

Feedback on Practice Manual and Forms

Comments received from (not an unduplicated count):

22 Local System Manager

18 Service Coordinator

18 Other Service Provider

10 Other Administrator – CSB Infant Program Manager, Private provider agency admin

1 Parent of a child receiving EI services

4 Other (please specify) – included input from all EI staff/providers (3); supervisor; CoCoA Steering Committee

Practice Manual Comment Table:

PAGE #	COMMENT	RESPONSE
General Comments		
	Many systems print out copies of the Practice Manual. Please consider having each chapter begin with page number one (could do something as follows: first page in Chapter Three could be 3-1, second page 3-2, and so on). Please also consider including a date at the bottom of each page by the page number so that when there is a change made, we can print out a chapter instead of the whole manual. It would also help to have the chapter name in the footer on each page. (5)	We are not able to implement both this suggestion and the request to hyperlink from the Table of Contents. Since a large number of people requested the more detailed Table of Contents with page numbers and the ability to click on something in the Table of Contents and link directly to that spot in the manual, we have opted to implement that change instead.
	There needs to be a consistent numbering of all chapters, pages, and parts (including attachments, addenda, etc.) of the Practice Manual, beginning in the Table of Contents and throughout the entire text. Please show all attachments and the addenda in the Table of Contents and use page numbers.	<u>Change</u> : Revised as suggested
	Please make sure that the website version is the same as the version that is sent out to the field, including the page numbering.	We will not be sending a copy to the field routinely. Instead you should access and print the manual from the website. When it is necessary to send a copy to someone without internet access we will send the pdf copy so that it matches the website version.
	Staff spend a lot of time trying to find things in the Practice Manual. A more detailed Table of Contents and/or Index and/or a search (searching by key words) or hyperlink mechanism for the online version would really help. (11) <ul style="list-style-type: none"> • Need an index with page numbers. It would be especially helpful to have the index refer to major sections, with subheadings of important info (like which page to find the info on physician signatures...) 	<u>Change</u> : Added page numbers in Table of Contents, with hyperlinks. Due to time constraints, the request for an index will be considered in the next set of revisions to the manual (i.e., in 6 months or one year).

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	<ul style="list-style-type: none"> • Having page numbers included in the table of contents would be helpful as we search for particular topics in the practice manual (6) • When an appendix or another form is listed in the manual can there be a hyperlink to that form? 	
	<p>Please put all information/clarifications into the revised Practice Manual that has been included in the many MAD memos, Part C Updates, Q&As, Task Force Updates, and other correspondence that have come out since the Practice Manual was disseminated. (6)</p>	<p>All information has been incorporated in the revisions to the manual</p>
	<p>Throughout the entire Practice Manual, please consider using numbered bullets instead of circles or boxes. It would be easier to say to a SC or a provider “look at bullet number 3 on page 45” instead of trying to count circle or square bullets.</p>	<p><u>Change:</u> Revised as suggested</p>
	<p>Please cross reference the contract and the Practice Manual to ensure that contract requirements are included in the Practice Manual. It is very helpful to have a single source of comprehensive information / requirements.</p>	<p>Ensured consistency to the extent possible, recognizing that some of the specifics in the contract change annually and, therefore, do not belong in the manual.</p>
	<p>The complexity of the new service pathway has left providers very confused. Despite excellent and thorough training provided in our local system, there are too many possible different scenarios to have a complete, ongoing understanding of this. The new service pathway has made a system that was smooth and running well very quite confusing and incredibly difficult to navigate. As a provider with early intervention for almost 10 years, the system now feels very broken and burdensome.</p>	<p>All stakeholder comments related to specific aspects of the service pathway were taken into consideration as we made revisions to the manual.</p>
	<p>Overall, having a practice manual is SO HELPFUL to all of us because now we have useful, accessible guidance that is consistent across the state. While there is still some room for local interpretation, the manual provides us with a wonderful resource for how supports & services happen in our state.</p> <p>It has been very nice to have a practice manual that has most all of the information that we need to provide services.</p>	<p>We are pleased that you have found the manual helpful.</p>
<p>Chapter 1: Principles of Early Intervention</p>		

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Chapter 2: State Infrastructure		
Chapter 3: Referral		
8	<p>Under bullet for Businesses –</p> <ul style="list-style-type: none"> • Laundromats is capitalized but other examples are not. • Add churches to the list of places of business. 	<p>The list includes “Places of worship,” to be encompassing of not only churches but also synagogues, mosques, etc.</p> <p><u>Change:</u> Corrected laundromat</p>
8	The sentence at the bottom stops midstream. (4)	This was a function of the conversion to web format and has been corrected.
8	<p>Race:</p> <ul style="list-style-type: none"> • Race should be added to the information the CPE gathers unless edits are made to ITOTS to remove the race requirement for initial referral data entry. (3) • Consider moving “race” until after eligibility determination or IFSP. We do not always know the race at referral, and if the incorrect race is entered and SC forgets to change, information is incorrect. • State TA was to “guess” at race for those referrals that don’t come for an intake (Practice Manual indicates in Chapter 4, page 18 that this information is needed). We realize this is an ITOTS issue, but it also carries over into the practice manual if it is going to be required for a referral. 	Race is no longer being required at referral. Instead, as indicated in the Practice Manual, race/ethnicity information must be gathered during Intake.
8	Should there be a suggested number of days listed here under the single point of entry responsibilities that addresses making sure that all can be completed in 45 days. The collection of medical information, screening, eligibility determination. The family may have scheduling preferences prior to the 45 days that delay the entire process. Would this be entered in ITOTS as family scheduling preference?	<p>We have chosen not to make a state-level recommendation about the number of days for the single point of entry to accomplish the required task since local systems operate differently and almost all local systems have a very high level of compliance with the 45-day timeline. Local systems may choose to develop local timelines.</p> <p>If the reason for exceeding the 45-day timeline is a family scheduling preference, regardless of when during the 45 days this occurs, then the mitigating circumstance entered into ITOTS is family scheduling preference.</p>
9-10	Can it be standard practice to receive verbal permission to obtain records from the physician at the referral phone call? This would be very beneficial in the process and getting everything completed within the 45 days. Please explicitly discuss verbal consent (and given the timelines if at all possible we recommend that this be acceptable).	A physician is going to require written permission to release information to the local system. You may encourage the family to contact the physician and request copies of medical information to have available for the intake visit.
11, 21	Sending the <i>Declining EI Services</i> form and the Safeguards form to referrals who decline the intake or any further	This step ensures the family has written information about their rights and safeguards under Part C and what they are choosing to decline. It also helps protect the system by

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	contact is a waste of paper and postage to already financially strapped systems. If the family's refusal could just be documented in the contact note, that would be better.	documenting that this information was provided to the family, and, if the family returns the form, it documents the family's choice to decline eligibility determination. If so many families are declining at referral that mailing these forms is financially taxing to the system, it might be helpful to look at the reasons families are declining. You may also want to consider copying the safeguards document double-sided to reduce the number of pages you're mailing.
11	In the box titled "talking with the family about notifying the physician", is verbal permission ok? Or does it have to be written permission? Please consider clarifying.	Written permission is required and this is already stated in the box.
11	Is getting a child's social security number mandatory?	No, obtaining the child's social security number is not mandatory. However, having the SSN has allowed the Part C staff to add children's EI benefit in VAMMIS when there have been issues with the Medicaid number
11	It would be helpful to have some clarification about timelines for entering information in ITOTS for those children who are not eligible for Part C services or those children whose families decline Part C services.	<u>Change:</u> Clarified that, for children whose families decline Part C services or who are found not eligible, ITOTS data must be entered within 10 business days of the date the family declines to proceed or the date of eligibility determination, respectively.
11	It would be helpful to have some guidance about procedures for those children who transfer from another Virginia locality in reference to IFSP reviews, timelines for IFSP services to begin, etc.	Although information about how to handle the IFSP when a child transfers from one local system to another in Virginia is included in Chapter 7, we agree that information here in Chapter 3 would be helpful. <u>Change:</u> Added a section about referrals from another local Infant & Toddler Connection system, addressing procedures to follow depending on the point in the early intervention process at which the child transfers (i.e., intake, eligibility, assessment, IFSP, etc.).
12	ITOTS data should be timely and accurate; however, due to unforeseeable circumstances, data could be delayed. Having data entered within 30 days would allow more opportunity to have the children entered timely	The timelines established in the local contract for data entry must be followed to ensure reimbursement and ongoing availability of accurate data for monitoring and supervision.
13	4 th bullet – additional parenthesis needed before (including a grandparent, ...	<u>Change:</u> Corrected typo
13-14	The <i>Biological Parent</i> letter that informs the parent of the child's referral has wording that we cannot use and that our local DSS says is incorrect and potentially dangerous. It says "...until such time as you attempt to act as the parent." When a child is removed from parental care, the parent does not have the right to "act" as parent as DSS has designated someone else to do that. If the bio parent were to call us, this could be very problematic for us, the child, and the foster family. Our local DSS	The letter must be used as provided by DBHDS. Please ensure you correct the wording of your local letter to match the letter provided by DBHDS. Page 13 of the manual specifically states that "Notice is not required if the biological or adoptive parent's rights have been terminated."

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	required that we reword that line to say "...until such time as you regain physical custody of your child." Please consider this revision in the best interests of the child.	
13-14	If the biological parent makes contact with the service coordinator after the eligibility process has started with a person "acting as a parent", do all of the previously signed forms need to be re-signed by the biological parent? Does the Part C process need to "start over" to include the biological parent at that time?	It is neither necessary nor appropriate to "start over."
14	Sending the <i>Parental Prior Notice</i> form to the biological parents when a child is in foster care for each IFSP change is problematic when the bio parents' address is unknown or changes often. It is also difficult because the parent doesn't actually have the right to change things according to DSS. Our DSS would prefer that we send these forms to the foster care worker (but I realize that there is a risk, then, that the bio parent wouldn't actually receive them).	The procedures must be followed as written. Your Part C technical assistance consultant can assist you in working with the local DSS if needed. Please note that these requirements do not apply if the biological parent's rights have been terminated.
14	Parental Assertion of Rights – this is not technically correct if the child has been removed and placed outside of the home. Even if parental rights haven't been terminated, DSS does not allow the parent to make all decisions because they "assert" themselves as parent.	Under IDEA, the biological or adoptive parent, when attempting to act as the parent and when more than one party is qualified under the definition of "parent," must be presumed to be the parent unless the biological or adoptive parent does not have legal authority to make educational decisions for the child.
	Definition of Parent - This section is very well explained. We appreciate that the State took the stand of adopting the Part B regs in the interim until the Part C regs are finalized	We appreciate the positive feedback.
Chapter 4: Intake		
16	If the Medicaid number will be entered at Eligibility Determination, as was mentioned in the recent Update, the financial needs to be completed at intake.	<u>Change:</u> Revised to state that if the child has Medicaid, the Family Cost Share Agreement form must be completed prior to eligibility determination to ensure timely entry of Medicaid data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services.
16	The entire process seems more confusing, overwhelming for families. (8) <ul style="list-style-type: none"> • There are multiple forms that families must sign and initial and families frequently comment about the amount of paperwork and the number of signatures they must provide. (3) • This has added a layer of difficulty most of all for families, due to the 	Based on feedback received on the Practice Manual and information that TA and Monitoring Consultants have heard from local systems, it is clear that some local systems are finding the intake and eligibility determination processes challenging and uncomfortable, whereas others are now experiencing few, if any, problems implementing the new practices. Before considering any changes to the intake and eligibility determination processes, it is important for State Part C staff members to understand what is happening differently in those local systems where things are going more smoothly versus those systems that are

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	<p>significant increase in paperwork and the “unanswered questions” that frequently seem to be part of the current process.</p> <ul style="list-style-type: none"> • When the screening is complete most families ask if we think their child is eligible for services. I know what to say to them, but it feels awkward and like we are leaving the families hanging. It does not feel like a smooth process. • Family’s seem to prefer hearing from the full assessment team, rather than the staff conducting a simple screening 	<p>reporting more difficulty with the process. Therefore, State Part C staff members will spend the next few months talking with local systems (including the local system manager, service coordinators, other providers and/or families), reviewing records, and/or observing the intake and eligibility determination processes across the Commonwealth. The information gathered will be used to determine what technical assistance, training, and/or Practice Manual changes are needed to support an effective and efficient process for intake and eligibility determination.</p> <p><u>Change</u>: None at this time</p>
16	<p>The intake process as listed in the Practice Manual has been difficult and time consuming to implement. This process has increased the cost to our system due to the increase in staff time, without a decrease in the number of children evaluated and not found eligible. (6)</p>	<p>Please see response directly above</p>
16	<p>Add to 4th bullet that an IFSP will be developed “if that is what the parent would like to happen.”</p>	<p><u>Change</u>: Revised to read, “Explain that if their child is eligible and <i>they wish to receive early intervention services</i>, an Individualized Family Service Plan ...”</p>
16	<p>Although families need to understand the process, the bullets outlined on pg 16 have very little to do with the family’s primary concern – is there something wrong with my child, and what can you do to help?</p>	<p>The bullets on page 16 explain the process by which you and other providers will be helping the family to find out if there’s something wrong with their child and what you and the family can do to help. As indicated at the top of the text box, the list is intended to guide conversation with the family. The service coordinator can follow the family’s lead and weave this information into the conversation ... keeping it in the context of what’s important to the family.</p>
18	<p>Some of this information could be collected during the referral call?</p>	<p>Yes.</p> <p><u>Change</u>: Clarified that some of this information may have been discussed during the referral call.</p>
18	<p>Are we supposed to ask the family the federally–required 2 part question exactly the way it is stated in the practice manual? Or can we just ask for the child’s race?</p>	<p>As indicated in the Practice Manual, you must ask about race using the federally-required 2-part question. If the family states their race as something other than one of the given categories, then record in the contact note or on an intake form the race stated by the family. Based on the race stated by the family, you can then enter the appropriate race category into ITOTS.</p> <p><u>Change</u>: Added the clarification given above about what to do if the family gives their race as something other than the one of the federal categories.</p>
19	<p>This is the first time screenings are mentioned. Can you state by whom the screening can be done? Can the particulars for the exceptions to the mandatory screening be highlighted somehow?</p>	<p><u>Change</u>: Added information about who can do screenings; added underline to make the exceptions stand out more.</p>
19	<p>If a family signs the consent for the</p>	<p>Yes, as long as the child has a diagnosed condition or an</p>

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	vision and hearing screening at intake can it be delayed until the ASP if this is deemed most appropriate for the child?	obvious delay or atypical development that will make the child eligible and as long as the decision is documented in a contact note. <u>Change:</u> Clarified that if the family gives consent for hearing and vision screening on the Notice and Consent for Screening form, the family may then agree to wait and complete it at the assessment for service planning, as long as the child has a diagnosed condition or an obvious delay or atypical development that will make the child eligible and as long as the decision is documented in a contact note.
20	ASQ: <ul style="list-style-type: none"> • Is a poor screener for verbal communication. Only one item for verbal amid 3-4 for receptive for a total lang score. • We find that the ASQ is a poor tool and that even if children “fail” the ASQ may not qualify for EI. 	Although the ASQ is one of the recommended screening tools, you are not required to use the ASQ or to have it as the only screening tool you use. If you find that another tool works better for a certain group of children or for a particular area of development, then you are welcome to use another tool. In addition, the results of the screening tool are not the only information used to determine eligibility. Observation, parent report, health and medical information and the team members’ informed clinical opinion are combined with screening results in making a determination about the child’s eligibility for Part C.
20	We recommend removing the requirement for screening unless there is a diagnosed condition, documented DD/Atypical or child has already received an assessment	Developmental screening, as outlined in the Practice Manual, is an appropriate step in the Eligibility Determination process and is supported by both the literature and the proposed federal Part C regulations.
20	Please consider clarifying that an ED meeting can occur in the home with the parents present	<u>Change:</u> Added language to clarify where the eligibility determination may take place if it will be a face-to-face meeting.
20	The first circular bullet states that the person who completed the intake visit should document, in a contact note or through other written means, the information shared by the family and gathered through screening and observation.....the reports I’m doing are 2-3 pages long in a contact note. But when I talk to other local system managers, they aren’t doing anything that long. Can you please be more specific on the requirements?	<u>Change:</u> Clarified by adding the following: Since this information will be used by the Eligibility Determination team, the documentation needs to clearly communicate to individuals who were not present at the intake visit what the service coordinator and/or other provider observed about the child’s development and learned through screening and/or parent report.
20	Second Bullet Down: What if a family indicates that they do not want to go to a doctor (obtain a primary care provider) at this time. Can the system deny services to this child?	No. As stated on page 20, you offer assistance to the family in obtaining a primary medical care provider. <u>Change:</u> Clarified that the family cannot be required to obtain a primary care doctor in order to access Part C services.
20	Third Bullet Down: Can we require that a family apply for Medicaid?	No <u>Change:</u> Clarified that the family cannot be required to apply for Medicaid.
20	First Bullet Up: This reads as if a family with a child with a diagnosed condition should be given a choice between going to eligibility determination and	This is the family’s choice. One of the primary reasons for developing the service pathway with eligibility determination and assessment for service planning as distinct steps was to ensure families were being given the

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	assessment for service planning or just having eligibility determination held at the same time as the assessment for service planning. Is this the family's choice or can the system make this determination?	opportunity to make informed choices at the required points in the early intervention process. Even the family of a child with diagnosed condition may want to first have the child's eligibility confirmed before deciding whether to proceed to assessment for service planning.
21	<p>Medical Records for Eligibility Determination:</p> <ul style="list-style-type: none"> • Eligibility should not be delayed in order to wait for medical records, particularly if we know from screening or other information received that a child is eligible. We do not want to jeopardize the good relationships we have developed by making another request for records when we know they will send them as soon as possible. If we believe there may be medical issues that affect the eligibility process, we will wait for the records or ask the practice to expedite them on occasion. However, we would prefer to do this at our discretion as needed rather than have to make a second request for records we do not need to know a child is eligible. (2) • Please clarify if medical records are required for eligibility determination. We have them on most cases but when we don't we proceed so as to avoid a delay in initiating services and review screening info, clinical observations, etc. to make our determination. 	<p><u>Change:</u> Clarified that eligibility determination should not be delayed in order to wait for medical records unless the medical information is essential in determining eligibility. Also added: Remember, though, that in some situations (e.g., with premature infants) the medical information will be very important in ensuring the eligibility determination team has complete information to consider since informed clinical opinion can be used to determine a child eligible even when screening or assessment instruments or other information does not establish that eligibility.</p>
	We have had some challenges getting a written confirmation of a diagnosed condition from the doctor in a timely manner. If the family states that their child has Down Syndrome and we don't have that in writing can we move forward as if the child is automatically eligible or do we have to do a screening that shows a delay in order to determine eligibility. This does not happen often but has come up a handful of times in the 6 months. Does the written diagnosis have to come from a physician or can it come from an ancillary service provider such as a PT or OT who is stating it in a written report? How about an IFSP from another state?	Determining a child eligible based on a diagnosed condition requires documentation that the condition has been diagnosed by a professional qualified to make the diagnosis. In your example of Down Syndrome, this diagnosis must be made by a physician. If you are unable to get written confirmation in a timely manner, you may get the information verbally from the physician's office with a hard copy received later. An ancillary service provider, like a PT or OT, is not qualified to make a diagnosis of Down Syndrome. An IFSP from another state would serve as confirmation only if the IFSP clearly documented that the other state had received confirmation of the diagnosis from a physician.
22	ITOTS data should be timely and accurate; however, due to	The timelines established in the local contract for data entry must be followed to ensure reimbursement and

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	unforeseeable circumstances, data could be delayed. Having data entered within 30 days would allow more opportunity to have the children entered timely	ongoing availability of accurate data for monitoring and supervision.
Chapter 5: Eligibility Determination		
23	Could we add a sentence at the end of that opening paragraph “and will then become part of the information used by the multidisciplinary team to determine eligibility”.	<u>Change:</u> Added wording similar to the suggested language.
23	More examples on atypical; social emotional development needed as numbers expected to grow	The Infant and Child Mental Health Committee of Virginia is working to expand training and resources for providers in the area of mental health, including social and emotional development in infants and toddlers. In addition, the monthly TA Update from the Part C Office provides information about evidence-based resources and trainings in the area of social-emotional development and infant mental health.
23	This page states that chronological age is used once the child is 18 months old. However, the ASQ manual requires adjusting for prematurity until age 2. Which policy should we follow for screenings?	Since this page in the manual states Virginia’s definition of eligibility, this is what must be followed.
23-24	<p>Eligibility for premature infants:</p> <ul style="list-style-type: none"> • Virginia’s continued struggle to meet the federal targets for the birth to 1 population seems directly related to the strict guidelines Virginia uses when it comes to prematurity. We repeatedly come across children who are premature and are not found eligible based on a delay OR on atypical development on the day they are seen. We suggest that the age for adjustment be brought down until at the most 12 months and more appropriately 6-9 months. • Recommend we make extreme prematurity an automatic eligibility. (2) <p>Close monitoring of these children is crucial throughout their first 3 years. We feel this should be the responsibility of the Part C system and not only the follow along clinics at the hospitals. The services provided to families whose children are premature and are not showing any obvious delays or atypical development, can be very infrequent (just as they are at follow along clinics), but allow a trained eye to watch for emerging feeding, tone, or delay issues.</p>	One of the improvement activities we identified for Indicator 5 (percent 0-1 served in Part C) in the Annual Performance Report we submitted to OSEP for 2/1/10 was to study the potential impact (on children and on the system) of eliminating the current policy of age adjustment for children born prematurely. Timelines call for this issue to be explored with the VICC no later than July, 2010. The planned discussion will be expanded to include the possibility of automatic eligibility for children who are born extremely prematurely. Any resulting changes to Virginia’s definition of eligibility would need to be made in accordance with Part C public participation requirements (e.g., public availability and comment periods) before those changes could be incorporated into the Practice Manual.

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	<ul style="list-style-type: none"> Although the definition of micro preemie varies, we recommend that 26 weeks + 6 days and younger would be eligible regardless of skill level. This would help us to bring in the very young preemies who have an adjusted age of newborn at enrollment. 	
24	<p>Information used at Eligibility Determination:</p> <ul style="list-style-type: none"> As currently described in the Practice Manual, eligibility determination can be based on intake information from a provider who does not meet the standard to determine eligibility - along with using information from a completed screening tool (which is not designed to determine eligibility) along with often incomplete and hard to read physician records. Eligibility determination is one of the most important steps of the early intervention process and should be based on more complete/more thorough information than it currently can be. It should include observation of the child by at least two disciplines who meet the standard to determine eligibility. Virginia has moved from a more rigorous eligibility process (prior to October 1st) to a less rigorous process. (2) It is worrisome that a child can be determined eligible for admission into the early intervention system based on a screening tool. Suggestion: Determine eligibility from the initial assessment with a comprehensive intake prior to the assessment. 	<p>The Notice of Proposed Rule Making for Part C, based on the IDEA 2004 statute and published in 2007, includes a number of statements that support the practices we are using in Virginia to determine eligibility. Those statements include the following:</p> <p><u>§303.420 Parental consent and ability to decline service.</u> (a) The lead agency must ensure parental consent is obtained before--</p> <ol style="list-style-type: none"> (1) Administering screening procedures that are used either to determine: <ol style="list-style-type: none"> (i) Whether a child is suspected of having a disability; or (ii) A child's eligibility under this part; <p>-and-</p> <p>§303.320(a)(2)(iii) would clarify that the use of a child's medical and other records may be used to establish eligibility (without conducting an assessment of the child and the family) if those records contain information, required under proposed §303.320, regarding the child's level of functioning in the developmental areas.</p>
24	<p>It does not feel like this step of the process is in keeping with VA's family-centered philosophy. (7)</p> <ul style="list-style-type: none"> This important step should always be done with the family. It should not be an option to exclude families from anything in our system that involves an important decision about their child. We should, as a service delivery system, have as part of our operating practices, the automatic inclusion of families whenever decisions are made about their child. (3) 	<p>Based on feedback received on the Practice Manual and information that TA and Monitoring Consultants have heard from local systems, it is clear that some local systems are finding the intake and eligibility determination processes challenging and uncomfortable, whereas others are now experiencing few, if any, problems implementing the new practices. Before considering any changes to the intake and eligibility determination processes, it is important for State Part C staff members to understand what is happening differently in those local systems where things are going more smoothly versus those systems that are reporting more difficulty with the process. Therefore, State Part C staff members will spend the next few months talking with local systems (including the local system</p>

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	<ul style="list-style-type: none"> In many instances it is hard to make it “family friendly” and able to truly involve families as active participants, due to the reality of large distances and limited providers. More paperwork and more signatures required from the parents. The entire process seems more confusing to families. Families just want to get help for their child, and having multiple visits and steps (intake, screening, eligibility determination, assessment, IFSP) seems cumbersome to families. 	<p>manager, service coordinators, other providers and/or families), reviewing records and/or observing the intake and eligibility determination processes across the Commonwealth. The information gathered will be used to determine what technical assistance, training, and/or Practice Manual changes are needed to support an effective and efficient process for intake and eligibility determination.</p> <p><u>Change:</u> None at this time</p>
24, 32	The listed diagnoses of myelodysplasia and meningomyelocele are used interchangeably on these two pages; however these are two different diagnoses.	<u>Change:</u> On page 24, replaced myelodysplasia with meningomyelocele.
25	Finding a child eligible as developmentally delayed without age equivalency scores is problematic when we consider an OSEP monitoring visit. We are concerned that the audit would not go well without having a clear documented delay in accord with the state’s eligibility criteria	<p>Although it is not necessary to document age levels in order to find the child eligible, nothing in the Practice Manual prohibits documentation of age levels. Children who are found eligible will go on to assessment for service planning where additional information about their level of functioning will be gathered and documented. Local systems have the flexibility of deciding for themselves if, when, and where it is most beneficial to document age levels and/or percentage of delay. Age levels may be documented in the assessment summary narrative on the IFSP, on the <i>Eligibility Determination</i> form, in contact notes, and/or on screening or assessment instruments that are maintained in the child’s record.</p> <p><u>Change:</u> Added under the last bullet in the Multidisciplinary Team Responsibilities section: Although age levels or ranges are not required in order to determine eligibility, these may be recorded on the Eligibility Determination form, in contact notes, and/or on screening or assessment instruments that are maintained in the child’s record if age levels or ranges were identified for some or all areas of development.</p>
25	First paragraph states that it is not necessary to determine the child’s specific age level in each area of development. Is it acceptable to ask the family if they would like to hear age scores if applicable?	Although it is not necessary to document age levels in order to find the child eligible, nothing in the Practice Manual prohibits documentation of age levels. Nor is there a prohibition against sharing that information with a family.
25	The first paragraph under general states that we do not need to have actual age levels or ranges to determine eligibility. However we understand that administration of a standardized tool is required for the determination of the child’s entry indicators. This continues to	The indicators require a tool as a foundation because items from the tool can be cross-walked to help determine a child’s functional status on the OSEP child indicators. There is no requirement to report a child’s scores in each area of development in conjunction with determining the child’s status on the indicators.

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	<p>cause confusion to those reading the manual as they see this as contradictory. We have put the process in place to address this but wonder if these 2 issues can be addressed more succinctly in the manual as to reduce confusion.</p>	<p><u>Change:</u> Clarified in Chapter 6 (Assessment for Service Planning) under Service Coordinator Responsibilities, 4th bullet, that the reason for using a foundation tool is not to generate age levels but to serve as an anchor for the assessment and to provide a standard measure to be used in combination with other assessment sources for determining the child's functional status on the OSEP child indicators in relation to same-age peers.</p>
25	<p>Is it required to attach a copy of whatever was used to make the eligibility determination (screening, note from intake visit etc.) to the Eligibility Determination form? Is it enough just to document it on the Eligibility Determination form and not provide a copy of the form?</p>	<p>It is not necessary to attach that supporting documentation.</p>
25	<p>If during the assessment process a child is determined eligible in more ways than originally determined at the point of eligibility determination, is a new eligibility determination form completed with the additional information? Is the original one somehow amended? If yes, what about the date of Eligibility Determination that has already been filled in?</p>	<p>The purpose of the Eligibility Determination form is to document the findings of the multidisciplinary team at the time of eligibility determination. Therefore, a new form is not filled out after the assessment for service planning, nor is the original form amended to show additional or different reasons for eligibility. This new information should be reflected in contact notes and/or on the IFSP. When the ITOTS enhancement project is complete in 2011, you will be required to enter into ITOTS additional information about the child's eligibility, if there is any, after the assessment for service planning.</p> <p><u>Change:</u> Clarified in Chapter 6, under Service Coordinator Responsibilities, where to document any new or different reasons for eligibility identified during the assessment for service planning.</p>
25	<p>Please reconsider the Eligibility Determination process and whether it is benefiting the Part C system. Is this entire eligibility process necessary and a documented cost savings? (11)</p> <ul style="list-style-type: none"> • We find that it is not changing the way we process assessments as most children who come through ED proceed to assessment for eligibility because the level of at least a 25% delay cannot be confirmed. We have only had a few children proceed but then be found ineligible, typically due to the child's progress between the intake and assessment. • The eligibility determination requirement requires an extra 1-1 ½ hr meeting weekly for 2 staff persons and results in most children (estimated to be 85-90%) proceeding to assessment anyway. • I perform ED for one of our local systems and very rarely sign off on 	<p>Based on feedback received on the Practice Manual and information that TA and Monitoring Consultants have heard from local systems, it is clear that some local systems are finding the eligibility determination process challenging and uncomfortable, whereas others are now experiencing few, if any, problems implementing the new practices. Before considering any changes to the eligibility determination process, it is important for State Part C staff members to understand what is happening differently in those local systems where things are going more smoothly versus those systems that are reporting more difficulty with the process. Therefore, State Part C staff members will spend the next few months talking with local systems (including the local system manager, service coordinators, other providers and/or families), reviewing records and/or observing the eligibility determination process across the Commonwealth. The information gathered will be used to determine what technical assistance, training, and/or Practice Manual changes are needed to support an effective and efficient process for eligibility determination.</p> <p><u>Change:</u> None at this time</p>

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	<p>an ineligible child. I would estimate maybe 5 in the last 4 months. They are paying me to review the ED! Not to mention all the costs involved in screenings, travel, PAPERWORK. It's unreal.</p> <ul style="list-style-type: none"> • This process is still difficult, confusing, and very time consuming. This does not result in services beginning sooner for children and has significantly increased the time needed prior to the child actually being enrolled and receiving services. (3) • The whole process has about doubled the time the temp. service coordinator works on one referral between the added paperwork/documentation and screening. • What happened to the old process; it worked. • The folks who do the screenings do not feel qualified (even after many years of experience) to record and bring back information to determine elig. As a result most of our ED occurs at Assessment with the team present. • Service coordinators don't feel this has made any difference in the number of children identified in need of services. Some of our children take 1 & 1/2 hours of travel each way to serve. Having to make another trip to include this step makes their job more difficult and slows completion of the IFSP and the start of services. • We have found that the new process has not increased our child find numbers. In fact, if anything our numbers are decreased due to providers feeling as though as soon as a child is no longer eligible they must look at eligibility again and then discharge the family from services. (2) • This is an extra step and involves too much time • This step is not reimbursable and is costing local systems money to pull together a team to review paperwork (2) • There is usually not enough 	

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	<p>information to determine eligibility. It is rare to have something from the physician. Where this would be helpful is in determining children not eligible and thus saving the assessment. It is very hard to determine that a child is not eligible when there is so little information.</p> <ul style="list-style-type: none"> • What we have found since October 1st, is that we are spending \$220 / week to conduct eligibility determination meeting (\$220 x 26 weeks = \$5720). We have only found 3 children ineligible (savings of 3 evals= \$780). We have spent nearly \$5000 to conduct this process. • Not working as predicted 	
25	<p>In the 6 months that we have been doing this we have evaluated hundreds of children for eligibility without needing to carry out assessment activities. In fact we have gone to assessment in less than 25 instances. However, we will occasionally send out a certified professional with the SC to do the screening. We have had instances where the child was found eligible by the eligibility team but the child was determined not eligible at the assessment for service planning. Our rule of thumb for this is that it should be very infrequent and should only happen if the child has made significant gains since the screening was completed.</p>	<p>We are pleased to hear that your local system is finding that the eligibility determination process generally works well.</p>
26	<p>Is an Eligibility Determination form completed at the annual IFSP if the child has a diagnosed condition that was already documented at the initial eligibility determination?</p>	<p>Yes</p> <p><u>Change:</u> Clarified here and in Chapter 8, under Annual IFSP, that annual confirmation of eligibility is required regardless of the original reason for eligibility.</p>
26	<p>Eligibility should not be delayed in order to wait for medical records, particularly if we know from screening or other information received that a child is eligible. We have a good relationship with most of our medical practices and they will typically send medical records when requested, but it does sometimes take a couple of weeks. We do not want to jeopardize the good relationships we have developed by making another request for records when we know they will send them as soon as possible. If we believe there may be medical issues that affect the eligibility process, we will wait for the records or ask the practice</p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Added the following language to Chapter 4, under Other Intake Activities Following the Intake Visit, in the second point, which begins, "Service coordinators are expected to make every effort to obtain physician and other appropriate records prior to eligibility determination ..." -- How quickly the service coordinator follows up after an initial request for medical or other records may depend on the extent to which those records are needed in order to determine eligibility. Keep in mind, though, that these records may also be helpful to the team that is conducting the assessment for service planning and to the IFSP team even if they are not needed for the eligibility determination. • Added another sentence after the two points in this

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	to expedite them on occasion. However, we would prefer to do this at our discretion as needed rather than have to make a second request for records we do not need to know a child is eligible. (4)	section to state: Eligibility determination should not be delayed to wait for medical records unless other information gathered through intake or through intake plus assessment for eligibility is insufficient to determine and document the child's eligibility.
26	<p>Simplify/clarify the process for completing Eligibility Determination prior to annuals.</p> <ul style="list-style-type: none"> This process has really increased the workload for SC, particularly when a child is only receiving SC or is receiving SC and one other discipline and another person must be brought in to determine eligibility, even if the child clearly continues to be eligible. If a child has met the outcomes and is demonstrating appropriate skills and the parents do not feel a need for further services and the home visitor agrees then it becomes burdensome at this point. At time of discharge: The parent can decline services in lieu of eligibility meeting. This would increase the number of declinations for a system and not reflect favorably on the system. 	<p>As indicated in previous responses, State Part C staff members will spend the next few months talking with local systems (including the local system manager, service coordinators, other providers and/or families), reviewing records and/or observing the eligibility determination process across the Commonwealth to understand what is happening differently in those local systems where things are going more smoothly versus those systems that are reporting more difficulty with the process. The information gathered will be used to determine what technical assistance, training, and/or Practice Manual changes are needed to support an effective and efficient process for eligibility determination (both initial and annual). In the meantime, your technical assistance consultant can assist with reviewing your local practices to determine strategies for streamlining this process in conjunction with the annual IFSP.</p> <p>We agree with the second point made in the comment and will clarify that eligibility determination must be offered in this scenario but is not required.</p> <p><u>Change:</u> Added the following clarification under the first bullet on page 90 and in the Annual IFSP section: If at any time the family feels their child is demonstrating age-appropriate skills and is no longer in need of services, the service coordinator must offer to coordinate an eligibility determination to confirm the child's status. If the family declines this offer, the service coordinator must document both the offer and the family's decision in a contact note. When reporting in ITOTS the reason for discharge in this scenario, please use "Completion of IFSP prior to reaching age 3."</p>
26	If a family requests a delay in the assessment for service planning is there a time limit as to how long they can remain eligible without a written IFSP? Does the less than 6 months also apply in the situation at the top of page 26.	<u>Change:</u> Added clarification that if a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or longer or is currently enrolled but has been lost to contact for 6 months or more, then the local system must conduct eligibility determination and assessment for service planning, establish new entry ratings on the child indicators (if the child is still 30 months old or younger), and establish a new IFSP before resuming services. If a child has been out of services for less than 6 months, then it is only necessary to conduct a new eligibility determination if there is an indication of a significant change in the child's developmental status.
26	Add to paragraph at top of 26 review of contact notes in ways to determine ongoing eligibility	<u>Change:</u> Added "...based on the progress reports <i>and/or review of contact notes</i> ..."
26	Clarify the Eligibility Determination process if a child is exiting due to IFSP	The manual refers the reader to Chapter 8 for more details.

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	completion. Do you have to complete the ED form?	<u>Change:</u> Added more specific guidance and examples in Chapter 8.
26	There needs to be a form or some way to get permission to determine eligibility at a time other than the initial or annual or clarify if this can be done by completing a PPN.	Another checkbox has been added to the top of the Eligibility Determination form that can be marked when there is a need to confirm eligibility at a time other than the annual IFSP.
26	Please define the professional qualified to make a diagnosis. Frequently we receive reports from professional other than physicians who state a diagnosis in the body of the report they are sending.	The professional qualified to make the diagnosis will vary. While physicians can make a diagnosis within any of the categories of conditions listed, some diagnoses may also be made by other professionals. Vision impairment may be diagnosed by optometrists; hearing impairments, by audiologists; and autism, by psychiatrists or psychologists.
26	The sentence on endocrine disorders and hemoglobinopathies is unclear. Why is this any different from other diagnosis? If there is a specific difference here, please state what it is.	<p>The difference between these categories and the other diagnosed conditions is that not all disorders within these categories have a high probability of resulting in developmental delay for all children (depending on the child's response to medical treatment of the disorder).</p> <p><u>Change:</u> Added a sentence at the end of the first bullet under Multidisciplinary Team Responsibilities to read: Not all disorders within these categories have a high probability of resulting in developmental delay for all children.</p>
27	Eligibility Determination form seems to be insufficient to document the basis for the eligibility determination – particularly for an initial determination when a full team assessment in all areas of development has not been conducted. Too open to interpretation. If this form will continue to be utilized, recommend more training on how to implement in the practice manual.	<p>The Eligibility Narrative provides open space for the team to document the basis for the eligibility determination.</p> <p><u>Change:</u> Added instructions for completion of the Eligibility Determination form in Chapter 5 (Eligibility Determination) under the last bullet in Multidisciplinary Team Responsibilities.</p>
27	It is indicated that if an assessment is needed to determine eligibility, to consider starting in the area of concern. It then states you can stop, if it becomes clear that the child is not eligible. But on page 19 it says that no child may be found ineligible for Part C without having a developmental screening completed in all areas of development. So, should we be screening in all areas of development when we think we may need an assessment to help determine eligibility? This will be very time consuming and redundant for the family. (2)	<p>Chapter 4 of the Practice Manual states that: For those children who must receive a developmental screening using a tool, it is acceptable to first screen in the area of the suspected delay or atypical development. If screening in that area(s) indicates the child will be eligible for Part C, then it is not necessary to screen in the remaining areas of development.</p> <p>In the situation described in the question, the child should have been screened in all areas of development prior to the eligibility determination team meeting since the criteria described in the above excerpt from the Practice Manual were not met (the screener did not find an area of development where it was clear, based on the screening, that the child was eligible).</p> <p><u>Change:</u> Added to #2 at the bottom of page 19 that “Otherwise, the child must be screened in all areas of development.”</p>
27	Clarify that if medical records contain information that verifies a child's eligibility, such as a diagnosed condition, the SC, if they meet criteria to determine eligibility, can determine	Yes, as long as the service coordinator is certified as an Early Intervention Professional in addition to an Early Intervention Service Coordinator and documentation of a diagnosed condition has been received from a physician. The exception would be for a diagnosis of an endocrine

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	<p>eligibility with the family at the initial visit after the Permission to Determine Eligibility form is completed. SC would be one discipline, medical records/doctor would be second discipline.</p>	<p>disorder or a hemoglobinopathy. Not all disorders within these categories have a high probability of resulting in developmental delay for all children. Therefore, with these diagnoses the documentation from the physician would need to specifically state that this has a high probability of resulting in delay for this child or a second discipline would need to participate in the eligibility determination along with the service coordinator/EI Professional.</p> <p><u>Change:</u> Added this example in a text box in Planning and Preparation for Eligibility Determination section of Chapter 5.</p>
27	<p>If an assessment is needed to help determine eligibility, is the Assessment for Service Planning form signed before completing this assessment?</p>	<p>The <i>Notice and Consent to Determine Eligibility</i> form includes the statement “Assessments are conducted as part of the eligibility determination process if your child’s eligibility is uncertain based on existing information,” so it’s not required that you have the family sign the Notice and Consent for Assessment for Service Planning prior to conducting assessment that’s needed for eligibility determination. However, if you’re going to combine assessment for eligibility and assessment for service planning, it makes sense to get the family’s signature on the <i>Notice and Consent for Assessment for Service Planning</i> form ahead of time too, explaining that you will move to assessment for service planning if the child is found eligible.</p>
27	<p>If a screening is completed, the practice manual states that if, after looking at the area of concern, the child is eligible, you do not have to look at the remaining areas. However, when you are completing the assessment for service planning, the PM states that if you determine a child is not eligible in the area of concern, you do not complete the assessment for service planning in all areas. This is confusing/challenging because 1) the PM says that you can not make a child ineligible without looking at all areas - so does the SC have to go back and screen in the other areas? Do you complete the assessment for service planning and look at all areas and then pay for that from EI funds? Sometimes children are not eligible in the area of concern but are eligible in another area, such as cognitive or adaptive. If we stop after looking at only the area of concern, we will not catch this.</p>	<p>You will only stop a screening before looking at all areas of development if you have already found enough evidence that the child is clearly eligible. Therefore, you should never be in a position of needing assessment information in order to determine this child eligible. If you find that this is happening, it indicates a need for additional technical assistance or training for those individuals in your system who conduct screenings and/or those participating in eligibility determination.</p>
28	<p>Top paragraph-how do we document the other areas of delay or concern other than on the IFSP form in the narrative?</p>	<p>This might also be documented in contact notes.</p>
29	<p>First full bullet (If the child is ineligible -- Facilitate an opportunity for the family to</p>	<p>The family should always have the opportunity to talk with the eligibility determination team if they have questions.</p>

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	talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family) ...should this also be listed as a strategy if the child IS found eligible?	<u>Change:</u> Added language similar to that in the first bullet on page 29 to the second bullet under Service Coordinator responsibilities.
	The screening process has been very useful to help SCs make better decisions about who to include on the assessment team. I like the requirement to conduct screenings.	We are glad to hear you have found this helpful.
29	Interim IFSP: <ul style="list-style-type: none"> • Please designate whether or not the IFSP pages that correspond to the required elements of an interim IFSP must be used. This is confusing to some SCs. • Provide a general definition of an interim IFSP. More detail in what has to be done to complete this. • If the child has an interim IFSP how many days do you have to start services after the IFSP is signed? 	<u>Change:</u> <ul style="list-style-type: none"> • Clarified that there is no requirement to use pages or sections from the statewide IFSP form in developing an interim IFSP. • Added language in the first bullet to further define/describe an interim IFSP. • Specified what information about services must be included. • Clarified that, although the services must begin within 30 days of the date the family signs the interim IFSP, because services on an interim IFSP have been identified based on an immediate need, these services should begin right away and certainly in much fewer than 30 days.
29	There is no way to document in ITOTS if a child was originally found eligible then at the time of the assessment for service planning they are not eligible. (2) ITOTS: At initial eligibility the child has often been screened in only the main area of concern or the child has been found eligible based on a diagnosed disabling condition. Should we be adding eligibilities after the ASP when more information has been obtained? Doesn't this give us a more accurate picture of the children we serve?	The capacity to add more information in ITOTS after the assessment for service planning about the reasons for eligibility is being addressed through the ITOTS Enhancement Project and will be available in 2011. In the meantime, if additional reasons for eligibility are identified at the assessment for service planning, please go back in ITOTS and add those to the reasons identified at eligibility determination. Since the current ITOTS system captures point in time data and does not keep a history, do <u>not</u> update the reasons for eligibility determination after an interim or annual determination.
29	It would decrease the confusion in filling out the ITOTS form if the language was changed from "child evaluated" to "eligibility determination completed".	ITOTS Version 1.8, which is nearing completion, will add "EI eligible?" (to allow for earlier enrollment in the Medicaid EI benefit for dually enrolled children and will change "Child Evaluated" to "Eligibility Determination Completed."
30	How is the second bullet measured by the Part C staff? There seems to be EXTREME variability in this across the state (Assessment is carried out for eligibility determination only if the multidisciplinary team finds that existing information is insufficient.....)	Monitoring of this practice is being incorporated into the Quality Management Review and expanded General Part C Monitoring Review processes. The first rounds of these reviews will focus on identifying the need for technical assistance and training around new requirements and practices like this one, rather than on citing non-compliance.
30	Please define "necessary information" on the eligibility determination form if age equivalency is not required.	<u>Change:</u> Added in parentheses after "necessary information:" (i.e., all sections of the form are completed, including the signatures/names, and the narrative is detailed enough that someone who was not a member of the team could read the form and understand why the child was found eligible/not eligible)

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30	Eligibility determination form is more time consuming and open to interpretation errors than the former page 4 of the IFSP (score page).	We believe that providers who were capable of accurately determining eligibility before October 1, 2009 are still capable of doing so and that they can accurately complete the Eligibility Determination form. Ongoing local monitoring and supervision should identify any patterns of errors or reasons for concern, which can then be addressed locally or with support from your TA Consultant.
	Interpretation of EligibilityShould this be an appendix (it is not entered in the table of contents)?	<u>Change:</u> Revised the Table of Contents to reflect this section.
31	Should it say greater than or equal to a 25% delay....	<u>Change:</u> Corrected as suggested in comment.
31	Add atypical articulation in the description of atypical sensory motor even though it is referenced below.	<u>Change:</u> Added reference to articulation as suggested, with an asterisk to the Note.
31	Is unilateral hearing loss automatically eligible? This is not clear.	<u>Change:</u> Clarified that any degree of hearing loss (unilateral, bilateral, mild, moderate, severe) makes the child eligible.
32	Under – “chromosomal abnormality – should read type number or length. (2)	<u>Change:</u> Corrected typo
32	Under diagnosed conditions, please consider adding muscular dystrophy here	The section at the end of Chapter 5 entitled “Other’ Diagnosed Conditions with a High Probability of Resulting in Developmental Delay” notes that IFSP teams are given the discretion to identify “other” diagnosed conditions under this eligibility category. Under #2 in the table provided in this section you’ll find that muscular dystrophy is most likely listed correctly as an “other” diagnosed condition, qualifying the child as eligible for Part C.
33	Failure to Thrive can be diagnosed by whom? Autism can be diagnosed by whom?	Failure to thrive must be diagnosed by a physician. Autism may be diagnosed by a physician or a psychologist.
33	Add cleft lip and palate to the list of diagnosed conditions. (5)	<u>Change:</u> Added as suggested.
35	Torticollis: <ul style="list-style-type: none"> • Shouldn’t this be listed as “atypical development” given it indicates atypical muscle tone in the neck and / or shoulders? • We recommend that torticollis be automatically eligible. 	Staff at the Health Department have reviewed the list of conditions that local systems have entered into ITOTS in the past as “other” diagnosed conditions, and have stated that torticollis is a risk factor rather than a diagnosed condition with a high probability of resulting in developmental delay. Torticollis is already covered by/allowed in atypical development since atypical development includes limitations in joint range of motion.
35	Recommend that Myotonic dystrophy and SMA be listed as automatic eligibility.	The section at the end of Chapter 5 entitled “Other’ Diagnosed Conditions with a High Probability of Resulting in Developmental Delay” notes that IFSP teams are given the discretion to identify “other” diagnosed conditions under this eligibility category. Under #2 in the table provided in this section you’ll find that both congenital myotonic dystrophy and spinal muscular atrophy are most likely listed correctly as an “other” diagnosed condition, qualifying the child as eligible for Part C.
	What gestational age do we start adjusting for prematurity? 36 weeks 6 days?	Yes
Chapter 6: Assessment for Service Planning		
37	Edit- first paragraph 10 th line should be	<u>Change:</u> Corrected typo

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	"development and assists"	
38	In the final bullet the manual comments about revisiting or expanding info from intake and eligibility for the ASP...it would be good if this was at the beginning of the chapter. This would help people to focus on getting info from the family at their first visit and using it for eligibility and ultimately ASP and IFSP development	<u>Change:</u> Added a sentence in Chapter 4, in the point related to beginning a conversation with the family that lets you get to know the child and his family and their activities: If the child is found eligible, this information will also be helpful in completing the family assessment and for IFSP development.
39	Can you have a separate heading for what to do if the child is found not eligible by the ASP team?	Moving this information to a separate section takes it out of the natural flow of steps. Instead, we will try to use an enhanced table of contents, an index and/or hyperlinks to make this information easier for the reader to find.
39	1 st bullet - If a discipline specific tool is used (i.e. Speech – REEL), does the comprehensive assessment tool (i.e. ELAP) have to be scored in the communication domain? This is more a question for clarification.	As indicated on page 39, you may use a discipline-specific tool <i>in addition to</i> the comprehensive assessment tool. We would expect that, generally, the practitioner can be completing items on both tools at the same time.
39	Do the two assessors referenced in the 3 rd bullet need to sign the IFSP?	At least one assessment team member is required to participate in the IFSP meeting. If he/she is unable to be at the IFSP meeting, arrangements must be made for him/her to participate through other means, such as by phone or by providing written information. Only those IFSP team participants who attend the IFSP meeting are required to sign the IFSP (those who participate through other means are listed as participants but not required to sign).
39	Bottom of Page-regarding children not found eligible at the assessment for service planning: If a child was found eligible at Eligibility Determination, should a new Eligibility Determination form be completed to clearly document this? (3)	The purpose of the Eligibility Determination form is to document the findings of the multidisciplinary team at the time of eligibility determination. Therefore, a new one is not filled out after the assessment for service planning, nor is the original form amended to show additional or different reasons for eligibility. This new information should be reflected in contact notes and/or on the IFSP. When the ITOTS enhancement project is complete in 2011, you will be required to enter into ITOTS additional information about the child's eligibility, if there is any, after the assessment for service planning. <u>Change:</u> Clarified in Chapter 6, under Service Coordinator Responsibilities, where to document any new or different reasons for eligibility identified during the assessment for service planning.
39	<u>Age levels:</u> <ul style="list-style-type: none"> Recommend information related to a child's age levels be included in the assessment for service planning and then listed in the IFSP. This information is necessary for determining entry ratings and for determining whether a child meets the criteria for TCM. Also, many parents specifically ask about the age level their child is functioning at. 	Although it is not necessary to document age levels, nothing in the Practice Manual prohibits documentation of age levels or sharing that information with families. Age levels may be documented in the assessment summary narrative on the IFSP, on the <i>Eligibility Determination</i> form, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record. There is no requirement to report a child's scores in each area of development in conjunction with determining the child's status on the indicators.

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	<p>School systems also find this information very helpful as part of the transition process. (3)</p> <ul style="list-style-type: none"> • If it is not added to the IFSP, would at least like to have a form on which it is recorded to include in the child's record. This information is also needed for TCM eligibility so it needs to be on a consistent format in the chart. • Recommend that each child's EI record include clear documentation of the child's age levels at each assessment so they are available to document TCM eligibility, support a family's application for Social Security Disability, assist in the eligibility process for Part B services, and use as a measure for the team to track a child's progress over time. (2) 	
39	<p>Are scores required to complete the VA Child Indicators Summary form? If they are, where does this need to be documented?</p>	<p>There is no requirement to report a child's scores in each area of development in conjunction with determining the child's status on the indicators.</p>
39	<p>Talks about the comprehensive assessment tool as the foundation for child assessment (and of course child indicators). There has been much confusion about using a tool and when. For consistency sake could there be one area that explains how the comprehensive assessment fits into initial eligibility, the initial ASP, and annual IFSP, and discharge/ transition (for indicators).</p>	<p><u>Change:</u> Added information in Chapter 6 that explains the different types and purposes of assessment and when a tool is needed.</p>
	<p>From the "Virginia Service Pathway: Questions and Answers Part 1 (Referral through Assessment for Service Planning) 47 Questions. - Question #23: "...If the discharge summary from the physician includes information that can be used for service planning, then the physician may be considered one of the disciplines for the assessment for service planning step." The above needs to be included in Chapter 6. Also, the above statement needs to include more information such as detailing the types of information provided that will allow the physician to be the 2nd discipline for assessment for service planning.</p>	<p>There is already a reference to the physician as the second discipline on page 39.</p> <p><u>Change:</u> Added the following to the end of the 2nd bullet under the point about two disciplines: "...can be used to meet the requirement for one of the disciplines if the physician includes information that can be used for service planning. This information may include, but is not limited to, results from an assessment tool, observations of child development, and information about current or projected impact of the child's health on his/her development. The local system determines whether the information provided by the physician can be used for service planning (e.g., whether it is helpful in identifying outcomes, short-term goals, necessary supports and services, and/or treatment modalities)."</p>
40	<p>If the family requests an interpreter is that a valid reason for the child to be out of timeline if we can't find an interpreter</p>	<p>No, that would be a system reason for exceeding the timeline.</p>

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	in time.	
40	Bullet 5- Are these all required members at the IFSP as stated? We do not routinely have the team members who participate in eligibility at the ASP.	At least one of the eligibility determination team and/or assessment for service planning team members is required to be a participant in the IFSP meeting. If that individual is unable to attend the meeting, arrangements must be made to him/her to participate through other means, such as by phone or by providing written information.
41	Consider changing "Notify all participants in writing of the date, time and location.....using the Confirmation of IFSP Schedule form" to just "notify all participants in writing." We typically do 2-4 assessments in a day and use a spreadsheet to send to providers that lists all children, insurance provider, time and place of the assessment and discipline/therapist providing assessment. This gives the same information but we are able to put everything for one week on the same page instead of faxing multiple pages.	Federal Part C regulations require written notice of the meeting date and arrangements to the family and other participants far enough ahead of the meeting date to ensure their participation. The Confirmation of IFSP Schedule form provides a way to notify all participants using one form. However, if your local system has another written mechanism for notifying provider participants, you may use that. If requested during monitoring, you must be able to produce the documentation that shows providers were notified in writing in advance of the meeting. <u>Change:</u> Revised the bullet that starts "Notify all participants in writing of the date, time and location for the IFSP meeting using the <i>Confirmation of Individualized Family Service Plan (IFSP) Schedule</i> form" to reflect the option to notify provider participants using a different written mechanism.
41	What form do we use to send out confirmation of the assessment for service planning?	We have added an optional form for providing written confirmation of the assessment for service planning. <u>Change:</u> Added reference to this new, optional form.
41	Blank IFSP form to family: <ul style="list-style-type: none"> • We are not giving families a blank copy of the IFSP form because of the waste involved. We do thoroughly review the process and facilitate family participation. Could this bullet be reworded as a suggestion to support families who need it? • Giving the parent a blank IFSP form to fill in their information to prepare for the meeting seems to be placing a lot of burden on the family. 	Families are not required to fill out the form, but this gives them an opportunity to become familiar with the form and the option of jotting notes in different sections of the form before the IFSP meeting if that's helpful to them. We recognize that not all families will wish to receive a blank form. <u>Change:</u> Re-worded this bullet to reflect that service coordinators will review the blank form with families, explaining the different sections, and offer to leave a blank form or select pages of the blank form with the family if the family wants it.
42	First Bullet do all participants need to be notified in writing or just the family? This implies that all of them must receive this confirmation in writing.	All participants are to receive written confirmation (34 CFR 303.342(d)).
42-43	One of the responsibilities for providers at assessment is to provide a written report of developmental skills etc. Please consider adding a statement that providers can write the assessment report in the home or that it needs to be to the SC within 3 days after the assessment.	While there are no federal or state requirements about where the assessment summary can or must be written or when, we agree that it would be helpful to add language requiring that information be available to other IFSP team members ahead of the IFSP meeting unless clearly not feasible to do so (e.g., both activities occur on the same day). <u>Change:</u> Added at the end of the 5 th bullet under Responsibilities of Other Early Intervention Service Providers: Assessment results must be provided to the

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		service coordinator prior to the IFSP meeting, unless clearly not feasible to do so, so this information is available to all IFSP team members.
43	Add a bullet to remind other providers that services are not discussed during the assessment since they are outcome-driven.	The first bullet under Responsibilities of Other Early Intervention Service Providers already states this. <u>Change:</u> Added underline
	There will always be instances when a child will need to be assessed but then will be found to have “caught up” when the assessment for service planning is conducted. In our locality this has occurred in particular with children with speech or articulation differences. Not receiving reimbursement for assessments when children with Medicaid are not found eligible is a hardship to local systems. All assessments for service planning should be able to be reimbursed. (3)	Since this child was eligible at time of the assessment for service planning (i.e., he/she was found eligible by the eligibility determination team), Medicaid will reimburse for the assessment for service planning even if that assessment leads to a determination that the child is no longer eligible. ITOTS Version 1.8 will allow you to enter the child as of the date of eligibility so that the child can be enrolled in the Medicaid EI benefit.
Chapter 7: IFSP Development		
45	Completion of the CISF in the home is awkward. I think the team would decide on the same ratings whether the parent was present or not. I’m not sure of a better way to do this, though...	You may find it helpful to view or review the online training modules for Virginia’s System for Determination of Child Progress. These modules can be accessed through either http://www.infantva.org/ovw-DeterminationChildProgress.htm or http://www.vcu.edu/partnership/ITC/index.htm and demonstrate how to include parents in a discussion of child progress ratings.
45	Do we have to complete the COSF (3 rd bullet) if everything is entered electronically. If that information can come from the electronic record then the COSF should not have to be completed.	If you can produce the information on the CISF form in full from an electronic record then it is not necessary to also complete a hard copy of the form. <u>Change:</u> Added this clarification to the manual.
47	Provide more direction about specifics of which AT devices are considered medical. (2)	<u>Change:</u> Added examples of medical devices in the first bullet of the text box: Medical devices include, but are not limited to, suction machines, glucose monitors, feeding pumps, apnea monitors, enteral and parental solutions and supplies, nebulizers and ventilators.
47	We would like to have the opportunity to discuss AT devices with the State Part C office. We provide a great deal of assistive technology service and purchasing of device. Specifically we recommend that if we have paid more than 50% for any device (regardless of base cost) IT should be owned by the system. What is stated currently in the practice manual \$5000 is much too high. We stock our loan closet with equipment that families have returned to us and this is often done regardless of the pay source! Regardless of how much we pay, we NEVER take the equipment back until they no longer need it. We	We applaud the efforts of local systems or groups of local systems coming together to collect, refurbish and re-use AT devices of any cost. The practice currently in the manual was developed based on a consultant recommendation that took into account other states’ policies and procedures as well as the EDGAR regulations. We are open to reconsidering this practice, but need more time to further research the issue before making any change, particularly since changes will have ramifications and potential costs for local systems in terms of storing, tracking and refurbishing. We will be talking with local systems and the Family Involvement Project as well as reviewing additional information from other states. Any revisions would be made at the time of the next review and revision to the manual (in either 6 or 12 months).

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	<p>have not had any difficulty getting this expensive equipment back when the child no longer needs it. We strongly recommend that the practice manual be changed to reflect the two principles above. This has been researched and is consistent in other systems around the country.</p>	
47, 61	<p>The need to call an IFSP meeting to add “adaptive equipment” to the IFSP prior to trying new equipment/tools is very frustrating and limiting to the child’s best outcomes. We strive to have the best forethought regarding what a child might possibly need for the next year. As any therapist knows, however, this is often quite difficult to predict. It is another burdensome step to have yet another IFSP meeting to try a piece of equipment that may not even be used in the long term. We strive to be excellent clinicians and to provide absolutely the highest services to the children we serve. With these seemingly ever-increasing limitations, we feel very stunted in our ability to provide ongoing, creative, and comprehensive services. Suggestion: Add “adaptive” to the IFSP only if an equipment purchase through EI will be made</p>	<p>The Practice Manual does not require you to hold an IFSP review and list an assistive technology device on page 6 to try a piece of equipment.</p> <p><u>Change:</u> Clarified in the text box on page 61 that: It is not necessary to list equipment on page 6 of the IFSP when the provider is trying out potential equipment with a child to determine whether or not it is appropriate to meet the child’s and family’s needs and the IFSP outcomes. Once an appropriate assistive technology device has been identified and will be acquired for this child (through loan or purchase), an IFSP review is held to add this device(s) to the entitled services listed on page 6 of the IFSP.</p>
48	<p>Please clarify that the physician signature is not required if the payor does not require it and that it is not required for children whose services are paid for by Part C. We have been encouraged by how well the physician’s offices are working with us on processing the signatures; it has gone very well. (2)</p> <ul style="list-style-type: none"> • Bullet 5- Makes it sound as if every child whose services COULD be covered by a third party is required 	<p><u>Change:</u> Clarified by adding the italicized language: “... medical necessity for services if the child <i>is covered by public (Medicaid or TRICARE) or private health insurance and will receive services that can be reimbursed under that insurance plan.</i>”</p>
48	<p>Bullet 5- How do we proceed if we have been unable to obtain a physician cert? If PT is one of the services, is the process different?</p>	<p>Service coordinators are expected to make every effort to obtain physician certification quickly enough to ensure the timely start of services. Page 6 of the Practice Manual explains that local systems are not permitted to delay the start of supports and services while waiting for insurance authorization or physician certification, except by parent request. If there is difficulty in getting timely physician signature from the child’s primary care physician, service coordinators may seek signature from another physician on the child’s medical team or IFSP team or may be able to get the signature of a physician assistant or nurse practitioner associated with the physician.</p> <p>In those rare occasions when the service coordinator is</p>

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		<p>unable to obtain the physician signature in a timely manner, Part C funds must be used, as needed, to avoid a delay in the start of services. Remember that Medicaid allows the service to start without a physician signature and will still reimburse for the service as long as the physician (or physician assistant or nurse practitioner) signature is obtained no more than 30 days after starting the service.</p> <p>Physical therapists must follow Virginia PT regulatory requirements governing physician referrals for services and will not be able to begin services without such a referral, except under the limited exclusions specified in the PT regulations, even if Part C funds are available as payor of last resort.</p> <p><u>Change:</u> Added the above clarification under bullet 5.</p>
48	Clarify when a Declining EI form should be used. Let's say a child qualifies for EI due to a hearing impairment but the family thinks the child hears ok so only SC is on the IFSP. We would offer SLP services but the family doesn't want it. Should we complete the declining EI form for SLP services?	<u>Change:</u> Added a text box in this section to include examples of when the top half of a Declining EI Services form is needed.
49	The guidance on how to document when a family requests services, frequencies, etc. that the rest of team does not feel are needed is very helpful.	We are pleased you found this helpful.
50	First bullet reads that the service coordinator will...select a provider(s) using the practitioner database. While it is realized that this database has not yet been fully developed; once developed, how is this to be implemented? What if a family does not have internet access? I would suggest that the database have the ability to be sorted and printed by locality so the service coordinator can easily take a hard copy with him/her to the home.	<p>The database will allow the user to sort and print. In addition, there are other functions within ITOTS that allow the user to access information similar to what will be included in the practitioner database:</p> <ul style="list-style-type: none"> • Local Supervising Users can access a list of practitioners (and their discipline) associated with their local lead agency. This list is available on the Agencies page, and, though it is not a report, the user can cut and paste the list into a document that can be printed. • ITOTS Version 1.8 will provide a report that lists provider agencies and disciplines.
50	In some of our areas, we only have one therapy company to provide services but within that company, we have multiple therapists. What about 2 SLPs or 2 OTs in the same provider agency? Does the family sign for the company or do they sign for the specific provider within the company?	<p>The key is that parents should always have a choice of providers. If there is only 1 agency, then offer a choice of providers from within that one agency. If the family has a concern about receiving services from that agency, then the local system must work to identify an additional provider.</p> <p><u>Change:</u> Added the above clarification to the manual.</p>
50	What are the procedures when you have no providers available to serve a family? It is very hard for us to get a PT in certain areas. It would be helpful to have written procedures on what to do in these cases. What about procedures if a therapist is full and can't take any new families?	This kind of situation should be addressed with your TA consultant. Effective strategies for dealing with this scenario will vary based on specific local issues, capacities, etc.

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51	Bullet 2- is assessment date the same as the date of the ASP??	Yes
51	IFSP addendum page - does it need to be completed when a new service is added...new signature by the parent at the bottom of the page? Does it need to be signed again at each annual even if the provider agency has not ended?	Yes. <u>Change:</u> Added language about requirement for family to sign addendum page each time a new service(s) is added to the IFSP.
51, 75-76	The addendum page can be confusing as it is not clear for which services the family is signing for indicating they have been given provider choice. For example, at the initial IFSP, the family may be signing for service number 1 only or service numbers 1 and 2, or 1, 2, and 3, etc. However, the family only signs once. At a future IFSP review, the family may be signing indicating provider choice on line 2 of the addendum page, but it is unknown from this page which entitled service the family is signing for. It would be easier to follow if there were enough signature lines (8) to match up with each entitled service listed on IFSP page 6 or if an additional space was provided next to signatures to indicate which entitled service numbers that signature included.	We agree that some cross-reference is needed. In order to save space, we will reference the service number with the signatures rather than adding so many signature lines. <u>Change:</u> Added next to each signature and date a place to indicate the number(s) of the service(s) to which that signature applies.
	Is it possible to delete the signature on the addendum page and have the signature on page 8 cover the provider choice? Parents have to sign their names so many times from intake through IFSP development. Would be nice to reduce the number of times they have to sign when possible. (7)	Since the family will not always be offered a choice of providers on the same date they sign the IFSP it is necessary to have separate signatures on page 8 and the addendum.
52	General information- Instead of referring to EPSDT here, can this be changed to the EI initiative.	<u>Change:</u> Revised as suggested.
52	Bullet 5- We assume that the Medicaid reimbursement for SC sentence will be removed	<u>Change:</u> Deleted sentence as suggested.
53	3 rd bullet. Please explain why a blank is not applicable. Why does it always have to be marked N/A	A blank is not allowed because then it is not clear whether the item is not applicable or was overlooked.
54	Please clarify if the IFSP meeting takes more than one meeting to complete does only the first meeting have to be within the 45 days	Yes, only the first meeting must be within 45 days. <u>Change:</u> Clarified on page 45 (first bullet under Service Coordinator Responsibilities) that, if more than one meeting is needed to complete the IFSP, the first meeting must be within the 45-day timeline.
55	Use of the word routine tends to lead service coordinators and therapists into the process of asking more questions about the "typical day". Is there another word that could be used to get the	This is exactly the information we would hope to get by asking about the child's and family's routines. This will help the IFSP team to identify functional outcomes and to integrate supports and services into the family's life in a way that is least intrusive and most helpful.

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	information we are really looking to get from the family	
56	Under Narrative: Please better define "An integrated report summarizing the findings from all assessments..."	<u>Change:</u> Inserted italicized language: "An integrated report <i>describing the child's developmental status and functional skills across developmental domains</i> and summarizing the findings from all assessment sources is strongly recommended."
56	<p>Recommend that information related to a child's age levels be included in the IFSP. (9)</p> <ul style="list-style-type: none"> • This information is necessary for determining entry ratings and for determining whether a child meets the criteria for TCM. Also, many parents specifically ask about the age level their child is functioning at. School systems also find this information very helpful as part of the transition process. • Our locality has needed to continue to use the scores page with the IFSP, to meet the requests of parents and partnering agencies. Without the scores page, the IFSP is not as effective or appropriate for referrals and linkages to other needed services or resources, such as Part B, SSI, or waivers. • We have to document it and we use it to start discussion for indicators. We have providers document it on the indicators sheet-it feels like we are hiding something from families when they are writing it down. Families want to know what scores their child received as well as it is needed to determine TCM and the school systems like it when we make transitions/referrals. • Recommend adding an optional age levels page in the IFSP form. (2) 	<p>As indicated in the October 1, 2009 System Transformation Q&A, there is no requirement to report a child's scores in each area of development in conjunction with determining the child's status on the 3 child outcome indicators. A child's status on the 3 child outcome indicators is based on his/her functional skills rather than on scores from assessment instruments.</p> <p>There is also no TCM requirement to report age levels on the IFSP/Consumer Service Plan (now called a Person Centered Individual Support Plan). Information used to support determination of the child's eligibility for TCM may be documented in the same places as that for Part C eligibility (see next paragraph).</p> <p>Under no circumstances may the old page 4 of the IFSP form be used. The IFSP is a state form and may not be altered in this way. As has been clearly stated back as far as the Eligibility Determination Q&A (2/09) and the Service Pathway Q&A (3/09) local systems are still permitted to document age levels. The Service Pathway Q&A even states that for local systems that wish to document age levels, there are a number of places where that documentation can occur: in the assessment summary narrative on the IFSP, on the <i>Eligibility Determination</i> form, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record.</p> <p>Given the options above, which have been shared verbally and in writing with local systems for over a year, it is difficult to understand why anyone would have the impression that there is any intent to keep this information from families or to promote secrecy of some kind. Beyond the options for documenting age levels in writing, you are certainly welcome to share this information verbally with families, something we also have stated repeatedly. Local systems with the inaccurate impression that they should be withholding age level information from families are urged to get immediate assistance from their TA Consultant in developing strategies to share accurate information about eligibility determination, assessment for service planning, and IFSP development requirements with all providers in their system.</p>
57	(Page 4)- if the child is SC only is it ok for the only goal to be the SC goal or must there be another goal on the plan?	It is acceptable for the only outcome to be the service coordination outcome.
58	(Page 5)- Can you provide a definition of activity settings?	<u>Change:</u> Added definition of activity settings to the glossary – a situation specific experience, opportunity, or event that involves a child's interactions with people and

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		the physical environment; the social and physical places where learning takes place (from Dunst and Bruder, Family and "Community Activity Settings, Natural Learning Environments, and Children's Learning Opportunities," Children's Learning Opportunities Report, 1999, vol. 1, number 2)
58	(Page 5) Second paragraph - Is this the same way the SC goal should be numbered?	As noted in the parenthetical phrase at the end of this paragraph, the service coordination outcome will always be #1.
61	It has been very challenging in our system for providers to distinguish between a therapy service and the service/AT service. Often we do not know that a child will need AT services, so we just list PT, ST, or OT. The provider then feels that if they take out anything that might be considered an AT device, even if just for a visit or 2 (such as a therapy ball or modifications for feeding) they cannot do so without the SC changing the IFSP to include AT services. This, they believe, severely limits their ability to serve children appropriately. From a billing perspective, it is impossible to track, as our providers do not distinguish in their billing whether a service is including AT service. Please provide further clarification or consider just dropping AT services (which would be preferred) and allow IFSP teams to list things that might be considered AT services in the modalities. Then, at the time the team felt a child needed a specific item that met the AT criteria, AT device could be added to the IFSP.	Assistive technology services are defined as a service under Part C of the Individuals with Disabilities Education Act and must be listed on the IFSP as an entitled service if the IFSP team identifies such services as necessary to achieve the outcomes listed on the IFSP. Therefore, if assistive technology services emerge as a needed service after the IFSP is developed, an IFSP review is necessary to add this service to the IFSP. An IFSP review need not be a time-consuming or cumbersome step, especially since it does not require a face-to-face meeting and can be accomplished between the service coordinator and family with input ahead of time from other providers.
63	(bullet 4) We have written some guidance for IFSP teams on how to write up service recommendations for twins and triplets. We have provided it to the state Part C office through our TA. Perhaps it would be helpful if it was included in the manual	Thank you for sharing these written service guidelines. Since we do not include such specific service guidelines in the Practice Manual for any other groups of children, we will not be adding these to the manual. The manual already emphasizes the main points of your guidance: the importance of individualizing services based on each child's and family's unique situation and on the IFSP outcomes.
	I have worked as a service coordinator for approximately one year. I have read that there are a number of services available to our consumers. My experience has been that the families usually utilize PT, OT, ST and developmental services. My question is if other services are needed such as assistive technology, nursing services etc., how do we assess services for our families, who are the providers of these services, etc.	Initial assessment to identify outcomes and necessary services occurs in the assessment for service planning step of the process. Ongoing assessment occurs as a routine part of service delivery. If the IFSP team determines that it is needed, a specific assessment may be planned after the initial assessment to better understand a child's functional status in a particular area(s) of development and the need for an additional or different service. The table at the end of Chapter 12 identifies what types of providers can deliver what services. The practitioner database, which is under development, and some ITOTS reports, list providers of each service by local

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		system area.
64	<p>Our team of experienced therapists is well versed in working in a natural setting. There are occasions, however, when despite best efforts, providing services to children in a daycare room is contraindicated. There are several daycares we frequent that are chaotic, tiny rooms, and have lack of resources. We often find ourselves struggling for the child's attention in these situations. Our therapists have been asked not to come back because the teachers are either not supportive of our services, or they feel our presence is disruptive to their classroom. In these situations where alternative scheduling options have been exhausted, denial of payment of services is unfortunate. We are penalizing working families and at times denying services to their children if no other alternative scheduling/settings can be worked out. We cannot provide our services for free. Suggestion: In situations where repeated efforts to provide services in the daycare setting has been deemed unsuccessful, allow pull out services with careful contact with the family through either phone conversations or written documentation.</p>	<p>It is difficult to tell from the scenario in the comment whether we would agree that all options have been exhausted. We would expect that other natural environments have been explored as options for service delivery, including the option of receiving services in the home during the evening or on weekends. There are also a number of resources available that may be helpful in identifying new ways of providing services in the day care setting that are not disruptive to the classroom, that engage not only the child enrolled in Part C but also his/her classmates in a way that is helpful to the child receiving services and to other children and the teacher, etc. The Part C Technical Assistance Consultants can help with developing strategies to address these kinds of situations.</p> <p>Principle #2, in Chapter 1 of the manual, states that "The purpose and focus of Part C supports and services are to increase the child's participation in family and community activities identified by the family..." Since day care is where the child in the comment spends the bulk of his/her time, efforts need to be focused on how to that environment can be adapted and adult caregivers can be taught to create the opportunities for learning and practice.</p> <p>As indicated in the Early Intervention Rates table in Chapter 11, services provided in center-based settings are still reimbursable though at a lower rate than services provided in natural environments.</p>
64	<p>Under natural environment / location: What if the family is not sure of the natural environment at the time of the IFSP? Many families will say "I need to talk to my child's babysitter." Is it appropriate to put home or daycare. Or can that be changed later without an IFSP meeting?</p>	<p>Since an IFSP review is needed to change the location of a service, it may be better to wait until the family decides before recording the location and having the family sign the IFSP.</p>
64	<p>Please clarify what would be listed on the IFSP if a treating therapist is looking at all areas in order to determine outcome indicator ratings. We do not add an assessment for a therapist to summarize progress referencing a tool in their discipline, but if they feel comfortable looking at all areas, they generally do a more specific assessment using a tool. (2)</p>	<p>The treating therapist should be able to complete the tool based on ongoing assessment, their knowledge of and interaction with the child during service delivery. Therefore, the assessment is not a separate service and is not listed on the IFSP.</p>
64	<p>Second bullet on page: Please consider elaborating on the difference between a consult and an assessment and the requirements of each. I've had MANY questions from SCs and Providers on when they have to write a report and the length of each activity.</p>	<p>Consultation and assessment are methods that may be listed for a service on the IFSP. The Practice Manual defines consultation as being between 2 service providers <u>without</u> the child and family present. Assessment is listed as the method when an assessment will be completed after the initial assessment for service planning (this does not include ongoing assessment conducted at each session by</p>

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		<p>the service provider). There are no specific requirements about the length of a consultation or assessment or about writing a report. Whether it's a consultation or an assessment, the activity must be documented in a contact note.</p>
64	<p>Please clarify the consultation process – when specifically it should be added, how to add it (do you list the person who will be doing the consulting or the discipline that will be consulted with or both?), and address billing issues related to consults. In our area, providers are not willing to do a consult unless it is listed on the IFSP so that they can bill for it. This seems unreasonable, as it requires a SC to make a visit to a family to complete a review to add a consult that sometimes lasts 5-10 minutes. (2)</p>	<p>Please see the response directly below in relation to the issues of when to add consultation to the IFSP and billing. When consultation is listed on the IFSP, you list the person (service) who will be doing the consultation.</p> <p><u>Change:</u> Clarified in the description of consultation as a method that page 6 will list the service (discipline) that is providing the consultation.</p>
64	<p><u>Consultation Between Providers:</u> Clarify (if this is true) that consultation between providers is not reimbursable unless it is done with both providers together with the family and child. (2)</p> <p>2nd bullet- Is the consultation paid for if it is written on the plan.</p> <p>It is frustrating that we cannot provide paid consults over the phone to our developmental therapists. (2)</p> <ul style="list-style-type: none"> Many of the children we serve are incredibly complex. By limiting availability to skilled therapists, we are adding more work to already over burdened service coordinators as well as discouraging developmental therapists from pursuing important assistance from licensed professionals that meet highest standards. It feels as if early intervention is attempting to discourage this process. It is difficult to understand why a child cannot receive a paid consult with a phone conversation, but can be determined eligible for the early intervention program (either initially or at the annual) via phone consult. This seems very contradictory in nature. With our busy schedules and our desire to provide the most excellent services possible, it would be beneficial to be able to provide paid phone consults. Suggestion: Allow paid phone consults. 	<p>Consultation between team members who are both providing ongoing services to the child using the method “coaching, including hands on as needed” is not listed on the IFSP as consultation between the two providers (without the child and family). Instead this is considered teaming, an expected part of service delivery that is included in the EI rate paid for the service they are already providing.</p> <p>Although an IFSP service delivered by the method “consultation” (between team members without the child and family present) is not reimbursed by public or private insurance, it can be reimbursed with Part C funds as payor of last resort. The standard EI rates for reimbursement of consultation between team members without the child or family present will be the same as:</p> <ul style="list-style-type: none"> The center-based individual services rate, if no travel is involved; or The individual EI services rate, if travel by the provider is required. <p>A provider will not be reimbursed for participation in consultations/team meetings by phone.</p> <p><u>Change:</u> Added clarification to distinguish consultation from teaming in Chapter 7 and clarified reimbursement in Chapter 11. Specified in Chapter 11 that team meetings must include parent and child to be reimbursable and must be planned ahead of time with prior notice to participants. Team meetings are not a catch category to use as a default for billing purposes.</p>

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	<ul style="list-style-type: none"> We worked hard with our providers when we had to develop a mechanism of oversight to not automatically add a service but to consult first. Plus all of our providers do not work for the same agency and could be 45 minutes from one another. We use a lot of Developmental Services and it strengthens the system when they can consult and learn from therapists. 	
65	At an initial IFSP meeting, it is a requirement to put the anticipated end date for provider services as the 6 month review date? Then at the 6 month review, we update for the next 6 months? Or can you put the anticipated end date at the annual IFSP?	There is no prohibition against listing a projected end date that corresponds with the annual IFSP rather than the 6-month IFSP review. However, you may wish to consider that, if the child and family fall into the no-show situation and become inactive in the system, that IFSP will remain open until the last projected end date is reached, which could be close to 12 months down the road rather than 6 months.
65	Page 6 – What documentation, if any, is needed on page 6 if the service begins after the projected start date noted?	No documentation is needed on page 6. Contact notes must document efforts to begin the service and the actual start date.
65	Is it necessary to have an end date for a 1X visit or assessment?	Yes. <u>Change:</u> Clarified under Projected End Date that the projected end date for a one-time service would be the same as the projected start date.
66	The implication is that if the projected start date will reflect that fact- is that an ok reason for it to be after 30 days when services start. We don't believe this to be true but it is not clear here.	The second paragraph in this section explains the acceptable reasons for planning a later start date.
67	Entitled Vs Other. In the instance that a child does not yet have the official diagnosis of autism we will often refer a family to a developmental pediatrician. This does not change the type of services we recommend. Would this be entitled or other?	Since the purpose of the referral is not to obtain medical assessment or diagnostic information for purposes of determining eligibility, this is not an entitled service and would be listed at the bottom of page 6 under "Other Services."
67-68	Page 7 – Instructions state that Part C is required to send the notification information as the child becomes age eligible unless parent initials the box. But instructions also state to do this as child nears third birthday if parent does not plan to transition at age 2. How do we handle this notification if parent doesn't yet know when they want to transition- they don't initial that you cannot share the info, but they haven't decided yet when to transition. Do we send the info if the child will be 2 by 9/30 even if parent hasn't decided whether they want to transition at age 2 or wait until age 3. Need more clarification.	We agree that this language is confusing. Since children are age eligible for Part B services in Virginia when they are 2 by September 30 th , LEA notification really should occur prior to this point. <u>Change:</u> Revised instructions to require that the date is no later than the April 1 prior to the start of the school year in which the child turns 2 by September 30. Clarified that if the parent opts out of notification at that time, they may use the "I have changed my mind" line in the Notification box on page 7 of the IFSP to allow notification at a later time, as their child approaches age 3.

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69	Clarify that it is OK to combine the child find activity (notification of child's name, DOB, address, phone number) with a referral for Part B if both happen to occur at the same time. (3)	See response directly above.
70	If the family changes their mind and decides they no longer want a transition planning conference is another signature required?	Recent clarification from OSEP indicates the family's verbal approval for the transition conference is sufficient. <u>Change:</u> Deleted signature line from 3b and reference to <i>Parent Approval for Transition Planning Conference</i> form on page 7 of the IFSP. Removed <i>Parent Approval for Transition Planning Conference</i> form from website and any reference to it from the manual. Revised practices in the Transition section of Chapter 8 to allow verbal consent and to remind service coordinators to document that consent on a contact note and on page 7 of the IFSP.
70	Should the SC put N/A's on the transition page if the child exits the program prior to starting or completing the transition process? Let's say a child exits Part C at 12 months of age, does the SC still put N/A's on the transition page?	Yes.
72	Again the physician certification is referenced differently from page 48...in different chapters this is described differently.	<u>Change:</u> Reviewed for consistency across sections and changed as needed.
72	Please add the Right to Appeal required by Medicaid to the record review page (9) of the IFSP OR to the Parental Prior Notice.	<u>Change:</u> Collaborated with DMAS to integrate Medicaid Right to Appeal language into relevant Part C procedural safeguards forms and documents.
72	Clarify what process should be taken to determine when it is appropriate to add an additional service to an IFSP. In past years, when required by contract, our system developed a Mechanism which required consulting by the treating provider before adding a service. With new confusion about consulting and the difficulty in completing a consult when it must be added to the IFSP, is it enough to justify in an IFSP review that strategies have been attempted by treating therapist and family even if consult has not been completed and an additional service can be added.	There is no requirement for a consultation to be provided prior to adding a service. If a team member identifies the potential need for an additional service, then an IFSP review is held and the team determines whether that service is necessary to achieve a new or existing outcome.
74	If an IFSP review occurs and there are no changes, does the parent still sign that the services continue?	Yes. This is stated in Chapter 8 under IFSP Review. <u>Change:</u> Added on page 74 that "Parent signature is required even if no changes were made."
74	IFSP Review By Phone: <ul style="list-style-type: none"> Clarify what to do if the prior notice has not been signed first. Suppose a SC is on the phone with a parent and something comes up that was not anticipated prior to the call – for 	Although, a service coordinator and family may conduct the IFSP review, other team members must at least be informed of the meeting and have an opportunity to provide input. The phone conversation described in the example is not an IFSP review. The top bullet in the text box of "Other Requirements Associated with IFSP Reviews" clearly

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	<p>example, suppose the parent brings up concerns about speech on the call and then the parent and the SC agree over the phone that a speech assessment is needed. Can that conversation count as an IFSP review even if a prior notice form is not signed prior to the call? Or can a phone call count as an IFSP review <u>only</u> if a prior notice form is already signed before the call is made? (2)</p> <ul style="list-style-type: none"> Suppose the parent's signature is not obtained on the IFSP review form for two weeks following the call. Does the 30 day count for timely begin on the date of the phone call or the date of the parent signature? (3) 	<p>states that "<i>Prior Written Notice and Confirmation of IFSP Meeting</i> procedural safeguard forms must be used prior to an IFSP review."</p> <p>The 30-day timeline for timely start of services always begins on the date of parent signature.</p> <p><u>Change:</u> Added a bullet in the box of "Other Requirements Associated with IFSP Reviews" stating that any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs. Added the same information under the IFSP Review section of Chapter 8.</p>
75	<p>Bullet 5)-does this projected start date need to be the date when the parent signs or can it be the date of a phone review.</p>	<p>This is the date each specific change is projected to start so the date you use may vary. If it's a change to an outcome, for example, you would use the date of the review. If it's a new service, then the projected start date might be 2 weeks from the date of the review.</p>
75	<p>This is another place that physician certification is discussed. It is also on page 91 and seems to be contradictory</p>	<p><u>Change:</u> Reviewed for consistency across sections and changed as needed.</p>
75	<p>Need clarification regarding when physician signature is required (5):</p> <ol style="list-style-type: none"> Prior to any assessment (OT, PT, ST, Dev Services)? Any time a new service starts (including OT, PT, ST, Dev Services)? Each time there is a change in a service (frequency, intensity)? For each annual IFSP, even when the same services continue from initial IFSP? Each time a service ends (even if the child is still in Part C)? When the child is discharged altogether from Part C? <p>A chart like the chart for reviews (p. 73) would be helpful.</p>	<p>Physician authorization is needed for examples 1*, 2, 3, 4.</p> <p>* For PT, OT or SLP assessment if the child has TRICARE; otherwise only for PT (see Virginia PT regulations for specifics; for instance, no physician authorization needed for a one-time assessment if the PT has at least 3 years of experience).</p> <p><u>Change:</u> Added a text box in the instructions for page 8 of the IFSP and added information elsewhere within the manual to describe when physician signature is needed.</p>
76	<p>When are the second and third lines used on the addendum?</p>	<p>To document parent choice of providers for services added during IFSP reviews.</p>
76	<p><u>Under #4).</u> Parent Signature: This section seems to indicate that the parent is to sign and date the choice statement at the bottom of the Addendum at the Initial IFSP, the Annual IFSP <u>and at Reviews whenever a new service is added</u>. It makes sense to have families sign the choice section on the Addendum at Initials and Annuals.</p>	<p>We agree that there needs to be a way to connect the parent signature for choice to those services added at an IFSP review and will make the change to the addendum page described in our response to the comment above that relates to pages 51, 75-76. The service coordinator will need to access the addendum page from the original IFSP anyway, in order to make revisions based on the review, and can then obtain the family signature.</p>

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	<p>However, I would suggest that a choice section be added to the IFSP Review form so that whenever a review is completed, that adds services, the family can indicate that they have been provided Choice directly on the Review form. This seems to make sense, since the Review form must be completed anyway. Often SCs do not take entire original IFSPs out to the home with them and so they may not have the addendum page when a review is completed. Overall, it just seems to be a more streamlined and efficient process to have the choice statement located on the Review page.</p>	
77	<p>Need clarification on which forms are needed prior to the annual. On page 93, only the Parental Prior Notice form is specified but this is not clear in the instructions for completing an annual.</p>	<p><u>Change:</u> Added a text box for “Other Requirements Associated with the Annual IFSP” and included information from page 93 to specify necessary procedural safeguards forms.</p>
77	<p>There needs to be more guidance about the eligibility determination process and the need for assessments at annual IFSP reviews. There are many different situations that potentially require different steps (screenings vs. assessments, review of medical information, etc.) through these processes. For example, we need specific steps for:</p> <ul style="list-style-type: none"> • A child who is receiving service coordination only but has a diagnosed disabling condition that makes him eligible • A child who is receiving service coordination only and it is unknown whether the child continues to meet eligibility based on developmental delay or atypical development • A child who is receiving service coordination and a specific service, but continued eligibility is unknown due to child progress • A child who is receiving service coordination and a specific service and whose continued eligibility can be determined through the use of progress notes and informal assessment by service provider • A child who will be turning 3 within 6 months and is requiring an assessment (formal or informal) by an Early Intervention Professional to complete a VA Child Indicators Summary exit assessment. 	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Added a text box for “Other Requirements Associated with the Annual IFSP” and included a summary of requirements associated with annual determination of eligibility, with link to more information in other chapters. • Added in Chapter 8 a text box with different scenarios (from the comment) and what is required at annual eligibility determination. <ul style="list-style-type: none"> ○ Still need 2 disciplines to review ○ Need 2 disciplines; SC does screening and compiles developmental and health info for team to review ○ Provider (other than SC) plus one other discipline review existing info. If need more info, targeted assessment is done to determine continued eligibility ○ Provider (other than SC) and another discipline review progress notes and determine eligibility ○ Could do exit assessment and determination of eligibility together or have 2 disciplines determine eligibility based on progress notes now and exit assessment closer to discharge.

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82	Page 3-Eligibility for Targeted Case Management: Based on the definition of adaptive development under TCM, please provide a crosswalk to the child's areas of development that we assess in Part C. For example, if a child has a delay in fine motor, would this be consider an adaptive delay under TCM?	<p>In our IFSP instructions we state that under TCM, adaptive skill areas include communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Based on that statement, delays in communication, social, and/or adaptive skills would constitute a delay in adaptive development under TCM. In addition, a delay in any other area of development assessed in Part C (except cognitive development, which must be considered separately for TCM eligibility) may indicate a delay in adaptive skills under TCM if that delay impacts on the areas we've listed in the IFSP instructions (e.g., self-care, community use, etc.).</p> <p><u>Change:</u> Added the above clarification to the manual.</p>
83	Please consider expanding on the QMRP requirements. If an ITC contracts with a local CSB to do their billing, is the ITC still under this requirement or does the CSB cover this requirement?	The CSB will have a QMRP that can sign if the case manager does not meet this qualification. If you need assistance with figuring out how this works in your specific system, your TA consultant can help.
83	We've been told that under new Medicaid regs, only the supervisor has to be a QMRP. It may no longer be required that the actual service coordinator also be a QMRP.	It was never a requirement that the case manager/service coordinator be a QMRP (Qualified Mental Retardation Professional), only that the IFSP be signed by a QMRP. If the case manager meets that requirement, then there's no need to get an additional signature. If not, then a supervisor who is a QMRP must sign along with the case manager. New licensing regulations are being developed that will eliminate reference to a QMRP and talk instead about the requirements (knowledge, skills and abilities) of a supervisor.
84	3 rd Bullet- now says "progress of lack of progress", which doesn't make any sense that I can figure out. Do you mean "progress or lack of progress."	<u>Change:</u> Corrected typo
84	Do you have to have an IFSP review to change a child to TCM?	Page 84 of the Practice Manual states that if a child becomes eligible for TCM after the IFSP is developed and you want to use the IFSP as the consumer service plan for TCM, then you must hold an IFSP Review to add the required elements of the Consumer Service Plan to the IFSP.
	<p>Much more information and clarification should be included about Targeted Case Management and how it relates and coordinates with Part C. There are many variations of how this is being implemented, who is being found eligible, and how the revenue is being used across Virginia. While there is specific information in the TCM regulations, there needs to be more detailed clarification and training for children receiving early intervention. (5)</p> <ul style="list-style-type: none"> Consider adding a statement or page on how to explain TCM to families using family friendly language. 	Due to time constraints, we are not able to add this information and clarification at this time. The Part C Office is collaborating with DMAS and staff within the DBHDS Office of Developmental Services to develop and deliver additional training to local systems on Mental Health (MH) and Intellectual Disabilities (ID) Targeted Case Management. In conjunction with these trainings, we will identify information that should be added to the Practice Manual during the next set of revisions. Please note that in order to avoid excessive copying costs for local systems and to control the number of versions of the manual in use, the Practice Manual will be revised no more frequently than every 6 months (we would prefer to make it annually). Between revisions, updated information will be posted to the website in the same section as the manual.

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	<ul style="list-style-type: none"> • Please consider expansion of the box called “Reminders” on page 82. This is useful information. • Instructions for completing an IFSP for a child receiving MH-TCM would be VERY helpful. 	<p><u>Change:</u> Added in Chapter 11 requirement for revenue generated through Part C to be put back in Part C (EDGAR).</p>
Chapter 8: IFSP Implementation and Review		
85	<p>The Practice Manual talks about when services “begin” when talking about the 30-day timeline. Does the 30-day timeline apply to services that continue from the initial IFSP to the annual IFSP?</p>	<p><u>Change:</u> Clarified that the 30-day timeline applies to new services (i.e., those listed on the initial IFSP and any new services added at a review or annual IFSP).</p>
85	<p>Include information on make up visits. (4)</p> <ul style="list-style-type: none"> • Consider more specific examples for make up visits. What if an interpreter cancels? Is that session made up with the family? What about the time frame for cancellations? If the family cancels and a provider can squeeze them in later in the week, is that ok? If the provider cancels but can’t make it up for two weeks, is that still acceptable? 	<p><u>Change:</u> Added information and examples on making up missed sessions, including the following:</p> <ul style="list-style-type: none"> • It is not necessary to make up sessions missed because the family cancels. • Sessions cancelled by the provider and sessions that fall on holidays must be made up, unless the family states that they do not wish to make up the missed session. Make-up visits are to be rescheduled as soon as possible after the missed session. • If the provider is unable to make up the session her/himself, every attempt should be made to schedule a make-up session with a therapist from the same agency so the service is still authorized and provided by a practitioner within the child/family’s insurance network. If there is not a provider in that agency, the substitute provider should be selected from among those participating in the child/family’s insurance network if possible; and, if necessary, pre-authorization should be obtained. • Missed sessions may be made up by scheduling a new, full session or by adding time to other sessions (e.g., if a 45-minute session is missed, a new 45-minute session may be added or 15 minutes could be added to each of the next 3 sessions). The determination of how best to make up the time missed in a previous session must be based on what is best for and meets the needs of the child and family. • Contact notes must document efforts to reschedule missed sessions and must clearly document when a session is a make-up from a missed visit or when it is extended in order to make up a previously missed visit.
85	<p>It would be helpful for providers if the state would provide duplicate contact notes (with a carbon) so that providers could write a note at the visit and leave a copy with the family. (3)</p> <ul style="list-style-type: none"> • This would be especially helpful for children seen in day care where family could see that the provider 	<p>While we recognize the benefits of duplicate contact notes, the State office budget for Part C does not allow for this cost. Local systems that are interested may wish to pool funds, perhaps ARRA funds, and explore the possibility of better rates with a bigger order.</p>

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	has been and what they should work on.	
86	<p>“A foreign language interpreter must be present” Under intake it states: “Procedural safeguard forms are provided in the family’s native language or other mode of communication unless clearly not feasible to do so.” Why then does this statement use the word “must.” If you went down every avenue and can not find an interpreter, what then?</p>	<p>We agree that it is appropriate to add “unless clearly not feasible to do so” here. Contact notes must document efforts to find a translator, including efforts to work with local school systems and neighboring Part C systems to identify available translators.</p> <p><u>Change:</u> Added “unless clearly not feasible to do so” at the end of the 3rd bullet under Service Coordinator Responsibilities (Ensure that the language or other mode of communication normally used by the child in the home or learning environment is used in all direct contact with the child.).</p>
88	<p>No Shows:</p> <ul style="list-style-type: none"> • This is entirely too specific and very difficult to follow. It suggests each time a family has missed a visit, a flowchart must be followed with excessive time needed to count days, “If blank then 3 “additional <i>business days</i>” and then it changes to “7 <i>calendar days</i>” then 10 day calendar days.” A certified letter is an unnecessary step. If families haven’t called back by then, then that should be it. Empower families, don’t enable them to abuse the system and bleed funds. • The issue of how to deal with “no shows” practically but sensitively is a difficult one and needs further review, beyond the strategies that are currently recommended in the Practice Manual. In our locality, the sending of certified letters to document attempts to give notice to parents following no shows can be seen as highly offensive to them. In our rural area, this is seen as a strategy that is used by “bill collectors” and as a way to enforce legal requirements. Hopefully, we can come up with more options and recommendations for this challenging issue. • Again we must comment that this policy for no shows is incredibly cumbersome. The fact that it takes an entire sheet to outline the procedure demonstrates the difficulty in actually putting it into practice and correctly documenting for it. Can there be a more practical way of addressing the issue of No Shows that continues to protect the 	<p><u>Change:</u> Clarified flexibility in use of the flow chart by adding the following information: There are four critical points that local system managers and service providers, including service coordinators, must be aware of when dealing with a no-show situation:</p> <ol style="list-style-type: none"> 1. A “no show” situation must be addressed promptly. This protects the child and family in their entitlement to receive supports and services in accordance with the IFSP. It also protects the local system and its available funding. 2. The service coordinator plays a very important role in addressing a no-show situation. 3. Documentation must be thorough and timely. 4. A child may only be discharged from the Part C system when all steps in the flow chart have been completed <u>and</u> there has been no contact from the family <u>and</u> the projected end dates for all entitled services listed on the IFSP, including service coordination, have been reached. <p><u>While implementation of the four points above is required, the timelines provided in the no-show flow chart may be viewed as guidelines.</u> Any monitoring activities associated with the no-show policy will focus on ensuring that the child and family were discharged only under the circumstances listed in #4 above and will not focus on whether the exact timelines in the flow chart were met.</p> <p><u>Change:</u> Changed from “require” to “recommend” use of a certified letter. (A certified letter has the advantage of letting the system know if the family received the letter).</p> <p><u>Change:</u> Added information to clarify that the situation where a children and family are lost to contact (without a no show) is handled similarly to the no show situation:</p> <ul style="list-style-type: none"> • Contact the referral source or physician to request additional or updated contact information. • If still unable to contact a family after requesting additional contact information or the family repeatedly fails to respond, then the dates of attempted contact must be documented in the child’s record. Attempts to contact the family may

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	<p>family but also allows resources to be used for family's that are "available". Perhaps the Service Coordinator responsibilities should stay the same while freeing the service provider up to see other children.</p> <ul style="list-style-type: none"> Suppose a certified letter is sent when the system has lost contact with a family and it is returned, unopened, because the family is either no longer at that address and left no forwarding address (and we have confirmed with the PCP that there is no other address that they might have) OR the family did not pick up the letter? Does the child get put on inactive status or is the child discharged because the local system no longer has a valid address? 	<p>be made by phone, mail, visiting the address provided, and/or other means based on the contact information available. It is recommended that no more than 15 – 20 calendar days pass during this process of attempting to contact the family.</p> <ul style="list-style-type: none"> Send a letter If no contact by the family within 10 calendar days of sending the letter, then put on inactive status. Cannot discharge until last projected end date has passed.
89	<p>Contact log:</p> <ul style="list-style-type: none"> Requirement to submit a contact log to the local lead agency no later than the 21st of each month for the previous month for any service for which reimbursement is sought from Part C funds needs to be re-looked at. No one has asked us to send this but it is in the practice manual. We currently send progress notes one time per month. How is the contact log submitted for payment when insurance is pending? This is not happening and is very difficult to get. 	<p><u>Change:</u></p> <ul style="list-style-type: none"> Added on page 89 that contact notes may be submitted instead of the contact log (to match what was already written in Chapter 11). Expanded contact log requirement to require the log (or contact notes) include all services provided that month regardless of whether or not Part C funds are being requested. This is critical information for service coordinators and local system managers to have in order to coordinate and monitor delivery of services in accordance with the IFSP. Changed the requirement for the provider signature to allow signature on the log by any authorized individual from the provider's agency. Clarified that when insurance reimbursement is pending, you include that service on the log for the month in which the service was delivered and mark it "insurance pending." Once the insurance company has acted, you then submit that service again, on a later log, for payment.
89	<p>Second Bullet Down – Ongoing Assessment</p> <ul style="list-style-type: none"> Please better define ongoing assessment. States that providers should provide ongoing assessments but I don't find that this is occurring. Consider making this statement stand out more and being more specific on circumstances where an OT is the only provider in the home is still responsible for providing information in all areas of development. 	<p><u>Change:</u> Added that service providers observe the child's functioning and skills across all developmental domains as a routine part of service delivery. When needed, the service provider may use an assessment tool as a reference point especially for areas of development outside his/her area of expertise. This still occurs as a part of the provider's interactions with the child during service delivery and is not a separate activity. Ongoing assessment gives the provider information not only on the child's progress on the outcomes and short-term goals being addressed by the current activities but also helps the provider identify any emerging concerns in other areas of development.</p>

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89	Can the first bullet state that the provider must make every attempt to reschedule.... Are there reasonable exceptions to this rule? Vacations, weather etc...	<p>The only exception is if the family does not wish to reschedule.</p> <p><u>Change:</u> Added to second sentence, "...unless the family does not wish to reschedule (contact notes must document the offer to reschedule and the fact that the family declined this offer)."</p>
89	Consider adding a statement that providers should be documenting all attempts to contact families to schedule visits especially for the first visit.	<p><u>Change:</u> Moved the existing bullet that addresses this up higher in this section and added specific reference to documenting all attempts to schedule visits, especially the first visit.</p>
89	Under responsibilities of Providers, consider adding a statement about it being helpful for providers to leave written recommendations to families of suggested activities to embed into daily routines after each visit.	<p><u>Change:</u> Added a new point at the end of the General section to read "Consider what information may be helpful to leave with the family to support them in implementing the activities practiced during the session. Leaving a copy of the contact note (the optional state-developed Early Intervention Activity Note provides a section for noting suggestions for follow-up during daily routines) or providing pictures or video of particular strategies or positions are potential methods for providing this kind of information to families."</p>
90	Include all the discharge scenarios that require an ED form and those that don't (examples: child turning three, child going to Part B, child/family moving from one local system to another and they will continue with Part C services there, the child/family is lost to contact, child who is 18 months old at age level/IFSP is complete, parent declines and child is still eligible, etc.). (3)	<p><u>Change:</u> Revised the wording in the first bullet on page 90 to read "If the family or another IFSP team member(s) believes the child may no longer be eligible <i>has reached age level in all areas of development and shows no sign of atypical development ...</i>"</p> <p>Added the following points under the first bullet on page 90:</p> <ul style="list-style-type: none"> • Ongoing assessment should document the child's functional status across settings and situations before a provider considers that the child's development is typical and at age level compared to same age peers. • It is only necessary to determine the child's eligibility prior to discharge if <u>the local system</u> is proposing to end services prior to the child's third birthday. • If at any time <u>the family</u> feels their child is demonstrating age-appropriate skills and is no longer in need of services, the service coordinator must offer to coordinate an eligibility determination to confirm the child's status. However, if the family declines this offer, the service coordinator must document both the offer and the family's decision in a contact note. When reporting in ITOTS the reason for discharge in this scenario, please use "Completion of IFSP prior to reaching age 3." • Eligibility determination also is not necessary prior to discharge if the child is leaving the local system for any of the following reasons: child is turning three, the child is transitioning to Part B, the family is moving out of the area served by the local system, the child and family are lost to contact, or the parent declines continued services.
90	Please clarify the role of an eligibility team in the situation where a child is no longer eligible but there is only one provider on the team. Does the child go	<p>In the scenario presented in the comment, there should be no need to add an assessment to the IFSP since the current service provider should be able to present information on the child's developmental status based on</p>

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	<p>to eligibility committee before a review? After a review? Are 2 reviews required in this situation? (one review to add an assessment for determination of ongoing eligibility and then a review to find the child no longer eligible). Currently our practice is that the one provider completed the assessment across several regularly scheduled appointments in all areas then sends that information to the eligibility team. The team reviews that assessment information and the contact notes and either agrees with the single providers thoughts of no longer eligible, asks for more information, or finds the child to continue to be eligible. Does this process meet all of the requirements for finding a child not eligible? This is covered later in the chapter but again confusing for the user of the manual.</p>	<p>the ongoing assessment that occurs as part of his/her service delivery. The child's continued eligibility can be determined during the IFSP review and any changes to outcomes or services determined then and there.</p> <p>The process stated in the comment is acceptable.</p> <p><u>Change:</u> Clarified on page 90 that the eligibility determination can occur during the IFSP review meeting (as long as 2 or more disciplines participate). Also clarified on page 90 and in the Annual IFSP section that if a child is receiving only service coordination, then the same types of information that are gathered for initial eligibility determination would be gathered for this annual confirmation of eligibility (e.g., current developmental screening results, observation, parent report, current information from the physician, etc.). The service coordinator, if properly trained, can conduct the developmental screening and observation and gather information from the parent.</p>
90	<p>Should discuss that assessment in all areas needs to be completed for the child not eligible not only to better determine eligibility BUT it is required for the completion of the exit indicators</p>	<p><u>Change:</u> Added to the first bullet on page 90 that the information gathered for determining eligibility can also be used to complete the exit ratings on the child indicators for those children found to be no longer eligible and who have been in the Infant & Toddler Connection of Virginia system for at least 6 months since their initial IFSP.</p>
90	<p>It would be helpful to expand that you still need 2 providers to determine eligibility even if the child has a diagnosed condition.</p>	<p><u>Change:</u> Clarified in the first bullet on page 90 and in the Annual IFSP section that a multidisciplinary team is required even for children who are eligible based on a diagnosed condition.</p>
90	<p>I think I need clarification. An IFSP review is held. The child receives one or more services. One of the providers of a particular service determines child no longer has a delay for that particular service so that service is ended. In order to end that particular service the provider/therapist has to do an assessment on the child to officially confirm there is no longer a delay. This does not mean the child is no longer eligible to receive the other services so the child is still eligible to receive EI services.</p>	<p>The wording on page 90 of the manual refers to the child's eligibility for the Infant & Toddler Connection of Virginia, <u>not</u> the child's eligibility for a particular service.</p>
91	<p>Physician signature at IFSP Review:</p> <ul style="list-style-type: none"> • Please better define. Is a physician's signature required every time there is an IFSP Review? Even when the only change is an update to goals? • Previously outpatient rehab required physician approval of the plan of care when it was revised. However, the plan did not require approval when the outcomes/goals were 	<p><u>Change:</u> Added the following clarification:</p> <ul style="list-style-type: none"> • If a child's services change from one discipline to another or the frequency and/or intensity increase or decrease, then it is necessary to get the physician's signature to certify that the new service or the service that is continuing but at a new frequency/intensity is medically necessary. • If, at an IFSP review, services stay the same but an outcome(s) and/or short term goal(s) changes, then physician signature is not required.

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	<p>revised. Would recommend not needing to get the physicians signature if we are only adding outcomes/goals but not changing a service. If requested, we could still send the doctor the new goals, but not request anything back from them. (4)</p> <ul style="list-style-type: none"> Require only an annual signature from the physician to authorize services. Getting signatures for each update has been difficult. (2) 	
92	<p>The section about a family requesting a service that is not recommended. This is a rare situation for us, we hope that by the end of the IFSP the family is in agreement with the service that we have recommended because we have discussed it. We have not had to put this particular process into place but perhaps we need TA to determine when this would come into play versus when the team has (perhaps begrudgingly on the parent's part) come to an agreement and has signed the IFSP. Doesn't signature of the IFSP with the recommended services apply here. Would this only be in the instance where the family refuses to sign the IFSP?</p>	<p>A family may sign the IFSP because they agree that the services listed on the IFSP are necessary to meet the outcomes but still feel that an additional service(s) that is not listed on the IFSP also is necessary. In this situation, using the Parental Prior Notice form documents both the parent's feeling that an additional service is needed and the system's reason for refusing to initiate that service.</p>
	<p>IFSP Review Needed?</p> <ul style="list-style-type: none"> Does a review need to be done to add modalities? Should a review be completed for a transition meeting, or is documentation on page 7 sufficient? Please state that an IFSP review is not needed when short term goals are met 	<p>An IFSP review is not needed to add modalities, to add transition information to page 7 or when short-term goals are met.</p> <p><u>Change:</u> Added information to "Review Required?" box in the IFSP instructions to address the questions in the comment.</p>
	<p>"Provide information to the family and other team members on the child's progress based on ongoing assessment for use in determining the child's ongoing eligibility and, if the child remains eligible, for use in developing the annual IFSP." -- We are being required to give actual scores at the annual. I believe this is due to a belief that it is required for targeted case management. In talking to our clinicians they are comfortable with making a statement as to progress and general development without formal testing but because we have to have scores, they have to retest, particularly in areas that are not in their normal domain.</p>	<p>Under TCM, there is not a specific timeframe by which you must confirm continued eligibility (e.g., there is no requirement to confirm annually). If there is a reason to believe there has been a change in the child's developmental status and there is a question about whether the child is still delayed, then a developmental assessment must be conducted using an assessment tool(s) to determine the child's status in cognitive and adaptive (as defined by TCM) development.</p>
92	Annual IFSPs need to occur within 365	It means, literally, 365 days.

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	days of previous IFSPs...does this mean that if an initial IFSP occurs on 7/1/10, the annual IFSP needs to occur on or before 6/30/11 or 7/1/11?	
92	Are physicians notified when a child exits Part C or do they have to sign a discharge note?	No physician signature is needed at discharge. We strongly recommend, however, that physicians be informed when a child is discharged.
93-94	<p>Clarify which procedural safeguard forms are needed for Annual:</p> <ul style="list-style-type: none"> • Is it just the Parental Prior Notice form or do we also need Notice of Assessment for Service Planning and Notice to Determine Eligibility forms. • Does parent receive copy of Eligibility Determination form at time of Annual. • The third bullet on page 94, says to notify all participants in writing of the date, time and location for the IFSP meeting. Does that include providers? Could an e-mail suffice? 	<p>The Confirmation of IFSP Schedule form is designed to be used as the required written notification to provider participants as well as the family. However, if your local system has another written mechanism (such as email) for notifying provider participants, you may use that. If requested during monitoring, you must be able to produce the documentation that shows providers were notified in writing in advance of the meeting</p> <p><u>Change:</u></p> <ul style="list-style-type: none"> • Clarified that the service coordinator provides the family with a copy of the Eligibility Determination form. • Clarified the option to use a written mechanism other than the Confirmation of IFSP Schedule form when notifying provider participants. [Make wording consistent with that from change in Chapter 6, page 41] • Revised Notice and Consent to Determine Eligibility form to include in the Description section that if their child is determined eligible and receives services, then eligibility will be confirmed annually or sooner if either they or service providers feel the child has reached age level in all areas of development.
	<p>Eligibility Determination at Annual:</p> <ul style="list-style-type: none"> • Very time consuming/costly when a developmental service provider is working with the family and you have to bring in another provider to determine ongoing eligibility and assessment. Providers typically know if a child will continue to be eligible at the annual. (3) • Is this a State or a Federal requirement to have this documentation? Recommend we have a process to allow the 2nd discipline to review documents at a later time and sign in agreement of the continued eligibility • The annual plan is due. The child only receives service coordination. It is my understanding that before the annual IFSP is developed, the child has to be evaluated again by two disciplines to determine if he/she is still eligible to receive EI services. This is done before the annual meeting is held. If the child receives only one service and service coordination then that particular 	<p>As indicated in previous responses State Part C staff members will spend the next few months talking with local systems (including the local system manager, service coordinators, other providers and/or families), reviewing records and/or observing the eligibility determination process across the Commonwealth to understand what is happening differently in those local systems where things are going more smoothly versus those systems that are reporting more difficulty with the process. The information gathered will be used to determine what technical assistance, training, and/or Practice Manual changes are needed to support an effective and efficient process for eligibility determination (both initial and annual). In the meantime, your technical assistance consultant can assist with reviewing your local practices to determine strategies for streamlining this process in conjunction with the annual IFSP.</p> <p>In response to the last bullet in the comment, please note that the expectation for providers to be able to make a statement regarding the child's development in all areas is not new. This has been a part of the IFSP instructions for many years.</p>

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	<p>service provider would assess the child in all areas of development and that information can be presented to the eligibility team to get the opinion of another discipline, before the annual is held (provided the child is still eligible). If this is the case it seems there are a lot of steps and confusion of who does what and extra meetings involved before the annual.</p> <ul style="list-style-type: none"> • It says here that providers are expected to be able to make a statement regarding development in all areas. In our system, If a child is receiving just one service and continues to qualify, providers are typically just writing a narrative for the qualifying area if an official assessment is not completed for another reason. If the providers need to be writing about all areas, please make that clear that it is a requirement 	
96	<p>Need clarification about statement that referral must be made by April 1st or 6 months prior to third birthday. I know that April 1st is to comply with Part C's agreement with Part B- but where is the rationale for 6 months prior to 3rd birthday?</p>	<p>These timelines have been agreed to with the Department of Education to ensure the child is able to begin school on his/her third birthday. However, there is flexibility for local school divisions to work with local Part C systems to request other referral dates or to allow staggered referrals.</p> <p><u>Change:</u> Revised language to reflect the option to work out agreements with local school divisions for other referral timelines.</p>
96	<p>Can documentation in contact notes be sufficient or must information be transferred to the IFSP.</p>	<p>Unless otherwise noted in the IFSP Instructions at the end of Chapter 7, the information required on page 7 of the IFSP must be recorded on the IFSP so that the family has documentation of the planned transition steps and services including the target date for completion of each activity.</p>
97	<p>Transition Planning Conference paragraph is unclear. The phrase before and after the 'or' appear to state the same thing. "occurs at least 90 days, or up to 9 months, prior to the child's eligibility for early childhood special education services under Part B <u>or</u> the date on which the child is eligible for early childhood special education services under Part B of IDEA."</p>	<p><u>Change:</u> Deleted "or the date on which the child is eligible for early childhood special education services under Part B or IDEA."</p>
97	<p>While transition is supposed to encompass community supports in addition to school transition, the emphasis of the planning is focused on the LEA. There is no conceptualization about a transition planning meeting where school is not the focus.</p>	<p><u>Change:</u> Added information about transition planning conferences for children not planning to transition to Part B (at the end of the first point under the open bullet that starts "Ensure scheduling of the transition conference..." - For families that wish to consider options in addition to or instead of early childhood special education services through the local school system, services coordinators should make every effort to include representatives from</p>

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		other community programs (e.g., head start, preschool/child care programs) in this transition planning conference. These representatives can explain the services available through their programs including timelines and requirements for enrollment.
96-97	Clarification is needed to provide consistent target dates for referral or notification to LEA dates for late referrals or for a family who has changed their minds at the last minute. We typically list 4/1 as our target date for referral to Part B for those children who have IFSPs in place well before this date. For children with late referrals or a later IFSP date, what should we list as a target date for referral or as a notification to LEA date?	<p><u>Change:</u> Clarified that the target date for notification should be the April 1 before the child turns 2 by September 30. Added the following additional clarification related to late referrals:</p> <ul style="list-style-type: none"> • If a child is referred to Part C fewer than 45 days before the child's third birthday, then the local system may, but is not required to, develop a transition plan as part of the IFSP and provide LEA notification for this child. • If a child is referred less than 90 days before the child's third birthday, then the local system may, but is not required to, hold a transition planning conference. • If a child is referred to Part C at least 45 days before the child's third birthday and the child is found eligible and is receiving services under Part C, then the local system must develop a transition plan (generally this would be part of the initial IFSP) and provide notification to the LEA. <p>These same timelines apply to a child referred close to the time he/she would be eligible to start school at 2 years old if the family wishes to transition to Part B at the beginning of the school year in which the child turns 2 by September 30.</p>
97-98	Sentence stops midstream and there is a big gap at the top of page 98	This was a function of the conversion to web format and has been corrected.
98	3 rd bullet. Please clarify if a parent signature is needed. What if the family changes their mind about a transition planning conference, is a new signature needed.	<p>Recent clarification from OSEP indicates the family's verbal approval for the transition conference is sufficient.</p> <p><u>Change:</u> Deleted signature line from 3b and reference to <i>Parent Approval for Transition Planning Conference</i> form on page 7 of the IFSP. Removed <i>Parent Approval for Transition Planning Conference</i> form from website and any reference to it from the manual. Revised practices in the Transition section of Chapter 8 to allow verbal consent and to remind service coordinators to document that consent on a contact note and on page 7 of the IFSP.</p>
98	If family has indicated to SC that they do not want to transition at age 2, does the family need to decline a transition planning conference using page 7 or the Parent Approval of Transition Planning Conference form?	It is not necessary for the family to decline a transition planning conference at age 2 if they do not plan to transition at that time. Use a contact note to document the family's decision to wait to transition at age 3.
99	Can the language sound less punitive when a family declines services "our family's needs have been met and we no longer feel the need to continue early intervention services".	It would not be appropriate to use the suggested language on the Declining EI Services form since not all families declining EI services are doing so because their needs have been met and they no longer feel the need to continue services.
100	Can parents initial the 5 day box on the final prior notice form - which then would mean services are terminated on the date the prior notice form is signed?	Yes

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100	First Bullet Under "To complete the exit ratings": Please define clearly "formal assessment" and distinguish from the completion of a HELP, ELAP, etc. Most of the instruments used require that you have at least some direct assessment of the child's abilities (not just review of progress notes). (2)	<u>Change:</u> Revised the note to read as follows: A formal assessment is not required. Instead, the provider(s) determines the child's developmental levels in all areas through ongoing assessment (which can occur over multiple sessions). The provider must document the child's abilities by filling in an assessment instrument (such as the HELP, ELAP, etc.). It is not necessary to use the same instrument that was used for the entry assessment.
101	If you are providing TCM and the child makes significant progress and only has a delay in speech for instance and no longer meets the definition of eligibility for TCM but remains eligible for Part C services, do you complete a review and change the pages of the IFSP that relate to TCM.	The TCM version of the IFSP may be used for any child and family, even if the child is not eligible for TCM, so you are not required to switch to the regular IFSP form. An IFSP review is necessary in this situation since a service will be changing (TCM-SC to Service Coordination), and the IFSP Review page should be used to document other changes as appropriate.
101	The next to the last bullet talks about ensuring that services are not delivered on or after the 3 rd birthday. This is an interesting fact that is very much embedded in the manual. I would have never known where to find this answer. The question comes up from time to time as to whether or not we can see the child on their birthday. My suggestion is that perhaps there be a frequently asked question section where simple answers like this are addressed	<u>Change:</u> Added this information (about ensuring services are not delivered on or after the 3 rd birthday) at end of the Eligibility Criteria section in Chapter 5 and in the IFSP instructions and bolded it in each place it is stated.
101	<u>Third Bullet Down with regard to ITOTS entry:</u> This reads "10 calendar days". I thought the final decision was 10 business days? Also, in rare circumstances it is difficult to enter discharge data within 10 calendar (business) days. If the situations are clearly documented (e.g., SC was out sick, data entry person was out sick) could exceptions be allowed?	<u>Change:</u> Updated to reflect final decision of 10 business days.
101	Suppose Part B services start on August 20 th and you are not able to get out to do the discharge paperwork with the family until the 18 th . What is the date of discharge? The 18 th – and the parents sign the 5 day box? The 20 th ? Or five days after they sign the paperwork? It is just not always possible to do discharge paperwork five days (or more) ahead of the date of discharge.	The discharge date would be the date of signature. If the family doesn't sign the form or it doesn't get signed until after the Part B services start, then the date of discharge must be August 19 th since a child may not be enrolled in both Part C and Part B on same date.
	If a SC has the qualifications to do an exit assessment for a child, does that exit assessment have to be added to the IFSP before it can be completed? Or can I just do assessment and determine w/2 nd person he/she is no longer eligible and then do discharge paperwork?	An exit assessment usually refers to completing the exit ratings on the 3 child indicators, but in this comment it appears to be related to determining eligibility. Both can actually be accomplished at the same time since ongoing assessment information should be available to determine both the eligibility, and if he/she is no longer eligible, to determine the exit ratings on the child indicators. Since the necessary developmental information should be available

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		through ongoing assessment, it is not necessary to hold an IFSP review to add assessment to the IFSP.
	If a child is discharging because they met all their goals and are now age appropriate, what paperwork exactly needs to be completed (ex-does the permission to screen need to be done and the eligibility determination (Hearing/Vision screening), etc)?	Since we are revising the Notice and Consent to Determine Eligibility form to include in the Description section that if their child is determined eligible and receives services, then eligibility will be confirmed annually, or sooner if either they or service providers feel the child has reached age level in all areas of development, it is not necessary to complete any notice and consent form in order to determine eligibility in the scenario presented in the comment. If the child is found to be no longer eligible, then the Parental Prior Notice form is used to provide the required written notice of that fact prior to discharge.
Chapter 9: The Early Intervention Record		
103	<p>Separate Financial File:</p> <ul style="list-style-type: none"> • Our electronic record system includes information on the child's 3rd party coverage and the family's financial information that is accessible to all involved with the child/family. (2) • It is difficult, if not impossible, to keep all communication related to determination of family cost share or other financial matters separate from the EI Record when electronic medical records are being used. (4) • The recommendation that a financial file is separate from the EI Record is burdensome and unnecessary if the financial information is already filed in a distinct section in the record. To add additional business practices that are not federally required is unreasonable. While we are concerned about all of the information in all consumer records the financials are separated out. Keeping a separate folder next to the EI folder will not secure the information any more than having it in a separate section. Staff sign a confidentiality statement that they access only items that are in the file that they need to know. They would also be risking their professional license if they violate this requirement. There are also space concerns and expenses involved with this decision. • Define separate for the financial file- does it need to be completely separate or can it be in different sections? • It states that all communication related to determination of the family 	<p>After considering all input on this issue and particularly in light of the challenge posed with electronic records, we have decided to eliminate the requirement for a separate financial file.</p> <p><u>Change:</u> Deleted requirement for separate financial file. Added recommendation for a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.</p>

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	<p>cost share or other financial matters should be included in the separate financial file. Do you interpret this to mean any contact notes in which the parent calls the office to talk about financial matters? Should those notes go in the separate file?</p> <ul style="list-style-type: none"> • What needs to happen to the financial file for those children who discharge from Part C and / or whose cases have been closed? 	
103	<p>Under EI Provider ...Responsibilities: It indicates that when a provider works in the agency where the EI record is housed all items are maintained in the same clinical file. Could this requirement be relaxed? It is difficult for two professionals to share the same paper record for the same child. Couldn't the same apply here as when the providers work for separate agencies?</p>	<p><u>Change:</u> Revised to eliminate different requirements for providers working in the agency where the record is held.</p>
103	<p>Is a contact log required in all systems or should the system determine if this is needed</p>	<p><u>Change:</u> Clarified in Chapters 8 and 11 that local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.</p>
103	<p>The middle of the page states that contact logs submitted by providers, including service coordinators. Are contact logs completed in addition to family progress notes?</p>	<p>If a contact log is completed, then it is in addition to the contact (progress) notes. Chapters 8 and 11 specify that the provider must submit a contact log or contact notes to the local lead agency monthly. If you submit contact notes, then the log is not needed.</p>
103	<p>Are providers required to turn in the assessment protocols including the vision and hearing screenings for the EI record?</p>	<p>No. The first bullet under Early Intervention Provider Responsibilities indicates these can be maintained in the provider's own clinical/working file.</p>
103	<p>CISF here says that the form does not need to be included in the record if the required information is fully documented –does this apply for the entry and exit indicators</p>	<p>The full parenthetical phrase already states where else the information could be documented at both entry and exit.</p>
104	<p>Under General Rules for Contact Notes: How is a note written when the provider is performing two roles (e.g., the Service Coordinator and Educator)? Specifically, for a child with Medicaid, how is the provider to document time spent in each role? Divide the time and write two notes??</p>	<p>In this situation, you can write one note, specifying the time spent and activities completed in each role.</p> <p><u>Change:</u> Added the above clarification to the manual.</p>
105	<p>3 Days for Contact Notes:</p> <ul style="list-style-type: none"> • State if a system cannot – or can - get reimbursed if a note is signed more than 3 working days following the time of contact. In other words, is the 3 day rule a deal-breaker when it comes to reimbursement if every other requirement is met? • Clarify how the three days work as 	<p>As stated in the Response to Local System Manager Questions (January – March 2010) document: This question is not one that can be answered with a simple “yes” or “no” answer. The decisions about whether requirements are met and whether pay-back is needed are made through the Medicaid Quality Management Review process, which is the responsibility of the Part C Office. That response also reiterated that if a handwritten note (that is to be transcribed into the electronic health record) is</p>

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	<p>the Practice Manual says “3 working days from the time of the contact.” Does that mean if a service is provided from 5 to 6 PM on Monday that the provider has until 6 PM on Thursday to write and sign the note (72 hours/3 days from the time of the contact) or does Monday count as day one – so the note would have to be written by sometime Wednesday?</p> <ul style="list-style-type: none"> • Unless system goes web-based, 3 days hard to meet 	<p>completed within three working days, that meets the requirement even if the note is not entered electronically until after the 3-working day deadline.</p> <p><u>Change:</u> Added the clarification from the last sentence above into the last bullet on page 105 (Complete contact notes in a timely manner...).</p>
105	<p>Last bullet – MR TCM / MH TCM do not have requirements for the timeline for progress notes. Since Medicaid EI Services do not pay for Service Coordination, we recommend taking out the 3 day requirement for Service Coordinators. We agree with this requirement for the provision of OT, PT, ST & Developmental Services as their funding source is clear</p>	<p>The 3-day requirement applies to all contact notes regardless of service or funding type. Timely availability of contact notes is important for communication between providers and for ensuring accurate and complete recording of what occurred during a contact with or on behalf of the family.</p>
105	<p>Recommend that the EI Services Manual, MR TCM, MH TCM and Practice Manual have consistency in requirements to the greatest extent possible which may mean that the Practice Manual defers specific issues i.e. documentation to the funding source’s manual.</p>	<p>We have collaborated extensively with DMAS to make requirements consistent among these programs whenever possible. However, when the Part C manual requires something more stringent than one of the Medicaid manuals, you must follow the Part C requirement.</p>
105	<p>Please clarify the need for a contact note in the following situations:</p> <ul style="list-style-type: none"> • Does a note separate from the IFSP need to be written or is the narrative in the IFSP itself sufficient for documentation of the assessment if there are no differences of opinion among team members? Does each discipline need to write a note or is their signature on the IFSP evidence of their participation in the assessment? (2) • Does the services page document what services are supplied or must these be documented in a note as well? • Does the provision of Notice of Safeguards need to be in a note? 	<p>A contact note is necessary for any contact made with or on behalf of the child and family. Therefore, one is needed to document a provider’s participation in the IFSP meeting, assessment, eligibility determination, etc. A contact note must also document the fact that the notice of safeguards was shared with the family. Page 6 is sufficient documentation of what services are planned, though contact notes must document attempts to schedule the services and actual delivery of services.</p> <p><u>Change:</u> Added a text box to give examples of when a contact note is needed and when it is not, using the questions from this comment.</p>
	<p>If the assessment and IFSP are done on the same day, how should the documentation read?</p>	<p>You can write one contact note specifying your time and role in each activity (assessment and IFSP meeting) and refer in the note to the IFSP for the specifics about assessment information and IFSP decisions made.</p> <p><u>Change:</u> Added the above clarification to the manual.</p>

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106	Do you have to add the date by your signature on progress notes? What if notes were hand written on the day but then typed a week later? Do you sign the day that the note was written or do you sign the date it was typed and printed out?	<p>DMAS has clarified that the contact note must include the date it was signed by the provider (or provider agency representative).</p> <p><u>Change:</u></p> <ul style="list-style-type: none"> Added in the 4th bullet under Specific Content Requirements for Contact Notes, For All Contact Notes – If a contact note is handwritten on one day and later typed or entered into an electronic record the date of the note would be the date it was handwritten. Added in the 5th bullet under Specific Content Requirements for Contact Notes, For All Contact Notes (and on the contact note checklist) that the date the note is signed must be included.
107	What is the policy for the destruction of EI records? How long are we required to keep EI records? Do parents have to sign permission for records to be destroyed?	<p>After reviewing agency requirements through the Library of Virginia, talking with OSEP and discussing the issue with DMAS, we are requiring that records be maintained for a minimum of 3 years following the child’s discharge from the Infant & Toddler Connection system. Local systems have the option to maintain records for a longer period. The 3-year time period ensures access to the records in case dispute resolution or due process proceedings requesting reimbursement of any kind occur after the child’s discharge.</p> <p>Parents must be notified of the local system’s intent to destroy the record, but parent permission is not required. Local systems must have procedures for notifying families of their record retention policy, the fact that the record will be destroyed at the specified time, and how the family can request a copy of the record if desired.</p> <p><u>Change:</u> Added the above information in Chapter 9.</p>
107	Service Coordinator Responsibilities first bullet- Emphasis about record retention early on in the process. This is not what families are concerned about when they first contact the program. It seems more logical for this discussion to occur later.	<p>We agree that the wording here suggests a lengthier explanation and conversation than we intended at intake. However, it is important to introduce the topic at intake since some families may be concerned about sharing personal information without knowing how it will be stored, accessed, etc. An introduction at least opens the door for additional discussion if the family has questions or concerns.</p> <p><u>Change:</u> Revised the wording to say “During the intake visit, point out where information related to storing, accessing, and correcting records is included in the <i>Notice of Child and Family Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System.</i>” Deleted the second bullet in this section.</p>
Chapter 10: Dispute Resolution		
109	Under Service Coordinator Responsibilities-Third Bullet Down: The requirement that the child continue to receive services during dispute resolution is not congruent with the EI Medicaid and TCM Medicaid right to appeal and due process requirements. It	The Part C requirement must be followed. Medicaid does not prohibit services from continuing during the dispute, but the family will have to request it (i.e., services do not automatically continue).

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	would be helpful if these could be better aligned or if further guidance could be provided as to how providers and families are to proceed when Medicaid is being billed for services.	
Chapter 11: Finance and Billing		
112	Last sentence cuts off in middle of sentence	This was a function of the conversion to web format and has been corrected.
112, 115	<p>Using Part C funds to pay the difference between private insurance and standard rate:</p> <ul style="list-style-type: none"> • Since the reduction in Part C funding there has been much need for local systems to pay for children who have private insurance, Tri-care and children who are uninsured. This is placing a burden on the systems as they have already incurred a reduction in state and federal monies. The thought that developmental services would bring extra monies through Medicaid is overrated. (2) • The requirement to utilize Part C funds to bridge the gap from Private Insurance and Tricare to the standard rate of \$150/110 has doubled the cost of therapy services in our system. A conservative estimate is that we are paying \$27,000 per month for only 1/3 (90) of our children (the other 2/3 have Medicaid). We have found that on average, it costs \$100 per hour of service (OT, PT, ST) of Part C funding to bridge the gap between the insurance reimbursement and the set rate. We are concerned that we will be out of money prior to the ending of the fiscal year. 	As expected, the Medicaid EI Program has significantly increased revenues for some local systems, while others, with a smaller Medicaid population, have not seen such increases and have even incurred increased costs to ensure the standard rate for children without Medicaid. This is why it is no longer equitable to allocate federal and state Part C funds based solely on child count figures. The allocation methodology used for State Fiscal Year 2011 takes into account the need to factor in Medicaid revenue before allocating all of the available Part C funding.
112	It may be helpful to discuss here that ongoing assessment is not included in "at no cost to families"	<u>Change:</u> Added language to clarify that this does not include the ongoing assessment that is integrated into and occurs as a routine part of service delivery.
113	<p>Using Part C funds until family fee is established:</p> <ul style="list-style-type: none"> • 2nd bullet-this example is unclear • It is still unclear why in this circumstance the family would not be full fee until they have given the information or have completed the financial • Is it possible to have a form that the family completes that states they would like to decline start of services until they can collect their 	<p>It is necessary to keep this wording for those circumstances where the family may really be unable to produce the necessary information to establish the fee cap (e.g., the family has just moved or is about to move and all documents are packed in boxes). However, we agree that additional information is needed to ensure this situation is handled consistently.</p> <p><u>Change:</u> Added here that in the event of extraordinary circumstances, the family must provide income information within 30 calendar days of the parent signing the IFSP if they wish to access the fee scale. At the end of 30 days, if the family has not provided income info, the family has the</p>

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	information in order to complete the financial form or the fee appeal?	choice to begin services at full fee or sign a form that they're declining to start services until they can provide income information (this would be a family reason for delay in start of services).
113	<p>Separate Financial File:</p> <ul style="list-style-type: none"> • Our electronic record system includes information on the child's 3rd party coverage and the family's financial information that is accessible to all involved with the child/family. • In 4 years at this job in a director position, no parent has ever mentioned a concern about financial pieces being in the medical record. • It is difficult, if not impossible, to keep all communication related to determination of family cost share or other financial matters separate from the EI Record when electronic medical records are being used. (3) • We are concerned about being able to merge the files at discharge – if we are not able to do this and the record goes into permanent storage, the cost would be double (2x) to pull out 2 retrieve two files rather than one 	<p>After considering all input on this issue and particularly in light of the challenge posed with electronic records, we have decided to eliminate the requirement for a separate financial file.</p> <p><u>Change:</u> Deleted requirement for separate financial file. Added recommendation for a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.</p>
113-114	Need more comprehensive definitions/descriptions of billable activities for Initial Assessment; Initial and Annual IFSP; Team Meetings. It is not clear whether a provider can bill for entire time spent in an IFSP meeting or team meeting or whether they can only bill for that portion of the meeting where they were directly using their particular expertise. It is not clear what constitutes a team meeting- only if listed on IFSP- how listed on IFSP. The DMAS manual also does not provide enough detail on what is billable in these areas.	<p>A provider bills for the entire time they are participating in the assessment and in the IFSP meeting (initial, review or annual). Participation includes active listening, analyzing what other team members are saying, and observation of the child interacting with another assessment team member as well as your interaction with the child and family or the time you are speaking and sharing your expertise.</p> <p><u>Change:</u> In the Reimbursement Information table at the end of Chapter 11, under T1024 changed "team meetings with child and family present" to "IFSP review meetings (must be in person)." Also clarified that providers may bill for their entire time spent in an IFSP meeting or assessment.</p>
115	Clarification is needed to determine when and how often services with the family (without the child present) can be reimbursed.	<p><u>Change:</u> Added the following clarification to the manual - No service that is <i>planned</i> solely for the parent is reimbursable by Medicaid. If the child falls asleep during an intervention session, it is okay to provide teaching/coaching to the caregiver and to bill for this service (including Medicaid). This situation should be infrequent and well-documented; and the length of the session will generally be shorter than planned since the provider and caregiver are not able to practice the strategies with the child.</p>
	Recommend that DMAS/DBHDS revisit the possibility of reimbursement for Part C service coordination for children not	Both DBHDS and DMAS are aware of this request. At this time our focus is on providing support to providers to assist them in accurately and effectively implementing the

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	eligible for TCM. (2)	Medicaid EI program that went into effect on October 1, 2009 and on refining the data systems in both agencies to facilitate the data entry and data sharing necessary to support the program.
	<p><u>Reimbursement for eligibility determination:</u></p> <ul style="list-style-type: none"> • Is there consideration of including a set rate for eligibility determination? • Our system has had several complaints from service providers because we can reimburse eligibility determination for initial eligibility and ongoing eligibility at annual by phone but cannot pay for consults by phone. 	<p>We have decided to adopt the rates recommended in the November 2, 2009 System Transformation Update as the standard rates for eligibility determination:</p> <ul style="list-style-type: none"> ▪ Use the center-based individual services rate; or ▪ Use the individual early intervention services rate (natural environment) if travel is necessary in order to be with the family. <p>These rates are for each 15 minutes of provider time for eligibility determination. No separate reimbursement is needed or appropriate if the provider participating in eligibility determination is a salaried employee of the local lead agency or if the eligibility determination is combined with the assessment for service planning (and the child is found eligible).</p> <p><u>Change:</u> Added the information above to Chapter 11 along with the following additional clarification:</p> <ul style="list-style-type: none"> • While the eligibility determination does not have to be a face-to-face meeting, it must be planned ahead of time. (Also added this clarification in Chapter 5) • A provider may participate by phone, protected email, videoconference, etc. or a combination of those mechanisms to allow for review of available information and team interaction. Both the time spent for review/preparation and the time for team interaction are reimbursable.
	Dietitians and nutrition services should be part of the EI initiative.	Some nutrition services are reimbursable under EPSDT.
115	<p>Family Cost Share – General Comments:</p> <ul style="list-style-type: none"> • There is no perfect Family Cost system. Therefore, because of the amount of training time that would be needed if we started over with a new system, I strongly recommend that we work from our current system. (6) <ul style="list-style-type: none"> ○ Consider adjustments annually in the sliding scale (2) ○ Refine directions as needed to help with consistency in implementation. ○ The sliding fee scale and the fee appeal form could be updated, and it would be fine. It is not difficult for families. In our locality it has been received well by families. ○ Update sliding fee scale and implement mechanism to adjust annually • If significant changes are made, I 	<p>We will adopt the new fee scale that the Family Cost Share Stakeholder Group recommended and the Part C Office had endorsed but will continue to use taxable income rather than adjusted gross income as had been proposed previously. Continuing to use taxable income will reduce changes for local systems and will help to ensure fees do go down a bit compared to the current scale. This will also help to address concerns about out-of-pocket costs for developmental services (and the impact on choice of services) for families with private insurance and high fee caps by reducing the caps. Since this new scale is based on the federal poverty level, it can be easily updated over time.</p> <p><u>Change:</u> Replaced fee scale on website</p>

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	<p>would not want to see a set amount that families pay per month regardless of whether or not they received services.</p> <ul style="list-style-type: none"> • As the sliding fee scale is reviewed, know that while some systems may have families at high incomes who somehow manage to pay little or nothing, there are other systems whose families do not have very high incomes but still end up with a high amount on the scale - and so cannot afford the scale as it currently is and have to move to the appeal. Keep the appeal process and have a way to monitor its use if this is a concern (systems could report annually how many go to appeal perhaps). • Please don't significantly raise the fee scale. VA is struggling with getting our child count up. Raising fees will not result in more children getting services. We have to keep in mind that (1) many families are unsure that their children need EI services when they first are referred and we do not want to make the fees a deterrent/a reason not to access services – instead, we want to do everything we can to bring the families in; and (2) families who are concerned about their child can get free services from the school division when their child is two by Sept 30th and so will wait if our costs are too high for them. • Consider renaming the whole process as many families do not share in the cost (because they either are on Medicaid/FAMIS or fall at a zero fee on the scale/on appeal) – the name (“Family Cost Share”) implies that they do or should. It also is an awkward-sounding name. • If the current system is disbanded and a new one developed, a suggestion: pilot it first before statewide implementation in order to work out any issues. • We agree with the Family Cost Share Practices and recommend leaving these pages as currently written. We feel that these pages adequately address the main 	

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	<p>concerns including deductibles and assistive technology.</p> <ul style="list-style-type: none"> • Leave base system intact. Close loop hole for systems having troubles. Works well for our system 	
115	<p>Family Cost Share – Training:</p> <ul style="list-style-type: none"> • An online training module should be developed that all SCs and others who do the Part C FCS process can access at any time – and this topic should also be covered very thoroughly in K1 and K2 training. I think most of our issues with Family Cost up to this point have been a training issue and not because of the FC system itself. (3) • More training/support is needed for service coordinators on explaining financial information- constant changes in this area and very hard to stay up to date since we do not have access to insurance billing specialists. 	<p>These suggestions have been shared with the Integrated Training Collaborative.</p>
116	<p>If we are going to have to enter into ITOTS the Medicaid number after ED, the financial needs to be completed at the intake.</p>	<p><u>Change:</u> Revised to state that if the child has Medicaid, the Family Cost Share Agreement form must be completed prior to eligibility determination to ensure timely entry of Medicaid data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services.</p>
116	<p>Confirming changes to insurance at least once a month is very difficult to do and to share. Need more guidance on how to do this either from state or from system manager.</p> <p>It should be the family's responsibility to keep the system aware of changes in insurance</p>	<p>To ensure reimbursement, it is the provider's responsibility to confirm the family's insurance situation, the same way doctors and dentists confirm your insurance each time you come for an appointment.</p> <p>A May 20, 2010 memo from Mary Ann Discenza provided additional information about confirming Medicaid coverage, and this information has been added to the practice manual.</p>
116	<p>Revise family cost participation so that we can verify taxes instead of having to get a copy of parents tax forms, which feels invasive to families and is often difficult to get. (2)</p>	<p><u>Change:</u> Added the following - Visual regard of the income documentation is adequate verification of income, and it is not necessary under federal and state Part C requirements to retain a copy of the document viewed. Signatures of the parent and the individual reviewing the income documentation confirm that the required income documentation was viewed. Local agency or local system requirements may be different from the state practice that allows visual regard of income and expense documentation. The individual designated to implement the family cost share practices for the local Infant & Toddler Connection system must be aware of and comply with any local requirement to receive and maintain a copy of income and expense documentation.</p>
116	<p>The way the P Manual is written makes it sound like the family is charged a fee/set amount – when it is really a cap. Should define “fee” early on in this section and also define “cap.” Or drop</p>	<p>While we understand the confusion expressed in the comment, a fee and a cap are not the same thing. In Virginia's family cost share system, the family pays a <i>fee</i> that cannot exceed the <i>cap</i> established by the fee scale. The fee the family pays and the monthly cap will not always</p>

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	out the word “fee” altogether, since it is so misleading to all involved, and just use “cap.” (8)	<p>be the same. Rather than change the use of the words, we will add definitions of each.</p> <p><u>Change:</u> Added the following definitions:</p> <ul style="list-style-type: none"> • Family fee – Amounts required as payment from families for IFSP services based on the accrued charges and co-payments incurred as a result of the services a family receives each month. The family fee may not exceed the monthly cap. • Monthly cap – The maximum amount, as determined by the Family Cost Share fee scale, that a family will be required to pay per month for IFSP services regardless of the number, type, frequency or intensity of services a child and family receive.
116	“Conduct financial intake following eligibility determination and prior to the initial IFSP meeting.” -- In several programs we serve, most children go to the assessment for service planning team to determine eligibility. This then means that the financial intake is conducted in front of the assessment team. It is not only inappropriate for the family but also a waste of time for the service providers. (2)	<p>We agree that it is inappropriate for financial intake to be conducted in front of the assessment team.</p> <ul style="list-style-type: none"> • If the child has Medicaid, the financial intake will occur prior to eligibility determination. • If there is documentation from the physician of a qualifying diagnosed condition prior to the eligibility determination and the family wishes to combine the eligibility determination with the assessment for service planning, and potentially the IFSP meeting, then financial intake can be conducted prior to the combined activities. • Otherwise, when eligibility determination and assessment for service planning are combined (and they really should not be for <i>most</i> kids), then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family’s home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake since it impacts their time and availability for other activities and services. <p><u>Change:</u> Added the above clarification in Chapter 11, Chapter 4 and Chapter 6.</p>
116-117	Second bullet from the bottom-assistive technology cost should be spread across more than one month. Text box- If a family’s fee has been determined as the amount they can pay each month for services then why would we not spread the cost of AT across months. It would only go up to the amount the family is able to pay each month so it seems reasonable to do this	<p>The decision to treat AT devices as a one-time cost incurred in the month of purchase was made by Part C staff after consideration of all questions, concerns and input provided by members of the original Family Cost Participation stakeholder group. Since there was only one comment suggesting a change in this practice, no changes will be made at this time.</p>

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117	Is there a form that families should sign when they don't want to bill insurance for the limited reasons listed, an attestation?	<u>Change:</u> Revised the Family Cost Share Agreement form to include an option for not billing insurance for one of the acceptable reasons.
117	"If the family chooses not to provide....." can it also be that the family has not yet been able to provide.....	No. Page 118 provides a number of options for documenting income.
118	Final paragraph (d) can services be delayed if the family does not want to be at full fee until their tax information is received	No. Statement (2) in paragraph (d) provides directions for estimating income until the tax information is received.
118	Don't know if the correction has been made that if Insurance is used Part C needs to pay the deductible	The information about how the deductible and co-pay relate to the monthly cap and the fact that the full deductible/co-pay (minus the amount the parent pays that month) is the responsibility of Part C were already added.
118	Could you provide address for IRS for families to request transcript?	<u>Change:</u> Added that a transcript can be requested by calling 1-800-829-1040 or accessing a request form (IRS Form 4506T) at www.irs.gov .
119	Asking families to redo the 1040 in the middle of the year does not seem realistic	This is only necessary if the annual 1040 grossly misrepresents the family's current financial situation.
119	Please spell out that Part C covers the co-pays for FAMIS recipients	<u>Change:</u> Added the clarification requested.
119	For "f" – provide information so the person reading this manual knows how to find out if a family's income is low enough for Medicaid/FAMIS and/or does not require completion of a federal income tax return. Not everyone knows how to determine this/where to find this information.	As indicated farther along in the instructions for completing the agreement form, "If the family's income qualifies them for Medicaid/FAMIS, then documentation of Medicaid/FAMIS eligibility" can serve as proof of income. <u>Change:</u> Added that to determine if income is too low to require a tax return, you can visit www.irs.gov .
119	Under Complete the Family Cost Share Agreement: The current Family Cost Share Agreement form does not seem to match what is written in this section of the manual. For example, the Family Cost Share Agreement form indicates that a family can access the sliding fee scale in only two instances, 1). if they have a copy of their tax forms or 2). if they complete a blank 1040, using current information. The form does not seem to allow for the use of a pay stub or written information and, in fact, indicates that families that can only provide these types of income documentation <u>are to complete the Appeal form and are not to use the sliding fee scale.</u> Please clarify and/or align the practice manual with the form.	<u>Change:</u> Reviewed and revised the Agreement form to ensure consistency with the practices in Chapter 11.
120	Last sentence ends in midstream	This was a function of the conversion to web format and has been corrected.
120	<u>Fee Appeal Process:</u> • "The basis for the fee appeal is disposable income derived from net	Based on previous input from the Family Cost Share Stakeholder Group and more recent research on expenses included in the calculation of disposable income, we will be

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	<p>income less actual expenses. “ Could we have more clarity on what are accepted as actual expenses? I have seen many monthly expenses such as tithing, college savings plans, second homes, house upgrades etc.</p> <ul style="list-style-type: none"> • The average allowable amounts need to be updated. It is intrusive and requires significant documentation for those items because most families spend more than the amount and it requires the documentation. • Please clarify where credit debt falls in to the fee appeal procedure. It is not one fixed amount-the others listed have a fixed amount. • Overall we think the process can be simplified by having one way of viewing income. Currently we use taxable income for the monthly fee and then disposable income for the appeal. The disposable income concept puts many people at a zero fee who are in high income brackets. We do not want to be making judgments on families choice of where they spend their money but with options of super cable, direct TV, iPhones etc they diminish disposable income. I would like to see one process that takes a family to an appeal with minimal documentation that is clearly articulated or listed and already considers normal living expenses. 	<p>making the following changes:</p> <ul style="list-style-type: none"> • Instead of using net monthly income, which requires the family to produce pay stubs, divide the taxable income figure (for families who were able to provide it for the Agreement form) by 12 to establish monthly income figure at the top of the appeal form. • The list of expenses on the appeal form will be expanded to include internet, cable, car payments, loans and credit card payments (taking the place of credit debt), elder care, educational expenses, job-related necessities, entertainment/recreation, and expenses to maintain the home in livable condition (e.g., adaptations to meet child’s needs; repairs due to natural disaster). • We will delete “Other expenses” from the appeal form because we believe the expanded list of categories covers all allowable expenses. However, we will state in the Practice Manual that if you think you have an expense that doesn’t fit in an existing category, contact Bev Crouse who will determine either that it fits elsewhere, can be added as an “other,” or cannot be deducted. Over time, this will help us determine if we need to add “Other” back as a line item or if we need to add clarification on what goes in the existing categories. • We will clarify that the amount allowed for credit card debt is the current minimum monthly payment or the documented monthly payment negotiated with the creditor, through a debt counseling service or court-ordered. • For transportation, we will add tolls and change bus to public transit. • Reviewed and updated average amounts, as appropriate based on research findings, for those expenses that currently have an allowable amount on the appeal form. • Removed “Taxes” since these will have already been taken into account in getting the taxable income or net monthly income figure • Changed the calculation of the monthly cap to be 5% of disposable income instead of 10%. Because the new fee scale is lower than the current scale, 10% of disposable income did not reduce the monthly cap from that established by the fee scale in most scenarios tested. <p><u>Change:</u> Revised the Practice Manual and Fee Appeal Form to match the changes described above.</p>
121	<p>Recommend centralized billing. This would greatly simplify the process for providers who serve multiple systems as well as reduce confusion as now the providers must call local systems who then either give them an ITOTS number so they can contact the state or call the state for clarification. (3)</p>	<p>Thank you for your comment. There is no plan to pursue centralized billing at the state level at this time.</p>

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121	Please clarify in the practice manual whether or not services can be paid for if they go over the intensity listed on the IFSP occasionally (and clarify what occasionally would look like). – (3)	<u>Change:</u> Added clarification that you cannot exceed the frequency and intensity listed on the IFSP over a one month period unless making up missed sessions from another month.
121	More detailed examples should be provided for billing/reimbursement for children with private insurance. Address co-pays, deductibles, covered charges, what “allowable” means and how it plays into Part C reimbursement, etc. (4)	<u>Change:</u> Added a text box with reimbursement scenarios.
121	<p>Consider a “co-pay” system or cap for Developmental Services until this is a service that can be billed to private insurance. (6)</p> <ul style="list-style-type: none"> • It is not fair for families with a large FCP amount to have to pay \$110/hour for a service when their child could get a different service (e.g. Speech) for much less because insurance will cover. • Although families have access to a monthly cap-if their cap is higher or they choose not to do the sliding fee scale-families choose therapy over Developmental Services because of the cost. The team should be able to help decide on services based upon who is the best provider to go in and give the family ideas-not based upon the cost. • Could a system be considered that would “cap” the fee paid for Developmental Services to be the same as the family’s copay/deductible for services covered by their insurance (aka – a copay for speech therapy is \$40 for a specialist visit, so the family would pay no more than \$40 for developmental services – subject to the sliding fee scale)? • The cost of developmental therapy services for families without Medicaid and without a very low fee cap is a significant hardship. This is not a practical way to address the needs of children in these families and there needs to be some way to remedy this inequity. 	While we understand the desire and rationale behind this comment, we are unable to establish a co-pay system or cap for developmental services since such a system could not ensure equitable treatment of all families for the same service. The “unbalanced” cost of developmental services is only an issue for families who have private insurance, agree to use their private insurance for EI services and have a higher cap on the fee scale. We cannot establish a fee system that treats that group of people differently than others. What we can and have done is adopt a new fee scale that lowers the fee caps compared to our existing scale and revise the fee appeal process to take into account additional expenses that may affect a family’s ability to pay.
122	<p>Clarify last bullet. (4)</p> <ul style="list-style-type: none"> • Not exactly sure what the final sentence says but this paragraph should perhaps be reworded as it sounds like all companies that provide insurance in VA have the EI 	<u>Change:</u> Revised wording to clarify that the mandate applies to insurance companies domiciled in Virginia and to the fully insured market. Insurance companies based outside of Virginia (even if operating and covering services provided in Virginia) as well as self-insured policies are not covered by the early intervention insurance mandate.

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	<p>mandate. Many out of state insurance companies provide health insurance in VA and do not include the EI mandate as a benefit.</p> <ul style="list-style-type: none"> • Provide more clear information about the insurance EI mandate (including the information that if a company is self-insured, they are not required to participate. It took me 3 years to understand why some companies pay for services and others do not. • Clarify last bullet. Insurance companies that provide health insurance in Virginia are not required to cover early intervention services. Lots of insurance companies domiciled in other states provide health insurance in Virginia. Insurance companies that are DOMICILED in Virginia are required to cover early intervention services. This nuance creates a significant gap in the number of children who are covered by the mandate 	
122	<p>Under Information Required in Itots: The process to determine if a child has EI Services <u>and</u> Medicaid and communicate this to DBHDS and then to DMAS within 15 days is convoluted and likely to result in a significant loss in Medicaid billing to the EI System. With that said, I unfortunately do not have a solution to this problem. Would it be beneficial to have a small committee research a better, more effective and efficient way? In addition, other Virginia Medicaid programs allow Medicaid to be backed billed for up to a year. Why is this not possible under EI Medicaid?</p>	<p>The start date for the Medicaid EI benefit is based on local systems meeting the timeline requirements for data entry in ITOTS and informing the Part C office if a child has changes in their Medicaid coverage (see May 20 Memo from Mary Ann Discenza). Medicaid/FAMIS reimbursement is available for services that are provided within the past year, just as is the case for other Medicaid programs.</p> <p>We recognize that there is a delay in adding the EI benefit to the child's Medicaid/FAMIS coverage. This will be improved with implementation of ITOTS version 1.8. In addition, local systems can speed the process by entering the information in ITOTS as soon as it is available. The Part C office is enrolling most children (who have complete, accurate information) within 24 hours.</p>
122	Last sentence ends in midstream	This was a function of the conversion to web format and has been corrected.
123	<p>7th bullet- the way this paragraph is written it sounds as if third party insurances never pay for services in natural environments. I think the intended meaning is that they don't reimburse for the increased costs incurred when the service is provided in the natural environment.</p>	<p><u>Change:</u> Revised wording to communicate that insurance companies typically do not reimburse for the increased costs incurred when services are provided in natural environments.</p>
	<p>AT Devices - More clarification and examples would be very helpful. (4)</p> <ul style="list-style-type: none"> • Especially about which devices are considered medical (3) • Specific issues in our localities are 	<p><u>Change:</u> Refer reader to Chapter 7 for more information about what is considered an AT device under Part C.</p>

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	hearing aides and requests for FM transmitters.	
	Is it possible for AT to become part of the Medicaid initiative? The lives of children are often changed much more dramatically	Medically necessary assistive technology devices still may be reimbursed by Medicaid, though outside the Medicaid EI Program, as durable medical equipment.
128	It says on the Reimbursement Info page: <i>The maximum daily units/per child/per code/per provider agency is 12 units with a maximum of 18 units (for any combination of codes) per day per child for all providers.</i> So, does this mean that one agency (for example, a CSB) cannot bill more than 12 units a day for a child – but a CSB plus a private therapy provider could bill a total of 18 units between them? Could one agency provide 12 units of Dev Services a day at a maximum – or 18 units? Could you give some examples of the combinations that would be allowed and not allowed? (2)	DMAS has clarified that the maximum number of units is 6 per individual provider per child per day and 18 per child per day for all providers. The 18 units can be a combination from 2 or more agencies/providers or can be all from one agency as long as each individual provider does not exceed the 6 units/individual provider/per day limit. <u>Change:</u> Revised table to reflect the clarification given above.
128	Define nursing services	<u>Change:</u> Revised and/or added wording where necessary in the manual to reflect the 11/12/09 memo on this topic.
Chapter 12: Personnel		
	Whatever happened to the highest standard? At least, this gave people, who were trained, the opportunity to work with kids while obtaining their credentials	“Highest standard” means the meeting the requirements to be certified, licensed or otherwise credentialed in the individual’s field (e.g., OT, PT, Educator, etc.). That requirement remains. Those who have some, but not all, of the training and education required to meet the highest standard for an Early Intervention Professional may seek certification as an Early Intervention Specialist and work as an Early Intervention Assistant while completing their training and education for one of the highest standards required for certification as an Early Intervention Professional.
	Please list link for practitioner’s database	The provider database is not yet operational. Once it is, we will add a link.
129	Dietitians should be included in practitioner quals	Some nutrition services are reimbursable under EPSDT, and dietitians are still welcome to complete the EI training modules.
	Align OT requirements to practice with State certification requirements (OTs awaiting licensure can practice under supervision)	This is being addressed through the regulatory process and the correct wording has been added to the permanent personnel regulations.
130	Please have the EI certifications backdated to the date of application. Delays in receiving certifications which could not be backdated have cost our system money in developmental services billing.	Applications for certification are being processed very quickly when complete information is provided by the practitioner. Delays occur when incomplete information is submitted.
130-131	Need more explicit directions included in the manual on how to complete the training log and professional development plan. We request a	Additional information and instructions are being added to the manual. Since there is no one required form for the professional development plan and since each plan should be tailored to the individual needs of a practitioner, a

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	sample of a completed professional development plan.	<p>sample completed plan is not appropriate in the practice manual. You are welcome to ask your TA Consultant to review a completed plan if you want some feedback.</p> <p><u>Change:</u> Added instructions (from the 11/16/09 TA Update) for completion of the professional development plan and training log.</p>
131	<p>CoCoA Steering Committee members were unanimous in their agreement that there should not be a two hour minimum for a training to count for recertification. A focused, well-organized hour-long training can be very beneficial. The two-hour minimum seems arbitrary and makes meeting the training requirement more difficult. We request that consideration be given to allowing an hour-long training count toward recertification.</p>	<p>The concept of a minimum number of hours to count as a training activity was not arbitrary and is consistent with Virginia Department of Education requirements (though they use 5 hours). As indicated in the November 16, 2009 TA Update, these 2 hours do not have to be consecutive and a training activity can include a planned combination of activities that total two or more hours. For instance, a provider whose professional development plan indicates the need to expand her skills in evidence-based practices related to feeding might participate in a 1-hour feeding workshop and then spend an hour with a mentor practicing the skills taught during the workshop. These 2 pieces together make 1 training activity of at least 2 hours and count toward the 30 hours of training for recertification.</p>
131	<p>Need more details about the 30 hour training plan and what activities can count. (4)</p> <ul style="list-style-type: none"> • Do college courses count and, if yes, how much? What about online training, like the Autism Internet Modules? What about reading a relevant book (self-study activities)? What about K1 and K2? What about the Leadership Academy? If an EI provider does a training for the rest of his/her team and/or for his/her region, would this count as training time • Can all this be left up to the supervisor to determine with the individual provider, based on the provider's training needs? • While it is helpful not to have too much "prescription" about the training that is needed, more specifics would be appreciated. 	<p><u>Change:</u> Added the following detail to the manual to clarify what counts toward the 30-hour training requirement:</p> <ul style="list-style-type: none"> • <i>College courses</i> – 1 semester hour = 10 hours; must be earned at a regionally accredited 2-year or 4-year college; must be taken for credit; must earn passing grade; could be pass-fail; must keep transcript as documentation • <i>Professional development activities</i> – Hours based on amount of time spent (1 hour spent = 1 hour). Must be signed off by supervisor who signed the professional development plan: <ul style="list-style-type: none"> ○ Self-study – online; journal; book group; may be group or individual. Documentation: written summary of what was done. Maximum of 5 hours per 3-year period ○ Mentoring ○ Online training – Documentation: Printed certification, if available, or printed summary of training topic, sponsor org, content ○ Inservice training – Examples: Could be provided within own agency; CoPA meeting with speaker (only the time when the speaker is presenting counts as training). • <i>Professional Conference</i> – Defined as 4 or more hours in length. Certificate will give # of hours. Time in conference sessions, not counting breaks or meals. • A text box with FAQs about what counts and what doesn't count.
	An outside contractor voiced his displeasure with having to do the modules, register with the state, and develop a staff development form to be recertified with the state in the future.	While we are sorry to hear about any providers that choose not to remain in the infant & Toddler Connection system, this is not a scenario we are hearing as a widespread issue. In fact, we are hearing about increased inquiries from providers interested in information about the Part C

PAGE #	COMMENT	RESPONSE
	Other providers have dropped out rather than complete the requirements.	system since October 1.
132	Please clarify that an agency specific Professional Development Plan may be used and the state form is not required	<u>Change:</u> Clarified as requested
132	Does the LSM keep a copy of the professional development plans yearly? Do we keep a copy for providers within a contracted company?	<u>Change:</u> Clarified that each practitioner is responsible for maintaining a copy of her/his own professional development plan and for making that available to the local system manager and the State Lead Agency upon request.
	RE: K1 & K2 – we recommend that these trainings be offered regionally or there is a large train the trainer program instituted so that we can do the training regionally as necessary	These trainings will be offered regionally on a rotating basis.
Glossary		
	It would be helpful to include page numbers with the glossary so that we could reference or cross reference certain topics throughout the manual.	
	Define nursing services	<u>Change:</u> Added definition
	Please consider putting in the definition of medically fragile from the ITOTS manual	That term is used only in conjunction with ITOTS data entry and is defined in the ITOTS Manual.
	Social work services-these services can be provided by other qualified personnel? Such as LPCs?	An LPC would provide counseling.
Topics That Should be Added to the Manual		
	More explanation of advantages/reasons for team treatment and how this could be documented as needed service on IFSPs.	Additional information about consultation and teaming has been added based on comments earlier in this table.
	Something along the lines of “When to Use What Form” document which clarifies when to use each type of form.	Because of the flexibility built into the service pathway, the timing of forms will be different for families based on the choices they make (e.g., whether they choose to combine steps in the process, etc.) and making a list of forms that are used at each step or creating a flow sheet that is simple and works for all families is impossible. The text of the manual states when forms are needed.
	FERPA as it related to Part C (3)	While we understand that this information would be helpful, we are unable to add it during this revision due to time constraints. This request will be reconsidered during the next revision (in 6 months or one year).
	EDGAR as it relates to Part C practices	Some basic information about EDGAR requirements was added to Chapter 11.

Forms Comment Table:

Form Name	Comment	Response
<p>Notice of Child and Family Safeguards</p>	<p>Put in large letters on the front cover that these are the family’s rights – to match what is written in the Family Survey. (7)</p> <p>Also, allow systems to continue to use a blue cover as this makes this important document distinctive from all the other papers that families get – it helps it stand out to families. (3)</p>	<p>We agree that it is important for this document to stand out from other paperwork. We also feel it’s important for this document to look the same from one local system to the next so we need to require the same cover for everyone. Rather than require the extra cost of a blue cover, we will reformat the document to have a true cover page with a large title and large logo. This should help differentiate it from other documents and paperwork.</p> <p><u>Change:</u></p> <ul style="list-style-type: none"> • Added “Rights” to the title. • Created a cover/title page
<p>Strengthening Partnerships</p>	<p>Put in large letters on the front cover that this includes the family’s rights – to match what is written in the Family Survey. (3)</p> <p>Format Debra’s letter for spacing between paragraphs and ensure consistent indenting as this is one of the first things that all families see. The formatting of her letter should look professional.</p> <p>Debra’s letter should also use the word “rights” in it.</p> <p>Page 13 – add a space before the last paragraph</p> <p>Page 14, 3rd paragraph – unfortunately, more and more two years olds do not get to go to preschool when they are 2 by September 30th. Should change this paragraph to reflect the reality. They may get Part B services at age 2 by Sept 30th but not <u>preschool</u>.</p> <p>For the whole booklet – suggest narrower margins and a smaller font to reduce printing costs. (3)</p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Added “Rights” to the cover. • Reformatted Debra’s letter and included the word “rights” where appropriate • Added a space on page 13 • On page 14, changed to read “many” instead of “most” and “services through the school system” instead of “preschool.” • Removed some of the “Things I Want to Remember Boxes” <p><u>Responses to other comments:</u></p> <ul style="list-style-type: none"> • While we understand the concern about copying costs, the parents that helped revise this document for October 1, 2009 felt it was very important that it be easy to read, without an overwhelming amount of text on each page. They were not in favor of reducing the margins but suggested that we could remove some or reduce the size of the “Things I Want to Remember” boxes, which we have done.
<p>Eligibility Determination Form</p>	<p>Add box to check for discharge (a place for “other” in addition to initial or annual, such as IFSP completion, unless the ED form does not need to be completed for IFSP completion) – (9)</p> <p>Having a solid line under this statement:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Child is determined eligible for the Infant & Toddler Connection of Virginia based on the following criteria (check all that apply):</p> </div> <p>makes it look like the three things that follow underneath (Dev Delay, etc.) do not connect</p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Added check box for Interim • Changed formatting of the Statement of Eligibility section as suggested • Added a line to specify the “other” condition in the diagnosed condition section • Improved the formatting with respect to “Person Completing Developmental Screening” and “Developmental Screening Tool Used.”

Form Name	Comment	Response
	<p>with it. Suggest deleting that solid line. Then the info that includes the three areas of eligibility should be indented under the sentence that states the child is determined eligible – so it is clear those three things are the criteria for eligibility.</p> <p>Have a place to write in the “other” condition in the diagnosed condition section. (2)</p> <p>Need to include the specifics under “atypical” that the ICDF and ITOTS include. (2)</p> <p>Need to pull out the part that says “Person Completing Developmental Screening” and “Developmental Screening Tool Used” because it looks like it is stuffed in there randomly. These two things should be placed under the check box for “Comprehensive Developmental Screening.” Way too cramped. (3)</p> <p>Section: Methods & Documents used to determine elig Recommend moving “Person completing comprehensive developmental screening’ to section that lists Eligibility Determination Team members. A box can be added to this section that gives the option to indicate the person completed the developmental screening- as well as a place to list the instrument name</p> <p>Should have an “other” box under methods so that we can add the names of the assessment tools, if used. (2)</p> <p>On the signature page on the back - what would the SC check if the SC does not meet the standard to determine eligibility? Attended meeting?</p> <p>The very last thing says that typed names are acceptable – so signatures are not needed? The SC could just write in the names of the team members who determined eligibility? (2) States that a typed name is sufficient. Is a hand written name (written in by the SC if the conversation took place by phone) acceptable?</p> <p>Before this form is finalized, let a few local systems pilot it to make sure that it works well.</p>	<ul style="list-style-type: none"> • Added an “other” box (with space to specify) in Methods and Documents Used section. • Added "Ongoing Assessment (only for interim or annual determination)" in the Methods and Documents section • Improved spacing in the Methods and Documents Used section • Replaced myelodysplasia with meningomyelocele <p><u>Responses to other comments:</u></p> <ul style="list-style-type: none"> • We did not add the specifics under atypical for the same reason we did not list the areas of development under developmental delay. It is not necessary to be that specific at the point of eligibility determination. You may use the narrative section to further describe the type of atypical development found. The specifics will be entered into ITOTS (once the ITOTS Enhancement Project is completed) after the assessment for service planning to be sure that all reasons for eligibility have been identified and documented. • The service coordinator may have conducted developmental screening and observation and may, therefore, be submitting a written report. • Typed or handwritten names are acceptable instead of signatures. • Since the changes made to the form are not substantive there is no need to pilot it. • As indicated in the System Transformation Responses from January 2010, we have consistently found that it is problematic to provide specific examples of how to write narratives. Local systems find that the example(s) does not apply to them for some reason, or the examples are taken as the only way to meet a given requirement when it is rare that one or even a few examples appropriately address all scenarios possible when working with children and families • It is not accurate to state that the child is found eligible for assessment for service planning rather than eligible for services. Please see responses to comments under Chapter 5 (Eligibility Determination)

Form Name	Comment	Response
	<p>Need to provide a section to more clearly document the outcome of the initial eligibility determination meeting. (For example, who participated? What was the outcome?) Currently, it is difficult to document this and to clearly show that two different teams looked at the child's eligibility.</p> <p>Space is very tight to write in documentation of medical resources.</p> <p>An example of a narrative for this form would be helpful in the manual to allow for some consistency.</p> <p>Please provide a definition of outside source (in the manual not on the form)</p> <p>Should state eligible for assessment for service planning, NOT eligible for services. Unless the child has an automatic qualifier, we are essentially using the ASQ as the qualifying instrument. Screenings are not intended for eligibility, just to identify the need for further assessment.</p> <p>Eligibility form should be adapted to better accommodate the annual eligibility versus the initial eligibility</p> <p>Please change the Diagnosed conditions on the ED form to match the ICDF – #6 Meningomyelocele (spina bifida) is on the ED form as "myelodysplasia". (2)</p>	<p>for discussion of the appropriate use of screening in eligibility determination.</p>
<p>Parental Prior Notice</p>	<p>The three boxes which state why a child is not eligible don't make sense in real life. If I am doing discharge paperwork today because a child's Part B services start on Monday or a week from Monday, they are not receiving Part B services yet, however the statement says that they are. Could rephrase to say, for example: "Your child will soon be receiving early childhood special education services through your local school division. On the date Part B services begin, your child is no longer eligible for Part C services." The same thing applies when we go out to do the final visit for a child who is 35 months, 15 days old, and have the parent sign this notice. We won't be going out once the child is three. So we are checking a box that says the child is three – but they are not yet three. Could rephrase to say, for example. "Your child will be turning three on _____. Effective on that date, your child is no longer eligible for Part C services." That would be</p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Revised the language as suggested in the first comment. • Added in the manual that if additional space is needed in the situation described in the second comment, then additional documentation may be attached to the form and referenced in the Reason section. • Revised wording as suggested in the last comment.

Form Name	Comment	Response
	<p>more accurate. (2)</p> <p>There is not sufficient space on Prior Notice Form to document when parent requests a service not supported by the team. Need additional form or suggested format to attach to this form.</p> <p>Also on the line that says "your child is 3 and no longer eligible for Part C services" could we get rid of the jargon and call "Part C" early intervention services through the Infant & Toddler Connection? On the next line, "your child is receiving early childhood special ed services through the local school division" they did not write "Part B services"; they did get rid of the jargon and made it more understandable for families.</p>	
Physician Referral	<p>Need to take out all references to "evaluation" and the reference to "special instructor."</p> <p>Contains way too much small print. We have received comments from doctor's offices that there is not enough room to write information, lines are too small and too narrow, and the form does not fax well. We often cannot read the information when we receive a fax and need to call to obtain information. My personal experience with this form is that it is usually <u>very</u> difficult to read when I get it because the space for the doctor's office to write is <u>so</u> small. (2)</p>	<p>The physician referral form is under revision. References to "evaluation" and "special instructor" have been removed.</p> <p>The form is being reviewed by physicians before changes are finalized.</p>
Family Cost Share Agreement Form	<p>The current Family Cost Share Agreement form does not seem to match what is written in this section of the manual. For example, the Family Cost Share Agreement form indicates that a family can access the sliding fee scale in only two instances, 1). if they have a copy of their tax forms or 2). if they complete a blank 1040, using current information. The form does not seem to allow for the use of a pay stub or written information and, in fact, indicates that families that can only provide these types of income documentation <u>are to complete the Appeal form and are not to use the sliding fee scale</u>. Please clarify and/or align the practice manual with the form.</p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Reviewed and revised the form to ensure consistency with the manual. • Revised the Family Cost Share Agreement form to include an option for not billing insurance for one of the acceptable reasons.
IFSP form	<p>Because there are so many things to remember to include on the IFSP and there are already many other preprinted prompts to assist SCs, add preprinted prompts that say at the top of the narrative page: <i>the referral source and reason for referral, any medical diagnoses (especially those related</i></p>	<p><u>Change:</u></p> <ul style="list-style-type: none"> • Added prompts as suggested • Made line longer in the Important Dates for Transition Planning box and clarified in the instructions that you should write in both target dates (for transition at 2 and at 3)

Form Name	Comment	Response
	<p><i>to the reason for referral), pertinent health and physical development information (including pertinent medical history, clinical signs and symptoms, current health status).</i> This would be a <u>big</u> help to the SCs. Prompts for information that must be included on all IFSPs help to ensure consistency and compliance. (4)</p> <p>There is nowhere to note required hearing and vision screening results since the old pg 3 was done away with. Consider a prompt for this.</p> <p>Consider adding statements in the box on page 8 as well as page 9 to say a family has had opportunity to participate in the assessment as well as given an opportunity to choose providers. This would allow families to sign only one time instead of 3 separate places on the IFSP.</p> <p>Signature line should contain a statement for those areas that do not have enough providers for families to have a true choice that reads something to the effect of "I understand that there is only one agency that provides EI services in my area. If another agency becomes available, my SC will inform me of my choice of providers so I may consider all provider choices." Families who do not currently have a choice are signing an inaccurate statement as it is currently written.</p> <p>We could use some additional lines in the "target date for referral" under "important dates for transition planning" and "notification to the local school division" for those children who may be eligible for a referral to the local school system for two consecutive years while receiving Part C services. For example, a child who has a birthday of 8/1/08 could potentially be referred to the local school system in 2010 and in 2011. Families may decline for 2010, but agree to refer for 2011. There is no where to indicate this in these two sections.</p> <p>The parent is asked to sign that they "approve or do not approve" of a transition planning conference. Looking at the dictionary definition #2 below, I see that the form is likely using the term correctly in a legal-type way. But, our families are not jargon oriented, and they typically look at the approve/disapprove</p>	<ul style="list-style-type: none"> • Added in parentheses after Physician Certification on pages 8 and 9: (Required in order to bill insurance) • Added suggested statement to Addendum page. <p><u>Responses to other comments:</u></p> <ul style="list-style-type: none"> • We have explained elsewhere in this table why it is not appropriate to add provider choice to this signature box. There is only a need for a separate parent signature for assessment at the initial and annual IFSPs and we do not believe this to be a burden. • When there is only one provider agency within the area, families should be offered a choice of providers from within that agency. • Additional lines for target date in the notification box are unnecessary since we have revised the IFSP instructions to require that the target date is the April 1 prior to the start of the school year in which the child turns 2 by September 30. We have also clarified that if the parent opts out of notification at that time, they may use the other line in the Notification box on page 7 of the IFSP to allow notification at a later time, as their child approaches age 3. • "Approval" is the word used in federal regulations with regard to the transition conference. Based on recent clarification from OSEP that verbal approval is sufficient, we have deleted the signature line from 3b and the reference to <i>Parent Approval for Transition Planning Conference</i> form on page 7 of the IFSP.

Form Name	Comment	Response
	<p>selection more like the # 1 definition. Many parents have said that it is not that they "disapprove" but they just don't need one.</p> <p>1. to think (something) wrong or reprehensible; censure or condemn in opinion.</p> <p>2. to withhold approval from; decline to sanction: <i>The Senate disapproved the nominations.</i></p> <p>My suggestion is to change the wording to something less strong -- such as the parent "chooses to have a TPC or does not choose to have one".....</p> <p>Consider adding a statement to the physician's signature on the IFSP that states that physician's signature is required to bill insurance, etc. so that physicians might be more timely in returning the signed IFSPs. (4)</p> <p>Add this statement to the Addendum page on the IFSP: <i>The family may request to change their service provider at any time by contacting the service coordinator.</i></p> <p>These kinds of prompts help SCs - and also help families as it is a permanent reminder.</p>	
<p>Notice and Consent forms</p>	<p>Please combine any possible forms. For example, could Notice and Consent for Screening and Notice and Consent to Determine Eligibility be combined? Since Vision and Hearing Screens are routinely completed, even those children with a diagnosed condition will be receiving a screening. If as many activities as possible were combined on one form, it would be much simpler to explain to families without sounding repetitious. (7)</p> <ul style="list-style-type: none"> • It seems that these three forms could be combined into one form with check boxes to indicate in which situation(s) the form is being used (2) 	<p><u>Change:</u> Added the relevant information from the <i>Notice and Consent for Screening</i> form into the <i>Notice and Consent to Determine Eligibility</i> form, eliminating the need for a separate notice and consent for screening.</p>
<p>Parent Approval for Transition Planning Conference & PPN forms</p>	<p>To document transition, we have the Parent Approval for Transition Planning Conference form and the Parental Prior Notice form and they are very redundant when talking with families. Perhaps the planning conference could be specifically referred to on the PPN form as a line to check to document the family's choice to accept or decline the conference.</p>	<p>Based on recent clarification from OSEP that verbal approval is sufficient for the transition planning conference, we have removed the <i>Parent Approval for Transition Planning Conference</i> form from our website since it will not be needed.</p>
<p>Confirmation of IFSP Schedule & PPN</p>	<p>Could these two be combined by using the PPN form to provide confirmation of the upcoming IFSP? (2)</p>	<p>The IFSP meeting date will not always be known at the time you are providing Parental Prior Notice. If it is, you could</p>

Form Name	Comment	Response
		certainly staple the 2 forms together.
Contact Note template	The section marked as “Educated on” would be better titled as “Purpose and goals of visit” or something like that.	The optional state-development Early Intervention Activity Note does not have a section marked “Educated on.”
Declining EI Services	<p>Can we have “choices” of why declination by the family. Could it be with check boxes?</p> <p>Recommend the following changes:</p> <p><input type="checkbox"/> I understand:</p> <ul style="list-style-type: none"> a. eligibility determination may be conducted to determine if my child is eligible to receive services through the Infant & Toddler Connection of Virginia. And b. I do <u>not</u> choose to have my child or family receive an eligibility determination/IFSP/ services through the Infant & Toddler Connection of Virginia System at this time. c. I understand that I may change my mind, and if so, I will call my service coordinator at the number provided on this form. <p><input type="checkbox"/> I understand my child is eligible for Infant & Toddler Connection of Virginia and has a right to obtain the early intervention services outlined in an Individualized Family Service Plan (IFSP).</p> <ul style="list-style-type: none"> a. I do not choose to have an IFSP developed for my child through the Infant & Toddler Connection of Virginia. b. I understand that I may change my mind..... <p><input type="checkbox"/> I understand my child is eligible for Infant & Toddler Connection of Virginia and has a right to obtain the early intervention services outlined in the Individualized Family Service Plan (IFSP) developed on _____.</p> <ul style="list-style-type: none"> c. I am fully aware of the nature of services being offered and that my child will not be able to receive services from Infant & Toddler Connection of Virginia unless I give my consent. d. I understand that I may change my mind..... 	<p>If the family shares with you the reason for declining some or all early intervention services, then it is appropriate to document that information in a contact note rather than on this form.</p> <p>We agree with the suggestion to change the format of the statements on the bottom half of the page and will revise it in a way that is similar to what is suggested in the comment.</p> <p><u>Change:</u> Put the “I do not choose...” statement at the end of each choice on the bottom half of the form rather than as a check off statement at the end. Put the “I understand I may change my mind...” statement after the three choices and without a line in from of it.</p>
General Comments about Forms	<p>Way too many forms required with way too much verbiage. Families report that they are totally overwhelmed by the paperwork and do not remember the purpose of forms even after they are explained thoroughly. We get frequent comments/complaints about the number of forms and the number of times families must initial and/or sign. (6)</p> <p>Please provide copies of forms to localities</p>	<p>If families are feeling overwhelmed and/or not understanding the reasons for each form, this may indicate a need to slow down. One of the primary reasons for developing the service pathway was to ensure families were being given the opportunity to make informed choices at the required points in the early intervention process.</p>
Hearing	Should there be an option for Fail with	Infants who fail the newborn hearing

Form Name	Comment	Response
Screening Form	newborn hearing screening results	<p>screening are referred for a full audiological evaluation so "Refer" is marked on the hearing screening form.</p> <p><u>Change:</u> Added the above clarification in the instructions for the hearing screening form.</p>
Forms Needed but not Currently Available		
Reminder Letter to Families	<p>Need a letter to send to families for AFSP and possibly ED and possibly the IFSP meeting so they are reminded in writing. Letter should have places to check off which activities may be occurring.</p>	<p>Since there is not a requirement to invite families to an eligibility determination meeting, it would be misleading to include that on a confirmation form, though we will develop an optional form for confirmation of assessment for service planning and the IFSP meeting. Local systems are welcome to develop their own letter to use a reminder to families who will be participating in an eligibility determination meeting.</p>
Confirmation of assessment	<p>A written reminder is helpful for families. We did have a form for confirmation of evaluation and it was very helpful. (2)</p> <p>Do we no longer have the confirmation for assessment form?</p>	<p><u>Change:</u> Added an optional Confirmation form that addresses assessment for service planning and IFSP meeting</p>
Translated forms and rights booklets		<p>Translations will be completed once the forms are revised. Translated forms are expected to be available sometime this summer.</p>
	<p>Could we have the Procedural Safeguard forms that are written in foreign languages list the title in English as well as in the other language? This would make managing these forms in the child's file for QA purposes so much easier. Now, some systems are filing both an English and Spanish version so that QA staff know what the form says.</p>	<p><u>Change:</u> When the new translated documents are prepared, we will provide the English title in the document footer.</p>

Other Changes to the Practice Manual

In addition to the changes made in response to feedback from local systems, the following changes were made based on questions and concerns noted by Part C staff during the first 6 months of implementation:

- Throughout
 - Changed practices related to handing out the rights document: Have to leave it the first time; after that, have to offer but if parent declines then don't have to leave it; must document in contact note that you offered and family declined.
 - At end of each section about declining services, added what should be entered into ITOTS in that situation.
- Chapter 3
 - Before Receiving and Processing a Referral, added a section called Provider Responsibilities with the following statement under it: Refer to the single point of entry any child potentially eligible for Part C who becomes known to the provider through a source other than the Part C system and who is potentially eligible for Part C.
- Chapter 4
 - Clarified that if a developmental screening is required, then the screener must actually see the child prior to eligibility determination.
 - Clarified that if the family states more than 1 race for their child, then all need to be recorded.
- Chapter 5
 - Clarified that the Eligibility Determination team's job is to focus solely on whether or not the child meets Virginia's eligibility criteria. The assessment for service planning team will gather the information necessary to determine what supports and services an eligible child needs.
 - Added a new (3rd) bullet under General in the Determining Eligibility section to clarify that if a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or longer or is currently enrolled but has been lost to contact for 6 months or more, then the local system must conduct eligibility determination and assessment for service planning, establish new entry ratings on the child indicators (if the child is still 30 months old or younger), and establish a new IFSP before resuming services.
 - At the end of the General section under Determining Eligibility added a bullet that explains eligibility determination when the family or another team member believes the child has reached age level (copy from Chapter 8).
 - Added under ITOTS Data Entry the requirement that eligibility (Yes/No) must be entered into ITOTS within 10 business days of the eligibility determination date and that the Medicaid information (Medicaid/FAMIS coverage selected from the dropdown menu under Third Party Coverage and 12-digit Medicaid number) must be entered accurately within 10 business days of this date for children who have Medicaid.
 - Added under Local Monitoring and Supervision that the local system manager monitors that providers participating in eligibility determination have a complete and accurate understanding of Virginia's eligibility criteria.
 - Added info on newborn screening at the end of the chapter and deleted from the website as separate document.
- Chapter 6
 - Reformatted to include separate sections called "Completing the Assessment for Service Planning" and "Planning for the IFSP Meeting."
 - In the bullet that says, "Complete the following steps in those rare instances where the child was found eligible by the multidisciplinary team ... but is no longer eligible based on the information gathered during the assessment for service planning." Added that this should happen only when the child has made progress between the time of eligibility determination and the assessment for service planning not because the assessment for service planning team is disagreeing with the decision of the eligibility determination team.
 - Moved the indicator assessment information here from Chapter 7.
 - Clarified under the indicator ratings section that if a child leaves the Part C system and returns within 6 months of discharge, then the initial ratings continue to be used as the entry ratings. If the child is out of the system for more than six months but returns to the system when he/she is still 30 months old or younger then new entry indicator ratings are completed.

- Added under Local Monitoring and Supervision – Child indicator ratings appear to be appropriate based on the documentation of child functioning.
- Chapter 7
 - Added under the 3rd square bullet in the Selecting Service Providers section that a targeted case manager (ID or MH) cannot provide both service coordination/TCM and another Part C service to the same child and family. Please note that the targeted case manager may provide assessment for the purpose of identifying service needs.
 - Deleted the 3rd square bullet in the Selecting Service Providers section related to the blended model of service coordination to avoid confusion.
 - Clarified in the IFSP instructions that when a new short-term goal is added at an IFSP review, you must include the date it was added when you write or enter the new short-term goal on the outcome page.
 - Added a text box in the IFSP instructions to clarify what to list on the IFSP when a nurse will be providing developmental services and how that service will be billed.
 - List “developmental services” as the service on page 6 of the IFSP even when that service is provided by a nurse
 - When billing for developmental services provided by a nurse the provider will use billing codes G0154/G0154 U1 for services in natural environments and T1026/T1026 U1 for center-based services. Similarly, when a nurse is providing assessment, participating in IFSP meetings, team treatment activities, etc., the appropriate billing codes are T1023 U1 and T1024 U1.
 - Added a reference to the indicator assessment information that has been moved to Chapter 6.
 - Clarified that you may obtain physician signature on the new IFSP Summary Letter instead of the IFSP itself to document medical necessity and to serve as the physician order for services.
 - Added under Selecting Service Providers that if the family’s choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.
 - Added the following clarification (see italics) in IFSP instructions related to a child moving from one local system to another with an IFSP ... The revised IFSP must reflect the new local system name; new service coordinator; *new demographic information (city/county, family contact information)*; any changes to outcomes, supports and services (based on child and family needs); and a completed IFSP review page (page 9) with parent signature. *Since there will be new information in several sections of page 1, it may be easiest to create a new page 1 for the IFSP. In this case, maintain the old page 1 in the child’s early intervention record.*
 - Added the following clarification in the IFSP instructions for page 6 of the IFSP, under Actual End Date: When an annual IFSP is developed, the actual end dates must be completed for each service on the previous IFSP (the IFSP that ends when the annual IFSP is developed). To do this, write “continuing” in the actual end date column for those services that will continue, as written, on the annual IFSP. Fill in the actual last date of service for any services that will not continue, as written, on the annual IFSP.
 - Added wording (see italics) in the IFSP instructions for page 9, in the last bullet of the text box called “Review Required?” - A review is not required to change the service provider for an entitled Part C service. *If the change is to another provider within the same provider agency selected by the family, then a contact note must document that the family was informed of the change and of their options for informing the services coordinator if a change from the new provider is desired. If a change in provider is necessary or requested by the family and no other provider from the same provider agency is available, then documentation of parent choice of a new provider agency is required on the Addendum page.*
 - Added IFSP Summary Letter to website
- Chapter 8
 - In General section, under Service Coordinator Responsibilities, added that if the family indicates they wish to decline all services after having started services, then the service coordinator should offer to hold an IFSP review to (1) discuss the outcomes, supports and services and whether the family would like changes in the current supports and services instead of ending all services and/or (2) to make a determination of child progress on the child indicators if the child has been receiving services for at least 6 months. If the family wants to end services immediately and declines to participate in a determination of child progress, then that decision must be documented in a contact note. See the Discharge and Determination of Child Progress

- o at Exit section later in this chapter for additional information on determining child indicator ratings at exit.
 - o Under Annual IFSP, with the bullet that talks about completing the FCS Agreement form, added a reference to direct the reader to the appropriate section of Chapter 11 in the event the family does not sign the new FCS Agreement form promptly.
 - o Added in the Discharge section, under the bullet related to child indicator exit ratings, that if Part B entry assessment data is being used for the Part C exit assessment data, then that Part B assessment must occur no more than 3 months after the child's discharge from Part C.
 - o Added under Local Monitoring and Supervision – Child indicator ratings are appropriate based on the documentation of child functioning.
 - o Transition
 - Copied the definition of potentially eligible for Part B from the IFSP instructions into Chapter 8 (page 98 under notification), and clarified that the determination of whether a particular Part C toddler with a disability is potentially eligible for Part B is made by that toddler's IFSP team as part of the transition process.
 - Added that the LEA Notification may also include the service coordinator's name and contact information and the language(s) spoken by the child and family to further assist the LEA in meeting its child find responsibilities.
 - Added that in those rare instances when the LEA representative is unable to participate in the transition planning conference, the local Infant & Toddler Connection system must provide parents at the conference with information about Part B preschool services, including a description of the Part B eligibility definitions, timelines and process for consenting to an evaluation and conducting eligibility determinations under Part B, and the availability of special education and related services.
 - Added that the service coordinator must make every effort to participate in the initial IEP meeting if invited by the LEA at the request of the parent.
- Chapter 9:
 - o Revised wording under the first bullet in the General Rules for Contact Notes section to indicate that if 2 or more providers participate in the same treatment session, then they may each write a separate note documenting their time and activities or there may be one note to document the team treatment as long as that note specifies each provider's time and how each participated in the session. If a joint note is written, it must be signed by each provider. The option to write a joint contact note does not apply if separate sessions (e.g. at two different times) by 2 different providers occur on the same day.
 - o Added that activity notes must include a narrative description of what occurred during the session including what was done, how the family/caregiver participated, how the child responded during the session (including what the child was able to do in relation to goals, etc.) A check off list does not provide the level of information required to know what occurred during the session.
 - o Clarified that either on the IFSP/IFSP review form or in a contact note the provider must document the length of the IFSP or IFSP review meeting in minutes. Since providers are billing for these services, the time spent must be clearly documented.
 - o On Contact Note Checklist:
 - Added date of provider signatures
 - Clarified that note must specify that the child was present
 - Added a check box that the narrative included: What the provider did during the session including interventions/methods; What the family/caregiver did during the session; What the child did – including specifics about what the child did in relation to the goals; Sufficient information to allow the reader to know what occurred during the session. Also put the suggestions for follow-up section here and required description with enough information that a reader can understand what support and suggestions were given.
 - Deleted from the checklist: to whom the service was delivered, interventions/methods used, and how the child/family/others participated in the session, complete and accurate information about the contact or activity, suggestions for follow-up
 - o Revised the optional Intervention Activity Note to reflect revisions to the contact note checklist
- Chapter 10:
 - o Added flow charts for each dispute resolution option

- Added information on family's right to appeal certain actions with DMAS when the child has Medicaid
- Added that any time a family chooses to appeal a decision using the DMAS Appeal Process, then that family must also be informed of their dispute resolution options under Part C.
- Chapter 11
 - Added language in italics at the end of the following statement and revised as indicated by strikeout and italics: "Since private insurance companies do not typically reimburse for services in natural environments, Part C funds are used to bring the ~~third-party-payer~~ reimbursement to *the provider* up to the standard *early intervention* rate or up to the rate charged by the provider, whichever is less."
 - Clarified the statement "Part C funds cannot be used to reimburse a provider for a Medicaid billable service when the child has Medicaid, except when necessary to prevent a delay in the timely start of services" by adding the following – Once Medicaid funds are received they must be used to reimburse the local system for the Part C funds originally paid. For example, suppose a family is in the process of applying for Medicaid when a Part C service begins on March 16. The child's Medicaid eligibility is established on April 1 and coverage is backdated to March 1. If Part C funds were used to pay the provider for the service delivered on March 16, then Medicaid must be billed for that services and the local system must be reimbursed for the Part C funds originally used to pay for that service.
- Chapter 12
 - Clarified that professional development plan is fluid and can change over the 3-year period to reflect emerging/changing needs
 - Added requirement for certified EI Service Coordinators to complete KI and KII within 18 months of initial certification unless the individual has already completed this training.
 - Added that audiologists who provide Part C services other than audiological testing are strongly encouraged to become EI certified
 - Revised Table A to:
 - List that nurses, nurse aides and LPNs can provide nursing services, developmental services, AT services (rather than nursing, including developmental services).
 - List that audiologists may provide developmental services
 - List that Educators of Vision Impaired may provide vision services
 - Added a section before Restoration of Lapsed Certification to be called Lapsed Certification and moved the first bullet from the Restoration section to this new section. Added that a practitioner with a lapsed certification may neither provide nor bill (Part C or Medicaid) for early intervention services until his/her certification has been restored.
 - Added at the end of Practitioner Responsibilities section that they must ensure their licensure information stays updated in EI Cert (i.e., when the their discipline-specific license expires, they must update the information in EI Cert to reflect the new expiration date).
- Physician certification: (Where appropriate in Chapters 7 and 8)
 - Clarified that physician signature is required at initial, annual and any time a service changes. (Chapters 7 and 8).
 - Clarified that physician certification of the IFSP is considered a part of the IFSP (from DMAS' perspective). Ie, the IFSP is not complete unless the physician has signed it or the physician signature letter or summary is attached to the IFSP.
 - Clarified that the IFSP must be certified in whole; ie, components can not be farmed out to various agencies to obtain certification for their specific service. The local system/service coordinator is responsible for assuring that the physician certifies the IFSP and that the physician certification is a part of the IFSP document (as above). The local system may delegate this process, but only to one individual/agency so that physicians receive only one request for review and certification of the IFSP as a whole. If it is delegated to an individual/agency, that individual/agency must send the signed document to the local system to be filed with the IFSP in the child's EI record
 - Added in IFSP Instructions that physician signature needs to be dated by the physician