

Guidance Document
Early Intervention Process
for infants, toddlers
and their families

Eligibility Determination
IFSP Development
Intervention Planning



Maine Department of Education
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INTRODUCTION

The purpose of this document is to provide early intervention personnel in Maine's Part C program, including service coordinators and service providers, with guidelines on the process and the necessary steps that must be completed while working with children and families, beginning with referral to Part C (children birth to age three) through evaluation and assessment, Individualized Family Service Plan (IFSP) development, IFSP implementation/review, and transition. The guidelines are designed to streamline procedures, provide a framework for consistent and quality practices, while ensuring compliance and supporting efficient use of existing resources. (NOTE: When child is 45 days or less from 3rd birthday, procedures for the 3-5 year olds will be followed.)

Information contained in the guidelines attempts to assist Part C service coordinators and service providers in understanding the interconnectedness of the various steps of the process with the statewide forms (and instructions for filling them out) that were developed in conjunction with this guide. Information is provided regarding which forms are used and completed during the specific steps of the process. The guidelines also emphasize steps and practices that support positive relationships with the parent/caregiver and the use of the family's interests, concerns, and priorities for their child as the foundation for service provision. As a result, guidance is embedded through the document on how best to gather and use information from families when conducting the Initial Contact, First Visit, evaluation and assessment, developing a meaningful IFSP, and implementing IFSP services and supports that are fluid, meet the needs of children and families, and ensure positive results. A separate section on the roles of families in Maine's Part C Program is also provided.

The guidelines are based on evidence-based practices that are reflected in current early intervention literature. The information included reflects a paradigm shift from the professional addressing the child's development, to the professional enhancing the family's capacity to support their child's learning and development through everyday routines and activities. A summary of the current early intervention literature regarding evidenced-based practices in working with infants and toddlers with disabilities and their families is included in the Appendices.

MISSION AND MODEL OF MAINE'S PART C PROGRAM

The mission of Maine's Part C Program for infant and toddler services is to identify young children (birth through two years of age) with disabilities and who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delays; to provide supports to families that meet the individualized developmental needs of their child; and to facilitate the child's learning and participation in family and community life through the partnerships of families, caregivers, and service providers.

The purpose of Maine's Part C Program is to provide services that promote the child's learning through participation in everyday routines and activities while supporting the parent/caregiver in enhancing their child's development, learning and participation in family and community life.

To accomplish its mission, Maine's Part C Program promotes the following approaches as its service model:

- Use of a **collaborative partnership** with regular communication among team members as professionals and families work together;
- Use of a **multi-disciplinary, family-centered** approach in the evaluation and assessment process;
- Use of **functional outcomes** on the Individualized Family Service Plan to address family concerns and priorities;
- Use of a **primary service provider** in the team approach for service delivery;
- Use of **coaching**, modeling and information sharing to support families' and caregivers' confidence and competence;
- Use of a **relationship-based** approach that increases positive interactions between Parent and child as the foundation upon which new developmental skills can be built;
- Use of **naturally occurring routines** in which instruction is embedded as selected and preferred by the child's family.

Current literature identifies some key concepts that support the implementation of these purposes through effective quality practices. These key concepts are critical to keep in mind.

- Children learn best:
 - when participating in natural learning opportunities that occur in everyday routines and activities as part of family and community life; and
 - when interested and engaged in an activity, which in turn strengthens and promotes competency and mastery of skills.
- The parent/caregiver has the greatest impact on their child's learning since parents know their child best and already intervene in their child's development everyday through planned or naturally occurring learning opportunities.

- Learning opportunities facilitated within the context of family and community life have greater impact on child progress than intervention sessions.
- The parent/caregiver prefers interventions that are easy to do, fit into their daily lives, and support their child in learning skills that help them be a part of family and community life.
- Embedding instruction in routines selected and preferred by families will greatly increase the likelihood that the family will repeat therapeutic activities independently.
- There is a direct correlation between families' perceptions of themselves as competent and empowered to the families' level of follow-through in facilitating learning opportunities throughout daily activities and routines.
- Frequency and intensity of services need to be based on the amount of support the family needs in using natural learning opportunities throughout everyday routines and activities of family and community life. Visits provided too frequently can be disempowering or send the message that the parent/caregiver is not competent.
- Providing early intervention through a primary provider approach does not preclude other team members from consulting or interacting with the family or caregivers.
- Team consultation and collaboration are critical to support family and caregiver competence and confidence related to child learning.
- Supports and services need to be tailored to meet the unique needs and characteristics of every child and family.
- "More is better". This means more learning opportunities, not more services. Learning is what happens between intervention visits. Learning occurs for all children through daily child-initiated play, multiple repetitions and lots of practice with family and friends in their community.

These concepts are not necessarily new to those who have been practicing early intervention. What has changed, however, is how these concepts are translated into practice. Effective early intervention services are not achieved by "taking clinical practice" into the child's home. The practitioner is no longer viewed as "the expert with the toy bag," but as a resource and partner for families and caregivers who are enhancing their child's development and learning. In this new role, the practitioner shares his/her knowledge and resources with the child's key caregivers and provides support to them in their day-to-day responsibilities of caring for their child and in **doing the things that are important to them**. The primary focus of each individual intervention session is on enhancing family capacity and competence in facilitating their child's learning and **participation** in family and community life. Intervention sessions focus on **what's working and what's challenging for the child's and family's functional participation in their everyday routines and activities of community life**.

GUIDING PRINCIPLES OF MAINE'S PART C PROGRAM

Children are special and unique:

- All children are unique, with their individual strengths and talents. The presence of a disability or special need is not the defining characteristic of a child.
- Children grow, develop, and learn within the context of relationships with their families and other caregivers in the activities of everyday routines in their caring environments as well as activities within their community settings.
- Early intervention services enhance and support the capacity of community partners in serving and including young children with disabilities and their families. All children have the right to belong, to be welcomed, and to participate fully in their community.

Families are central to decision making:

- Each family's priorities, values, hopes and diversity are honored throughout the service delivery process.
- Families are partners and decision-makers in all aspects of services; they are the experts about their child's and family's needs.

The early intervention role:

- Service providers across all disciplines value and encourage family participation and collaboration throughout delivery of intervention services.
- The family-provider relationship builds on family strengths and is characterized by mutual trust, respect, honesty and open communication.

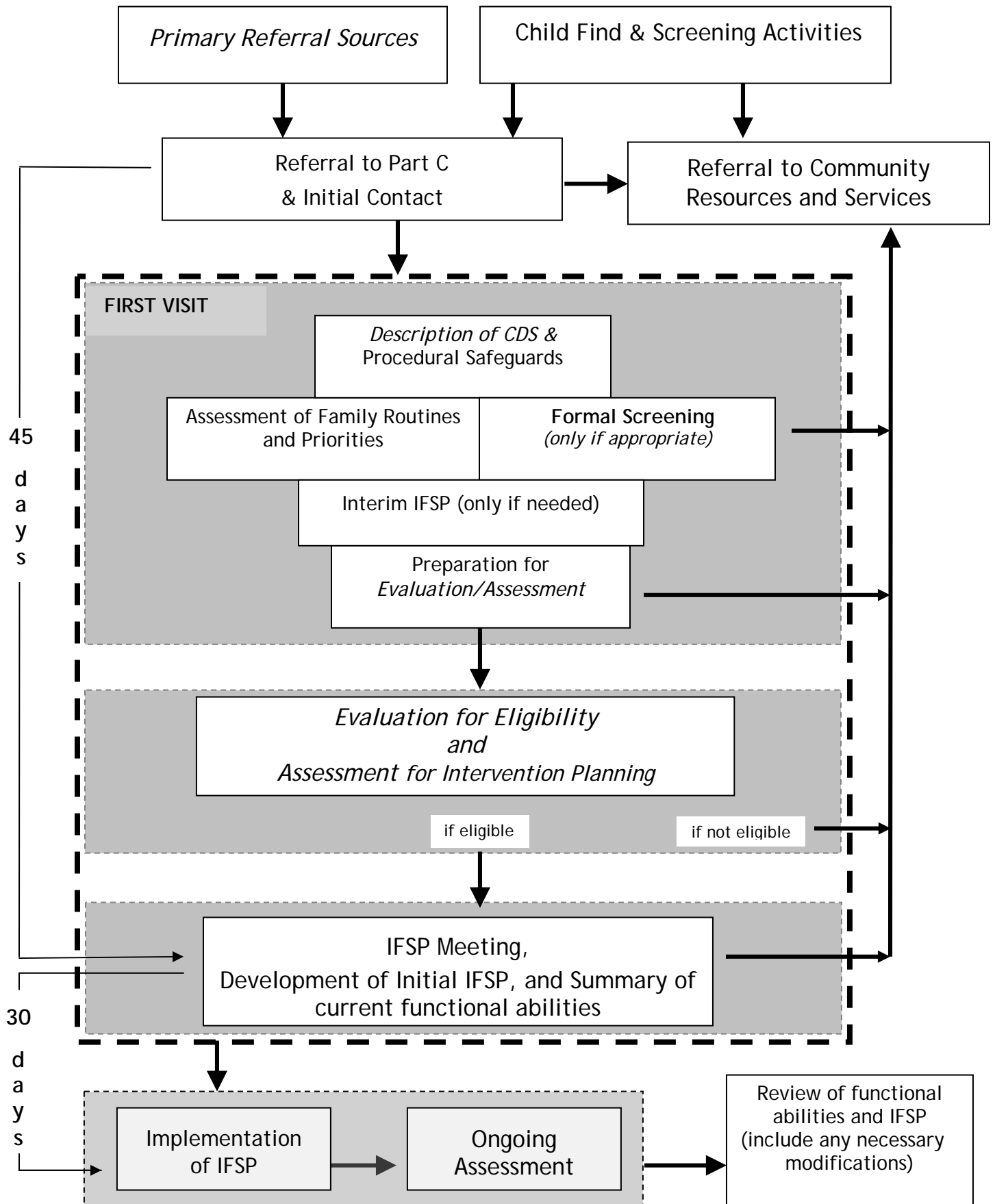
Services and supports:

- Supports, services and resources need to be timely, flexible, individualized and responsive to the changing needs of each child and the child's family.
- Supports and services must be in compliance with federal and state laws and regulations, fiscally responsible, and coordinated with other agencies.

PROCESS FOR MAINE'S PART C PROGRAM

The following flow chart illustrates Maine's Part C program's process of Part C programming, beginning with referral to Maine's Part C Program, intake (Initial Contact and First Visit), evaluation and assessment, IFSP development, followed by intervention/services, ongoing assessment, and IFSP modifications and reviews.

Maine's Early Intervention System



FAMILY ROLES IN MAINE'S PART C PROGRAM

Families play a key role in the successful implementation of Maine's Part C program. Beginning with the first contact, families are provided with information about the purpose of early intervention to enhance the capacity of families to meet their children's developmental needs. Families are also provided with information on what they can expect from Maine's Part C Program as well as the important role families play as a member of the team throughout the process. Once families have this information, they can make informed decisions to define their particular role and involvement in their child's Part C programming.

Essential roles of families/caregivers in Maine's Part C Program are as follows:

- **Initial Contact and First Visit, including Family Assessment** – Families share their concerns related to their child's development, provide the multi-disciplinary team with information regarding their current family routines and schedule, and identify what interactions are working well at home. Families are invited to answer questions (those which they are comfortable answering) and share any additional information they feel the team needs to gain a holistic, ecological view of their family. During this time, families also receive information about Maine's Part C program, including rights and procedural safeguards, and they complete required paperwork.
- **Evaluation and Assessment Process** – Families participate with their child during the evaluation and assessment process; communicating whether their child's functioning during the evaluation and assessment process is typical. They also begin sharing their priorities for the focus of early intervention supports and services.
- **IFSP Development** – Families are active participants in the IFSP meeting. They add pertinent information regarding their child's skills to complement the information gained through the evaluation and assessment. They also identify their priorities for outcomes for their child and their family as well as collaborate with the other team members on strategies for embedding skill development. This will include ways to develop their child's skills within the context of everyday routines and activities as well as through relationships with the people who are important to their child.
- **Part C Programming** – Families work with service providers to identify and learn a variety of strategies to enhance their child's learning and development within their typical, everyday, home and community routines.
- **Review and Evaluation of IFSP Outcomes, Strategies, Supports and services** – Families talk with service providers continually about what is making a difference in their child's and family's life. Families and service providers discuss which strategies are working, how much support the family needs in order to incorporate the strategies into their everyday routines and activities, whether outcomes have been achieved, and what changes, if any, need to be made.

REFERRAL AND INITIAL CONTACT

Demographics, Description of Maine's Part C Program, And Child Medical/Developmental History

Families find out about Maine's Part C Program in a wide variety of ways, including through public awareness materials (e.g., brochures, posters), communication with their child's caregivers, physicians or other health professionals, and/or information shared by relatives, friends or acquaintances. Regardless of how families are connected with the program, the Initial Contact with families made by the designated CDS staff member serves as the foundation for building a trusting partnership between families and service providers. Professional staff (e.g., service coordinator, referral coordinator, case manager) are usually designated the responsibility for carrying out the steps and procedures included in the Initial Contact.

The Initial Contact is usually completed by phone with the family. Since phone contact is not possible for all families, some Initial Contact steps may occur through written communication while other steps are completed during the first face-to-face visit. Part C program sites have procedures that specify how steps and activities associated with the Initial Contact may be carried out in such situations.

During the Initial Contact, conversations are used by designated CDS staff members to gather relevant information in order to plan for next steps and to share information about the program/community resources that may be available to the family. Open-ended questions and prompts are used to support families in sharing their story and other important information about their child in a way that suits the family's communication style. When referral concerns about the child are uncertain/unclear, questions about the child's development are asked to determine whether the parent/caregiver wishes to proceed to the next step.

Procedures: Referral and Initial Contact

(NOTE: When child is 45 days from 3rd birthday, follow procedures for 3-5 year olds)

1. Designated CDS staff member assigned to take referral information completes *Referral Information (Form 1)* that covers demographic information about the child and family, information about the referral source and the reason for referral. If the referral source has any information about the child's medical and developmental status, designated CDS staff members should document this information in the relevant sections of *Child Medical and Developmental Information (Form 2)*.
2. Designated CDS staff member assigned to take referral information determines the family's primary language and means of communication and, if necessary, arranges for an interpreter in accordance with Maine's Part C programming procedures to be available during the Initial Contact and subsequent steps.
3. Designated CDS staff member contacts the child's parent/caregiver by phone. If phone contact is not possible, they use alternative means of connecting with families in accordance with Maine's Part C program site procedures.
4. If the referral source was anyone else besides the family, designated CDS staff members should review developmental and medical information with the family that was shared by the referral source. Designated CDS staff members should ask the family to supply any additional relevant information and document it in the appropriate portions of *Child*

Medical and Developmental Information (Form 2). Some families may be able to readily share information about their child over the phone while others may prefer to complete the discussion during the First Visit.

5. The designated CDS staff member explains the following to the parent/caregiver:
 - The purpose of Maine's Part C programming is designed to assist and support the family in enhancing their child's development through participation and learning in everyday routines and activities;
 - Maine's Part C programming and supports may not necessarily take the place of medical services prescribed by their child's physician or existing service provider;
 - Maine has a family cost participation provision. For children covered by Maine's Medicaid insurance program (MaineCare), the insurance will be accessed. For families with private insurance coverage, parents will be asked to choose between contributing toward the cost of their child's Part C programming on the basis of a sliding fee scale or authorizing access for their private insurance to be billed for some services. If a service is not covered by the insurance policy, the family will be expected to contribute the calculated fee; and
 - Maine's Part C programming and supports are provided in the child's natural environment. Natural environment is each child's existing daily routines and activities and can include the family's home, the community, child-care locations, etc. See Natural Environments section, Federal Part C Regulations.
6. Designated CDS staff member confirms with the family whether they wish to access Maine's Part C programming at this time. The following decisions are made:
 - **Family decides to proceed to the next step in the process:**
 - In accordance with each CDS site's procedures, the designated CDS staff member creates a file that at minimum includes the following forms in preparation for the First Visit:
 - *Referral Information (Form 1)* and *Child Medical/Developmental Information (Form 2)*. These will have already been filled out. The rest of the forms will be blank at this point;
 - Relevant IFSP pages (i.e., *Cover Page, IFSP Pages 2-2a: Family Routines and Priorities, IFSP Pages 3-3d: Present Abilities, Strengths and Needs*) needed for the First Visit; and
 - Consent Forms (i.e., *Authorization to Share Information, Consent for Evaluation and Assessment, Consent for Screening, Prior Notice Form and Notice of Child and Family Safeguards*);
 - Designated CDS staff member determines whether formal screening is needed prior to making a decision that an evaluation and assessment is needed. Formal screening may be appropriate if the designated CDS staff member has questions about whether the child's developmental needs warrant an evaluation and assessment. Guidance about making this decision is located in the First Visit section that follows. Formal screening is usually conducted during the First Visit. A designated CDS staff member schedules a time with the family to conduct the formal screening and to complete all necessary procedures related to the First Visit. When formal screening is completed, results are documented with the child's medical/developmental information (*Form 2*); OR
 - If the designated CDS staff member determines that **evaluation and assessment is appropriate** and that a formal screening is not needed, the designated CDS staff member schedules the First Visit with the family to further explain the

- program, procedural safeguards, and complete the family assessment.
- o Designated CDS staff members determine whether an interpreter is needed or if there are any other communication needs;
- o Designated CDS staff members determine if a surrogate parent needs to be appointed; and
- o Designated CDS staff members compile information for entry into Maine's Part C Program data systems.
- **Family decides not to proceed to next step in the process:**
 - o Designated CDS staff members must complete the following:
 - Inform the family of the right to contact Maine's Part C Program at any time in the future;
 - Share information with the family about other appropriate community resources they may access and connect them to these resource if the family requests; and
 - Send Written Prior Notice and Declining EI form to the family documenting their desire to not access early intervention services at this time and their right to contact Maine's Part C Program at any time in the future.

Service Coordination Assignment and Responsibilities

Federal Part C Regulations: Service Coordination Requirements

34 CFR Part 303.23: Service coordination (case management).

(a) General.

- (1) As used in this part, except in Sec. 303.12(d)(11), service coordination means the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.*
- (2) Each child eligible under this part and the child's family must be provided with one service coordinator who is responsible for--*
 - (i) Coordinating all services across agency lines; and*
 - (ii) Serving as the single point of contact in helping parents to obtain the services and assistance they need.*
- (3) Service coordination is an active, ongoing process that involves--*
 - (i) Assisting parents of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan;*
 - (ii) Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;*
 - (iii) Facilitating the timely delivery of available services; and*
 - (iv) Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.*

(b) Specific service coordination activities. Service coordination activities include--

- (1) Coordinating the performance of evaluations and assessments;*

- (2) *Facilitating and participating in the development, review, and evaluation of individualized family service plans;*
- (3) *Assisting families in identifying available service providers;*
- (4) *Coordinating and monitoring the delivery of available services;*
- (5) *Informing families of the availability of advocacy services;*
- (6) *Coordinating with medical and health providers; and*
- (7) *Facilitating the development of a transition plan to preschool services, if appropriate.*

(c) Employment and assignment of service coordinators.

- (1) *Service coordinators may be employed or assigned in any way that is permitted under State law, so long as it is consistent with the requirements of this part.*
- (2) *A State's policies and procedures for implementing the statewide system of early intervention services must be designed and implemented to ensure that service coordinators are able to effectively carry out on an interagency basis the functions and services listed under paragraphs (a) and (b) of this section.*

(d) Qualifications of service coordinators. Service coordinators must be persons who, consistent with Sec. 303.344(g), have demonstrated knowledge and understanding about--

- (1) *Infants and toddlers who are eligible under this part;*
- (2) *Part C of the Act and the regulations in this part; and*
- (3) *The nature and scope of services available under the State's early intervention program, the system of payments for services in the State, and other pertinent information.*

Note 1: If States have existing service coordination systems, the States may use or adapt those systems, so long as they are consistent with the requirements of this part.

Note 2: The legislative history of the 1991 amendments to the Act indicates that the use of the term "service coordination" was not intended to affect the authority to seek reimbursement for services provided under Medicaid or any other legislation that makes reference to "case management" services. See H.R. Rep. No. 198, 102d Cong., 1st Sess. 12 (1991); S. Rep. No. 84, 102d Cong., 1st Sess. 20 (1991). [58 FR 40959, July 30, 1993. Redesignated at 63 FR 18294, Apr. 14, 1998].

Federal Part C regulations require that every child in a Part C Program be assigned a service coordinator to; coordinate services across agency lines; to serve as the point of contact; to support the family through the multiple steps of the process and ensure receipt of the rights, procedural safeguards, and necessary services and supports. The service coordinator is assigned for each child and family following referral in accordance with each Maine Part C Program site's procedures.

The intent of service coordination is to guide families toward greater confidence and independence in enhancing their child's learning and development through everyday routines and activities. The service coordinator has a role of great responsibility, one that is equally as important as the role of service provider. The service coordinator assists the family in understanding the early intervention process and the family's roles throughout the process. They also ensure that the family receives sufficient information to make informed decisions and to participate as an equal partner in decision making. To ensure this, the service coordinator must assist the family to fully understand what is happening at each juncture, why, and what the impact is for their child and family. In addition, the service coordinator is responsible to ensure that the child and family are receiving all of the services and supports needed to meet their unique needs. This requires coordination within the early intervention program as well as knowledge of other community services and resources. It is also hoped that service

coordinators can assist families to effectively communicate their children's needs in order to prepare them for the future as they transition from Maine Part C Program supports and services.

Procedures: Service Coordination Assignment and Responsibilities

1. Each CDS site assigns a service coordinator following referral to early intervention services in accordance with state requirements and local procedures.
2. Each CDS site can designate the title of the position that is responsible for carrying out service coordination responsibilities (e.g. case manager, intake coordinator, service coordinator, etc.)
3. Each CDS site ensures that personnel assigned to carry out service coordination responsibilities have competencies to carry out these functions.
4. Each CDS site has procedures to ensure that service coordination activities are carried out as required.

Note: Specific service coordinator (e.g., case manager, intake coordinator, etc.) responsibilities are embedded in subsequent steps of the early intervention process.

FIRST VISIT

Screening, Procedural Safeguards, Family Assessment, Interim IFSP, and Preparation of Family for Evaluation and assessment

A designated CDS staff member conducts this part of the process with the child's parent and/or caregiver face-to-face in the child's home or a natural environment appropriate to the child and family.

The information obtained during the First Visit builds upon the results of the Initial Contact to achieve several different outcomes. The combined information is the informed screening process used to determine next steps for the family. If the next steps include evaluation and assessment by Maine's Part C Program, the screening information will be used in the following ways:

- o To determine the composition of the evaluation and assessment team;
- o To prepare the team for the evaluation and assessment of the child; and
- o To determine the next steps of the process for children with diagnosed physical or mental conditions.

Procedures: General Steps and Responsibilities

1. The First Visit is conducted face-to-face with a child's family in a natural environment.
2. Designated CDS staff members will be assigned the responsibility for carrying out the steps and procedures included in the First Visit.
3. The child will need to be present for at least part of the First Visit.

4. These steps are to be completed within 15 calendar days from referral in order to ensure that the 45 day timeline from referral to IFSP meeting is met.
5. If any of the demographic information on *Referral Information (Form 1)* or any information on *Child Medical and Developmental Information (Form 2)* was not completed during the Initial Contact, this information should be completed at this point. In addition, appropriate information should be entered onto the *IFSP Cover Page*.
6. Designated CDS staff members provide information about the family-centered focus of Maine's Part C Program and eligibility criteria to the parent/caregiver during this visit. Designated CDS staff members provide clarification about the program, including a detailed review of the family cost participation provision.
7. Designated CDS staff members inform the parent/caregiver that participation in Maine's Part C Program is voluntary and that the family can decide what information they chose to share with the program about their child and family. They are, however, encouraged to share information that will be helpful in meeting the needs of their child and family. They are informed that all information shared is confidential.
8. Designated CDS staff members are responsible for providing the family with a copy of and explaining the *Notice of Child and Family Safeguards* and completing the following with the parent/caregiver:
 - *Authorization to Share Information, when appropriate*
 - *Consent for Screening, when appropriate*
 - *Consent for Evaluation and Assessment, when needed*
 - *Written Prior Notice*
 - *Family Cost Participation Form*

Screening

One of the objectives of the First Visit is completing a screening of the child. The First Visit and the information and observations provided by the parent/caregiver serve as the screening process for the child. In most instances, formal screening (e.g. administering a screening tool) will **not** be necessary, especially when sufficient developmental information is available to determine that an evaluation and assessment is appropriate.

Note: Part C regulations require that information provided by hospitals, physicians and others involved with the child be reviewed as part of the child's evaluation and assessment; therefore, developmental assessments, including screening results, conducted prior to referral to CDS will be considered in determining whether an evaluation and assessment of the child is appropriate.

Formal screening is not required under Part C of IDEA (34 CFR Part 303). However, formal screening can be very helpful when insufficient developmental information is available to determine whether conducting an evaluation and assessment is appropriate. Gathering developmental information from the referral source and parent/caregiver during the referral and Initial Contact is an appropriate step prior to determining if a formal screening is needed.

Procedures: Screening

1. Based on information gathered during Referral and Initial Contact, CDS staff decides if formal screening is needed to determine if evaluation and assessment is necessary. The following information guides decision-making about whether screening needs to be completed and how best to conduct the screening. A child may not be determined eligible based on the results of a screening tool alone.

(NOTE: When child is 45 days from 3rd birthday, follow procedures for 3-5 year olds)

NO FORMAL SCREEN NECESSARY	
Information Received	Action Needed
Child has a diagnosed physical or mental condition (an established condition)* that has a high probability of resulting in development delay * see Appendix for list of established conditions that have a high probability of resulting in developmental delay	<ul style="list-style-type: none"> a. Formal screen is not necessary. b. A Part C evaluation and assessment is scheduled. c. Designated CDS staff members obtain information from the physician that documents the established condition.
Child is referred to a Maine Part C Program with an existing evaluation and assessment	<ul style="list-style-type: none"> a. A Part C evaluation and assessment is scheduled. b. Designated CDS staff members inform the evaluation and assessment team that one or more areas have already been evaluated/assessed. This information is considered as part of the assessment process and if the child is found eligible can be used to develop the IFSP.
Child is referred to a Maine Part C Program with existing formal screening.	<ul style="list-style-type: none"> a. Determine if existing formal screening information is reliable. Proceed to next appropriate step. b. If previous screening results seem unreliable and it is questionable that the child needs an evaluation and assessment, then another formal screening may be administered.

REASONS FOR CONDUCTING A FORMAL SCREENING (IN PERSON OR BY PARENT/CAREGIVER RESPONSE)

- The referral source or initial family phone call reveals that the parent has some difficulty when asked to verbally share accurate or sensitive information about their child’s development to determine if the child is in need of an evaluation and assessment.
- There may be qualitative developmental concerns that cannot be easily conveyed through verbal report.
- No other professional has seen the child and it is highly likely that it would be difficult to get clear information from the parent.
- During conversations with the family, the child’s developmental skills and behaviors fall within a typical developmental range (i.e., screens out) but the family requests a developmental screening.
- In the case of a child with an international adoption history or a family in which English is a second language, special care will need to be taken to determine whether the child and family (due to language or other cultural issues) may require a different evaluation/assessment procedure.

2. If a decision is made to conduct a formal developmental screening, designated CDS staff members explain and provide the parent/caregiver with the *Notice of Child and Family Safeguards*, explain the *Consent to Screen* form, and obtain the signature of the

parent/caregiver. *Written Prior Notice* is also provided and explained. Copies of the signed *Consent to Screen* and *Written Prior Notice* forms are maintained and placed in the child's record.

3. When formal screening is conducted, a nationally normed and standardized tool will be used. A child may not be determined eligible based on the results of a screening tool alone.
4. If formal developmental screening is conducted, screening results are documented in *Form 2: Child Medical and Developmental Information*.

NEXT STEP DECISIONS AND ACTIONS NEEDED

The following steps summarize the necessary actions related to whether an evaluation and assessment is appropriate or desired by the family based upon formal screening results and/or information gathered from Referral and Initial Contact:

Decision	Actions Needed
<p>➤ Family chooses not to proceed to evaluation and assessment at this time.</p>	<ol style="list-style-type: none"> a. <i>Declining Early Intervention Services</i> is explained and signed and <i>Notice of Rights</i> is explained and provided to the parent/caregiver. A copy of the <i>Declining Early Intervention Services</i> is maintained and filed in the child's record. b. Parent/caregiver is provided with Maine Part C Program contact information and is informed that they may contact a Maine Part C Program at any point in the future if they have concerns about their child's development. [Maine Part C Program sites may also choose to offer re-screening at intervals determined with the family. Offers to re-screen are not required by federal or state law, and do not initiate timelines for compliance or imply entitlement to the same parental rights as those of an eligible child with a disability.] c. Parent/caregiver is provided with information about child development. d. Available community resources are discussed with the parent/caregiver and assistance in accessing these services is provided if requested by the family.
<p>➤ Family chooses to proceed to evaluation and assessment.</p>	<ol style="list-style-type: none"> a. <i>Consent for Evaluation and Assessment</i> is explained and signature of the parent/caregiver is obtained for the child's record. b. <i>Written Prior Notice</i> is completed, a copy is provided to the family, and a copy is placed in the child's record. Notice of Child and Family Safeguards is explained and a copy is provided to the Parent/caregiver.
<p>Child screens at age level in all developmental areas and family requests a development evaluation and assessment</p>	<ol style="list-style-type: none"> a. Compliance timeline ends; designated CDS staff members schedule an evaluation and assessment. All applicable notices must be completed, provided, and placed in the child's record (see box above).

Family Assessment

Federal Part C Regulations - Family Assessment

Sec. 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.*

Family assessment is usually completed during the First Visit once it is clear that the evaluation and assessment is appropriate and desired by the family. The purpose of the family assessment is to gather information from the family about their everyday routines and activities, their child's and family's interests, as well as their concerns, priorities, and resources. In accordance with federal Part C regulations, the identification of concerns, priorities and resources is voluntary, with the concurrence of the family.

Designated CDS staff members will be assigned the responsibility for carrying out the steps and procedures included in the family assessment

Gathering family priorities, concerns, and resources should be as conversational as possible. To do this, the person asking for the information should create a climate in which the family feels free to talk about their child and family. This individual must have sufficient training in conducting interviews, including rapport-building, active listening and use of appropriate and effective questions. Using conversations to learn about the child's and family's background, strengths and needs, as well as their interests and activities in which they participate is imperative. For some children, it is also important to learn about the child's early care and education settings. During this exchange, the family is given the opportunity to share their "story", including their experiences with their child as well as previous medical, health, or developmental evaluation information, and to describe their concerns, priorities and information about their child's development. It is important that families be asked to provide information about their child's day, including what is working and what is challenging.

Procedures: Family Assessment

1. The family assessment is usually conducted during the First Visit. Information gathered from the family during the Initial Contact should be used as a foundation for the family assessment.
2. Information gathered through the family assessment process is documented on *IFSP Pages 2-2a: Family Routines and Priorities* which has two parts: (a) *Everyday Routines, Activities and Places*, and (b) *Family Concerns, Priorities, and Resources*.

3. Prior to initiating the family assessment, designated CDS staff members inform the parent/caregiver that:
 - the family assessment is voluntary
 - the information that the parent/caregiver chooses to share about their child and family is confidential; and
 - the family helps determine what information is recorded on the IFSP regarding their family routines and priorities.
4. Designated CDS staff members inform the parent/caregiver of the purpose of family assessment including identifying the following:
 - the child's and family's strengths and interests.
 - the settings where the child and family currently live and play (home, community, and child care or preschool settings), along with the people who are involved.
 - The way the child has affected the activities that the family is involved in.
 - the family's concerns and priorities for the child's participation in family, community, and early care and education activities and routines.
 - the family's need for additional supports, including information, materials, and emotional supports.
5. Designated CDS staff members use conversations, rather than a structured interview, to gather this information about the child and family.
6. Designated CDS staff members may use a number of specific family assessment tools/methods in conjunction with conversations with families based on local program procedures. (See Appendices for examples of family assessment tools/methods).
7. Designated CDS staff members may wish to incorporate some of the following kinds of questions when conversing with the family to complete *Everyday Routines, Activities, and Places* of the *IFSP Pages 2-2a: Family Routines and Priorities*, especially if the parent/caregiver struggle(s) in telling their story:
 - Can you tell me about your day? Where do you go? What do you do? Who do you spend time with?
 - What types of things happen on most mornings? Afternoons? Nights? Weekends?
 - 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 any other activities that you and your child would like to try?
3. Designated CDS staff members summarize for the parent/caregiver the **concerns** that they heard identified during the conversation regarding everyday routines, activities and places and confirm these concerns with the family. Designated CDS staff members assist the family in identifying which of these concerns are their most important **priorities**.

9. Designated CDS staff members summarize for the family any resources including family members, friends, community groups, financial supports, and other community resources etc. that were identified during their conversation about everyday routines and activities that may be helpful in addressing their priorities. The parent/caregiver is asked if this “summary of resources” is accurate and if they can think of others that were not previously mentioned.
10. Designated CDS staff members summarize for the family strengths that were identified during the conversation about everyday routines and activities.
11. Concerns, priorities and resources confirmed by the family are recorded on the *Family Routines and Priorities* section of *IFSP Pages 2-2a: Family Routines and Priorities*.
12. Additional information gathered from the family about their interests, concerns and priorities following the evaluation and assessment and during the IFSP meeting should be incorporated into the Family Assessment.

Preparation of Family for Evaluation and Assessment

Preparing for the evaluation and assessment of the child is a critical step, not only for the family, but also for the designated CDS team members who will be conducting the evaluation and assessment. It is important that the family understand the purpose of the evaluation and assessment, the process that will be used in the evaluation and assessment, an idea of who might be involved in conducting the evaluation and assessment, when eligibility will be determined, and what happens if their child is or is not found eligible.

Each team will conduct a **transdisciplinary evaluation and assessment** in which all members of the team are involved in planning based on information received from the Initial Contact and other available information. A transdisciplinary model allows for an interactive and integrated process across domains to get a holistic picture of the child.

Evaluation and assessment activities are conducted for two different purposes. The outcome of *evaluation* is to expeditiously confirm eligibility for Maine’s Part C Program and to determine the child’s level of functioning in all five required developmental domains. An *assessment* is conducted for intervention planning through the identification of the child’s unique strengths and needs in each developmental area and the supports and services appropriate to meet those needs.

Procedures: Preparation for Evaluation and Assessment

1. Prior to completing the visit with the family, designated CDS staff members inform the family about evaluation and assessment and the eligibility determination processes. The following points are included in the explanation:
 - The purpose of the initial evaluation and assessment is to determine eligibility and to identify the unique strengths and needs of the child;
 - At least two (2) professionals and the parent will be involved in conducting the initial evaluation and assessment and determining eligibility. Designated CDS staff members who conduct the First Visit and family assessment should participate in the child’s evaluation and assessment of and be responsible for preparing the evaluation and assessment team.

- During the initial evaluation and assessment, the team will use procedures including a standardized developmental evaluation tool, pertinent records, observation of child (whenever possible involved in their everyday routines and activities), parent/caregiver feedback, etc. to determine the child's developmental status and unique strengths and needs in each developmental area;
 - The family will have an opportunity to identify their concerns, provide their observations, and ask questions of the team;
 - If the child is eligible for Maine's Part C Program, a meeting to develop the initial IFSP must be conducted within 45 days of the date of referral. The professionals who complete the evaluation and assessment will work with the family to develop an IFSP that identifies supports and services appropriate to meet the child's and family's needs; and
 - If the child is not eligible for Maine's Part C Program, the team will discuss other options that might be appropriate for the child and family.
2. Designated CDS staff members discuss with the family their potential roles in the evaluation and assessment process. The parent/caregiver is encouraged to be an active team member, but they have the final decision regarding their level of participation. Designated CDS staff members ask the family about the best time and place to conduct the evaluation and about any suggestions the family might have to make the process go smoothly. This information is recorded on *Preparation for Evaluation and Assessment* and is used to prepare all individuals involved in conducting the process.
 3. The family and designated CDS Staff member should discuss and determine whether the IFSP Meeting will be conducted at the same time as the Evaluation and Assessment. If holding the Evaluation and Assessment and IFSP Meeting on the same day, then CDS staff must also prepare the family for their participation in developing the IFSP. (Guidance relating to this, including appropriate procedural safeguards, can be found in the section of this document on the IFSP Meeting and Development of Initial IFSP.)

EVALUATION AND ASSESSMENT OF THE CHILD

Federal Part C Regulations: Evaluation and Assessment, Nondiscriminatory Procedures, and Multi-disciplinary

Sec. 303.322: Evaluation and Assessment

(a) *General.*

- (2) *Each system must include the performance of a timely, comprehensive, transdisciplinary 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.*
- (3) *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--

- (4) 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.*
- (5) 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 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.*

Sec. § 303.17 Transdisciplinary.

As used in this part, transdisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in § 303.322 and development of the IFSP in § 303.342.

Evaluation and assessment are conducted *concurrently as a convenience* to the family, eliminating the need for an additional visit before implementation of the IFSP for an eligible child. Need for additional assessments may be determined based on the findings of the initial evaluation and assessment.

Evaluation and Assessment Team Selection and Preparation

Prior to conducting the evaluation and assessment of the child, appropriate team members must be selected to ensure that sufficient information is gathered during the evaluation and assessment to support the determination of eligibility and the identification of the unique needs of the child for intervention planning. Team composition is one of the most important components of the evaluation and assessment process.

Preparing for the evaluation and assessment of the child is a critical step, not only for the family, but also for the team members who will be conducting the evaluation and assessment. Team preparation is critical to ensure the following:

- The transdisciplinary team is familiar with the relevant information regarding the child and family, including relevant health, developmental and medical information; and
- The evaluation and assessment team uses procedures in the evaluation and assessment process that are non-discriminatory and that are appropriate to the needs of the child.

Procedures: Transdisciplinary Team Selection and Preparation

1. Procedures for selection must specify the following:
 - The selection of the transdisciplinary team members must be based on information gathered during the Referral/Initial Contact and the First Visit;
 - Circumstances when more than 2 disciplines need to be involved in the transdisciplinary team;
 - Designated CDS staff members who conduct the First Visit are strongly encouraged to be involved in the transdisciplinary team to ensure a complete understanding of the child's unique needs, and the supports and services necessary to meet those needs;
 - The team must include those individuals who are appropriately trained to conduct a transdisciplinary evaluation and assessment;
 - To the extent possible, the use of assessors and service providers with specialized expertise is encouraged to address the needs of children with complex medical needs or other issues; and

- Other team members as appropriate to the child's needs.
- 2. Designated CDS staff members that conduct the First Visit are responsible for preparing the transdisciplinary team members for the evaluation and assessment. Preparation of the team must include the following:
 - Sharing relevant medical and developmental information on the child, including information from other sources as well as results of any screenings that are conducted;
 - Providing a summary of information gathered from the family during Initial Contact and the First Visit. This information should be summarized on *IFSP Pages 2-2a: Family Routines and Priorities*;
 - Determining with the team any specific focus that should be included in the evaluation and assessment (e.g. observation of feeding or positioning).
- 3. The transdisciplinary team will designate a team leader who will:
 - ensure that all arrangements for the evaluation and assessment are completed including confirming MaineCare eligibility and obtaining physician referrals/prescriptions when necessary;
 - ensure that all procedural safeguards have been provided to the family prior to conducting the evaluation and assessment; and
 - confirm the evaluation and assessment appointment with the parent/caregiver to ensure timely completion of the child's evaluation and assessment. All efforts to contact the parent/caregiver must be documented in the child's record.
- 4. Preparation for the evaluation and assessment may be combined with the preparation for the IFSP Meeting or may be completed separately if the IFSP Meeting is scheduled for a different day than the evaluation and assessment. (See Preparation for the IFSP Meeting in this document)

Conducting the Evaluation and Assessment and Determining Eligibility

The evaluation and assessment process builds on the concept of using everyday places, routines, and activities to facilitate early intervention. If possible, the evaluation and assessment should include opportunities to observe the child in typical routines, especially those that the family reports as challenging and a priority. Developmental information and functional skills complete a whole picture of a child's abilities.

The evaluation shall include:

- Administration of the most recent version of the Battelle Developmental Inventory (BDI) or the Bayley Scales of Infant Development (Bayley) by individuals trained to utilize appropriate methods and procedures;
- Review of pertinent records related to the child's health status, medical history, and the assessment of the unique needs of the child; and
- When possible, observation of the child in typical routines, especially those that the family reports as challenging and a priority.

The results of the BDI or Bayley determine the child's level of functioning in each of the five developmental domains [Cognitive, physical (including vision and hearing), communication,

social or emotional, and adaptive] and serve as the foundation for eligibility determination. Additional specialized assessment instruments may be used by the team based on the child's established condition (for example, visual impairment, hearing impairment, or autism spectrum disorder). The informed clinical opinion of qualified evaluators is occurring throughout the entire process of interview, assessment, and administration of evaluative instruments.

The combined information of 1, 2, and 3 above is used by the team to determine eligibility. No one member of the team, nor the results of a single evaluation, can be the sole determiner of eligibility. Informed clinical opinion may be used as the primary determinant of eligibility under the following conditions:

- If the BDI or Bayley cannot appropriately be used with a child because instrument validity and reliability would be compromised (e.g. lack of culturally or linguistically appropriateness, adaptations must be used to elicit responses from children, etc.);
- If Professional Standards (related to the evaluation of children with disabilities) would be breeched (e.g. inability to follow publisher's administration requirements, etc.);
- When the informed clinical opinion is combined with the input of the designated CDS staff member, parent, and other team member(s) AND the informed clinical opinion is formed by individual(s) formally trained to use appropriate evaluation methods and procedures.

When informed clinical opinion is the primary determinant of eligibility, the Team must document the following in writing:

- An explanation of the reason(s) that the evaluation standards and procedures used with the majority of children resulted in invalid findings for this child;
- The objective data used to conclude that the child has a developmental delay (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, etc.);
- Which data had the greatest relative importance for the eligibility decision; and
- The IFSP Team members agree to the necessity of the use of informed clinical opinion as the primary determinant for eligibility. If one or more team members disagree with the decision, the dissenting team members will develop a written statement of the areas of disagreement, signed by those members.

When the results of the evaluation are combined with the information of an assessment to determine the unique needs of the child, including pertinent records related to the child's health status and medical history, the IFSP team is prepared to address the resources, priorities and concerns of the family, and determine the eligibility of the child. The supports and services necessary to enhance the family's capacity to meet the developmental needs of the eligible infant or toddler with a disability, are designed and articulated in the IFSP.

The verification of eligibility for early intervention services is obtained through a transdisciplinary evaluation which utilizes the infant's or toddler's history which has been obtained from parental input and pertinent records related to the child's current health status and/or medical history.

For children with established conditions, eligibility has been determined prior to the evaluation and assessment. *A licensed physician, or in the case of severe attachment disorder a licensed*

psychologist or clinical social worker, may provide verbal report of an established condition for determining eligibility in order to meet the 45-day timeline. However, verbal report must be followed-up with a written, signed confirmation of the child's condition. When necessary, medical services are accessed by a physician only for this diagnostic or evaluative purpose. Nonetheless, evaluation and assessment continues to be needed in order to develop a meaningful IFSP for children with established conditions.

During the evaluation and assessment, the team should also begin to note the preferred learning styles of the family and other primary caregivers, as they will be the primary learners in the intervention process. The team should determine how the family and other primary caregivers prefer information to be presented and what information will be most useful to them based on their preferred learning styles. This should be documented on *IFSP Pages 2-2a: Family Routines and Priorities*.

NOTE: Evaluations and assessments not ordered by designated CDS staff members and conducted by non-CDS staff members or contractors cannot be reimbursed as Part C evaluations.

Procedures: Evaluation and Assessment and Eligibility Determination

1. The evaluation and assessment should be conducted in the home or a natural setting where the child normally participates. In unusual circumstances, the evaluation and assessment may be conducted elsewhere; reasons must be documented in the child's file.
2. The evaluation and assessment team members also participate in the development of the initial IFSP.
3. The ongoing team leader/service coordinator must be a participant in the evaluation process. For children who are not eligible for MaineCare, the team leader/service coordinator may serve as one of the required disciplines if s/he meets the personnel standards and competencies as an evaluator.
4. All team discussions regarding the evaluation and assessment must include the family.
5. The multi-disciplinary team (not individual evaluators) **determines eligibility** based on the results from the initial evaluation and assessment. Eligibility for Maine's Part C program requires the following:
 - A delay of at least 1.5 standard deviations from the mean score of the BDI or Bayley in two or more of the five developmental domains, or
 - A delay of at least 2.0 standard deviations from the mean score in at least one of the five developmental domains.
6. The designated CDS staff member must provide the family with *Written Prior Notice* regarding the child's eligibility, along with a copy and explanation of the *Notice of Child and Family Safeguard*
7. If the child is not found eligible for Maine's Part C Program, the designated CDS staff member must also complete the following steps:
 - The parent/caregiver is provided with Maine's Part C Program contact information and is informed that they may contact the Part C Program at any point in the future if they have concerns about their child's development. If regional programs have established re-screening or follow-up procedures, families must also be provided with this information.
 - The parent/caregiver is provided with information about child development.
 - Available community resources are discussed with the parent/caregiver and contact

information is provided

8. If the child is found eligible and the family chooses not to participate in Maine's Part C Program, the designated CDS staff member must complete the following steps:
 - o The *Declining Early Intervention Services* form is explained, signed, and a copy is filed in the child's record. A copy and explanation of the *Notice of Child and Family Safeguards* is provided to the family.
 - o The parent/caregiver is provided with Maine's Part C Program contact information and is informed that they may contact the Part C Program at any point in the future if they reconsider their decision to decline Maine's Part C services.
 - o The parent/caregiver is provided with information about child development.
 - o Available community resources are discussed with the parent/caregiver and contact information is provided.
9. Results of the evaluation and assessment are documented in the IFSP on the *IFSP Pages 3- 3d: Present Abilities, Strengths and Needs*. These pages of the IFSP serve as the evaluation and assessment report.
10. Eligibility is documented in the IFSP on *IFSP Pages 3-3d: Present Abilities, Strengths and Needs*. Information gathered at the time of evaluation and assessment will be used as baseline for measuring the child's progress over time.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) TEAM MEETING

Federal Part C Regulations: Individualized Family Service Plans (IFSPs)

Sec. 303.340 General

- (a) *Each system must include policies and procedures regarding individualized family service plans (IFSPs) that meet the requirements of this section and Secs. 303.341 through 3.3.346.*
- (b) *As used in this part, individualized family plan and IFSP means a written plan for providing early intervention services to a child eligible under this part and the child's family. The plan must—*
 - (1) *Be developed in accordance with Secs. 303.342 and 303.343;*
 - (2) *Be based on the evaluation and assessment described in Sec. 303.322; and*
 - (3) *Include the matters specified in Sec. 303.344.*
- (c) *Lead Agency Responsibility.*

The lead agency shall ensure that an IFSP is developed and implemented for each eligible child, in accordance with the requirements of this part. If there is a dispute between agencies as to who has responsibility for developing or implementing an IFSP, the lead agency shall resolve the dispute or assign responsibility.

NOTE: In instances where an eligible child must have both an IFSP and an individualized service plan under another Federal program, it may be possible to develop a single consolidated document, provided that it -

- (1) *Contains all of the required information in Sec. 303.344, and*

(2) Is developed in accordance with the requirements of this part.

Sec. 303.342 - Procedures for IFSP Development, Review, and Evaluation

(a) Meeting to develop initial IFSP--timelines.

For a child who has been evaluated for the first time and determined to be eligible, a meeting to develop the initial IFSP must be conducted within the 45-day time period in Sec.303.321(e).

(d) Accessibility and convenience of meetings.

(1) IFSP meetings must be conducted--

(i) In settings and at times that are convenient to families; and

(ii) In the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

(2) Meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.

Sec. 303.343 - Participants in IFSP meetings and periodic reviews

(a) Initial and annual IFSP meetings.

(1) Each initial meeting and each annual meeting to evaluate the IFSP must include the following participants:

(i) The parent or parents of the child.

(ii) Other family members, as requested by the parent, if feasible to do so;

(iii) An advocate or person outside of the family, if the parent requests that the person participate.

(iv) The service coordinator who has been working with the family since the initial referral of the child for evaluation, or who has been designated by the public agency to be responsible for implementation of the IFSP.

(v) A person or persons directly involved in conducting the evaluations and assessments in Sec. 303.322.

(vi) As appropriate, persons who will be providing services to the child or family.

(2) If a person listed in paragraph (a)(1)(v) of this section is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including--

(i) Participating in a telephone conference call;

(ii) Having a knowledgeable authorized representative attend the meeting; or

(iii) Making pertinent records available at the meeting.

Preparing the Family for the Individualized Family Service Plan (IFSP) Team Meeting

The initial Individualized Family Service Plan (IFSP) is developed at a meeting following the child's evaluation and assessment and determination of his/her eligibility. The IFSP builds on those things that are working well in everyday routines/activities and that are valued and

enjoyed by the child and family. The IFSP also addresses the priorities, resources and concerns of the family (what is the family unable to do as a result of the child's disability).

The IFSP does the following:

- Summarizes information that the family chooses to share about their child and family;
- Identifies the developmental status of the child;
- Develops outcomes for the child and family based on their priorities, resources and concerns;
- Builds family capacity to meet desired outcomes as part of everyday routines and activities;
- Identifies necessary supports to achieve outcomes. The supports and plans for meeting the identified outcomes should be flexible enough to accommodate the child and family's changing needs.

Procedures: Preparing the Family for the Individualized Family Service Plan (IFSP) Team Meeting:

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| <ol style="list-style-type: none">1. The designated CDS staff member prepares the family for the IFSP Team Meeting by:<ul style="list-style-type: none">○ Explaining the purpose of the meeting and the IFSP;○ Explaining the importance of family participation on the Team;○ Reviewing the family priorities, resources and concerns; and○ Reviewing the relevant medical and developmental information.2. In planning and preparing the family for the IFSP Team meeting, the family and designated CDS staff member discuss and determine the following:<ul style="list-style-type: none">○ A meeting date, time and place that is mutually convenient;○ If the meeting is not held at the family's home, whether transportation is an issue for the family; and○ Whether the family wishes to invite other participants (other family members, an advocate or person outside the family) .3. The designated CDS staff member must also provide the family with a copy and explanation of the <i>Notice of Child and Family Safeguards</i>, along with written notification of the meeting date and time. |
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Preparing the Team for the Individualized Family Service Plan (IFSP) Team Meeting

Developing a meaningful IFSP with the family is a team responsibility.

Procedures: Preparing the Team for the IFSP Meeting

1. Team members who conducted the initial evaluation and assessment participate in the meeting in order to develop the initial IFSP.
2. The designated CDS staff member is responsible for preparing the team for the IFSP Team Meeting by:
 - Providing advance written notification of the date and time of the IFSP meeting to Team members (including participants that the family invites). The child's primary health care provider will always be invited to participate in IFSP meetings.
 - Determining whether team members can attend the IFSP Team Meeting or if alternate arrangements must be made for team member involvement (e.g., participate by phone, having an authorized representative, providing written information).
 - Summarizing pertinent medical, developmental and other information related to the child and family that are useful in the development of the IFSP.
 - Providing copies of all necessary IFSP forms.

Conducting the Individualized Family Service Plan (IFSP) Team Meeting and Developing the Initial IFSP

The IFSP is intended to be a fluid document that is modified as necessary to address the evolving needs of the child and family. Initial development of the IFSP is based on conversations and collaboration with the family. The initial IFSP must include the identification of outcomes based on those concerns that are most important to the family and the necessary supports and services to address these concerns. Revisions to the initial IFSP to address additional family concerns may occur after initiation of supports and services.

In developing the IFSP, it is critical for service providers to keep in mind several key purposes of Maine's Part C Program that are in accordance with IDEA 2004:

- enhancing the development of infants and toddlers with disabilities;
- minimizing the effects of the child's disability on everyday routines;
- recognizing that significant brain development occurs during the first three years of the child's life; and
- enhancing the capacity of the family to facilitate their child's development.

The process of developing the initial IFSP is another opportunity to strengthen the collaborative partnership with the family and to foster mutual understanding of the needs of the child and family. It is critical that service providers recognize and respect the role that a family plays in enhancing their child's development, and that this role varies from family to family. As a result, the team needs to ensure that the family is supported as a partner in the development of the IFSP. The family should be given the opportunity to understand other team members'

perspectives, make informed decisions, and reach consensus about the process that will help them reach their goals for their child and family.

Procedures: Conducting the IFSP Team Meeting and Developing the Initial IFSP

1. When a parent prefers, an IFSP may be developed through an IFSP Meeting on the same day that the evaluation and assessment is conducted. The family may request, however, that the IFSP meeting be held on a separate day and time.
2. The service coordinator is responsible for facilitating and participating in the IFSP meeting and the development of the IFSP.
3. The service coordinator is responsible for ensuring that all necessary IFSP forms are available and that the purpose of each form is described to the Parent/caregiver.
4. The parent/caregiver assists the team in deciding the information that is documented on the IFSP.
5. **IFSP decisions are made by the team.** No one team member dictates the IFSP content, including the outcomes, strategies, and/or the necessary services and supports.
6. The evaluation and assessment team leader is responsible for summarizing developmental information about the child and determining with the family if the summary reflects the family's perspective of the child's development.
7. The designated CDS staff member is responsible for reviewing with the Parent/caregiver their prioritized concerns shared during the First Visit and to confirm the accuracy and completeness of this information. The team discusses with the family which priorities are most important to address immediately.
8. The team and the family identify **functional outcomes** for the child, and if appropriate, outcomes for the family based on:
 - o Family concerns and priorities;
 - o Everyday routines and activities, interests of the child and family, and important people and places;
 - o The child's current functional skills; and
 - o Input from that child's medical provider for a child who has a complex medical condition.
9. The number of IFSP outcomes that are developed on the initial IFSP depends on the family's priorities that are most important to address immediately. The team needs to reflect what is reasonable and not overwhelming to the family.
10. The team develops outcomes that are functional and measurable and that can be realistically achieved within a reasonable time frame (usually 6 months).
11. The team develops short-term objectives that are developed for each outcome to help document how progress will be made. In addition, the team determines when and how progress will be measured and identifies how the team will know that the outcome has been achieved.
12. The service coordinator and service providers use information shared by the family regarding everyday routines and activities, child and family interests, and important people and places, to assist in the development of appropriate **strategies**, including natural learning opportunities, to meet the outcomes.
13. All information related to outcomes and strategies are documented in the IFSP on *Page 4: Child/Family Outcomes*. More specific instructions for completing this page can be found in *IFSP Instructions*.

14. Some guidance on the Targeted Case Management outcome page needs to be added by the small group that is working on revising the existing content of the form.
15. Services must be provided in a child's natural environment. The IFSP Team determines for each outcome, whether or not the outcome can be achieved (and if services needed to meet the outcome can be provided) in a **natural environment**. Since children learn best when interested and engaged in activities and when they can practice new skills during natural learning opportunities that occur in everyday routines and activities,
16. In developing the IFSP, outcomes and strategies are identified prior to determining the necessary services and supports and where they will be provided
17. In determining where services and supports are provided, the IFSP Team must value and preserve the family's typical routines when identifying services, supports and strategies necessary to achieve the outcomes. Services must "fit the family" instead of making the family "fit the service"
18. No individual member of the team may unilaterally determine the setting for service delivery. Every effort is made to select a setting that the entire IFSP team, including the parent, supports. The US Department of Education has clarified that family preferences, or the preferences of one IFSP team member, is not sufficient justification for not providing services in a natural setting.
19. The team must develop a **natural environment justification** if they determine that an outcome cannot be achieved in a natural environment. The justification must include the reasons why the team determined that the outcome could not be achieved in the context of everyday routines and activities of the child and family as well as steps that will be taken to generalize services and supports provided in specialized settings into everyday routines and activities, including timelines for moving services/supports into natural environments
20. The team must document the natural environment justification in the IFSP on *IFSP Pages 4-4a: Child and Family Outcomes under Natural Environment Justification*. (See *IFSP Instructions*)
21. During the IFSP Meeting, the team must have a conversation with the parent/caregiver regarding **transition planning** when early intervention services are no longer available for or needed by their child. An explanation regarding eligibility and age guidelines should be provided to help frame the discussions and determine potential transition planning activities for the initial IFSP.
22. The *IFSP Pages 6-6a: Transition Plan* provides a range of potential transition activities that may be applicable depending on the age of the child. (See *IFSP Instructions* for more information on how to use and complete these pages.)
23. The IFSP Team identifies the **services and supports**, including frequency, intensity and methods necessary to meet the identified outcomes. In determining necessary supports and services, the team must consider research findings indicating that visits provided too frequently can be disempowering or send the message that the parent is not competent. In addition, the team should determine frequency and intensity of services based on the amount of support the family needs in identifying and using natural learning opportunities throughout everyday routines and activities to promote their child's attainment of functional skills.
24. The team documents services and supports decisions in the IFSP on *IFSP Page 7: Supports and Services Needed to Achieve Outcomes*. (See *IFSP Instructions* for guidance on completing this page of the IFSP.)
25. Whenever possible, the IFSP is completed in one meeting of the IFSP Team. However,

some circumstances may require that the team reconvene to complete the IFSP.

26. Whenever the IFSP is completed, all IFSP Team members need to sign the IFSP on the *IFSP Page 9: Signature* (See *IFSP Instructions* for guidance on completing this form.)
27. The service coordinator explains to the Parent or guardian(s) that prior to initiating IFSP services and supports, their consent is required. They are informed that they have the option to accept all, some or none of the IFSP services and supports. If for any reason they chose to decline an IFSP service(s)/support(s), doing so does not jeopardize any other early intervention service their child and/or family receives. A copy of the *Notice of Child and Family Safeguards* is provided and explained to the Parent, including that they have the right to file a complaint and/or request due process and/or mediation. *Written Prior Notice* is sent describing the decisions made at the meeting.
28. Service providers should respect the family's decision to decline any or all IFSP services and supports.

Interim Individualized Family Service Plan

Federal Part C Regulations: Interim IFSP

Sec. 303.345 Provision of services before evaluation and assessment are completed.

Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment in Sec. 303.322, if the following conditions are met:

- (a) *Parental consent is obtained.*
- (b) *An interim IFSP is developed that includes--*
 - (1) *The name of the service coordinator who will be responsible, consistent with Sec. 303.344(g), for implementation of the interim IFSP and coordination with other agencies and persons; and*
 - (2) *The early intervention services that have been determined to be needed immediately by the child and the child's family.*
- (c) *The evaluation and assessment are completed within the time period required in Sec. 303.322(e).*

Note: This section is intended to accomplish two specific purposes:

- (1) *To facilitate the provision of services in the event that a child has obvious immediate needs that are identified, even at the time of referral (e.g., a physician recommends that a child with cerebral palsy receive physical therapy as soon as possible), and*
- (2) *to ensure that the requirements for the timely evaluation and assessment are not circumvented.*

Sec 303.322(e) Evaluation and Assessment 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).*

Interim IFSPs are applicable for those circumstances when early intervention services need to begin immediately. An interim IFSP is also appropriate in the event of exceptional circumstances (i.e. the child is seriously ill, preventing completion of the evaluation and assessment within 45 days). Developing interim IFSPs should be an exception rather than common practice. For the most part, interim IFSPs are applicable for children who will most likely be eligible for services based on diagnosed conditions.

If eligibility has already been determined through the evaluation and assessment process, the IFSP team will develop a comprehensive IFSP rather than an Interim IFSP. In situations where specific services are necessary immediately, those IFSP services should be implemented immediately, and all other IFSP services will be implemented as soon as possible. Under no circumstances can an interim IFSP be used only to extend the 45-day timeline.

Procedures: Interim IFSP Development

1. The service coordinator determines if an Interim IFSP is needed based upon individual circumstances for each child.
2. The service coordination documents in the child's record the specific circumstances that warrant the development of an interim IFSP.
3. The service coordinator is responsible for the following, prior to developing an Interim IFSP:
 - o Providing the family with *Written Prior Notice*; and
 - o Providing a copy of and explaining the *Notice of Child and Family Safeguards* to the family.
4. The service coordinator is responsible for developing the Interim IFSP using the IFSP forms.
5. The service coordinator is responsible for coordinating the implementation of the Interim IFSP.
6. If early intervention needs to begin immediately, an interim IFSP is appropriate. (Guidance relating to this can be found in the section of this document about when and how to develop interim IFSPs.)

Natural Environments

Federal Part C Regulations: Natural Environments

Sec. 303.12 Early Intervention Services

(b) Natural Environments. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate.

Sec. 303.167 Individualized Family Service Plans

(c) Policies and procedures to ensure that--

- (1) To the maximum extent appropriate, early intervention services are provided in natural environments; and*
- (2) The provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment.*

Sec. 303.18 Natural environments

As used in this part, natural environments means settings that are natural or normal for the child's age peers who have no disability.

Sec. 303.344 Content of an IFSP

(d) Early intervention services.

- (1) The IFSP must include a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified in paragraph (c) of this section, including--*
 - (i) The frequency, intensity, and method of delivering the services;*
 - (ii) The natural environments, as described in Sec. 303.12(b), and Sec. 303.18 in which early intervention services will be provided, and a justification of the extent, if any, to which the services will not be provided in a natural environment;*
 - (iii) The location of the services*

Note 1: With respect to the requirements in paragraph (d) of this section, the appropriate location of services for some infants and toddlers might be a hospital setting--during the period in which they require extensive medical intervention. However, for these and other eligible children, early intervention services must be provided in natural environments (e.g., the home, child care centers, or other community settings) to the maximum extent appropriate to the needs of the child.

Providing services in natural environments is the law and supports the purpose of early intervention services to enhance the capacity of the family in facilitating their child's development. Natural learning opportunities occur in community settings where children live, learn, and play. Providing early intervention within activities (bath time, mealtime, reading, playing, etc.) that occur in natural settings (home, childcare, playground, etc.) offers numerous opportunities for the child to learn and practice new skills to enhance growth and development. The provision of services in natural settings and in daily routines and activities fosters the use and development of natural supports in a family's social and cultural network, promoting the child's and family's full participation in community life.

In developing the IFSP, outcomes and strategies are identified prior to determining the necessary services and supports and where they will be provided. Determining intervention strategies begins with identifying and understanding the family's routines and daily activities. Services and supports provided within these activities maximize the child's opportunities for learning and practicing new skills and effectively problem solving challenges.

In accordance with federal Part C requirements, each IFSP service is required to be provided in natural environments unless an outcome or outcomes cannot be achieved satisfactorily by doing so. If a service cannot be provided in a natural environment, a **justification** must be provided on the IFSP (see Conducting the IFSP Meeting and Developing the IFSP above and *IFSP Instructions*, regarding documenting natural environment justifications.)

The US Department of Education, Office of Special Education Programs (OSEP) has clarified that family preferences, or the preferences of one IFSP team member, is not sufficient justification for not providing services in a natural setting through the following letters to states:

- OSEP states in a letter to *Heskett, Missouri, May 26, 1999* in response to a question about whether it violates Part C for a parent to chose a non-natural environment (e.g., center-based program or clinic for children with disabilities) that they deem is best for their child: *"Although Part C recognizes the importance of, and requires, parent involvement throughout the IFSP process, Part C does not relieve the State lead agency of its responsibility to ensure that other regulatory and statutory requirements, including the natural environments provisions, are met. While the family provides significant input regarding the provision of appropriate early intervention services, ultimate responsibility for determining what services are appropriate for a particular infant or toddler, including the location of such services, rests with the IFSP team as a whole. Therefore, it would be inconsistent with Part C for decisions of the IFSP team to be made unilaterally based solely on preference of the family. The State bears no responsibility under Part C for services that are selected exclusively by the parent; however the State must still provide all other services on the IFSP for which the parents did consent."*
- OSEP states in a *Letter to Elder, Texas, July 17, 1998* in response to a question about whether it violates Part C to provide services in a setting selected by the parent, which does not meet the definition of a natural environment even if the parents are incurring the cost of the setting, if the IFSP team determines services can be satisfactorily achieved in the natural environment: *"... if the parents do not consent to a particular location for a service specified in the IFSP, the State may not use Part C funds to provide that service in a location different from that identified on the IFSP. The parents are free to reject any service(s) on the IFSP by not providing written consent for that service(s) or by withdrawing consent after first providing it. If the parents do not provide consent for a particular early intervention service, which also includes the location, that service may not be provided...."*

When determining if a setting is a natural environment, the following guidance established by the Infant Toddler Coordinator's Association should be considered:

- Children and families participate in a variety of community activities that are natural for them including those that occur in their home. Therefore, **if the family does not want services in their home, another community setting is identified** where the child's needs may be addressed.
- **Natural groups of children are groups that would continue to exist with or without children with disabilities.** Groups that are not "natural groups" include playgroups, toddler groups or childcare settings that include only children with disabilities. However, even the most "natural" of groups is not a natural setting for a particular child if it is not part of that child's family's routine or community life.
- Programs originally designed as a program for only children with disabilities and would not be considered a natural environment. However, if the program now includes children without disabilities then it could be considered a natural environment. OSEP has provided guidance in this instance and in all of its policy letters since August 2000 has stated:
"Many center-based programs that formerly served only children with disabilities have now integrated children without disabilities, creating a child care or preschool program constituting a natural environment. If services were provided to an eligible child in such an integrated environment, the child's IFSP would not require a justification for services in that integrated setting." (Letters to: *Morris, Washington, June 7, 2005*;

Individual (personally identifiable information redacted), July 30, 2002; Shelby, August 6, 2001; June 14, 2001; Individual (personally identifiable information redacted), November 1, 2000)

- Service settings that are not “natural settings” include clinics, hospitals, therapists’ offices, rehabilitation centers, and segregated group settings. This includes any settings designed to serve children based on categories of disabilities or selected for the convenience of service providers.
- Justification for providing services in a setting outside of a natural environment includes sufficient documentation to support the IFSP Team’s decision that the child’s outcome(s) could not be met in natural settings and identifying a plan on how such services will be transitioned to a natural setting. OSEP has provided guidance in a Letter to *Shelby, District of Columbia, August 6, 2001* regarding IFSP team decision-making requirements around providing services in non-natural settings:

“Early intervention services provided to infants and toddlers with disabilities and their families are designed to meet the unique needs of the child, taking into consideration the strengths and challenges of the child and the child’s family. After careful evaluation of the child and significant input from the family as to its typical routines and dreams for the future of the child, a team that includes qualified professionals and the parents, meets to determine the types of early intervention services needed, how often the services will be provided, by whom, where services are to be provided, and who will pay for these services. The discussion of, and decision about, the location of any service takes place in the context of an IFSP meeting. In all instances, supports and services are to be determined based on the individual needs of the child. Nothing in Part C of IDEA or its implementing regulations at 34 CFR Part 303 requires that early intervention services always be provided in a child’s home or in a day care center where there are other children without disabilities. In general, providing services in a setting limited exclusively to infants and toddlers with disabilities would not constitute a natural environment. However, if a determination is made by the IFSP team that, based on a review of all relevant information regarding the unique needs of the child, the child cannot satisfactorily achieve the identified early intervention outcomes in natural environments, then services could be provided in another environment. In such cases, a justification must be included on the child’s IFSP.”

- Since parent-to-parent support through parent groups or other means, is critical for families of children with disabilities. OSEP has determined that such parent activities do not have to be provided in a natural environment. Specifically, OSEP states in a *Letter to Yarnell, Pennsylvania, October 19, 1999* that “...for services directed solely at the parent such as parent support, those services are not required to take place in a natural environment. No justification, therefore, is needed on the IFSP. Such services solely for the parent, however, cannot be used as a justification for providing services to the child in other than natural environments.”

Documents from which information was pulled to develop Maine's EI process guide:

NV- Effective Practice Guidelines: Foundation and Philosophy

- Mission & Guiding Principles (p. 5)
- adapt whole of Module I- (pp. 6-16)
- Common Themes: Review of Literature
- Key concepts and frameworks underlying effective practice

NV -Effective Practice Guidelines: Intake, Evaluation and Eligibility

NV- Effective Practice Guidelines: IFSP

FL- Service Delivery Policy and Guidance, p.26-38

- Team-based Primary Service Provider Model, including key role of families
- First Contacts and Family Assessment
- Eligibility Evaluation
- Assessment

FL- Component 3 on Evaluation and Assessment

Shelden & Rush, 2001

Dunst & Bruder, 1999

McWilliam & Scott, 2001

APPENDICES