

Intake,
Evaluation/Assessment
& Eligibility
Effective Practice
Guidelines

Nevada



Includes:

- Child Find
- Referral
- Intake
- Evaluation and Assessment
- Eligibility
- Family Needs Assessment and IFSP Preparation

Module 2

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How to Use This Guide

Regardless of which staff member answers the phone, a family's first contact with early intervention services sets the tone for all future interactions. This is the first time that information is shared and data collected. Throughout this process the goal is to gather information from the family, while explaining to them the next steps in the process and informing them of their rights and roles in these steps. Nevada Early Intervention Services (NEIS) offers a wide variety of services, including: comprehensive evaluation, occupational, physical and speech therapy, vision and hearing services, nutritional planning, parent support, family training or counseling, and specialized instruction to children and families residing in Nevada.

NEIS needs to receive adequate information to make informed decisions about accessing services that appropriately meet the family and child's needs for a variety of services. Families that are accessing Part C early intervention services need to be informed that 45 days starts at the time of the initial contact. Families need to be informed that the process of gathering information is meant to help in developing individualized services and supports for the child and family and to help families make informed decisions. It is important that the information collected in the initial contact and each subsequent step be shared with all early intervention staff involved with the child and family, as needed, to eliminate asking the family the same questions numerous times. This is an especially critical time for families, as it may be the first call they make and say, "there is a problem with my child" or "my doctor told me to call."

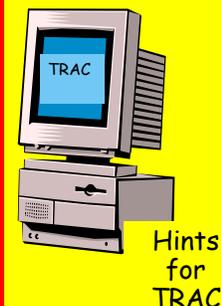
The purpose of this module is to provide referral/intake coordinators with guidelines on working with families in a sensitive manner, making them comfortable, and developing a partnership through the intake, evaluation and assessment, and eligibility determination process that will last throughout the family's time with early intervention services. This module is also designed to help all service providers learn about the interconnectedness between information gathered from families during the initial contacts, including evaluation/assessment and the development of meaningful and functional services and support plans that are individualized for each child and their family. Service providers must follow guidance in this document as well as local program procedures.

To ensure the competency of whatever person answers the first phone call or has the first contact with a family, NEIS is committed



Tips for
Service
Coordinators

When you see this box look for information that is especially helpful for Service Coordinators.



Hints
for
TRAC

to comprehensive training and mentoring for all staff. This Effective Practice Guidelines Module is an important part of the support provided to referral/intake coordinators.

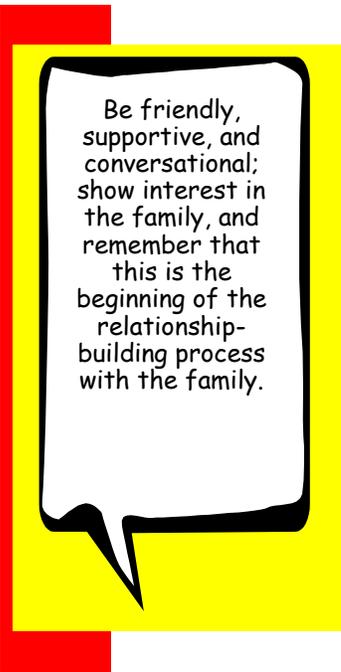
Some of the key ideas that will be shared throughout this module include:

1. Setting the tone for the family's experience with early intervention services.
2. Using active listening skills (giving families time to talk, probing, reflecting, etc.).
3. Providing information in a sensitive manner.
4. Supporting families in making informed decisions and developing a partnership with them.
5. Focusing on family priorities and concerns.
6. Recognizing parents' expertise and knowledge of their child.
7. Helping families understand that early intervention is designed to incorporate strategies into their daily routines and includes training and support for the primary caregiver (whoever that may be).
8. Explaining the parents' role and responsibilities in this process as we work together to provide support and intervention.
9. Implementing Part C federal regulations pertinent to the steps involved in intake, evaluation/assessment and eligibility.

This Effective Practice Guideline Module will take service providers through the various steps as outlined in the flow chart for Nevada Early Intervention Services (see page 6).



Remember to follow local program procedures.

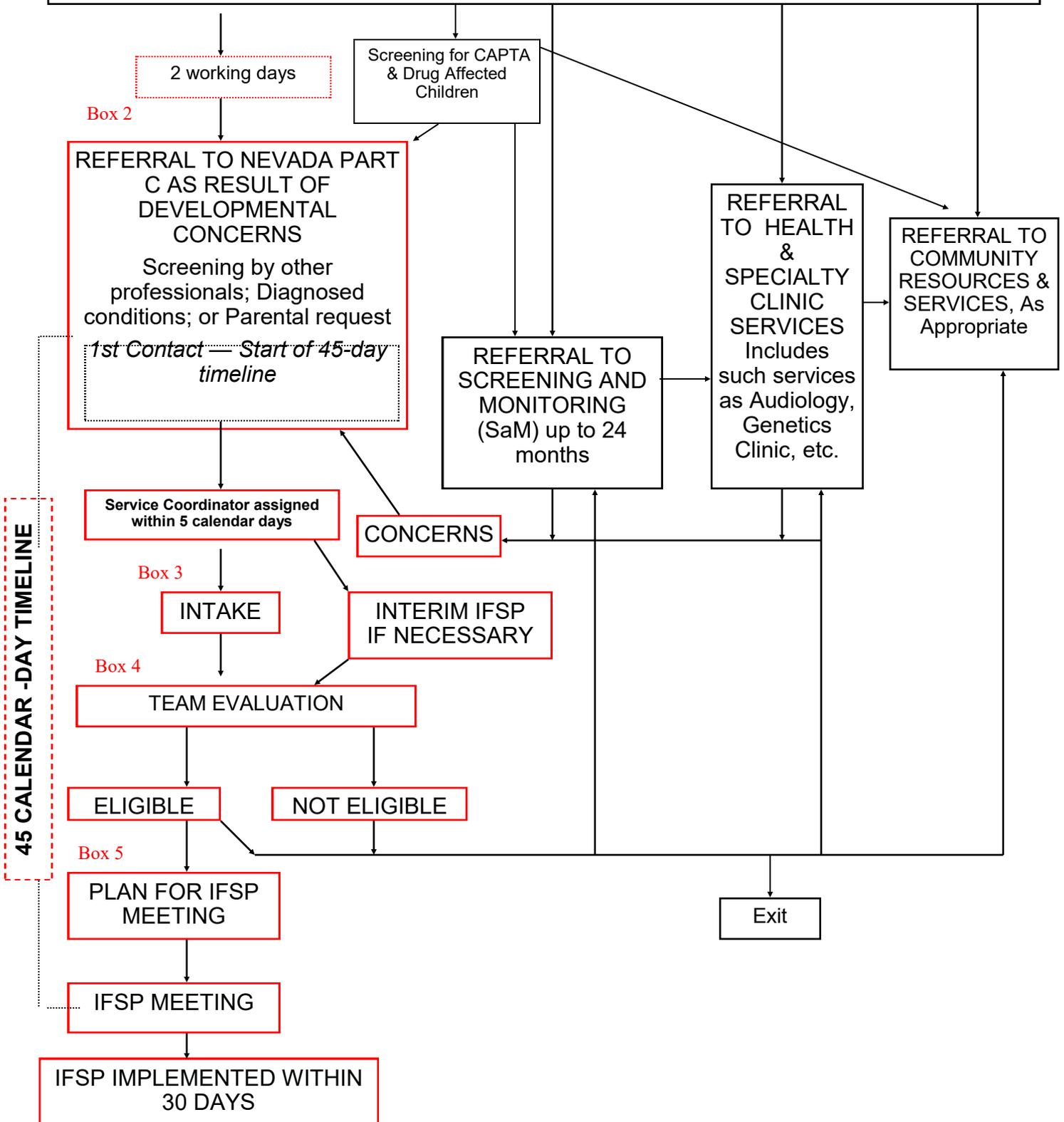


Be friendly, supportive, and conversational; show interest in the family, and remember that this is the beginning of the relationship-building process with the family.

Box 1

NEVADA UNIVERSAL INTAKE ACTIVITIES

Activities conducted to identify children who may be eligible for Part C or children at-risk of developmental delay who are in need of screening, monitoring or further evaluation.



Federal Part C Regulations: 34 CFR Part 303

303.321 Comprehensive Child Find System

(b) Procedures. The child find system must include the policies and procedures that the state will follow to ensure that ---

(1) All infants and toddlers in the state who are eligible for services under this part are identified, located, and evaluated; and

(2) An effective method is developed and implemented to determine which children are receiving needed early intervention services.

(c) Coordination

(d) Referral procedures

(1) The child find system must include procedures for use by primary referral sources for referring a child to the appropriate public agency within the system for

- (i) Evaluation and assessment, in accordance with Secs. 303.322 and 303.323; or
- (ii) As appropriate, the provision of services, in accordance with Sec.303.342(a) or Sec. 303.345.

(2) The procedures required in paragraph (b)(1) of this section (see above) must—

- (i) Provide for an effective method of making referrals by primary referral sources; and
- (ii) Ensure that referrals are made no more than two working days after a child has been identified.

(3) As used in paragraph (d)(1) of this section (see above), primary referral sources includes—

- (i) Hospitals, including prenatal and postnatal care facilities;
- (ii) Physicians;
- (iii) Parents;
- (iv) Day care programs;
- (v) Local educational agencies;
- (vi) Public health facilities;
- (vii) Other social service agencies; and
- (viii) Other health care providers.

e) Timelines for public agencies to act on referrals.

(1) Once the public agency receives a referral, it shall appoint a service coordinator as soon as possible.

(2) Within 45 days after it receives a referral, the public agency shall—

- (i) Complete the evaluation and assessment activities in Sec. 303.322; and
- (ii) Hold an IFSP meeting, in accordance with Sec. 303.342.

Flow Chart (page 6) Box 1

INITIAL CONTACT:

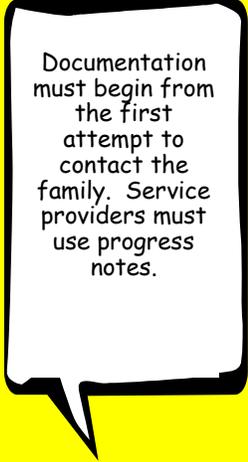
Families find out about Nevada Early Intervention Services (NEIS) in a wide variety of ways, including through public awareness materials (e.g. brochures, posters, magnets), communication with their child's caregivers, physicians or other health professions, and/or information shared by relatives, friends or acquaintances. Regardless of how families are connected with NEIS, the initial contact with families by NEIS serves as a foundation for building a trusting partnership between families and providers.

Keeping in mind the importance of continuity for the family, the local program decides which professional will have the initial contact with the family. Although an administrative assistant may speak with the family and get their name and phone number, the referral/intake coordinator will either answer or return the initial call and will talk with the family on the phone or in person. The referral/intake coordinator is responsible for gathering the information needed to provide appropriate guidance for the family to make a decision about which program (Screening and Monitoring, Part C, CAPTA Screening, or Specialty Clinics) they should be referred to if this is not known prior to the initial contact.

If the first call is from a hospital, physician's office, or other primary referral source, the first contact with the family must be initiated within two (2) working days of the referral call. If the parent does not respond to attempts to contact within the 2 days, unless it is clear that the referral is for Screening and Monitoring (SaM) or specialty clinics, the default is to Part C. If the parent make the referral the two (2) working day requirement does not apply. If the family walks into the site office, efforts will be made to complete the intake in person at that time.

Conversations are used by the referral/intake coordinator to gather relevant information from families. The referral/intake coordinator must determine the family's primary means of communication and, if necessary, arrange for an interpreter (follow your programs procedures). Questions and prompts are individualized and are based on each family's story and style of communication. Conversations with open ended questions and prompts will make it easier to gather more information from the families. To help families make an informed decision, the referral/intake coordinator might ask the family the following questions:

- What are your concerns about your child's development?
- If someone told you to call us, what were their concerns?
- Did anyone look at your child's development?
- Who suggested that you call early intervention services?
- Was a screening done (and explain what that means)?
- Has your child received early intervention services in another



Documentation must begin from the first attempt to contact the family. Service providers must use progress notes.



When talking with the family, refer to the child by name.

state through an IFSP?

- What things are going well with your child?
- Does your child have a pediatrician that s/he sees? Have you talked with your doctor? Is s/he concerned?
- Does your child have any medical concerns?
- How do you think your child hears/sees?
- How is your child eating and sleeping?
- Tell me about your child's communication, walking, etc. Do you think s/he talks/walks like other children his or her age? *(See Appendix M for developmental milestone charts and what to look for at certain ages)*
- Does your child have any behaviors that concern you?
- How can we help you?
- Based on the child's age, ask some developmental questions, for example, is s/he sitting, walking, how many words does s/he use?
- Is there anything about your family such as your cultural background or beliefs, that would be helpful for us to know in working with you, your child and your family?
- Has your child received early intervention services in another state through an IFSP?

If the referral is from a community provider, make sure to respond back to the referral source, either by a form letter, phone call, etc. acknowledging the referral.

A summary of the conversation and the response from the family to the questions must be documented in the child's record, (e.g. progress notes, intake forms) based on local procedures. It is critical that there is documentation of which program the family decided on and why.

The referral/intake coordinator also shares the following information with the family in order to help them make a decision regarding services for their child.

- Nevada Early Intervention Services (NEIS) provides a number of programs including Part C services, SaM program, Specialty Clinics, CAPTA referrals, and community resources. If it is not clear which program the child should be referred to default to Part C.
- Part C Early Intervention Services are provided at no cost to families. Private insurance may be billed for some services with the parents' permission.
- The purpose of early intervention is to assist and support the family in enhancing their child's development through participation in everyday routines and activities.
- Early intervention services do not take the place of a medical home or regular pediatrician visit.
- Early Intervention Services are provided at a variety of locations. These can include the family's home, the community, child care locations, community parks, etc. In situations where the outcome cannot be met in a natural

The information gathered by each professional should be cohesive and shared with all other team members. It is the responsibility of each service provider to review the previously gathered information PRIOR to meeting with the family.

environment (in specialized settings) appropriate justification must be documented.

Based on information shared by families, the referral/intake coordinator is responsible for informing families when applicable that Part C services are the most appropriate for meeting their child's needs (e.g. a child with established conditions, or medical eligibility (*See Appendix A for Medical Eligibility Diagnosis*)).

The referral/intake coordinator should not recommend services based on the availability of service providers but on what is the most appropriate for the child.

For children who have received early intervention services in another state the referral/intake coordinator must explain that Nevada may have different eligibility criteria. Information from the other state's early intervention program should be used to make a decision regarding referral to Part C.

If the referral is not an appropriate referral to any of the programs offered by BEIS, the referral/intake coordinator should attempt to assist the family in linking with other community resources e.g. Project ASSIST, Early Head Start, etc.

This is the first decision point. Determine appropriateness of referral to:

- Part C Early Intervention Services;
- Screening and Monitoring for Children at Risk (SaM);
- Part C and Community Resources & Services and Specialty Clinic Services such as Craniofacial, Metabolic or Fetal Alcohol;
- SaM and Community Resources & Services and/or Specialty Clinic Services;
- Community Resources & Services and/or Specialty Clinic Services, Project Assist, Early Head Start; or
- Child Abuse Prevention and Treatment Act (CAPTA) and Drug Affected Screening Program

CAPTA referrals are from children's protective services and are of children under the age of three who have been substantiated as having been abused or neglected; have positive drug screen or withdrawal at birth, pursuant to CAPTA Section 106(b)(2)(A)(x1). (*See Appendix B for CAPTA TRAC Technical Assistance Document*)

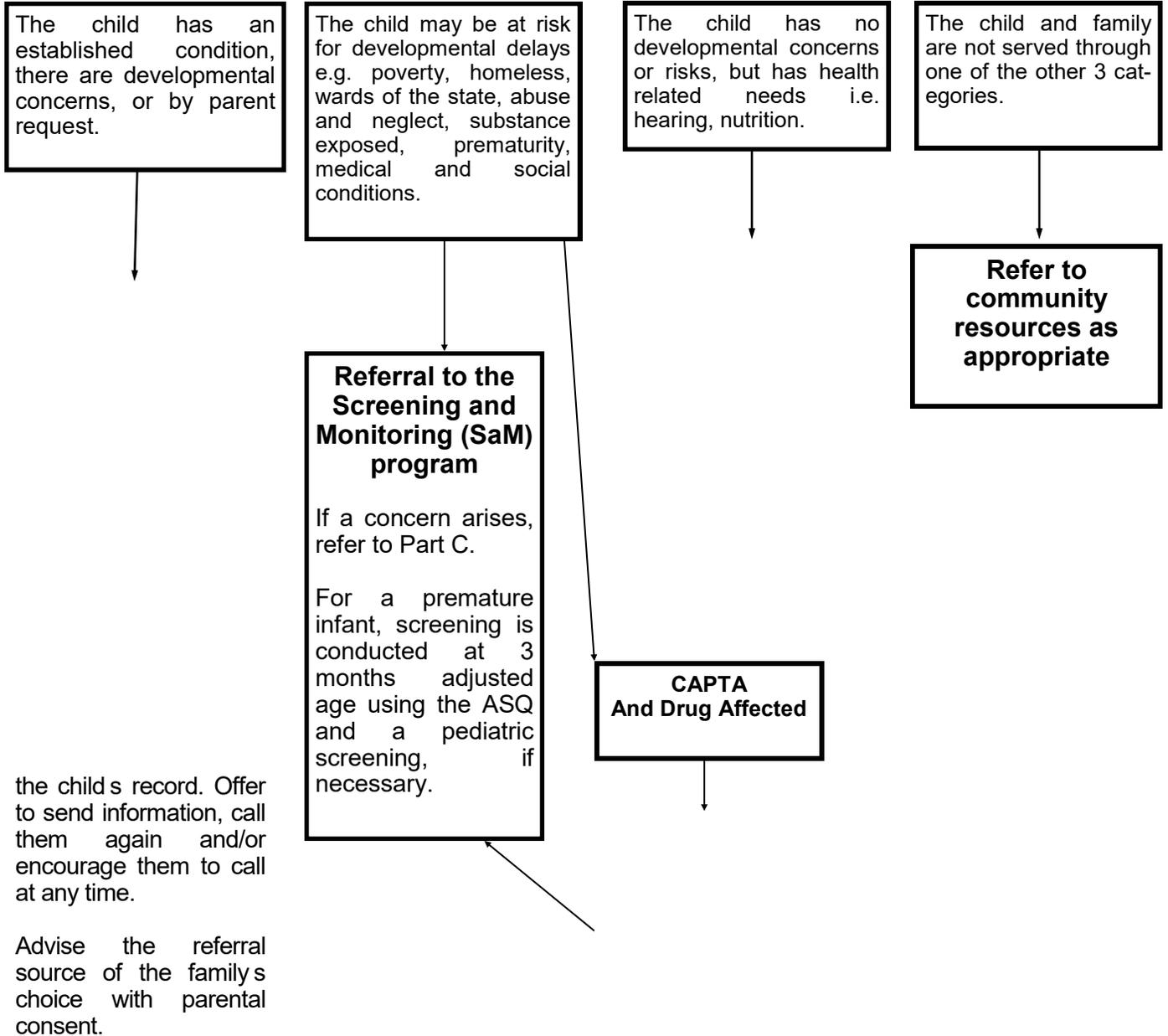
The referral/intake coordinator will send a letter to the family confirming which program the child will be referred to. A copy of this letter must be put into the child's record (*See Appendix C for a sample letter*).



Information gathered during the initial contact is the first time data is entered into TRAC. Children should be entered into TRAC within one week of referral. Ensure that the TRAC data is correct e.g. name spelling.

Remember to send a letter to the family confirming which program the child will be referred to and a copy of the letter must be put into the child's record.

NEIS Service Decision Matrix



***NOTE:** All infants and toddlers who meet the criteria, refer to Specialty Clinic services. If developmental concerns or risk factors are identified, children are referred to Part C or SaM as appropriate. Children in Part C or SaM can also be receiving Specialty Clinic services.

Flow Chart (page 6) Box 2:

REFERRAL TO NEVADA PART C SERVICES AS A RESULT OF DIAGNOSIS OR DEVELOPMENTAL CONCERNS, SCREENING BY OTHER PROFESSIONALS, DIAGNOSED CONDITIONS, OR PARENTAL REQUEST

In order to save the record in TRAC the referral/intake coordinator is responsible for ensuring that the following required information is entered into TRAC:

- Child's Name (Check for Correct Spelling)
- Child Contact Information
- Gender
- Date of Birth
- Referral Date
- Race/Ethnicity (if known)
- Referral Status (screening, referral, etc.)
- Service Coordinator
- Referral Source



Remember to update the service coordinator in the TRAC system any time there is a change.

If there are any developmental concerns identified during the initial contact, the child should be referred to the Part C system. The programs must have procedures for appointing the service coordinator and documenting the date of assignment including the process for ensuring that the timeline has been met. If a child has come from another state with an IFSP, utilize information from assessments and the IFSP as appropriate for decision making.

Programs complete all steps to meet the 45-day timeline with a minimum of two face to face visits unless there are exceptional circumstances e.g. child becomes ill, family has an emergency, the child has a medical diagnosis, or the child is coming from another state with evaluations and an IFSP. Local programs have procedures as to how to accomplish all required steps within these 2 visits (*Follow local program procedures*).

The process of completing eligibility and the IFSP within 45-days is not required to be met in the natural environment, but is encouraged if feasible to do so.

Once the decision has been made regarding referral to Part C, including children who have come from other NEIS programs e.g. SaM, the local programs must have procedures, which include the following components for intake.

For all referrals to Part C :

- A service coordinator is appointed within 5 days of referral and the same service coordinator will be maintained until the 45 day timeline process has been completed.
- Determine if a surrogate parent must be appointed, and if so appoint one. A surrogate parent must be appointed if the child is a ward of the state and no parent can be identified, and/or after reasonable efforts have been made to try to find the whereabouts of the parents (*See Surrogate Parent Decision Tree, Appendix D*).
- Determine the primary means of communication and, if necessary, arrange for an interpreter. Service coordinators need to follow local procedures for accessing interpreter services. Section 303.401(b) Native language, where used with reference to persons of limited English proficiency, means the language or mode of communication normally used by the parent of a child eligible under this part.
- Advise the family that a Resource Packet will be coming in the mail and that the service coordinator will sit down with the family at the intake visit to explain parent rights. Inform them that information on community resources (including respite information), training opportunities, and programs offered by NEIS will be included.
- Schedule an intake appointment.
- If the child has come from another state with an IFSP, utilize the information the family has including assessment results, IFSP information, etc.
- Review all information gathered during the initial contact and determine what additional information, if any, needs to be gathered during the intake.
- If other than a family member referred the child; send a letter thanking the referral source. Programs cannot share any information related to the status of the child without written parental consent. Programs can share whether the parent followed through with the intake/evaluation process or not.

INTAKE

Flow Chart (page 6) Box 3:

The intake visit is an opportunity for the service coordinator or the family specialist working under the service coordinator to meet with the child and family, and further discuss and clarify the Part C service delivery system in Nevada. Complete necessary paperwork and continue gathering relevant information from the family that will be helpful for the evaluation and assessment and in the development of an Individualized Family Service Plan (IFSP) if the child is eligible. The intake visit is also an opportunity for the service coordinator to continue the development of a collaborative partnership with the family.

The service coordinator is responsible for explaining to the parent at the intake visit:

- The purpose of the early intervention program
- BEIS philosophy, and information about the program
- How services are provided including information on how children learn

This explanation is critical to support the family in making informed decisions and to begin to understand early intervention services. The following information is included in this explanation:

The purpose of the program:

- To meet the child's developmental needs and support the family in enhancing their child's development.
- To provide services and supports for children under three (3) years of age who are experiencing developmental delays or have a medical or physical condition that may lead to a developmental delay.
- The philosophy of NEIS is to support the capacity of the family in enhancing their child's learning and development.
- Early intervention services and supports are provided to an infant or toddler with a delay in one or more of the following areas:
 1. Physical development (including fine and gross motor, vision and hearing)
 2. Cognitive development (thinking skills)
 3. Communication development
 4. Social or emotional development
 5. Adaptive development
- Services and supports are to be provided at no cost to families.
- Services and supports are designed to meet the child's and family's needs.
- Services and supports are most often provided at home or in the community where there is interaction with children who are typically developing and where multiple opportunities for natural learning occur.
- Services and supports, which are based on individualized needs of children and families and in the context of everyday routines and activities, are provided in accordance with an IFSP.
- The parent is entitled to all of the rights and procedural safeguards guaranteed under Part C of the IDEA, Section 303.400 to 303.460 (*see Parent Handbook*).

The focus of early intervention is on supporting the family and other key caregivers in facilitating their child's learning and development through participation in everyday routines. This is what happens between visits (e.g. activities of the family, community activities that the family and child participate in). All services and supports provided are based on the individual needs of the child and family. (See *Appendix E, Providing Services and Supports to Children and Families Fact Sheet.*)

Intake

At the intake appointment, the service coordinator is responsible for:

- gathering any additional information from the family in order to complete the intake form
- ensuring that relevant information about the child and family is available to adequately prepare for the initial evaluation and assessment (e.g. family and child interests, everyday routines and activities.)
- documenting family concerns/priorities, developmental status, relevant medical and social information, diagnosis if one exists, any screening or evaluation/assessment reports that have been performed.
- determining if other evaluations need to be completed and schedule the appointments. (See *Appendix F for criteria for referring for evaluation/assessment by discipline.*)

The service coordinator uses conversations to gather relevant information from families regarding their interests, priorities, concerns and everyday routines and activities, rather than a formal interview or solely by the family completing a needs assessment form. Gathering this kind of information is critical in order to obtain a complete picture of what's working, what's not working, and where the family would like assistance in their day-to-day caring for their child. Such information helps to focus the evaluation and assessment as well as help in developing meaningful family outcomes and designing intervention strategies that build on family strengths and capacity if their child is eligible for Part C services. (See *Family Assessment on page 26 for more information on conversations.*)

At the intake appointment, the service coordinator is also responsible for completing and fully explaining the following documents in family friendly language:

- Provide a copy of "Parent Handbook," and explain Parents' Rights.
- Explain the "Permission to Share and Obtain Medical Records" form and obtain signature.
- Explain the "Consent to Evaluate and Assess" form and obtain signature.
- Explain the "Consent to bill private insurance" form (if applicable) and obtain signature.
- Provide a copy of the HIPAA guidelines, explain and obtain signature.
- Explain other releases as appropriate or required and obtain signature.

If the family does not provide consent for the Initial Evaluation and Assessment, the service coordinator makes reasonable efforts to ensure that the family is fully aware of their options and understands that their child will not be able to receive the evaluation and assessment or services unless consent is given. Consideration should be given to talking with the family not only about the potential effects of refusal, but also to alert them to other available services (e.g. SaM, Specialty Clinic Services, Early Head Start, or private resources). If the service coordinator believes the failure to consent to evaluation and assessment would constitute neglect as defined in the child abuse and neglect laws of Nevada, the service coordinator should discuss next steps with their supervisor.

The service coordinator is responsible for documenting information gathered during intake and completing TRAC updates.

Preparing the Family for the Initial Evaluation and Assessment of Their Child

Prior to completing the intake visit, the service coordinator is responsible for informing the family about the evaluation/assessment and eligibility determination processes. The following points are included in the explanation:

- The purpose of the initial evaluation and assessment is to identify the unique strengths and needs of the child and to determine eligibility.
- At least two (2) professionals from different disciplines and the parent will be involved in conducting the initial evaluation and assessment and determining eligibility.
- During the initial evaluation and assessment as part of the process include: review of pertinent records, child observation, parent interview, developmental assessment to determine the child's strength and unique needs and informed clinical opinion. *(Note if using Informed Clinical Opinion to Make the Child Eligible see Criteria on Eligibility Form Appendix I.)*
- Complete the vision and hearing screening forms if not already completed. *(See Appendix G)*
- The staff who conduct the evaluation/assessment will observe the child playing with appropriate toys to identify the kinds of things the child can do. Eligibility will be determined following those observations. *(See page 17, Sec.303.322 Evaluation and Assessment.)*
- The family will have an opportunity to identify their concerns and ask questions of the full team.
- If the child is eligible for Part C services, the professionals who complete the evaluation and assessment will work with the family to develop an IFSP that identifies services and supports appropriate to meet the child's and family's needs. The IFSP meeting must occur within 45 days from the date of referral.
- If the child is not eligible for Part C service, the team will discuss other services and programs that might be appropriate for the child. A number of these programs and services are described in the Resource Notebook within each program.

Avoid using jargon such as PT, OT, IFSP, etc. Remind the family to ask questions if you say something they don't understand.

In accordance with 34 CFR 303.322 (e), the initial IFSP meeting must be within 45 calendar days of referral. As a result, intake, evaluation/assessment, and eligibility determination must be completed in a reasonable time frame to ensure that the IFSP meeting can be held within the 45-day timeline. The timeline may only be exceeded for family reasons. For example, the family may choose to take more time to consider their options or their child may be hospitalized causing a delay in the process. These delays must be documented in case notes and TRAC.

Team Evaluation and Assessment of the Child

Flow Chart (page 6) Box 4:

The service coordinator explains to the family that s/he will determine the other team members based on the concerns identified through conversations during the initial contact and intake. The service coordinator will contact the family to advise them of the composition of the team that will participate in the initial evaluation/assessment to determine eligibility, and schedule the evaluations and assessments.

Sec. 303.322

(a) General.

(1) Each system must include the performance of a timely, comprehensive, multidisciplinary evaluation of each child, birth through age two, referred for evaluation, and a family-directed identification of the needs of each child's family to appropriately assist in the development of the child.

(2) The lead agency shall be responsible for ensuring that the requirements of this section are implemented by all affected public agencies and service providers in the state.

(b) Definitions of evaluation and assessment. As used in this part--

(1) Evaluation means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of "infants and toddlers with disabilities" in Sec. 303.16, including determining the status of the child in each of the developmental areas in paragraph (c)(3)(ii) of this section.

(2) Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify--

(i) The child's unique strengths and needs and the services appropriate to meet those needs; and

(ii) 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.

(c) Evaluation and assessment of the child. The evaluation and assessment of each child must--

(1) Be conducted by personnel trained to utilize appropriate methods and procedures;

(2) Be based on informed clinical opinion; and

(3) Include the following:

(i) A review of pertinent records related to the child's current health status and medical history.

(ii) An evaluation of the child's level of functioning in each of

During the evaluation and assessment explain to the parent what you are going to do beforehand, and then describe it again as you are doing it.

Family assessment may be completed before or after the child's evaluation/assessment. It must be completed before development of the IFSP. Family Assessment is an ongoing process not just at the initial IFSP.

the following developmental areas:

- (A) Cognitive development.
- (B) Physical development, including vision and hearing.
- (C) Communication development.
- (D) Social or emotional development.
- (E) Adaptive development.

(iii) An assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c) (3)(ii) of this section, including the identification of services appropriate to meet those needs.

(e) Timelines.

- (1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in Sec. 303.321(e).
- (2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will--
 - (i) Document those circumstances; and
 - (ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with Sec. 303.345 (b)(1) and (b)(2).

Sec.303.323 Nondiscriminatory procedures

Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that--

- (a) Tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so;
- (b) Any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory;
- (c) No single procedure is used as the sole criterion for determining a child's eligibility under this part; and
- (d) Evaluations and assessments are conducted by qualified personnel.

HOW TO CALCULATE ADJUSTED AGE FOR ASSESSMENT AND OUTCOME DEVELOPMENT

If a child is born at 35 weeks gestation or earlier, you must adjust for prematurity unless the child has reached 24 months of age. The adjustment is no longer implemented after 2 years of age.

To adjust, subtract the number of weeks premature from 40 weeks (typical gestation is 40 weeks). Then use that number to subtract from the child's chronological age.

EXAMPLE:

A child was born at 29 weeks gestation with a birth date of 5-10-03 and was seen on 6-1-04. 40 weeks
~~-29 weeks~~
 11 weeks to be adjusted (11 weeks = 2 months, 21 days)

(You assume that a month equals 4 weeks, a month has 30 days, and a week has 7 days) 04 6 1 (Date seen)
~~-03 5 10~~ (Birth date)
 1 0 21 1 year 21 days chronological age

1 0 21 (Chronological age)
~~- 2 21~~ (Amount to be adjusted)
 10 0 10 months adjusted age

The percentage of delay is based on the adjusted age. You should use adjusted age when making eligibility determination.

The purpose of the initial evaluation and assessment of the child is to:

- determine the child's continuing and ongoing eligibility,
- determine the status of the child in each of the developmental areas, and
- identify the child's unique strengths and needs and the services appropriate to meet those needs.

This information is gathered for use in developing a meaningful IFSP and in providing appropriate services and supports. This process is a collaboration between parents and service providers as important members of the multidisciplinary team. During the evaluation and assessment process professionals continue to build their relationship with the family. Parents are the experts on their child and provide much of the information critical to developing a complete picture of the child's abilities. This is also an opportunity for parents to ask questions and receive clarification.

In order for the initial evaluation and assessment to be conducted, the service coordinator is responsible for the following:

- Preparing the family for the initial evaluation and assessment and helping them understand what happens during the steps that follow the evaluation and assessment, including eligibility determination, IFSP development, and implementation of early intervention services and supports that meet the individual needs of children and families. (*See Preparing the Family for the Initial Evaluation and Assessment page 16.*)
- Determining through appropriate local program procedures, those team members (at least two professionals from different disciplines) including the parent, that should be involved in conducting the Initial Evaluation and Assessment of the child and in determining eligibility based on the individual needs of the child and family. The team may include a pediatrician or other physician, an occupational or physical therapist, a speech language pathologist, a developmental specialist, a nutritionist, etc.
- Scheduling the initial evaluation and assessment with the team and family.
- Providing the family with Prior Written Notice for the evaluation, informing the family of their rights under Part C, and obtaining signed consent for assessment.
- Compiling information gathered from the family during the initial contact and intake, including any family concerns and priorities related to their child's participation in everyday routines and activities that were discussed.
- Preparing the professionals who will be a part of the Multidisciplinary Team in conducting the initial

Remember: .A diagnosis of prematurity, under the eligibility criteria of mental or physical diagnosed condition, does not automatically qualify a child for early intervention services unless the child is born at 750 grams or less than 25 weeks gestation. To be eligible, a child must have additional diagnosed condition (s) e.g. Hydrocephalus, Meningitis, etc. that has a high probability of resulting in developmental delays.

Engage the child and move at the child's pace while conducting the evaluations and/or assessments.

evaluation and assessment. Preparation of the team includes the following:

- a. Providing relevant medical and developmental information on the child.
- b. Providing a summary of information gathered from the family during initial contact and intake. This summary should include information on the child's and family's everyday routines and activities (what's working) family concerns (what's not working) and family priorities (where they would like help).
- c. Determining with the team, any specific focus that should be included in the evaluation and assessment (e.g. observation of feeding or positioning) and the specific evaluation/assessment tools that will be used based on individual needs of the child.

When in the family's home, remember to turn your cell phone off in order to give your undivided attention to the child and family, or notify the family when expecting a call.

The evaluation and assessment team, including the service coordinator and parent(s), must consider the following points and carry out specific actions as indicated.

- A. Sensitivity is especially important, during the initial evaluation and assessment. This may be the first time that parents receive confirmation that there are concerns about their child's development. As a result, the evaluation and assessment team, including service coordinator, is responsible for:
 - Sharing all information in an open and honest matter, and not withholding information.
 - Not deciding what parents can or cannot handle;
 - Being aware of the parents' level of understanding and avoiding jargon.
 - Not rushing the process; and
 - Being responsive to the family's questions and concerns.
- B. The service coordinator and team members are responsible for:
 - Respecting the parent(s) as the expert on their child. This means listening and valuing the parent's perspective.
 - Reassuring parents and focusing on the child's abilities rather than the skills they have not yet developed.
 - Validating the information the parents report and verify, "Is what we're seeing today representative of what your child can do on a daily basis?"
 - Sharing information and checking in with the family to help engage them in the evaluation/assessment process.
- C. Evaluation and assessment are used to determine the present levels of development and the unique needs of the child in the following five domains:

The 45-day timeline may only be exceeded due to family reasons. For example, the family may choose to take more time to consider their options or their child may be hospitalized causing a delay in the process. These delays must be documented in case notes and TRAC.

- Physical Development (fine/gross motor, including vision and hearing) (See *Appendix F for Vision and Hearing Screening forms.*)
- Social/Emotional Development
- Cognitive Development
- Adaptive/Self-Help
- Communication (including both receptive and expressive language and speech sound production)

The evaluation and assessment team is responsible for:

- Ensuring that no single procedure is used as the sole criterion for determining a child's eligibility.
- Selecting and administering tests/instruments that are appropriate for the child, based on individual strengths and needs.
- Selecting and administering assessment and evaluation procedures and materials so as not to be racially or culturally discriminative.
- Selecting and administering evaluations and assessments that the evaluation team is qualified to use.
- Administering tests and other evaluation materials and procedures in the native language of the parents or other mode of communication, unless clearly not feasible to do so.
- Reviewing pertinent records related to the child's current health status and medical history and any information shared from families regarding their everyday routines and activities, child and family interests and motivators, family concerns, priorities and resources, etc.

Service Coordinators must review all information in the child's record prior to the initial evaluation/assessment. Parents become frustrated when asked the same questions over and over again.

Best practice methods in early intervention related to evaluation and assessment promote an interdisciplinary team approach where professionals and the parents/caregivers observe typical **routines and activities in the life of the child and family** and offer an individualized developmental assessment for infants and toddlers. As a result, the evaluation and assessment team considers best practice strategies in conducting the evaluation and assessment including:

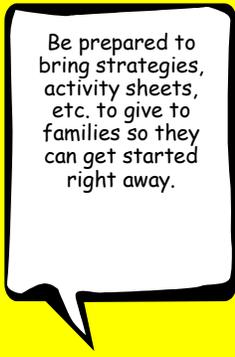
- Observing parent/child interaction;
- Interacting directly with the child and family within the context of their everyday routines and activities; and
- Determining whether a transdisciplinary/arena assessment is an appropriate method for evaluating and assessing the child.

Prior to child assessment/evaluation you must have the parents' signature for consent.

After completing the initial interview and child evaluation with the family, the team is responsible for sharing all information with the parents in a sensitive, honest, and forthright manner. When discussing the results of the initial evaluation, the following topics should be

included:

- If the family thought the abilities and behaviors observed during the evaluation were an accurate reflection of their child's development
- Results of the evaluation tools
- Reinforcement and discussion of the child's strengths
- Reflection on the family's concerns that initiated the referral to NEIS



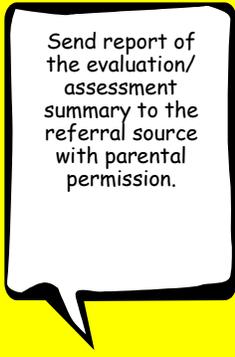
Be prepared to bring strategies, activity sheets, etc. to give to families so they can get started right away.

Documenting Results of Evaluation and Assessment

The results of the evaluation and assessment must be documented either in a written report and/or on the present levels of development page of the IFSP. This must be completed by the multidisciplinary team within ten (10) working days and a copy provided to the family in a language the family can understand. Team members are responsible for including their impressions of the child's strengths and needs and potential strategies for supporting the family in addressing the needs of the child. Team members should not include specific recommendations for services and supports including frequency and intensity, since these are IFSP team decisions and are determined based upon family priorities, functional outcomes, and the supports and services that are needed to meet the outcomes.

Ongoing Evaluation and Assessment

Throughout the child's and family's participation in early intervention, service providers assess the child's progress on an ongoing basis to determine response to intervention, progress toward outcomes and progression of the child's developmental and functional skills. This ongoing assessment occurs within the course of service provision. A service provider or parent, during the course of intervention, might identify the need for additional evaluation. This may occur as the service provider gets to know the child and family better. For example, a team member might notice that the child is having unusual difficulty going up and down steps and may be concerned that there is an underlying problem affecting the child's muscles and balance. A developmental specialist may recommend an evaluation by a physical therapist or physician. An additional evaluation or re-evaluation may be appropriate when a child has had a major medical event that has clearly impacted the child's developmental status or when continued eligibility of the child is needed.



Send report of the evaluation/assessment summary to the referral source with parental permission.

Documenting Additional Evaluations & Services After Initial IFSP

Regardless of when or how the need for additional evaluation is identified, it must occur within the context of the IFSP process. An additional evaluation or a consult by a team member, if it relates to an outcome on the current IFSP, may be added as a strategy. However, if as a result of the consult it is determined that a change is needed to the

IFSP, then a prior written notice must be provided and an IFSP meeting convened to make a change to outcomes or services and supports.

If there is not an outcome on the IFSP addressing an area of concern and it is determined that a therapist needs to provide a consult or evaluation/assessment, this would be considered a new service. Whenever there is to be a change in the child's service, **a prior written notice must be provided and an IFSP review must be conducted.** Therefore, any time an additional evaluation, or new consult is recommended, an IFSP review must be held and parents must sign the revised IFSP (which lists the additional evaluation, re-evaluation or consult) before that additional evaluation, re-evaluation, or consult can be conducted. At a minimum the IFSP review (which does not have to be a face-to-face meeting) must include the parent(s); any other friend or family member(s) requested by the family; the service coordinator; and any direct service providers as appropriate. The decision to conduct an additional evaluation is a team decision made by the IFSP review team. If the IFSP team determines that a full re-evaluation is needed (e.g. in the case where a child has experienced a major medical crisis that has resulted in significant loss of developmental skills or has had surgery that has drastically improved function), then that full re-evaluation must be conducted using two or more disciplines. Likewise, the IFSP review team must review the results of any additional evaluation and make decisions to change any outcomes or services as necessary.

Any evaluation/assessment conducted under Part C (regardless of whether it is the initial evaluation/assessment or a subsequent one) must be provided at no charge to the family.

Before sending a written report of the evaluation/assessment summary to the referring physician you must have release consent signed by the parent(s).



Document in TRAC the Child's criteria for eligibility. It is either delay, diagnosed condition, or Clinical Opinion not a combination.

Reviews of the IFSP that are not done face to face should be to accommodate the parent's needs, not program needs. IFSPs should be face-to-face in most cases.

Nevada's Eligibility Definition

- A. A child exhibits a minimum of fifty percent (50%) delay of child's chronological age in one of the areas listed below or a minimum of 25% delay of the child's chronological age in any of the two areas listed below.

The delay(s) must be identified in one or more of the following areas:

1. cognitive development;
2. physical development, including vision and hearing;
3. communication development;
4. social or emotional development; or
5. adaptive development.

- B. Children will also be eligible who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delays. (See *Appendix B-Medical Diagnosis for Automatic Eligibility*.)

NOTE: A diagnosis of prematurity, under the eligibility criteria of mental or physical diagnosed condition, does not automatically qualify a child for early intervention services. To be eligible, a child must have additional diagnosed condition(s) e.g. Hydrocephalus, Meningitis, etc. that has a high probability of resulting in developmental delays.

Informed Clinical Opinion is "a necessary safeguard against eligibility determination based upon isolated information or test scores alone. 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" (*Shackelford, 2002; see Appendix G. For complete document or <http://www.nectac.org/pubs/titlelist.asp#nnotes10>*).

According to Nevada's Early Intervention Policy Document, page 1, (available from the Part C office or at <http://health2k.state.nv.us/BEIS>) children ages birth through two years will be determined eligible for early intervention services if they meet one of the criteria above through medical diagnosis, test scores from reliable evaluation tools and/or by informed clinical opinion. Eligibility can be determined immediately upon referral if the child meets the criteria for medical eligibility. Evaluation and assessment will be conducted to identify developmental levels for the IFSP.

If a child is not eligible, document in notes that referral to other community programs was discussed and information given.

Explain to families coming from other states that the child will have to meet Nevada's Eligibility Definition. All states have their own eligibility definition for early intervention services.

Eligibility Decision

At the time of decision making for eligibility, the service coordinator is responsible for providing **Prior Written Notice** around this decision.

- If the child is eligible, sign the eligibility form (*See Appendix H for Eligibility Form and Technical Assistance*). Explain procedural safeguards related to next steps and the development of an IFSP. (*See Prior Written Notice TA document in Appendix I.*)
- If the child is not eligible, complete the prior written notice and remind parents of their procedural safeguard rights if they disagree. The eligibility form is not required if a child is not eligible.

Discussion of Next Steps. This is another time the four options diagrammed on page 6 should be reviewed and decisions made based upon the child's eligibility status and the unique needs of the child and family.

- Child Eligible for Part C: If the child is eligible for Part C, the service coordinator is responsible for preparing the family for the IFSP meeting, including Prior Written Notice. (*See Module III- Individualized Family Service Plan.*) In addition, based upon the unique needs of the child and family, referral to community resources and/or referral to Nevada's Health Services should be discussed with the family. If referral is made to community resources, appropriate release of information forms must be completed with the family prior to making the referral.

If the child is eligible and the family agrees to move to development of the IFSP on that day, make sure that the appropriate box on the PWN form is signed. If the family wishes to invite others to participate, needs to discuss with other family members, etc. then complete a PWN form for when the IFSP meeting is scheduled.

- Child Not Eligible for Part C: If the child is not eligible for Part C, the service coordinator is responsible for discussing other possible options with the family. If the child is at risk for developmental delay, information should be shared with the family regarding the Screening and Monitoring Program (SaM). Based upon the unique needs of the child and family, referral to community resources and/or referral to Nevada's Health Services should also be discussed with the family. If referrals are made to community resources, appropriate release of information forms must be completed with the family prior to making the referrals.

This discussion should function as the closure of the eligibility team's initial interview and evaluation. It is the responsibility of the team, to take as much time as needed and answer all of the family's questions regarding the above, or other, topics. Recommendations for type, frequency, and duration of services should not be stated at this time but will be addressed by the IFSP team.



If a child does not qualify for services note this in TRAC.



Part C is a voluntary program and parents may choose not to accept services. Document in TRAC the reasons for refusing services.

When referring a child to other community agencies appropriate release information must be obtained.

Family Needs Assessment

Section 303.322 Evaluation and Assessment

(d) Family assessment.

(1) Family assessments under this part must be family-directed and designed to determine the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

(2) Any assessment that is conducted must be voluntary on the part of the family.

(3) If an assessment of the family is carried out, the assessment must--

(i) Be conducted by personnel trained to utilize appropriate methods and procedures;

(ii) Be based on information provided by the family through a personal interview; and

(iii) Incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development.

(e) Timelines.

(1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in Sec. 303.321(e).

(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will--

(i) Document those circumstances; and

(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with Sec. 303.345 (b)(1) and (b)(2).

Another part of the assessment process, prior to development of an IFSP, is a family needs assessment. This may include the use of an Eco-map and a Routines-Based Interview (See pages 28-29). It is the responsibility of the service coordinator to complete the Family Assessment.

The following are aspects of a Family Assessment:

- It is a confidential, voluntary, family-driven process rather than a one-time event.
- Conversations are used to gather information about the family's interests, concerns, priorities, and resources as related to their child's development.
- Discussions about routines, activities, and environments help to identify functional outcomes and supports and services necessary for the child and family.

Keep in mind that this is a family-directed, voluntary process and it is up to the family regarding how much information they wish to share.

Family Assessment must be done within the 45-day timeline and prior to IFSP development.

- This on-going assessment should be documented through DAP (Data, Assessment, Plan) or SOAP (Subjective, Objective, Assessment, Plan) notes.
- The service coordinator must document the information gathered from the Family Assessment into the IFSP on the Concerns Priorities and Resources page.

Following are some examples of activities that may be used to help the IFSP team determine functional outcomes.

- The service coordinator should be familiar with information the family has already shared through previous early intervention contacts.
- When the service coordinator first meets the family, s/he can summarize the information and ask the family if anything has changed.
- The service coordinator should ask the family to tell their story about their child and family. Allow the family to begin from the place where they are most comfortable.

Conversations take place with the family from the very first contact. Information gathered and documented during the initial contact should be reviewed. The service coordinator may wish to consider the following kinds of questions during conversations to elicit family responses, especially if families struggle in telling their story:

- Can you tell me about your day?
- What types of things happen on most mornings? Afternoons? Nights? Weekends?
- Where do you and your child spend time?
- What types of things or activities do you and your child like to do (e.g., hiking, going on picnics, playing games at home)?
- What are your child's interests? What things does your child enjoy and what holds your child's attention (e.g., people, places, things such as toys, dog, being outside)?
- What makes your child happy, laugh and/or smile?
- What routines and/or activities does your child not like? What makes these routines and/or activities difficult and uncomfortable for your child? What does your child usually do during these routines/activities?
- Who are key family members, other caregivers, or important people who spend time with your child and in what settings does this occur?
- Are there activities that you used to do before your child was born that you would like to do again?
- Are there new activities that you and your child would like to try?
- Are there any activities or places that you go (e.g., doctor's appointments, visiting grandparents) that occur on a less regular basis (e.g., once a week)?

FAMILY ASSESSMENT TOOLS

Service coordinators may use a number of specific family assessment tools/methods in conjunction with conversations with families based on local program procedures. The Eco-Map, the Routines-Based Interview, and Activity Based Needs Assessment are examples. Information about each of these tools/methods are as follows:

The Routines-Based Interview (RBI)

The Routines-Based Interview is NOT a time schedule of the family's day. It is an instrument to guide discussion with families and leads to a conversation about their routines and how things are going for them within those routines. Some common routines include meal time, play time, bath time, etc.

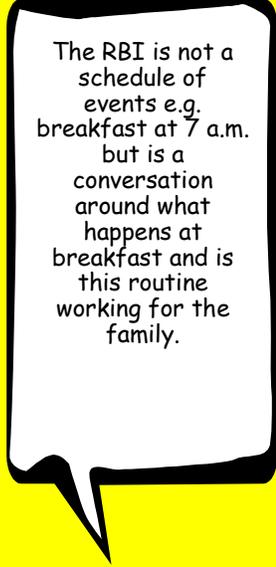
“The single most powerful component ... for conducting early intervention in natural environments is ... routines-based assessment. Professionals and parents who have watched or participated in one of these routines-based interviews (RBIs) are amazed at the amount of information that emerges about:

- The child's developmental status
- The family's day-to-day life, and
- The feelings of the family member being interviewed”

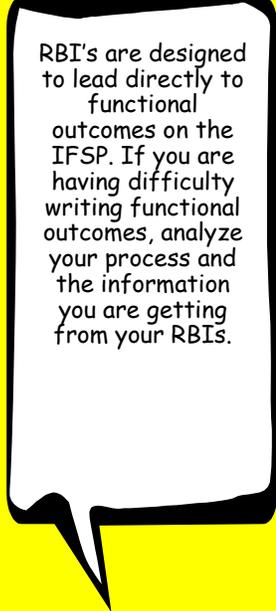
McWilliam 2001 outlines the steps early interventionists should follow to conduct an RBI to prepare the family to discuss their everyday routines. (See *Appendix K Functional Intervention Planning: The Routines-Based Interview developed by R.A. McWilliam, Ph.D.*)

The information gathered in the RBI is used to assist the team in developing outcomes and initial strategies that will assist the child and family during their daily activities. This, in turn, helps the team determine what types of supports the child and family will need to meet their outcomes.

When introducing the routines-based interview, this would also be a good time to explain the road map that the family and service providers will use to guide the early intervention services the family will receive through the IFSP (See *IFSP Module III*).

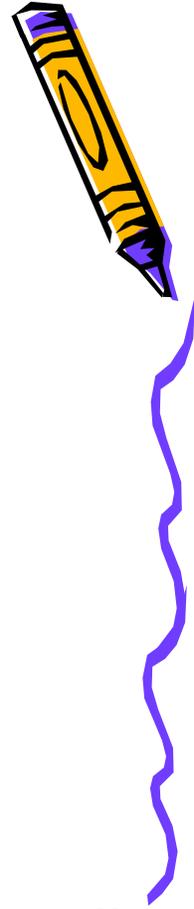
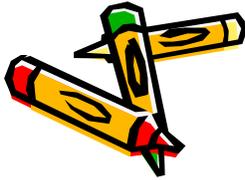
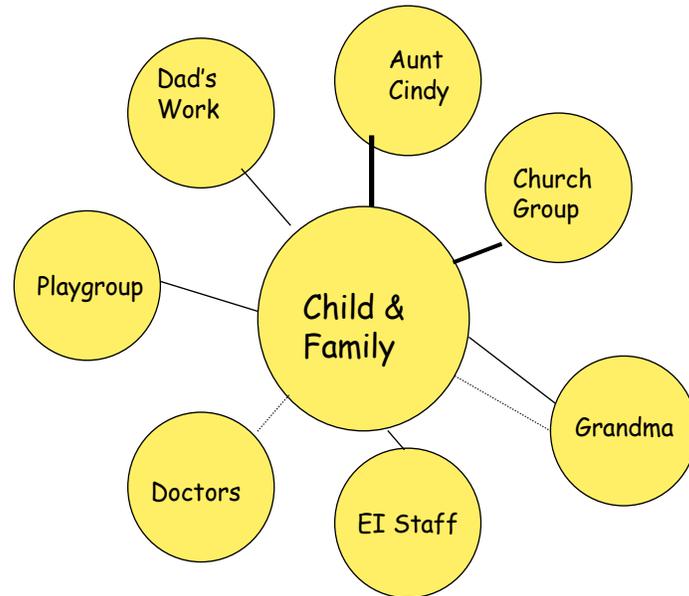


The RBI is not a schedule of events e.g. breakfast at 7 a.m. but is a conversation around what happens at breakfast and is this routine working for the family.



RBIs are designed to lead directly to functional outcomes on the IFSP. If you are having difficulty writing functional outcomes, analyze your process and the information you are getting from your RBIs.

Eco-Map



The Eco-Map

Eco-maps are developed through conversations with the family early in the intake and assessment process, keeping in mind that this is a family-directed, voluntary process and it is up to them how much information they wish to share. An Eco-map is a visual representation of who is a part of the family and the larger world in which the family exists. Its primary use is to highlight the relationships among the family and other systems and people. It provides a tangible, graphic picture of a family's situation.

Eco-maps use symbols to depict the nature of the relationships between the family and other systems. "Dunst, Trivette, and Deal (1994) suggest that the identification of resources should be done within the context of a family-identified need to ensure that the identification of resources and supports is not intrusive to the family" quoted in McBride and Brotherson (1997). Eco-map can be used with the Routines-Based Interview or the Activity-Based Needs Assessment for understanding the family's routines or activities.

Activity-Based Family Needs Assessment and Intervention

An alternative to the RBI is the Activity-Based Assessment developed by Dunst and Bruder. Activity Settings are described as "...situation-specific experience, opportunity, or event that involves a child's interaction with people, the physical environment, or both, and provides a context for a child to learn about his or her own abilities and capabilities, as well as the propensities and proclivities of others" (Dunst, Bruder, et. al., 2001).

Bruder suggests that the IFSP process includes:

- Identifying the family's concerns, priorities, and resources: beginning a partnership;
- Identifying the family's activity settings: [recognizing] the value of home and community;
- Identifying the child's developmental strengths and needs in the context of the family's activity settings: [using] functional assessment strategies; and
- Identifying collaborative outcomes:
 - ◆ To enhance family capacity
 - ◆ To enhance child competence
 - ◆ To expand activity settings

This process leads to the development of functional outcomes for young children and their families. Two simple forms to help providers identify and expand activity settings for children and families are included in *Appendix K*.

Flow Chart (page 6) Box 5:

See IFSP Module III for procedures on the development of an IFSP.

Appendix A

Medical Eligibility Diagnosis with Nevada Early Intervention Services

This list is not all-inclusive

Chromosomal

trisomy, deletions, Fragile X syndrome, Prader-Willi, Down syndrome, Cri-du-chat, Williams syndrome, CHARGE association, Robin Sequence (not a complete list & limited to syndromes associated with developmental delays)

Neuromuscular Disorders

Cerebral palsy, Muscular Dystrophies, Hemiplegia, Myopathies, Torticollis

Neurocutaneous Syndromes

Tuberous Sclerosis

Spinal cord injuries**Arthrogryposis****Central Nervous System**

Major brain malformations, Hypoxic ischemic encephalopathy, Periventricular leukomalacia, Grade 3 or 4 IVH, or hydrocephalus

Inborn Errors of Metabolism**Sensory Impairment** (vision or hearing loss)**Orofacial Malformations**

Cleft Palate, Treacher-Collins, Pierre-Robin sequence, Velo-Cardio-Facial

Congenital infections**Tracheostomy****G-tube dependent****Organic failure to Thrive****Cyanotic Heart disease****Fetal Alcohol Syndrome****Extreme Prematurity**

(<= 750 grams or <= 25 weeks gestation)—birth weight <1,000 grams with complex NICU history including BPD, ROP, IVH, needs to be individually assessed by the NEIS physician to determine eligibility.

Bacterial or Herpes Meningitis**Infantile Spasms****Shaken Baby Syndrome****Kernicterus****Autism spectrum disorders****List Updated/Reviewed 1/2004**

Dr. Lynn Kinman, Dr. Karin Sigdestad, Dr. Colleen Morris and Dr. Gerardo Rodriguez

Appendix B

CAPTA/Drug Affected TRAC Technical Assistance

When a child is referred to NEIS via a CAPTA/Drug Affected referral, they must meet the following definition:

1. **Is involved in a substantiated case of abuse or neglect**
2. **Is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure.**

When entering a child who is CAPTA/Drug Affected into the TRAC system the following fields must be completed:

1. Child's name
2. Child's date of birth
3. Child's Sex
4. Child's Race
5. Status – **CAPTA/Drug Affected (This is a new status added to our drop down list)**
6. Service Coordinator – **(This is the name of the CAPTA liaison designated within your region)**
7. Parent Information
8. Primary language
9. Interpreter needed
10. Child contact relationship
11. Address including County
12. Referral Date
13. Referral Source – (This drop down would stay the same and identify if social services, hospital, pediatrician, etc is making the referral)
14. Referral Reason – **(This is a mandatory field for CAPTA and Drug Affected, this field will not change regardless if the child's status changes, so that we have a permanent record that the child entered the system due to CAPTA or drug exposure) CAUTION when entering data into this field you must use exactly CAPTA or Drug Affected, do not use any variation from this so we can run queries on this field!**
15. Rights Mailed – **(use date 1/1/1900, this feature will be deactivated for CAPTA referrals in future)**
16. Training List Mailed – **(use date 1/1/1900, this feature will be deactivated for CAPTA referrals in future)**

Cont'd next page

Appendix B Continued

CAPTA/Drug Affected TRAC Technical Assistance

If a Child from a CAPTA/Drug Affected referral passes the screening then this child should be exited from the TRAC database. The following are the steps:

1. Exit date – Input the date the child passed the screening and was exited
2. Exit Status – Exit no IFSP
3. Exit Code – **CAPTA Exit (this is a new drop down in the menu) or**
Exit Code – **Drug Affected Exit (this is a new drop down in the menu)**

If a child from a CAPTA referral fails the screening and a referral is being made to Part C, do the following:

1. Change status – Referral
2. Contact Melanie in the Part C office to change the referral date to the date the child failed the screening. (Program data entry staff are not to change this date)
3. Assign a Service Coordinator (the CAPTA liaison must be changed to an active Part C service coordinator)

Notes – add a note with subject line CAPTA or Drug Affected and note the child failed the screening on date and is being referred to Part C for evaluation and eligibility determination.

If a child from a CAPTA/Drug Affected referral fails the screening, but will not meet Part C eligibility, or has other risk factors and the program determined SaM is appropriate do the following:

1. Exit the child using the CAPTA/Drug Affected exit protocol previously outlined.
2. Note – add a note with subject line CAPTA or Drug Affected in TRAC identifying that the child is being referred to SaM and the date. Enter the child into the SaM database.

Appendix C

Letter to Families Confirming Which Early Intervention Program Child is Referred to

Dear Parent,

The Nevada Early Intervention Services appreciates receiving your recent referral. This letter is being mailed to inform you of the programs offered by Nevada Early Intervention Services. All services are voluntary.

Hearing Screening Program – are available for any child under the age of three who may have a hearing concern and/or a hospital or physician has recommended a follow-up hearing test. These services are available in Las Vegas and Reno.

Early Intervention Program – provides services to children from ages birth through two years experiencing developmental delays and/or has a diagnosed condition that has a high probability of resulting in developmental delays. The services are provided to families to enhance their child's participation in home and community activities. This program operates under state policy and federal regulations that ensure specific parent rights. Before a child receives services, a comprehensive evaluation must be completed to determine eligibility. Specific services are determined by you and a team of professionals based on your child's needs. Additional information on the Early Intervention Program including parent rights can be accessed at www.health2K.state.nv.us/BEIS/.

Specialty Clinics are held in the areas of genetic disorders, metabolic disorders and cleft palate/craniofacial. Any child under the age of three can be referred to any of these clinics which are held in Las Vegas and Reno.

Screening and Monitoring Program – provides follow-up services to help you determine if your child is playing, talking, growing, and moving like other children the same age. At any time, you can request a referral to the Early Intervention Program to determine if your child is eligible for specialized services which are administered in accordance with federal law and include parent rights, which can be accessed at www.health2K.state.nv.us/BEIS/.

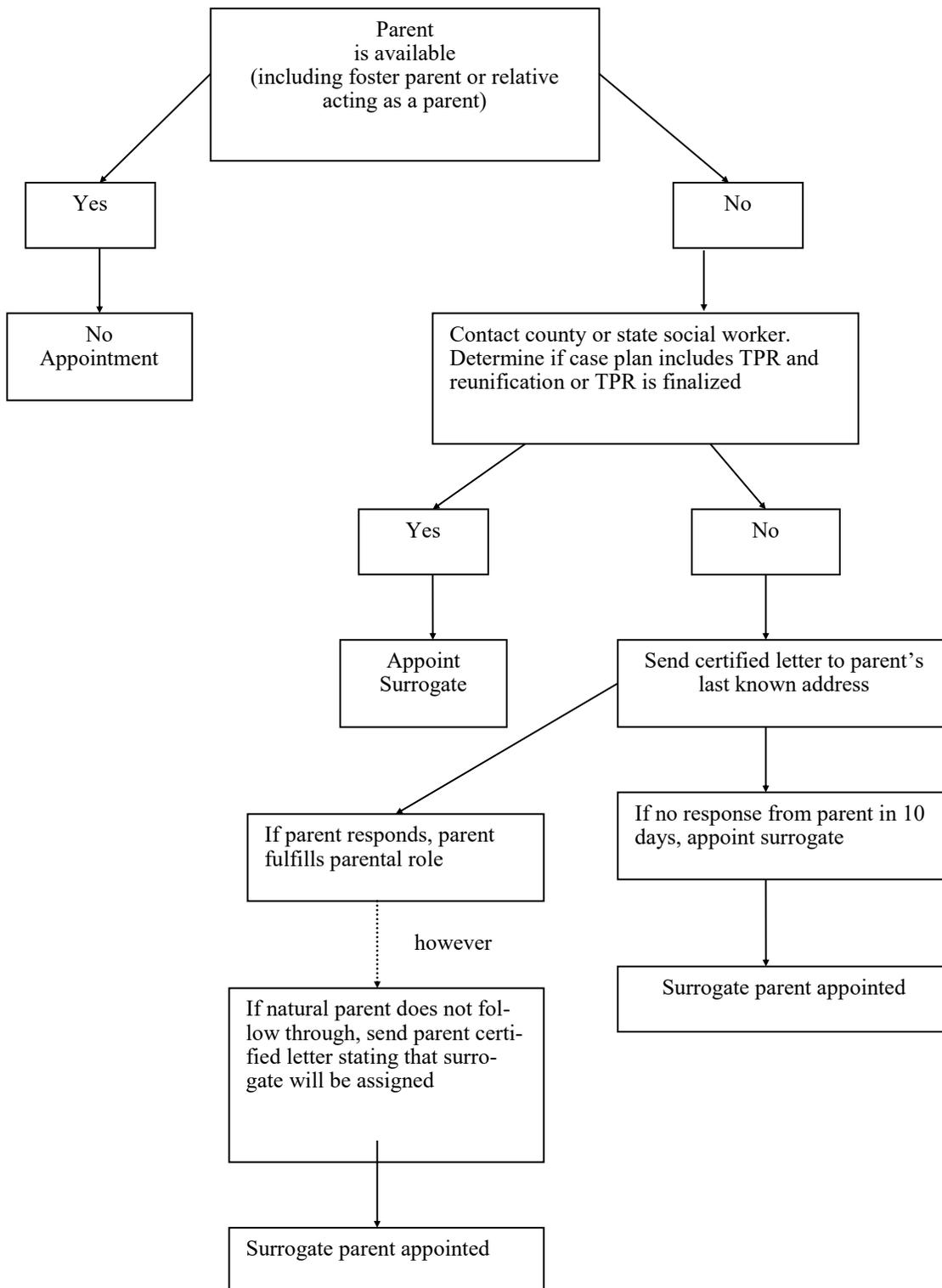
Based on the information provided by you, your child has been scheduled for an appointment for the _____ Program on _____ at _____. You are encouraged to contact Nevada Early Intervention Services at any time for additional information on any of these four programs.

Sincerely,

Name
Insert Name
Regional Program Manager

Appendix D

Surrogate Parent Decision Tree



Appendix E

NEVADA DEPARTMENT OF HEALTH AND HUMAN

Providing Services and Supports to Children and Families

Early Intervention:

Helping Families Meet Their Child's Needs

In early intervention having families and professionals work together as a team is the best way to help a family meet their child's needs. The method known as the primary service provider approach was developed after years of working with families who have young children with developmental delays or disabilities.

When families learn new ways to work and play with their child during normal daily activities and routines then the new skills can be practiced with the child many times every day. The child and

family do not always need to see many different specialists, but those specialists are available when needed. You and your primary service provider can decide when you need specialists to help you. This will usually happen when you need help in deciding what to work on next.

An important part of early intervention services is regular communication among the team members, which includes parents. Professionals suggest new activities and share information with the family and other people who are with the child on a daily basis.

Along with the family, professionals from different fields (for example, early childhood educators, parent educators/home visitors, speech, occupational and physical therapists, social workers, nutritionists, etc.) teach, learn, and work together to reach an agreed upon set of goals (also known as outcomes) for the child and family.

Team members play several roles. Usually one member (the primary service provider) will provide direct services and support to the family and other regular caregivers. Other team members consult with both the family and each other. They do this by sharing their knowledge and experience and by helping each other, and the family and

other caregivers, learn new ways to help the child.

Denver, Ronnee, & November Felzien
from the HAPPY Program in Elko

Goals (outcomes) for the child are developed through team agreement under the guidance of the family. Outcomes are based on the strengths and needs of the child and family.

Current studies have shown this



way of providing early intervention works very well with young children and families.

Early Intervention Service Providers Believe In:

- Families and Professionals Working Together
- Helping the Family Meet the Child's Needs
- Regular Communication Among Team Members
- Combining Activities Within Normal Daily Routines
- Goals (Outcomes) Based on Child's and Family's Needs and Agreed Upon by All Team Members

Appendix E Continued

Working With Your Primary Service Provider

Because your family has the most influence on the way your child grows and learns, the job of your primary service provider is to support you, and other important people involved with your child and family. Your primary service provider will give you suggestions about ways to work and play with your child in places where your child would be if he or she did not have special needs. This will help you help your child learn new things every day.

For the child, receiving services and support in this way means *being* with the people who your child wants and needs to be with and *doing* what the family wants and needs to do.

For the family and other care providers, services and supports provided by the primary service provider helps them develop the

skills and confidence needed to try new ways to help the child learn new things.

During regular visits, your primary service provider's job is to give you emotional support, help your family secure material support, and give you and the other important people involved with your family information and, "suggestions for eating, dressing, playing with toys, sitting independently, or whatever the outcomes for the child are."

"The purpose of the ... visit is to ensure that the family has all the support they need to meet their priorities.... So, ... visitors [primary service providers] will encourage family members, listen to them, make sure their basic needs are met, and provide them with information. One way to provide information

might be to show them things to do with the child. But such a demonstration or "model" is only one of many ways of supporting families" (McWilliam, 1999).

It is important to remember that, although your family will be working with one primary service provider, the other team members will also provide support, consultation, and direct services based on what you, and the rest of your child's team, decide is needed to reach your child's and family's outcomes.

Reference: McWilliam, R. A. (1999). *It's Only Natural... to Have Early Intervention in the Environments Where It's Needed. Young Exceptional Children Monograph Series No. 2.*

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Critical Concepts in Early Intervention

Culturally Competent, Family-Centered Care

- Every family is unique.
- Honors the diversity of families.
- The family is the expert on the child and the constant in the child's life.
- Families are equal team members and the final decision makers.

Natural Learning Environments

- Opportunities for learning occur as part of typical life activities both routine and spontaneous.
- The professional's role is to assist care providers to support or increase the child's participation in existing or desired activities.
- Focus is on activities and locations that are interesting and important to the child and family.

Functional Outcomes & Meaningful Activities

- Supports are designed to achieve outcomes that make a meaningful difference in the life of the child and family.
- Supports occur within and are a part of everyday life.
- Intervention is based on scientific research and analysis.

Appendix F

Occupational Therapy Referral Criteria

Conditions Warranting an Occupational Therapy Evaluation

- Missing digits/limbs
- Hemiplegia or asymmetries
- Movement disorder: inability to sit, roll, or creep, inability to control head
- Poor quality of upper extremity movements with fine motor task
- Global delays
- Delayed in self-care

For focus on sensory modulation/processing

- Poor self-calming
- Problems sleeping
- Doesn't like to be held
- Problems with changes in routine
- Poor suck
- Eating pickiness
- Seeking or avoiding movement or proprioception

Credits:

Debbie Michnal, Occupational Therapist
Kristie McMurray, Occupational Therapist
Janet Kofkin, Occupational Therapist
Anne-Marie Gottlieb, Occupational Therapist

Criteria for Feeding Evaluation

Feeding evaluations are considered for those children who have difficulties with the ability to take in food. Feeding problems may be evident soon after birth but also occur at later stages of development. These children may be identified at time of intake through the nutrition questionnaire or through the intake interview. They may be identified through the comprehensive evaluation process, or once the child is receiving early intervention services. Referrals may also come from specialists in the community, particularly from craniofacial surgery team. A child may be considered for a feeding evaluation based on the criteria below.

- Is the parent concerned about feeding?
- Is the child bottle-feeding and losing liquid while drinking or drooling excessively while drinking?
- Does it take longer than 30 minutes for the child to drink a bottle?
- Is the child at an adjusted age of 6 months not yet eating by spoon?
- After a month of spoon feeding, is the child still pushing food out of his/her mouth or not accepting solids?
- Does the child gag on baby foods?
- Does the child gag with lumpy foods?
- Is the child 8 months adjusted age or older and not yet finger feeding or taking sips from a cup?
- Is the child 12 months adjusted age or older and still on baby foods?
- Is the child 18 months and not interested in using a spoon?
- Does the child have poor head control and/or can the child only be fed in certain positions?
- Does the child have a cleft lip/palate and not growing well (e.g.-weight gain less than 1.5lbs/month during the first 2-3 months of life)?
- Is the child g-tube fed? Does the child gag while receiving g-tube feedings?
- Does the child have any medical conditions that may affect feeding (e.g.– BPD, cerebral palsy, other structural problems with face, jaw, etc.)?

Credits

Anne-Marie Gottlieb, Occupational Therapist
Debbie Michnal, Occupational Therapist
Janet Kofkin, Occupational Therapist
Esther Berenhaut, Registered Dietician
Shirley Farkas, Registered Dietician

Appendix F Continued

Criteria for Nutrition Referral

If the child meets any of the criteria below, it should be discussed at team meeting whether a nutrition evaluation is warranted. The more conditions the higher the risk factors.

- Is the child 30 weeks gestation or less?
- Is the child eating well and still appears thin?
- Has the child's doctor or other persons expressed concern about how the child is growing or eating?
- Does the child have excessive reflux, constipation, or diarrhea?
- Does the family avoid giving the child wheat, dairy, food dyes, sugar, animal products or fats?
- Does the family give the child megavitamins/minerals preparations?
- Does the child or other family members have a history of food allergies?
- Does the child have a medical condition that requires a special diet such as diabetes, metabolic disease (PKU, galactosemia, MSUD), cardiac problems, lung problems, kidney problems?
- Is the child anemic?
- Does the child have dental problems due to the use of bottle or excessive sweets/juice intake?
- Is the child underweight (less than 3%ile weight for height on CDC growth chart)?
- Is the child overweight (above 97%ile weight for length of CDC growth chart)?
- Is the child on any chronic medications-3.g. steroids, antibiotics, drugs for gastric motility or antacids, laxatives, diuretics, cardiac drugs, anticonvulsants, drugs to increase appetite (decadron)?
- Does the child have a syndrome that may affect size-Prader-Willi, Russell Silver Syndrome?
- Is the child at nutritional risk due to low income, food availability, poor parenting skills, etc.?

Credits:

Esther Berenhaut, Registered Dietician
Shirley Farkas, Registered Dietician

Appendix F Continued

Criteria for Speech and Language Referral

- If the child's caregiver or physician has concerns with speech and language development/child's primary area of concern is speech and language.
- If the child, by the age of two years or older, is not at least 50% intelligible to the primary caregivers (i.e., if a child omits the first sound in a word consistently, if it is reported that they are talking "their own language", etc.).
- If the child struggles to make sounds or words. The child may move their mouth without any sounds and appears to be attempting to imitate sounds/verbalizations but without success, or who produces a majority of open-vowel sounds accompanied by gestures to get their needs met (e.g., "uh"). This may be the child who gestures instead of using words and who may be demonstrating age-appropriate skills in all other domains with the exception of expressive language (Motor speech/Apraxic — A child who appears to have difficulty sequencing mouth movements to produce meaningful units of sound).
- Any child with a cleft palate/oro-facial anomaly or suspected/diagnosed syndrome that has an associated speech/language delay/disorder i.e. Down Syndrome, Beckwith-Wiedemann, Pierre-Robin Syndrome, etc. Any child born with a cleft palate and/or cleft lip, as well as Down Syndrome should be referred for a speech and language evaluation/consult immediately following intake.
- Any child who has a history of chronic middle ear infections, PE tube placement, or a hearing loss (Follow criteria on Hearing Screening).
- Any child who is demonstrating a 25% delay in the area of cognition due to the expressive/receptive language items. (SLP could possibly be the second professional to make child eligible).
- If a child is not using three words other than "mama" and "dada" by the age of 15 months.
- Any child who presents with a low oral musculature tone, an open mouth posture, protruding tongue, is drooling excessively, or is having feeding difficulties.
- A child whose language use is limited i.e. a child who mostly imitates and whose use of spontaneous language is limited, is echolalic — uses only a few phrases repeatedly, or doesn't use words for a variety of social functions.

Credits:

Tracie Weber, Speech and Language Pathologist
Angela Solberg, Speech and Language Pathologist
Tracey Solberg, Speech and Language Pathologist
Sandra Hambly, Speech and Language Pathologist
Marsha Ruben, Speech and Language Pathologist
Judy Austin, Speech and Language Pathologist

Criteria for Physical Therapy Referral

These are not complete lists, rather suggestions for referral. Basically, any child who is not meeting motor milestones appropriately, or who moves in an abnormal manner, should be referred for an evaluation.

- Abnormal muscle tone (decreased, increased, athetoid)
- Hypomobility: Limitations in range of motion, i.e., head kept rotated to one side
- Hypermobility: Excessive joint range of motion, i.e., knees locked in hyperextension in standing
- Delays in motor development: cannot lift head off mat by 3 months, cannot roll or reach by 5 months, cannot sit by 8 months, and cannot walk by 14 months
- Reluctance to accept weight on feet in supported standing
- Drug or alcohol exposure in utero
- Children with abnormal gait patterns or who fall frequently
- Children who will not walk and need wheelchairs or other equipment
- Children who were ventilator dependant at birth
- Children who are unable to actively dorsiflex
- Children with asymmetries e.g. not using both sides of the body equally
- Children who have tremors
- Children who are toe walking or walking on the medial borders of the feet
- Any child about whom you have any motor questions
- Parent request
- Physician referral

Diagnoses that should receive Physical Therapy evaluation:

- Prematurity, especially 34 weeks gestational age or earlier. Get evaluation complete by 4 - 6 months of age
- Any progressive neurological diagnosis
- Prolonged oxygen deprivation at birth
- Prolonged NICU stay
- IVH, especially grade III and IV
- Cerebral Palsy
- Spina Bifida, myelomeningocele
- Metabolic syndromes with resultant abnormal muscle tone, i.e., Prader-Willi syndrome
- Genetic syndromes with resultant abnormal muscle tone, i.e., Down's syndrome, CMV, Fragile X, etc.
- FAS or FAE
- All orthopedic diagnoses, i.e, arthrogryposis, JRA, achondroplasia, amniotic band syndrome
- All muscular dystrophy diagnoses, i.e., Werdnig-Hoffman syndrome
- Congenital amputation of a limb
- Erb's palsy. Need to be seen ASAP (before 3 months old)

Criteria for Physical Therapy Referral Continued

- Torticollis. Needs to be seen ASAP (before 3 months old)
- Seizures
- Periventricular leukomalacia
- Spinal cord injuries
- Head injuries

Developed by: Grace Kroll-Hendrix, Carol Aloupis, Lynn McGuire, Libby Brown, Lisa Everett-Bridgewater, Susan Richards and Christie Stitser, Physical Therapists.

Appendix G

Child's Name: _____
 Date: _____

CA: _____
 AA: _____

Vision Screening

The following screening is to be completed with the family to identify or address any concerns regarding the child's vision. If a concern is identified through this screening, a referral should be made to the vision specialist and/or primary health care provider.

Does the family have concerns about the child's vision? Yes___ No___

If so, what are their concerns? _____

Does the child have a documented syndrome, disease or disorder associated with vision loss such as:

- | | |
|---|--|
| <input type="checkbox"/> Congenital Rubella Syndrome | <input type="checkbox"/> Hydrocephaly |
| <input type="checkbox"/> Usher Syndrome | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Leber's Congenital Amaurosis | <input type="checkbox"/> Hurler's Syndrome |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Congenital cataracts | <input type="checkbox"/> CHARGE |
| <input type="checkbox"/> Cortical Visual Impairment (CVI) | <input type="checkbox"/> Other |

Appearance

- Eyes turn in or out
- Crusty or red eyelids
- Excessive tearing
- Different size pupils or eyes
- Eyes in constant motion or "wiggles"
- Droopy lids
- Consistently tilts/turns head to look at objects
- Consistently notices objects on one side only
- Squints/closes eyes/turns away in bright light

Looking

- Does your child look at your face, even momentarily? (1mo.)
- Does your child look at his/her own hands? (3-4 mos.)
- Does your child watch family members or pets around the room? (4-8 mos.)
- Does your child recognize familiar objects across the room? (3-6 mos.)

Reaching and Moving

- Does your child reach for dangling toys? (3-6 mos.)
- Does your child consistently over or under reach? (3-8 mo.)
- Does your child consistently trip over/bump into things in their path? (16-18 mos.)

Appendix G Continued

NEVADA EARLY INTERVENTION SERVICES
HEARING SCREENING QUESTIONNAIRE

Child's Name:		DOB:		CA:	
Date:				AA:	
Screener's Name:		Family Member:			
This form is being used at:		Intake or Initial IFSP (Required)			
		6 Month IFSP Review			
		Annual IFSP (Required)			
		Other			

Hearing Status and Ear Health:

1. Did the child pass the newborn hearing screen in the hospital at birth?	Yes		No	
2. Has the child ever had a formal hearing evaluation?	Yes		No	
Place		Results		
3. If a hearing loss has been diagnosed, what action is being taken (for example, fitted with hearing aids)?				
4. Has your child ever been given medication for an ear infection?	Yes		No	
How many times (approximately)?		When was the last time?		
5. Has your child had fluid in the ears?	Yes		No	
If yes, what was the treatment?				
6. Has your child had p.e. tubes placed in the ears or another type of ear surgery?	Yes		No	
Date		Doctor		
Type of surgery?				

Children identified as having at least one of the following factors should have a formal hearing evaluation

Parental or Professional Concern	Other Craniofacial Abnormalities (including those of the ear and ear canal)
Speech/Language Delays (including those associated with autism and low cognition)	Craniosynostosis
Family History of Childhood Hearing Loss	Wardenberg Syndrome
Referred on Newborn Hearing Screening	CHARGE Association
Repeated Ear Infections(>3/6 months, or 6/12 months)	Head Trauma w/Loss of consciousness or Skull Fracture/Shaken Baby
PE (Ear) Tube Placement	Any other Diagnosis Associated w/hearing loss
Cleft Palate	Vision Impairment
Cerebral Palsy	

Children identified as having at least one of the following factors should have a formal hearing evaluation every six months:

Down Syndrome	In Utero Infections (CMV-Cytomegalovirus, Rubella, Herpes, Syphilis, Toxoplasmosis)
Usher Syndrome (or family history of Ushers)	Bacterial Meningitis
Hunter's Syndrome	Neurofibromatosis
Persistent Pulmonary Hypertension Mechanical vent > 5 days	Osteopetrosis (Albers-Schonberg Disease)
Use of Extracorporeal Membrane Oxygenation (ECMO Therapy)	Jaundice w/Exchange Transfusion
Known Hearing Loss in One or Both Ears	

Appendix G Continued

Functional Hearing Assessment:

Check only those items at the child's age level

If one or more items are checked as "No," the child should have a formal hearing evaluation

Birth to 3 months

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Startles to loud sounds	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Recognizes parents' voices	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Calms to parent's voice when not seen by child	

4 to 8 months

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Turns head or eyes toward a sound he can't see	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Seems to enjoy shaking a rattle, ringing a bell or squeezing a toy	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	By six months, has begun to babble to himself or back at others who speak to him	

9-12 months

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Responds to his name	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Makes several different consonant sounds when babbling (m, p, b, g, etc.)	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Responds to music by listening, bouncing, "singing" along	

12-18 months

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Imitates and matches sounds he hears with his own speech	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Locates or points to familiar objects when asked	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Understands "mama," "dada," "no," "bye"	

18 Months to 2 Years

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	At 18 months, uses 5 or more words	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Uses his voice most of the time to get what he wants or to communicate with you	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Can get familiar objects that are kept in a regular place if you ask him (for example, "Get your shoes.")	

2 Years to 3 Years

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Uses 2-3 word sentences	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Follows 2 instructions together (for example, "Get the block and put it on the table.")	
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Speech is understandable most of the time	

Recommendations from the Hearing Screening

<input type="checkbox"/>	There are no factors outlined in the hearing screening which would indicate the need for a formal Hearing evaluation.				
<input type="checkbox"/>	There are one or more factors in the hearing screening which would indicate the need for a formal Hearing evaluation and an appointment will be scheduled by the service coordinator and/or family.				
<input type="checkbox"/>	There are one or more factors in the hearing screening which would indicate the need for a formal Hearing evaluation, but the child will not be referred at this time because:				
<input type="checkbox"/>					
<input type="checkbox"/>					



IDEAs ★ partnerships ★ results

NECTAC NotesIssue No. 10
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Informed Clinical Opinion

by Jo Shackelford

Based on previous paper by
Patti Biro, Deb Daulton, and Eleanor Szanton,
in consultation with Constance Garner

The term “informed clinical opinion” appears in the regulatory requirements for the implementation of Part C of the Individual with Disabilities Education Act (IDEA) as an integral part of an eligibility determination (see Table 1). It must be included in evaluation and assessment procedures, since it is a necessary safeguard against eligibility determination based upon isolated information or test scores alone. Since the term carries different meanings for individuals and agencies, it is important to clarify the meaning and use of “informed clinical opinion” in the context of Part C. This document uses a question-and-answer format to address three key issues:

- ★ What does informed clinical opinion mean in the context of Part C?
- ★ How does informed clinical opinion affect the determination of eligibility?
- ★ Why is it necessary to document informed clinical opinion?

What does informed clinical opinion mean in the context of Part C?

Informed clinical opinion is used by early intervention professionals in the evaluation and assessment process in order to make a recommendation as to initial and continuing eligibility for services under Part C and as a basis for planning services to meet child and family needs. 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.

Continued...

Table 1

Part C Regulations Pertaining to Informed Clinical Opinion**Subpart D - Program and Service Components of a Statewide System of Early Intervention Services.****§ 303.300 State eligibility criteria and procedures.****General**

Each statewide system of early intervention services must include the eligibility criteria and procedures, consistent with § 303.16, that will be used by the State in carrying out programs under this part.

(a) The State shall define developmental delay by—

(1) Describing, for each of the areas listed in Sec. 303.16(a)(1), the procedures, including the use of informed clinical opinion, that will be used to measure a child's development; and

(2) Stating the levels of functioning or other criteria that constitute a developmental delay in each of those areas.

(b) The State shall describe the criteria and procedures, including the use of informed clinical opinion, that will be used to determine the existence of a condition that has a high probability of resulting in developmental delay under § 303.16(a)(2).

NOTE: Under this section and § 303.322(c)(2), States are required to ensure that informed clinical opinion is used in determining a child's eligibility under this part. Informed clinical opinion is especially important if there are no standardized measures, or if the standardized procedures are not appropriate for a given age or development area. If a given standardized procedure is considered to be appropriate, a State's criteria could include percentiles or percentages of levels of functioning and standardized measures.

§ 303.322 Evaluation and assessment.

(c) *Evaluation and assessment of the child.* The evaluation and assessment of each child must —

(1) Be conducted by personnel trained to utilize appropriate methods and procedures;

(2) Be based on informed clinical opinion; and

(3) Include the following:

(i) A review of the pertinent records related to the child's current health status and medical history.

(ii) An evaluation of the child's level of functioning in each of the following developmental areas:

(A) Cognitive development;

(B) Physical development, including vision and hearing;

(C) Communication development;

(D) Social or emotional development; and,

(E) Adaptive development.

§ 303.323 Nondiscriminatory procedures.

Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that —

(a) Tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so;

(b) Any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory;

(c) No single procedure is used as the sole criterion for determining a child's eligibility under this part; and

(d) Evaluations and assessments are conducted by qualified personnel.

The knowledge and skill of the early intervention multidisciplinary team, including the parents, constitute the basic foundation for the process of becoming “informed” about a child’s developmental status within a socially valid context. In essence, they seek to answer the question, What are the child’s abilities and needs within his/her natural environment? Thus, appropriate training, previous experience with evaluation and assessment, sensitivity to cultural needs, and the ability to elicit and include family perceptions are all important elements of informed clinical opinion.

The individuals and agencies responsible for implementing Part C need to consider **who** might have an informed clinical opinion, **what** these people might have an informed clinical opinion about, and **how** their informed clinical opinion can be integrated into the process of evaluation and assessment. In the context of Part C, these questions should be considered both at the level of the individual early intervention professional and at the level of the multidisciplinary team.

How does informed clinical opinion affect the determination of eligibility?

Informed clinical opinion should be taken into account at both the individual and team levels.

INDIVIDUAL TEAM MEMBER LEVEL The individual early intervention professional uses both qualitative and quantitative information to shape an informed clinical opinion about a child’s development and need for early intervention services. To do so, the professional must have knowledge of the multiple domains of development characteristic of infants and toddlers; the expected sequence of development; and the broad range of individual variations that may be seen in appropriately developing infants and toddlers. In order to reach an informed clinical opinion about the development of a particular infant or toddler, the professional may use any or all of the following:

- ★ clinical interviews with parents;
- ★ evaluation of the child at play;
- ★ observation of parent-child interaction;
- ★ information from teachers or child care providers; and
- ★ neurodevelopmental or other physical examinations.

Information derived from these examples and additional psychometric and diagnostic data are synthesized to

become the “informed clinical opinion” of an individual. The informed clinical opinion should reflect a meaningful assessment of the individual child’s development and family resources, priorities, and concerns, and suggest areas that may require further evaluation.

TEAM LEVEL The multidisciplinary team, which includes family members, then synthesizes and interprets all available information, both qualitative and quantitative, about a child and family offered by the team participants.

This opportunity to integrate observations, impressions, and evaluation findings of the individuals facilitates a “whole child” approach to evaluation and assessment that goes beyond a reporting of test scores. In this way, the functional impact and the implications of noted delays or differences in development can be discussed and considered by the team in determining eligibility and developing the Individualized Family Service Plan (IFSP). Knowledge about available services is useful in formulating the IFSP, but should not limit the recommendations made by the team.

Why is it necessary to document informed clinical opinion?

Appropriate documentation of the sources and use of informed clinical opinion is important for two reasons. First, documentation provides a baseline against which to measure the progress and changing needs of the child and family over time. The initial recommendations of the multidisciplinary team reflect the needs of the child and family at a specific point in time. In Part C, assessment and subsequent eligibility determination is an ongoing process that may require modifications in the IFSP. The perceptions and impressions of individual early intervention professionals may change over time. Documentation of the individual and team findings can facilitate transition when families move, change service providers, or enter additional or new service delivery systems.

Secondly, documentation of the sources and use of informed clinical opinion also can provide information to assure that procedural safeguards were provided in the evaluation and assessment process and the determination of eligibility. This documentation should be maintained by a designated person, such as the interim or permanently assigned service coordinator and the parent.

Thus, the regulations regarding informed clinical opinion

are intended to accomplish the following: 1) ensure a dynamic assessment approach; 2) support and encourage the acquisition and interpretation of multiple sources of information as part of the evaluation and assessment process; and 3) permit greater compatibility between a child and family's needs and the provision of services.

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With Disabilities Rule of 2001, 34 C.F.R. §303 (2001).

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Constance Garner was a policy and program specialist for the U.S. Department of Education, Office of Special Education Programs, Early Childhood Branch, when the previous edition of this paper was prepared.

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Appendix I

DETERMINATION OF ELIGIBILITY FOR EARLY INTERVENTION SERVICES AND SUPPORTS



Nevada Early Intervention Services

Name of Child

Date of Birth

Date of Determination

Eligibility Criteria

Has been determined to be eligible for early intervention services under the Individuals with Disabilities Education Act (I.D.E.A.), Part C according to the criteria checked below:

Your child is under three years of age, and exhibits a minimum of 50% delay of his/her chronological age in the area listed below, or a minimum of 25% delay of his/her chronological age in the two areas listed below. Delays for infants less than 35 weeks gestation shall be calculated according to their adjusted age. The delay(s) must be identified in one or more of the following developmental areas: cognitive; physical, including vision and hearing; communication; social or emotional; or adaptive.

50% delay in _____

OR

25% delay in _____ and _____

OR

Your child is under three years of age and has a diagnosed physical or mental condition that has a high probability of resulting in developmental delays.

Condition: _____

OR

Informed clinical opinion _____

Atypical development and/or behavior (Criteria on back of page must be completed)

Signatures of Multidisciplinary Team Members in agreement:

Name/Signature

Title

Parent

_____ (Required)

Early Intervention Professional

_____ (Required)

Early Intervention Professional

_____ (Required)

Informed Clinical Opinion

Clinical observations and atypical characteristics and behaviors observed:

- Poor suck/swallow/breathe Choking/gagging Vomits following eating
- Indwelling thumbs atypical patterns of movement (describe) _____

- Poor speech intelligibility Echolalia speech
- Other _____

The following questions must be answered in order to use Informed Clinical Opinion:

1. Explain why the evaluation standards and procedures, used with the majority of children resulted in inconclusive findings for this child.

2. Indicate what objective data was used to conclude that the child has a developmental delay and is in need of early intervention services. Data may include test scores; parent input; childcare provider comments; observations of the child in his/her daily routine; use of behavior checklists or criteria-referenced measures; and other developmental data including current health status and medical history.

3. Indicate which data had the greatest relative importance for the eligibility decision.

Appendix J

Prior Written Notice Technical Assistance

1. Name of the child
2. Child's Date of birth
3. Parent or Guardian Name

More than one of the following may be checked depending on what is taking place e.g. IFSP and Transition, IFSP and Exit, Evaluation and Assessment and IFSP Review.

4. Evaluation/Assessment is necessary at this time – this should be checked on a PWN any time the child is going to be evaluated to determine eligibility or ongoing eligibility, or any other time that assessments are being proposed to update the IFSP and present levels of development, including any additional therapy evaluations the child might need.
5. Evaluation and assessment is not necessary at this time – this should be checked if the child was referred to Part C and a screening was completed that did not indicate the child had developmental concerns. If the child passed the screening and there are no other concerns i.e. medical, then the family would receive a PWN that indicates that NEIS is not going to provide evaluation or assessment for the child at this time. This also requires notice of procedural safeguards at this discussion.
6. Child is eligible – the PWN is given to the family at the time of decision of eligibility. When the MDT has concluded the evaluation, reviewed the medical records, has interviewed the parent, observed the child and has all of the information necessary to make a determination of eligibility, the PWN is given to the family advising them that the child is eligible. The MDT would then complete the Eligibility Form with the family and review procedural safeguards at this time.
7. Child is not eligible – the PWN is given to the family at the time of decision that the child is not eligible. When the MDT has concluded the evaluation, reviewed the medical records, has interviewed the parent, observed the child and has all of the information necessary to make a determination of eligibility and the child is determined to not be eligible; the PWN is given to the family advising them that the child is not eligible. An Eligibility Form is not filled out if the child is not eligible. Procedural safeguards must be reviewed with the parents at this time.
8. Meeting to develop an initial IFSP – prior to meeting with the family to develop the initial IFSP the family must receive a PWN advising them of the meeting. The following two scenarios may occur:
 - a. Within the 45-day timeline the MDT has met with the family to determine eligibility, and the family agrees at that time they are ready to move to IFSP development. The PWN would be completed with the family at that time, and 8a. would be completed that the family understands they have a right to timely notice, to invite others to participate and that they are choosing to participate in the action today. The parent would initial this understanding, the PWN would be given to the family and procedural safeguards would be reviewed with the family at this time.
 - b. Within the 45-day timeline the MDT has met with the family to determine eligibility. The family needs more time to think about this, to consult with the other parent, or wants to invite someone else to attend the IFSP meeting. 8b. would be completed that the family is choosing to reschedule the IFSP meeting. The PWN would be completed with the family to determine the date, time and location for the

Appendix J Continued

IFSP meeting. The IFSP meeting must be held within the 45-day timeline.

9. Review of the IFSP – Anytime there is an IFSP review the family must receive a PWN. This notice must be sent or given to the family in sufficient time so that they may prepare and invite others to attend the meeting if they choose. The box should be checked to indicate whether this is a 6 month review, Annual review, or any other review. Procedural safeguards must be reviewed with the family at every IFSP meeting.
10. Transition Plan or Transition Meeting – the Transition Plan is a part of the IFSP and therefore requires PWN when being created, and/or for notice of the transition meeting with the school district. If the transition plan is being created as a part of the initial IFSP, 6 month review, etc. then check the IFSP meeting box and the Transition Plan box, so the parents know that the IFSP is being created or reviewed which includes transition planning. Procedural safeguards must be reviewed with the family at every IFSP meeting. (Transition meetings are required for children exiting to Part B, and are encouraged if the child is exiting to another community program).
11. Program requesting a change – any time the program is proposing any change to the IFSP a PWN is required to reconvene an IFSP meeting. The box for IFSP review should be checked under other and the box for requesting a change. This includes any additions or deletions of outcomes, services, and any change in frequency or intensity, or a refusal of a service. (IFSP meetings are not required if the only change is to strategies within existing outcomes). Procedural safeguards must be reviewed at each IFSP meeting.
12. Parent requesting a change – the parents may request a change to the IFSP at any time. Any meeting to review an IFSP requires a PWN, regardless of who is requesting the meeting. If this request happens during a home visit, and there is an ability to make the change at that time, complete the PWN form with the parent and indicate the parent is requesting the change, and also check the IFSP review box under other. Review procedural safeguards with the parent. If the change requires additional team members, or the service coordinator does not have the IFSP with them, then either give or send a PWN for the IFSP meeting to be scheduled. Procedural safeguards must be reviewed at each IFSP meeting.
13. Exiting early intervention services – whenever a child is exiting early intervention services, regardless of the reason, the parents must receive a PWN. This includes exiting at age 3, moving out of state, exiting because the child has met the exit criteria, etc. If the service coordinator has lost contact with the family, a PWN must be sent requesting to reconvene the IFSP and a notation if the parent does not respond by a certain date that the child will be exited from the program.
14. Date of meeting – this is the date for whatever is being proposed, assessment, IFSP meeting, etc.
15. Time – this is the time for the meeting being scheduled
16. Location – this would indicate where the meeting is taking place. Please use complete addresses when completing this section.
17. Description of the action proposed or refused – what is going to happen needs to be clearly written out for the family, the following are some examples:
 - John has been made eligible for early intervention services. An Individualized Family Service Plan meeting is being scheduled so that services can be implemented.
 - NEIS is not going to provide further evaluation and assessment for Sally at this time.

Appendix J Continued

- A meeting to provide a six month review of Mary's IFSP.
18. Reason why this action is being proposed or refused – the parent has been advised of what is going to happen and this section provides the reason for why it needs to happen, the following will expand on the examples above.
 - The IFSP meeting will determine the outcomes the team, including you as the parents, will develop to meet John's and your family's needs including what early intervention services will be needed, the start and end dates and the frequency and intensity of those services.
 - Sally's screening information indicates that she is developing within normal limits and does not require further evaluation at this time.
 - Mary has been receiving early intervention for six months, the IFSP team, including you, will review the plan to determine Mary's progress, and to change or add any additional outcomes to assist in meeting her and your family's needs.
 19. The Parents Rights document must be given or mailed with the PWN and reviewed at every decision making juncture that requires PWN. (If the parent does not want another copy the rights at a minimum must be reviewed).
 20. Native language – if the parent does not have a written language that this notice can be translated into, or we do not have the ability to provide the translation into written format e.g. Chinese, this box is checked that assures the family has been given the notice in a way that they can understand it.
 21. Parent Acknowledgement – if the PWN notice is being completed with the parent present, then have the parent sign that they received their rights along with the notice. If the PWN is being mailed to the parent, then the parent's signature is not required.
 22. Notice given/sent by and date – this would be the name of the individual who was responsible for either giving or sending the notice. Circle whether the notice was given or sent and note the date that it was mailed or given. The service coordinator is ultimately responsible to ensure that all procedural safeguards are in place. The 2 page Parent Rights document must accompany the PWN.
 23. Notice given to the following IFSP team members -- there are two requirements related to notice for IFSP meetings. 1) Families must receive a PWN including parent rights. 2) In addition families and IFSP team members must receive a notice of meeting that identifies the date, time, location and who has been invited. To consolidate paperwork, Nevada has combined these two notices into one form. The notice for IFSP team members is only required for IFSP meetings. All early intervention providers that are providing services on the child's IFSP should be given a notice of the IFSP meeting. If a supervisor needs to be in attendance at the IFSP meeting, they should be noted in this section as well.

Appendix K

Functional Intervention Planning:
The Routines-Based Interview
R.A. McWilliam 2001

Activity Setting Recording Form

Interventionist: _____	Dates: _____
Parent's Name: _____	Child's Name: _____

EXISTING ACTIVITY SETTINGS	NEW ACTIVITY SETTINGS

Appendix M

Developmental Milestone Charts What to Watch for Tips

**Nevada Department of Health and Human Services
State Health Division**

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3427 Goni Road, Suite 108
Carson City, NV 89706
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