point of Entry (POE). Exceptions to this requirement are children who are in the program six (6) months or less or who is deceased. The exit 5AA is administered if no 5AA has been conducted within the previous ninety (90) calendar days. The Service Coordinator (SC) completes the authorization and contacts the Primary Service Provider (PSP)/Primary Coach. The PSP/Primary Coach schedules and conducts the exit 5AA, enters the item level data in Kentucky Early Childhood Data System (KEDS), enters the assessment report on the Technology-assisted Observation and Teaming Support System (TOTS) and mails a copy of the report to the parent. If possible, the exit 5AA must be completed at least thirty (30) days prior to exit.

Early intervention providers serving an exiting child enters a Discharge Report on the Progress Report page on TOTS at least five (5) working days prior to the exit. The discharge report states the intervention that the provider did with the child, the child's progress, outcomes achieved, and where the child is functioning at the time of discharge.

If a child exits KEIS without notification to the POE and the child/parent cannot be found, document this in the communication log as the reason no exit 5AA was conducted. However, discharge progress reports must still be written by each early intervention provider and placed in the Progress Report page on TOTS at least five (5) working days prior to case closure.

If a child exits KEIS before age three (3) for any reason, does not have an active IFSP, and the parent contacts the Local Education Agency (LEA) for services, the LEA will handle this case as a new referral to them. The LEA is not obligated to have an evaluation and Individualized Education Program (IEP) in place by the child's third birthday for a child without an active IFSP.

### **11.1 (1) Closure if Hearing Status Cannot be Confirmed**

The hearing component is necessary in order to determine the appropriate procedures for an initial evaluation. The hearing component is satisfied by either passing an Otoacoustic Emissions (OAE) screening or completing an audiological evaluation. If the child fails an OAE screening an audiological evaluation is required. The POE will offer to refer the family to the Office for Children with Special Health Care Needs (OCSHCN) or the parent can choose to follow-up with an audiologist or physician of their choice.

If the parent chooses to follow-up with their own audiologist or physician and is unable to schedule and complete the follow-up on the child's hearing for more than ten calendar (10) days, the POE staff discusses with the parent the need to close the case and reopen the case after the follow-up is completed. The parent needs to understand that without valid hearing results, the child cannot be further evaluated and eligibility cannot be determined. Provide the parent with a *Notice of Action (FS-9)*, indicating that the POE refuses to evaluate the child due to the lack of confirmed hearing status, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS. On the Transition/Exit Information page on TOTS, the SC must enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.



### **11.1 (2) Closure if Parent Cannot be Contacted**

Referral Phase: If the POE staff is unable to contact the parent by phone the *Unable to Contact Referral Letter (FS-4)* should be mailed to the parent. If the parent does not respond within five (5) calendar days of the date of the letter, the file is closed. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

IFSP Phase: If the parent cannot be contacted for early intervention services, the service provider notifies the SC. The SC attempts to contact the parent. If the SC is unable to make contact with the parent within five (5) working days, the SC sends the parent a *Notice of Action (FS-9)* indicating the services will end five (5) working days from the date of the notice and reason for case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

### **11.1 (3) Frequent Re-Scheduling By Parent**

Parents may have the occasional need to re-schedule appointments. Repeated requests to re-schedule because the parent is unable to attend may impact services. SCs may close a case after three (3) documented, consecutive attempts to re-schedule an event such as home visits, evaluation and assessment (including a hearing evaluation) or IFSP meeting with a parent.

For example:

- (a) An IFSP meeting is initially scheduled for June 10; parent cancels this meeting;
- (b) Meeting is re-scheduled for June 15; parent cancels this meeting; and
- (c) Meeting is re-scheduled for June 20; parent cancels for the third time.

The SC sends the parent a *Notice of Action (FS-9)* indicating the services will end five (5) working days from the date of the notice and the reason for case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

**\*Note:** If the parent contacts the SC within the five (5) working days to reschedule the appointment, this should be documented and the case proceeds as planned. If the scheduling barrier with the provider cannot be resolved, the provider may discharge the child from their caseload and notify the SC of this action. The SC then must seek another provider to accept the case. If the parent contacts the SC after the five (5) working days and wants to reschedule, because the case has been officially closed, this will be considered a re-referral.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

#### **11.1 (4) Child Not Available for Scheduled Services ("No-Show")**

There are times when a service provider may go to the home for a previously scheduled visit to deliver early intervention services, no one is there and the parent has not notified the provider that the session must be cancelled. If this happens for two (2) consecutive visits, the provider documents the "no-shows" in a service log on TOTS and contacts the SC. The SC must contact the parent to discuss the circumstances for the absence and come to a resolution of the barrier.

**\*Note:** Providers are not obligated or mandated to make up any "no-show" visits. It is left to the provider's discretion as to if the visit is made-up.

If the SC is successful in contacting the parent, the information concerning the absence is shared with the provider. If the barrier cannot be resolved, the provider may discharge the child from their caseload and notify the SC of this action. The SC then must seek another provider to accept the case.

If the SC is not successful in contacting the parent within five (5) working days, the SC sends the parent a *Notice of Action (FS-9)* indicating the services will end five (5) working days from the date of the notice and the reason for case closure with the following documents included in the letter:

- (a) the *Notice of Record Destruction (FS-32)*; and
- (b) the *Parent's Rights in Kentucky's Early Intervention System First Steps* brochure. Document the provision of the notices and request form to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

#### **11.1 (4) (a) Pattern of Inconsistent "No-Show"**

A parent may consistently, but not consecutively "no-show". In these cases, the provider needs to report the frequent missing of services without notification by the parent to the SC.

The SC attempts to contact the parent to investigate the barriers to implementing the IFSP. Discussion should focus on the following:

1. Does the parent need and want the service(s) in question;
2. Does the current number of sessions work for the parent;
3. Does the location of the services need to be discussed and revised; and
4. Does the parent understand their responsibilities to implement the IFSP and be available for service delivery?

The IFSP must be revised as appropriate and needed based on the SCs discussion with the parent. The discussion should be documented in the service log on TOTS.

If the SC is not successful in contacting the parent within five (5) working days, the SC sends the parent a *Notice of Action (FS-9)* indicating the services will end five (5) working days from the date of the notice and the reason for case closure with the following documents included in the letter:

1. the *Notice of Record Destruction (FS-32)*; and

2. the Parent's Rights in Kentucky's Early Intervention System First Steps brochure. Document the provision of the notices and request form to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Attempts to Contact Unsuccessful" from the "Exit/Close Reason" drop-down menu.

#### **11.1 (5) Child Moves Out of State**

If the parent notifies the SC that the child is moving out of state, the SC and parent determine date services will end. Within five (5) working days from the termination date, the SC sends the parent a *Notice of Action (FS-9)* indicating case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

There may be instances when a family moves without notifying the SC or other POE staff. The PSP/Primary Coach may know of the move or in some cases, will not know. When the POE finds out that a family has moved, there must be documentation of attempts to locate the family. All attempts to contact the parent must be documented in the communication log on TOTS. If the parent is located, the SC and provider(s) must follow the steps above. If the parent is unable to be located, the SC must notify each provider of the case closure and document the notification on TOTS. The SC should remind the providers to enter a Discharge Report on the Progress Report page on TOTS.

On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Moved out of POE/State/Country" from the "Exit/Close Reason" drop-down menu.

#### **11.1 (6) Child Temporarily Out of State or Country for Extended Period**

A family may take an extended vacation or trip to a location out of state or out of the country. The trip may be planned or unplanned. The child's case is closed if the child will not be available for services for more than sixty (60) calendar days. The SC sends the parent a *Notice of Action (FS-9)* indicating case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS.

SCs must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Moved out of POE/State/Country" from the "Exit/Close Reason" drop-down menu.

#### **11.1 (7) Parent Withdrawals from Services**

When a parent notifies the SC that they no longer wish to participate in KEIS, the SC sends the parent a *Notice of Action (FS-9)* indicating case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the provision of the notices and request form to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

**\*Note:** An exit 5AA must be completed if the child has received at least six (6) months of early intervention services from the initial IFSP date. If the parent declines the exit 5AA, this is noted in the communication log on TOTS.

The exit date will be the sixth (6<sup>th</sup>) working day from the date the *Notice of Action (FS-9)* was sent to the parent. On the Transition/Exit Information page on TOTS enter the "Exit/Close Date" and select "Parent Withdraw" from the "Exit/Close Reason" drop-down menu.

### **11.1 (8) Child Determined No Longer Eligible**

If a child is determined no longer eligible for early intervention services, due to IFSP goals met or ineligibility at annual re-determination, the SC calls the early intervention providers on the plan to notify them of the decision and ensure that they will complete their Discharge Reports and enter all documentation on TOTS because the record will soon be inactive.

The SC will contact the parent to notify them of the decision and that current early intervention services will stop. The parent is given the option to receive one final service from each provider on their current plan if they choose. Provide the parent a *Notice of Action (FS-9)*, indicating that the POE refuses to develop an IFSP because the child is not eligible, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. This action is documented in a communication log.

On the sixth (6<sup>th</sup>) working day from the date the *FS-9* was sent, the SC will:

- (e) Prepopulate a Requested Review IFSP;
- (f) Complete the "Eligibility Decision Justification" box on the Eligibility Information page on TOTS explaining the reason the child is no longer eligible for service;
- (g) Enter a new date for the "Determination Date"; and
- (h) Change the "Part C Eligible Decision" reason from "Eligible" to "Ineligible".

Once ineligible is marked as a choice on the Eligibility Information page, the file is immediately made inactive. The "Determination Date" will default as the "Exit/Close Date" on the Transition/Exit Information page on TOTS and "IFSP Goals Met" will show as the "Exit/Close Reason".

### **11.1 (9) Closure for a Deceased Child**

If a child passes away while enrolled in KEIS, the SC must complete the Transition/Exit Information page on TOTS by entering the "Exit/Close Date" and select "Deceased" from the "Exit/Close Reason" drop-down menu. Discharge reports are not necessary.

## **11.2 Record Closure at Age Three (3)**

On the third birthday, the child's eligibility for KEIS ends. At least five (5) working days before the child's third birthday, the SC sends the parent a *Notice of Action (FS-9)* indicating case closure, the *Notice of Record Destruction (FS-32)*, and the Parent's Rights in Kentucky's Early Intervention System: First Steps brochure. Document the notices and request form were provided to the parent in the child's record on TOTS.

The SC must notify the provider(s) of the effective date for termination of services and remind them to enter a Discharge Report on the Progress Report page on TOTS. The provider mails the Discharge Report to the parent

along with notification and request forms for destruction of records. The provider documents all attempts to contact the parent, mailing of the Discharge Report and destruction of records notification and request in the child's record on TOTS.

The SC must close the case within fifteen (15) calendar days of the exit date using the following procedures:

- (1) Ensure that all service notes, exit assessments, and discharge reports have been entered into TOTS; and
- (2) Make the chart inactive by entering information on the Transition/Exit Information page on TOTS:
  - (a) "Exit/Close Date": enter the effective close date. This date should be the date the child turns three (3). No other early intervention services can be provided for the child after this date;
  - (b) "Exit/Close Reason": select the reason for exit from the drop-down menu. If the child was referred for Part B eligibility determination, the SC is required to ascertain the status of the child in order to accurately indicate the reason for exit; and
  - (c) After the exit information is entered, the SC saves the information that has been entered. Once the save button is selected, the child's record is inactive.

**\*Note:** There must be an exit reason chosen and documented on TOTS on the Transition/Exit Information page on TOTS. This data is reported to the U.S. Department of Education.

Please use the following choices for "Exit/Close Reason". All cases must have a reason for closure. Identify the primary reason (e.g., only one):

Drop-Down Choice on TOTS	Definition
Part B Eligible	The child has been referred to and is eligible for the public school Part B/Preschool program. <ul style="list-style-type: none"> <li>• Part B Eligibility is confirmed.</li> <li>• Use this even if parents choose to not enroll child in public school program; child was still found eligible.</li> </ul>
Not eligible for Part B-Exit to Other Program	Use when the child is no longer age eligible for Part C: <ul style="list-style-type: none"> <li>• Child referred to Part B for eligibility and found not eligible; or</li> <li>• Parent Opted-Out of transition.</li> </ul> Child/family has been referred to (or parents plan to enroll in) private services, childcare, Head Start or other community program.
Not Eligible for Part B-Exit with No Referrals	The child is no longer eligible for Part C and no further referral is necessary. <ul style="list-style-type: none"> <li>• Child did not undergo eligibility determination for Part B services (parents opted out or decided to not refer to the LEA).</li> </ul>
Part B Eligibility Not Determined-Late Referral	Child referred to Part C forty-five (45) calendar days or less prior to the third birthday.
Part B Eligibility Not Determined-Other	Child was referred to Part B for eligibility determination and it was not completed by the third birthday.  <b>*Note:</b> The above statement is the only time this should be chosen.
IFSP Goals Met	This applies to: <ul style="list-style-type: none"> <li>• A child who no longer has a developmental delay; or</li> <li>• A child who has an Established Risk Condition and is age-appropriate and/or has met all IFSP outcomes; or</li> </ul>

Drop-Down Choice on TOTS	Definition
	<ul style="list-style-type: none"> <li>A child whose parents state they no longer want services because child is doing well and they feel the IFSP is met.</li> </ul> <p><b>*Note:</b> This reason will be automatically selected by the system when a child is determined ineligible at annual redetermination of eligibility.</p>
Moved out of POE/State/Country	<p>The child and family have moved to another state, POE, or country.</p> <ul style="list-style-type: none"> <li>Include children whose family indicates that they will be moving in the near future as the reason for withdrawing from service.</li> </ul>
Deceased	<p>The child has died.</p> <ul style="list-style-type: none"> <li>Include all children who died during the reporting year, even if their death occurred at the age of exit.</li> </ul>
Parent Withdrawal	<p>The parent has chosen to end Part C services and provided written or verbal indication of withdrawal from services.</p> <p><b>*Note:</b> This must be documented in the child's file.</p> <p>Do not include children whose parent states that child has completed the IFSP or that they believe child is doing well and no longer in need of service.</p>
Attempts to Contact Unsuccessful	<p>Repeated attempts to contact or provide services to family and child were unsuccessful.</p> <ul style="list-style-type: none"> <li>Attempts must be documented in the child's record.</li> <li>Include all children who have not reached the maximum age of service under Part C.</li> </ul>
Ineligible for Part C	<p>Child does not meet eligibility for Part C services.</p> <ul style="list-style-type: none"> <li>Can apply to child processed as an initial referral or re-referral.</li> </ul>
Screening Passed	<p>May use this only for children in the screening phase. Include only children initially referred or re-referred and screened.</p> <ul style="list-style-type: none"> <li>Do not use for children with an active IFSP at time of closure.</li> </ul>

### **11.3 Transferring a Record from One (1) POE Region to Another POE Region**

When a family moves from one (1) POE region to another POE region, the transfer of records and services must occur.

**\*Note:** *Consent to Release/Obtain Information (FS-10)* is not required when transferring records between POEs.

The sending SC must:

- (1) Notify providers of the transfer, date authorizations end, and need for a discharge report;
- (2) Update the Parent/Guardian Information page on TOTS with new address and phone;
- (3) Update the child's Demographic Information page with new address, phone and county (based on new address);
- (4) Ensure all service logs and discharge reports are completed;
- (5) Ensure that the IFSP is finalized before transferring the case;
- (6) Send the *Notice of Record Destruction (FS-32)* to the parent; and
- (7) Explain to the parent that all necessary records will be transferred to the new POE.

The sending POE Manager must:

- (1) Check the Account Payable Information page on TOTS to ensure that all POE billing is complete;
- (2) Notify the receiving POE of the transfer;
- (3) Transfer the record by completing the Transfer Child Between Districts page on TOTS. The POE Manager chooses the district that the child will transfer to from the drop-down menu and selects the "Transfer Now" button; and
- (4) Send a copy of the current IFSP signature page and any other current consent forms to the receiving POE.

The receiving POE must:

- (1) Assign a SC, schedule a meeting with the parent and open both the hard copy and electronic files. Referral, intake, eligibility, and IFSP dates should be the original dates listed in the hard copy file;
- (2) Prepopulate a Requested Review IFSP and edit the authorizations for services on the IFSP Planned Service Information page on TOTS;
- (3) Bring a list of available providers in the area so that the parent can choose new provider(s) if needed to the IFSP Meeting;
- (4) Schedule a follow-up IFSP meeting and invite the chosen early intervention providers;
- (5) Review the IFSP and make any needed changes; and
- (6) Enter authorizations on IFSP Planned Service Information page on TOTS and finalizes the IFSP.

The evaluation and assessment protocols cannot legally be copied due to copyright laws. The protocols must be maintained at the original POE. If eligibility has yet to be determined, the new POE will review the PLE/5AA report once completed by the previous DCES or contracted evaluator, along with all other available information. The new POE will confer with the DCES from the initial POE about the child's evaluation if there are any questions about the evaluation results.

#### **11.4 Transferring a Record from Another State's Early Intervention System to a KEIS POE**

When a family moves from another state's early intervention system to a KEIS POE, there is no automatic transfer of records and services. The parent must be informed that eligibility criteria and IFSP implementation vary by state. Eligibility must be determined using Kentucky's criteria and only services allowed in Kentucky will be offered, if eligible.

The POE must attempt to get records from the other state's early intervention system. The first and easiest option to do this will typically be to get the parent to request the records of the other state. If the POE is requesting the records or speaking with the other program, the *Consent to Release/Obtain Information (FS-10)* is required.

If the POE is able to obtain the child's records from the other state's early intervention system, the parent must give consent on the *Notice of Action & Consent for Screening, Evaluation and Assessment (FS-8)* for the POE staff to review the evaluation and assessment portion of the records. The screening process (ASQ) may be skipped. If the protocols are available, or the evaluation report is thorough and includes scores, the outside evaluation and assessment information may be used for eligibility determination if the records meet the following evaluation timelines:

- (1) Children under twelve (12) months of age, the evaluation was conducted within three (3) months of the referral; or
- (2) Children over twelve (12) months of age and under three (3) years of age, the evaluation occurred within six (6) months of the referral.

The DCES or SC also review the evaluation to determine if it meets the Kentucky testing requirements; for example, there is a recently conducted *Bayley Scales of Infant and Toddler Development* but there is no 5AA available. The SC would need to authorize the 5AA to be completed.

If the evaluation is still valid, but the protocols are not available and/or the report does not include scores, another evaluation protocol will need to be administered by the DCES or contracted evaluator. If the evaluation is no longer valid, the POE will need to administer a new evaluation following the steps for any new referral.

If the POE is unable to obtain the child's records from the other state's early intervention system, the screening process (ASQ) may be skipped. However, a new evaluation must be administered following the steps for any new referral.



## **Chapter 12: Early Intervention Records**

Early intervention records developed and maintained by the Kentucky Early Intervention System (KEIS) are under the jurisdiction of the Family Education Rights and Privacy Act (FERPA) and Individuals with Disabilities Education Improvement Act of 2004 (IDEA) provisions. Early intervention records are considered educational records. The IDEA regulation found at 34 CFR 303.3 states that references to state educational agency means the lead agency for Part C and that reference to special education and related services means early intervention services.

The Health Insurance Portability and Accountability Act (HIPAA) provisions apply to the business transactions of KEIS. KEIS collects and maintains personally identifiable health information for billing purposes and claims payment. The HIPAA and FERPA provisions intersect at times, depending upon the action being taken.

KEIS must comply with the provisions of IDEA, FERPA and HIPAA regarding the child's early intervention record. The *Notice of Confidentiality, Privacy Practices & Records (FS-29)* is used to cover all provisions.

### **12.1 Parental Access to the Early Intervention Record**

Parents must be permitted to inspect and review any or all portions of the electronic and hard copy record relating to their child as a part of the early intervention program. The Point of Entry (POE), or any other agency maintaining such records, must allow parents access without unnecessary delay. Parents cannot be denied access by the public agency due to physical limitations or geographic locations. Service Coordinators (SC) must provide assistance to parents wishing to review their child's record.

Parents have the right to receive an initial copy of the complete early intervention record maintained on their child at no cost. The regulatory requirements for sending copies of the Individualized Family Service Plan (IFSP), evaluation reports, assessment reports, and progress reports does not replace the parent's right to receive the first requested copy at no cost. Parents may be charged a fee for additional copies of the complete early intervention record. This fee shall not prevent the parent from exercising their right to inspect and review the record.

If an early intervention record or documentation includes information on more than one (1) child, the parents of those children have the right to inspect and review only the information relating to their child or to be informed of the specific information. The identifying information on other children or individuals must be redacted, or blacked out, prior to inspection.

Parents also have the right to request an explanation of the record or to request an amendment to the record. Inspecting and reviewing the record includes a right to:

- (1) A response from the POE to reasonable requests for explanations and interpretations of the record;
- (2) A request that the POE provide copies of the record containing the information, if failure to provide those copies would effectively prevent the parent from exercising the right to inspect and review the record; and
- (3) A representative of the parent to inspect and review the record.

If a parent believes that the information contained in their child's early intervention record is inaccurate, misleading or discriminatory in some manner, they may request in writing that this information be either removed or rewritten.

- (1) The written request to amend the record must be submitted to the State Lead Agency (SLA) and contain a detailed explanation of what information the parent believes is inaccurate, misleading or discriminatory.
- (2) SLA staff will investigate the request to amend the record and will issue a notice of the findings of this investigation to the parent within ten (10) working days.
- (3) The SLA may refuse to amend all or part of the record as requested by the parent.
- (4) The parent has the right to file a request for a due process hearing should they disagree with the SLA decision regarding amending the record.

### **12.1 (1) Electronic Access to Early Intervention Record**

KEIS offers parents the opportunity to view a portion of their child's early intervention record online through the Technology-assisted Observation and Teaming Support System (TOTS). This method of access does not substitute for access to the complete record held at the POE.

Key factors about parent access to TOTS:

- (a) The modified record is a read-only record of the critical pieces of the electronic record. Administrative sections are not viewable through a parent logon.
- (b) Parent access is not available until a child has a TOTS identification number.
- (c) Parent logons are child specific. If the parent has multiple children in early intervention, there will be a logon specific for each child.
- (d) Only one (1) parent logon is issued. In cases of shared custody, the parent with educational rights is provided a logon. If both parents have educational rights, only one (1) logon is provided and the child's parents must determine who has online access.
- (e) In cases of children in foster care, the parent logon is available only to the person who is recognized as the parent under IDEA. If parental rights have not been terminated and the natural parent is available, the logon will be issued to the natural parent. If the natural parent cannot be located, educational rights have been terminated, or the natural parent's right to make educational decisions has been subrogated by a court, the educational surrogate parent will be issued the logon. SCs must verify who is to receive the parent access logon and document this on TOTS.

**\*Note:** Logons are not provided to Department for Community Based Services (DCBS) caseworkers.

Parents who want online access to the early intervention record are provided the "TOTS Information for Parent Access" and "TOTS Parent Portal Acceptable Use and Safety Policy" documents. The parent must sign an agreement with all provisions of the *Parent Agreement for TOTS Access via Internet (FS-46)*. Directions for registering with TOTS are included in the "TOTS Parent Portal Acceptable Use and Safety Policy" document.

A "Step-by-Step Instructions for TOTS Parent Access" document for SCs is included in the Appendix. This resource provides detailed information about the Parent Portal.

### **12.1 (2) Non-custodial Right to Review Records**

In instances of non-custodial parents, the POE assumes that the non-custodial parent has access rights to the child's early intervention record and is a participant in the IFSP development unless advised otherwise in writing by court order.

## **12.2 Confidentiality of Personally Identifiable Information**

Each POE must ensure the confidentiality of personally identifiable information. Therefore, the POE will:

- (1) Appoint an individual to be responsible for ensuring the confidentiality of any personally identifiable information;
- (2) Provide training to all employees about the policies and procedures that govern personally identifiable information; and
- (3) Maintain a current list of the names and positions of those employees within the POE who have access to personally identifiable information.

The official early intervention record is maintained at the local POE administrative office. In order to adequately ensure that these records are protected, and the appropriate provisions put in place, the POE has the responsibility to monitor those having access to this information. Individuals listed on a current signed *Consent to Release/Obtain Information (FS-10)* in a child's early intervention record may access the information detailed on the release form, including obtaining a copy of the information. The staff at the POE should verify that a current release exists and the extent to which information may be shared prior to opening the full early intervention record to the individual named on the form.

SLA employees who are conducting compliance monitoring or providers selected by the parent to provide early intervention services may access the early intervention record without parental consent. All individuals who access the hard copy file, with the exception of designated POE staff must sign and document the *Record of Access (FS-27)*. The *Record of Access (FS-27)* is maintained in the child's hard copy file.

The protection of confidentiality also extends to members of the child's family who are not their legal guardian. In the event that POE staff needs to communicate directly with family members other than the child's legal guardian(s), a signed *Consent to Release/Obtain Information (FS-10)* must be obtained from the legal guardian. This requirement also applies to those instances when a child is in foster care, or is a ward of the State. When necessary, the educational surrogate signs the release.

### **12.2 (1) Use of Electronic Communication with Families**

Individuals working in KEIS must recognize that they have an ethical and legal obligation to maintain privacy and confidentiality at all times. Whether communicating with the parent, supervisor, team members or anyone associated with the child's services, reference to the child or parent should either contain only non-identifiable information such as the TOTS identification number, the child's initials, or be sent via secure manner such as encryption. This includes all attachments.

Electronic communication (emails, text messages, Facebook, LinkedIn and other social networking sites) is increasingly being used as a means of communication between KEIS providers, including POE staff, and parents. Caution should always be taken whenever using any form of electronic communication for the following reasons:

- (a) use of personal email, cell phone numbers or personal social network sites can be accessed by others not working with the family;
- (b) during a complaint investigation all electronic communication records (including personal email accounts) could be requested through the Freedom of Information Act; and
- (c) the use of electronic communication may make maintaining professional boundaries more difficult by allowing both parents and providers access to personal cell phones, emails and texts at all hours of the day and night.

The discussion of the use of social network sites should occur during the initial visits with the parent. Email and faxes may be used when supported by an encrypted communication system that includes firewalls that are HIPAA compliant. Video messaging such as SKYPE can only be used when supported by HIPAA compliant security. **Families should be informed that while their child is receiving services through KEIS the provider, including POE staff, will be unable to communicate with them via personal social network sites.**

Personally identifiable information such as name, diagnosis, address, etc. must not be included in the electronic communication. All electronic communication with parents must be documented in the child's TOTS record. This includes telephone, email and text messaging.

#### **12.2 (1) (a) Email**

1. Unprofessional personal email addresses should never be used by providers.
2. Joint personal email addresses, in which two (2) or more individuals share one (1) email address, should not be used when communicating with parents or other IFSP team members.
3. Careful attention should be paid to the address the email is being sent to in order to avoid sending the email to an unintended recipient.
4. Read the email carefully before you send it checking that all personal information about the parent or child is de-identified.
5. Keep messages short, clear and concise and encourage parents to do the same.
6. The signature at the end of the email should include your full name, email address, work address, phone number and job description (i.e. Occupational Therapist).
7. Never use all capital letters. This is the online equivalent of shouting.
8. Avoid using URGENT and IMPORTANT as the subject of the email.
9. The use of a confidentiality disclaimer at the bottom of emails for a professional working in KEIS is strongly encouraged.

### **12.2 (1) (b) Texting**

1. Always ask permission from a parent before you begin texting them. Some phone plans may not cover texting or may charge for each text sent. The parent may prefer voice messages left on their phone.
2. Use text messages sparingly.
3. Always end your text with your first and last name. Do not assume the parent has your name as a contact in their phone or will recognize your telephone number.
4. Make sure all information in the text is de-identified and does not contain any personal information about the child or parent.
5. Keep the text strictly professional. Do not use texting shorthand assuming the parent will understand. Do not use slang, all capital letters or emojis.
6. Do not respond to a telephone call with a text message.
7. Do not send text messages late in the evening or early in the morning.
8. Careful attention should be paid to the telephone number the text is being sent to in order to avoid sending the text to an unintended recipient.
9. Do not check your text messages or answer text messages while you are with a child and parent.
10. Do not rely on text messaging with parents as your sole form of communication with them.

As with emails, text messages are considered part of the record and must be included in the file. Providers must document the text conversation on TOTS. Providers can also email the text message where it can be printed out or archived where it can be retrieved. SLA compliance may request a copy of text communications as part of an investigation.

**\*Note:** If a personal cell phone is used to correspond with a parent, it is the responsibility of the early intervention provider to maintain confidentiality.

### **12.2 (1) (c) Social Media**

If social media is used by an individual in their life outside of the professional role in KEIS, care must be taken that no confidential information from early intervention is posted on a social media site. Please be aware of the following:

1. Maintain professional boundaries in the use of electronic media. The fact that the parent may initiate contact does not permit anyone working within KEIS to engage in a personal relationship with the parent.
2. Do not share, post, or otherwise disseminate any information (including images) about a child or family or information gained while in contact with the family. Do not identify children or parents by name or post or publish information that may lead to identification of the child or parent. Limiting access to postings through privacy settings is not sufficient, even if the child or parent is not identified.
3. Do not refer to the child or parent in a disparaging manner, even if they are not referred to by name.
4. Do not take photos or videos of children or parents and upload to any social media site.

### **12.2 (2) Breach of Confidentiality**

All early intervention providers, including POE staff, must develop written policies for, and give notice to parents of these policies, regarding the protection of confidentiality and the disclosure of personally identifiable information (PII). These policies must comply with the requirements of IDEA. In addition, all providers must also develop written policies for the protection of confidentiality and the disclosure of protected health information (PHI). These policies must comply with the requirements of HIPAA. Any disclosure of PII or PHI must be appropriately documented in accordance with the governing law.

Disclosing confidential information about children and parents in KEIS is a violation of IDEA, FERPA and may also be a violation of HIPAA. PII includes descriptions of a child or parent that enables others to identify them. Even if the child's name is not used, other descriptors may make it easy for someone to recognize the child.

Breaches of confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Examples of breaches in confidentiality may include:

- (a) Mistakenly entering a service log in the wrong child's early intervention record on TOTS;
- (b) Entering an assessment in the Kentucky Early Childhood Data System (KEDS) in the wrong child's record; and
- (c) Using PII in electronic communications.

If a potential breach has occurred, notify the SLA by email at: [chfs.firststeps@ky.gov](mailto:chfs.firststeps@ky.gov). Ensure that confidentiality is maintained in this correspondence. See the "Quick Reference Guide-Confidentiality" document in the appendix for further guidance.

### **12.3 Clarifications for Release of Information**

POEs may release the following information related to active children:

- (1) Evaluations;
- (2) Assessments;
- (3) IFSPs; and
- (4) Progress reports.

Requests for the service log/provider notes should be forwarded to the SLA. See the "Quick Reference Guide-Record Requests" document in the appendix for further guidance.

Most requests for information related to an inactive child must be forwarded to the SLA. The only exception is when a parent requests the record on the *Record Request Form (FS-33)*. As long as the request is made by the same parent listed in TOTS and the file has only been closed for six (6) months or less, the POE may release the same information as allowed above for active children. If the parent does not match, the file has been closed longer than six (6) months, or there are any questions and/or concerns with the request, it must be forwarded to the SLA.

All releases must be copies only. The original documentation must be kept for a minimum of six (6) years. Due to copyright laws, the POE is not legally allowed to copy the evaluation and assessment protocols to send to the family. The parent must only be sent a copy of the PLE/5AA report. In most instances this will be sufficient. If the parent specifically requests the protocols, the POE must inform the parent copies cannot be made. The parent can come view the protocols at the POE office. The parent can request the original protocols six (6) years from the child's last date of service when the retention period expires.

#### **12.3 (1) Releasing Information to Child Protection Agencies**

The POE may release a child's record to DCBS without parental consent if DCBS provides written verification there is an open, active investigation of abuse or neglect involving the child. Any requests for records by DCBS for a child no longer receiving early intervention services must be sent to the SLA for processing. See the "Quick Reference Guide- DCBS Record Request" document in the appendix for further guidance.

#### **12.3 (2) Releasing Information to School Districts**

Early intervention programs may disclose, without consent, "directory" information such as:

- (a) child's name;
- (b) address;
- (c) telephone number;
- (d) date of birth;
- (e) name of child's SC; and
- (f) date of enrollment.

However, the early intervention program must tell parents about directory information and allow parents a reasonable amount of time to request that the early intervention program not disclose the directory information. Parents who do not want directory, information released by the POE must complete and sign the *Transition Notice & Consent (FS-11)*.

Early intervention programs must notify parents annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a newsletter, handbook, or newspaper article) is left to the discretion of each early intervention program. Kentucky created and uses the *Notice of Confidentiality, Privacy Practices & Records (FS-29)* to be used as the annual notification of the parent's rights under FERPA, HIPAA and IDEA.

### **12.3 (3) Releasing to a Third Party**

A POE must have parent's consent prior to the disclosure of an education record, evidenced by a valid, signed and dated consent that states the purpose of the disclosure.

A POE may disclose early intervention records without consent when the disclosure is:

- (a) directory information to school officials who have been determined to have legitimate educational interests as set forth in the early intervention program's annual notification of rights to parents (FS-29);
- (b) from one (1) POE service area to another POE service area when a child and family relocate;
- (c) to state or local educational authorities auditing or evaluating Federal or State supported education programs or enforcing Federal laws which relate to those programs; or
- (d) pursuant to a lawfully issued court order or subpoena.

### **12.4 Destruction of Records**

Under IDEA regulations, KEIS must inform parents when personally identifiable information collected, maintained, or used under Part C of IDEA is no longer needed to provide educational services to the child. This notification is provided to parents upon the child's exit from KEIS. The minimum retention schedule for records in KEIS is six (6) years from the child's last date of service in the early intervention program. Providers and POEs must follow their agency's policy for destruction of records if the policy exceeds the six (6) year requirement.

#### **12.4 (1) Destruction of Records for POE**

At the child's discharge from the program when the Notice of Action (FS-9) is sent, the POE is required to inform the parent that the child's record will be destroyed in six (6) years using the *Notice of Record Destruction (FS-32)*. If the parent asks how to request their child's records, the POE will provide the *Record Request Form (FS-33)*. The POE must document that the notice and request form, if applicable, were provided to the parent in the child's record on TOTS and place a copy in the child's hard copy file.

**\*Note:** The parent or educational surrogate of record at the time of case closure is provided the *Notice of Record Destruction (FS-32)*. If the biological parent's contact information is known, the notice may be sent to them at the same time as the educational surrogate. The SC must document who was sent the notice on TOTS.

The record includes but not limited to:

- (a) *IFSP Signature Page (FS-15)*;
- (b) *Record of Access Form (FS-27)*;
- (c) Surrogate Parent Identification of Need (FS-23A) and subsequent surrogate forms (as needed);
- (d) medical and health records;
- (e) screening, evaluation and assessment protocols and score sheets;
- (f) notifications of meetings;
- (g) notices and consents; and
- (h) other personally identifiable information.

Each POE must create and maintain a destruction of records file. This file documents the POE's actions concerning the destruction of early intervention records and provides evidence of appropriately destroyed records. This file must be maintained permanently.

#### **12.4 (2) Destruction of Records for Service Providers**

At the child's discharge from the program when the discharge summary is sent, the service provider is required to inform the parent that the child's record will be destroyed in six (6) years. The *Notice of*

*Record Destruction (FS-32)* and the *Record Request Form (FS-33)* can be referenced as a guide to create agency forms. A request form is only required to be sent to the parent if they ask how to request their child's records. The provider must document that the notice and request form, if applicable, were provided to the parent in the child's record on TOTS.

**\*Note:** The parent or educational surrogate of record at the time of case closure is provided the *Notice of Record Destruction (FS-32)*. If the biological parent's contact information is known, the notice may be sent to them at the same time as the educational surrogate. The provider must document who was sent the notice on TOTS.

The record includes but not limited to:

- (a) *Record of Access Form (FS-27)*;
- (b) evaluation and assessment reports;
- (c) evaluation and assessment protocols and score sheets;
- (d) treatment plans;
- (e) progress monitoring data;
- (f) notifications of meetings;
- (g) notices and consents; and
- (h) other personally identifiable information.

Each provider must create and maintain a destruction of records file. This file documents the provider's actions concerning the destruction of early intervention records and provides evidence of appropriately destroyed records. This file must be maintained permanently.

# Appendix

## Established Risk Conditions

Aase-Smith Syndrome (Diamond-Blackfan Anemia)	Aase Syndrome
Acrocallosal Syndrome	Acrodysostosis
Acro-Fronto-Facio-Nasal Dysostosis	Adrenoleukodystrophy
Agenesis of the Corpus Callosum	Agyria
Aicardi Syndrome	Alexander's Disease
Alper's Syndrome	Amelia
Angelman Syndrome	Aniridia
Anophthalmia/Microphthalmia	Antley-Bixler Syndrome
Apert Syndrome	Arachnoid cyst with neuro-developmental delay
Arhinencephaly	Arthrogryposis
Ataxia	Atelosteogenesis
Autism	Baller-Gerold Syndrome
Bannayan-Riley-Ruvalcaba Syndrome	Bardet-Biedl Syndrome
Bartoscas-Papas Syndrome	Beals Syndrome (congenital contractual arachnodactyly)
Bixler Syndrome	Blackfan-Diamond Syndrome
Bobble Head Doll Syndrome	Borjeson-Forsman-Lehmann Syndrome
Brachial Plexopathy	Brancio-Oto-Renal (BOR) Syndrome
Campomelic Dysplasia	Canavan Disease
Carbohydrate Deficient Glycoprotein Syndrome	Cardio-Facio-Cutaneous Syndrome
Carpenter Syndrome	Cataracts-Congenital
Caudal Dysplasia	Cerebro-Costo-Mandibular Syndrome
Cerebellar Aplasia/Hypoplasia/Degeneration	Cerebral Atrophy
Cerebral Palsy	Cerebro-oculo-facial-skeletal syndrome
CHARGE Association	Chediak Higashi Syndrome
Chondrodysplasia Punctata	Christian Syndrome
Chromosome Abnormality a. Unbalanced numerical (autosomal) b. Numerical trisomy (chromosomes 1-22) c. Sex chromosomes XXX; XXXX; XXXXX; XXXY; XXXXY	CNS Aneurysm with Neuro-Developmental Delay
CNS Tumor with Neuro-Developmental Delay	Cockayne Syndrome
Coffin Lowry Syndrome	Coffin Siris Syndrome
Cohen Syndrome	Cone Dystrophy
Congenital Cytomegalovirus	Congenital Herpes
Congenital Rubella	Congenital Syphilis
Congenital Toxoplasmosis	Cortical Blindness
Costello Syndrome	Cri Du Chat Syndrome
Cryptophthalmos	Cutis Laxa
Cytochrome-c Oxidase Deficiency	Dandy Walker Syndrome
DeBary Syndrome	DeBoquois Syndrome
Dejerine-Sottas Syndrome	DeLange Syndrome
DeSanctis Cacchione Syndrome	Diastrophic Dysplasia
DiGeorge Syndrome	Distal Arthrogryposis
Donohue Syndrome	Down Syndrome
Dubowitz Syndrome	Dyggve Melchor-Calusen Syndrome
Dyssegmental Dysplasia	Dystonia
EEC (Ectrodactyly-ectodermal dysplasia-clefting) Syndrome	Encephalocele
Encephalo-Cranio-Cutaneous Syndrome	Encephalomalacia
Facio-Auriculo-Radial Dysplasia	Facio-Cardio Renal (Eastman-Bixler) Syndrome



Familial Dysautonomia (Riley-Day Syndrome)	Fanconi Anemia
Farber Syndrome	Femoral Hypoplasia
Fetal Alcohol Syndrome/Effects	Fetal Dyskinesia
Fetal Hydantoin Syndrome	Fetal Valproate Syndrome
Fetal Varicella Syndrome	FG Syndrome
Fibrochondrogenesis	Floating Harbor Syndrome
Fragile X Syndrome	Freeman-Sheldon (Whistling Facies) Syndrome
Fryns Syndrome	Fucosidosis
Galactosemia	Glaucoma-Congenital
Glutaric Aciduria Type I and II	Glycogen Storage Disease
Goldberg-Shprintzen Syndrome	Grebe Syndrome
Hallermann-Streiff Syndrome	Hays-Wells Syndrome
Head Trauma with Neurological Sequelae/Developmental Delay	Hearing Loss (25dB or greater in better ear as determined by ABR audiometry or audiometric behavioral measurements)
Hemimegalencephaly	Hemiplegia/Hemiparesis
Hemorrhage-Intraventricular Grade III and IV	Hereditary Sensory & Autonomic Neuropathy
Hereditary Sensory Motor Neuropathy (Charcot Marie Tooth Disease)	Herrmann Syndrome
Heterotopias	Holoprosencephaly (Aprosencephaly)
Holt-Oram Syndrome	Homocystinuria
Hunter Syndrome (MPS II)	Hurler Syndrome (MPS I)
Hyalinosis	Hydranencephaly
Hydrocephalus	Hyperpipecolic Acidema
Hypomelanosis of ITO	Hypophosphotasis-Infantile
Hypoxic Ischemic Encephalopathy	I-Cell (mucopolidosis II) Disease
Incontinentia Pigmenti	Infantile Spasms
Iniencephaly	Isovaleric Acidemia
Jarcho-Levin Syndrome	Jervell Syndrome
Johanson-Blizzard Syndrome	Joubert Syndrome
Kabuki Syndrome	KBG Syndrome
Kenny-Caffey Syndrome	Klee Blattschadel
Klippel-Feil Sequence	Landau-Kleffner Syndrome
Lange-Nielsen Syndrome	Langer Giedion Syndrome
Larsen Syndrome	Laurin-Sandrow Syndrome
Leber's Amaurosis	Legal Blindness (bilateral visual acuity of 20/200 or worse corrected vision in the better eye)
Leigh Disease	Lennox-Gastaut Syndrome
Lenz Majewski Syndrome	Lenz Microphthalmia Syndrome
Levy-Hollister (LADD) Syndrome	Lesch-Nyhan Syndrome
Leukodystrophy	Lissencephaly
Lowe Syndrome	Lowry-Maclean Syndrome
Maffucci Syndrome	Mannosidosis
Maple Syrup Urine Disease	Marden Walker Syndrome
Marshall Syndrome	Marshall-Smith Syndrome
Maroteaux-Lamy Syndrome	Maternal PKU Effects
Megalencephaly	MELAS
Meningocele (cervical)	MERRF
Metachromatic Leukodystrophy	Metatropic Dysplasia
Methylmalonic Acidemia	Microcephaly
Microtia-Bilateral	Midas Syndrome
Miller (postaxial acrofacial-dysostosis) Syndrome	Miller-Dieker Syndrome
Mitochondrial Disorder	Mobius Syndrome
Morquio Syndrome	Moya-Moya Disease

Mucopolysaccharidosis II and III	Multiple congenital anomalies (major organ birth defects)
Multiple Pterygium Syndrome	Muscular Dystrophy
Myasthenia Gravis-Congenital	Myelocystocele
Myopathy –Congenital	Myotonic Dystrophy
Nager (Acrofacial Dysostosis) Syndrome	Nance Horan Syndrome
NARP	Neonatal Meningitis/Encephalitis
Neuronal Ceroid Lipofuscinoses	Neuronal Migration Disorder
Nonketotic Hyperglycinemia	Noonan Syndrome
Ocular Albinism	Oculocerebrocutaneous Syndrome
Oculo-Cutaneous Albinism	Optic Atrophy
Optic Nerve Hypoplasia	Oral-Facial digital Syndrome, Types I-VII
Osteogenesis Imperfecta, Types III and IV	Osteopetrosis (Autosomal Recessive)
Oto-Palato-Digital Syndrome, Types I and II	Pachygyria
Pallister Mosaic Syndrome	Pallister-Hall Syndrome
Pelizaeus-Merzbacher Disease	Pendred's Syndrome
Periventricular Leukomalacia	Pervasive Developmental Disorder
Peters Anomaly	Phocomelia
Poland Sequence	Polymicrogyria
Popliteal Pterygium Syndrome	Porencephaly
Prader-Willi Syndrome	Progeria
Propionic Acidemia	Proteus Syndrome
Pyruvate Carboxylase Deficiency	Pyruvate Dehydrogenase Deficiency
Radial Aplasia/Hypoplasia	Refsum Disease
Retinoblastoma	Retinoic Acid Embryopathy
Retinopathy of Prematurity, Stages III and IV	Rett Syndrome
Rickets	Rieger Syndrome
Roberts SC Phocomelia	Robinow Syndrome
Rubinstein-Taybin Syndrome	Sanfilippo Syndrome (MPS III)
Schinz-Giedion Syndrome	Schimmelpenning Syndrome (Epidermal Nevus Syndrome)
Schizencephaly	Schwartz-Jampel Syndrome
Seckel Syndrome	Septo-Optic Dysplasia
Severe Attachment Disorder	Shaken Baby Syndrome
Short Syndrome	Sialidosis
Simpson-Golabi-Behmel Syndrome	Sly Syndrome (MPS IV)
Smith-Fineman-Myers Syndrome	Smith_Limitz-Opitz Syndrome
Smith-Magenis Syndrome	Sotos Syndrome
Spina Bifida (Meningomyelocele)	Spinal Muscular Atrophy
Spondyloepiphyseal Dysplasia Congenita	Spondylometaphyseal Dysplasia
Stroke	Sturge-Weber Syndrome
TAR (Thrombocytopenia-Absent Radii Syndrome)	Thanatophoric Dysplasia
Tibial Aplasia (Hypoplasia)	Toriello-Carey Syndrome
Townes-Brocks Syndrome	Trecher-Collins Syndrome
Trisomy 13	Trisomy 18
Tuberous Sclerosis	Urea Cycle Defect
Valocardiofacial Syndrome	Wildervanck Syndrome
Walker-Warburg Syndrome	Weaver Syndrome
Wiedemann-Rautenstrauch Syndrome	Williams Syndrome
Winchester Syndrome	Wolf Hirschhorn Syndrome
Yunis-Varon Syndrome	Zellweger Syndrome

Form Number	First Steps Forms Index
FS-1A	Referral Form
FS-1B	DCBS Referral Form
FS-2	Family Letter for Screen Passed (Spa)
FS-3	Notice of Referral to LEA/KDE (for children over 2 yr. 10.5 mo.) (Spa)
FS-4	Unable to Contact Referral Letter (Spa)
FS-5	Initial Home Visit Confirmation Letter (Spa)
FS-6	Notice & Consent for Release of Child Outcomes Data to the Kentucky Center for Statistics (KYStats) (Spa)
FS-7	Notice of Action & Consent for Assessment (Spa)
FS-8*	Notice of Action & Consent for Screening, Evaluation and Assessment* (Spa)
FS-9*	Notice of Action* (Spa)
FS-10*	Consent to Release/Obtain Information* (Spa)
FS-11*	Transition Notice & Consent* (Spa)
FS-12A*	Notice & Consent for Use of Private Insurance* (Spa)
FS-12B	Notice for Use of Medicaid (Spa)
FS-13*	Financial Assessment Verification* (Spa)
FS-14	IFSP Meeting Notice (Spa)
FS-15*	IFSP Signature Page* (Spa)
FS-16	Record Review Cover Letter & Request
FS-17	Service Exception Supporting Documentation Form
FS-18	Notice of Action for Annual Eligibility Determination (Spa)
FS-19	Referral Portal Letter
FS-20*	Complaint Form* (Spa)
FS-21*	Mediation/Due Process Request* (Spa)
FS-22	Health Information for Eligibility Determination
FS-23A	Surrogate Parent Identification of Need
FS-23B	Educational Surrogate Assigned Request
FS-23C	Parent Designation of Educational Decision-Making (Spa)
FS-23D	Referral Information Request for Caseworker
FS-24*	Family Share Extraordinary Family Expenses Worksheet* (Spa)
FS-25	Family Share Temporary Suspension or Waiver Request
FS-26	Notice of Action Family Share (Spa)
FS-27	Record of Access
FS-28	Child Find Plan
FS-29	Notice of Confidentiality, Privacy Practices & Records (Spa)
FS-30	Notice of Action & Consent for Secondary Level Evaluation (Spa)
FS-31	SLA Approval Request for Intensive Level Evaluation
FS-32	Notice of Record Destruction (Spa)
FS-33	Record Request Form (Spa)
FS-34	Waiver of Interpreter Services-Limited English Proficiency (LEP)
FS-35	Family Letter for Monitoring Area (Spa)
FS-36	Unable to Process Referral Letter
FS-37A	Referral Form to OCSHCN
FS-37B	Consent to Release & Obtain Information OCSHCN (Spa)
FS-38	Otoacoustic Emissions (OAE) Screen Reporting Form
FS-39	Neonatal Follow-Up Program (NFP) Referral
FS-40	Parent Consent to Share Information Referral Letter (Spa)
FS-42A	Assistive Technology Purchase Request
FS-42B	Assistive Technology Purchase
FS-44	Screening Cover Letter (Spa)
FS-45	Early Intervention Service Availability Notice (Spa)
FS-46	Parent Agreement for TOTS Access via Internet (Spa)
FS-47	Family Assessment Preparation Letter (Spa)
FS-48*	Notice of System of Payments (Spa)
FS-49	First Steps Transition: Part B Special Education Fact Sheet
	TOTS Information for Parent Access
	TOTS Parent Portal Acceptable Use and Safety Policy

	Step-by-Step Instructions for SCs Regarding Parent Access
	Quick Reference Guide Confidentiality
	Quick Reference Guide DCBS Records Requests
	Quick Reference Guide Educational Decision-Making Rights Decision Tree
	Quick Reference Guide Family Assessment
	Quick Reference Guide Home Visiting Safety Tips
	Quick Reference Guide Insurance Information Template
	Quick Reference Guide Parent Agreement
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	"I Speak" Language Selection Cards
	Know Your Rights Brochure-Arabic
	Know Your Rights Brochure-Cambodian
	Know Your Rights Brochure-Chinese
	Know Your Rights Brochure-Creole
	Know Your Rights Brochure-English
	Know Your Rights Brochure-Hmong
	Know Your Rights Brochure-Korean
	Know Your Rights Brochure-Russian
	Know Your Rights Brochure-Spanish
	Know Your Rights Brochure-Vietnamese

\*- Indicates forms incorporated in regulations  
(Spa)- Indicates forms are also translated into Spanish