Response to Local System Manager Questions

September 2010

Family Cost Share

1. The question and answer document from the July 28, 2010 statewide technical assistance call indicates that all related or non-related persons who share income as an economic unit are considered part of a family unit. Figuring out who shares an income can be difficult. Could you please provide additional guidelines and examples to assist local systems in this process?

   Response: In that same question and answer document, we also noted that "shared expenses" is not the same as "shared income" and does not define an economic unit. Here are some examples that may help in determining the size of the family unit:

   - A pregnant woman counts as 2 family members (or more in the case of multiple gestation). A woman's statement that she is pregnant is sufficient, and medical confirmation is not required.
   - A college student living away from home but receiving financial support from his family counts as part of the family unit.
   - Multiple families who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family unit.
   - A child and her mother live with the grandparents. The mother is employed and pays her own expenses. She pays rent to her parents. The child and her mother would be considered a family unit of 2 and only the mother's income would be used to determine the family cost share because payment of rent to grandparents does not constitute pooling of income.
   - A child lives with his unmarried father and his father's companion. Both adults are employed. They are both signators on their apartment lease and pay living expenses for food, utilities, etc. out of both incomes. The child, father and the companion would be considered an economic unit of 3 and both adults' incomes would be used in determining the family's cost share.
   - A family member who is paying child support for the eligible child is not considered a part of the child's family unit.
   - In cases where there is joint custody of the child, the parents must designate which of them is the head of the family (e.g., will the child be considered part of the mother's family unit or the father's family unit). If the head of the family unit is not designated, the parent presenting for services will be considered the head of the family.
   - A husband and wife who are separated and are not living together are considered separate units. If a husband and wife are legally separated, but are living together and sharing their income, the two of them become a single economic unit despite their separated status.

   If you have a situation that does not match exactly with one of those listed above, we encourage you to use the given examples to make your best effort in determining who constitutes the family unit in your specific situation. Your

technical assistance consultant is available to assist you in working through unusual situations, as needed.

2. If a child (who does not have Medicaid) has a documented diagnosis that makes them automatically eligible, can a service coordinator complete with the family the Family Cost Share Agreement form before the eligibility determination team says they are eligible? Or do they have to wait?

   Response: On page 22 of the Practice Manual, #4c discusses the situation in which referral and/or intake information indicates there is a diagnosed condition that meets Virginia's eligibility criteria. This section suggests that it may make sense to combine eligibility determination and assessment for service planning in this situation and goes on to state that, "Since the financial intake must be completed prior to IFSP development, if the family wishes to combine the eligibility determination with the assessment for service planning (and potentially the IFSP meeting), then talk with the family about completing the financial intake prior to the combined activities to ensure the financial information can be discussed privately."

   If the family whose child has a qualifying diagnosed condition chooses not to combine eligibility determination and assessment for service planning, then the Family Cost Share Agreement form may be completed either before or after eligibility determination.

<u>Forms/Documentation</u>

3. Can we change the sentence on the IFSP summary letter that references "your approval of this IFSP is required in order for <u>Medicaid</u> to cover services?" We want to replace "Medicaid" with "the family's insurance".

   Response: We will revise the state form to reference "Medicaid or your family's insurance." The revised form will be posted to the Infant & Toddler Connection website no later than 10/8/10.

4. When do we use the optional *Confirmation of Scheduled Meetings/Activities* form, and do we also have to use the required *Confirmation of IFSP Schedule* form?

   Response: The optional *Confirmation of Scheduled Meetings/Activities* form was developed in response to stakeholder requests for a form that could be used to confirm the assessment for service planning with the family* or used to confirm a combined assessment for service planning and IFSP meeting. If the optional form is going to be used, it would be used primarily as the child is entering the system since that's generally the only time you would be conducting an assessment for service planning that is not part of routine service delivery and the only time you would be combining an assessment for service planning and IFSP meeting. If you choose to use the optional form for the initial IFSP meeting, it is not necessary to also use the required *Confirmation of IFSP Schedule* form for that same meeting.

* It is neither a federal nor a state requirement to confirm in writing the assessment for service planning schedule. It is a federal requirement to confirm in writing the IFSP meeting schedule.

5. Do we need to record the names of providers on the addendum when there is a temporary change such as a different therapist during the summer, a different therapist while the original one is on maternity leave, or a substitute therapist when one can't make the appointment?

   Response: If you have a different therapist for a planned segment of time (e.g., summer, maternity leave), you would note that in the addendum and the family would need to sign to indicate that they have been provided a choice. If you have different therapists filling in (e.g., therapist sick, make up sessions, etc.) you would simply note that in contact notes.

ITOTS

6. What do we enter into ITOTS for children who were found eligible by the eligibility determination team but are no longer eligible by the time of the assessment for service planning?

   Response: While this situation should be rare, we realize that the current data entry fields in ITOTS do not lend themselves clearly and easily to entering data for those few children who do fall into this situation. To ensure consistency across the Commonwealth, please do the following in those rare instances when a child is eligible at the time of eligibility determination and no longer eligible at the assessment for service planning:

   - Mark that the child is eligible, will receive services,
   - Then, after the assessment for service planning, discharge the child. Mark the transition destination as "other" and specify the other reason as "no longer eligible at ASP."

7. What do we enter into ITOTS as the referral date when a child transitions between local systems? And how does this relate to adding and ending the Medicaid/FAMIS early intervention benefit?

   Response: As indicated on page 7 (#5c) in the practice manual, the date of referral for a child referred from another local early intervention system (from either in or out of state) is the date the child is available (i.e., has moved into the area served by the local system) or the date of referral, whichever comes last.

   - The begin date for the early intervention benefit in VAMMIS (Medicaid data system) must be after the end date for the benefit in the previous local system. Therefore, if the referral date (in ITOTS) for the new system is the same as the discharge date (in ITOTS) from the previous system, the start date for the EI benefit for the new system will be the next day.
   - Timeliness of entry of the Medicaid/FAMIS number in ITOTS for the new system is measured from the date of referral (10 business days).

   When discharging a child from your local system, do not enter a future date for the discharges. Accuracy of transition destination is not assured until the child actually is discharged. In addition, VAMMIS does not accept future dates.

Reimbursement

8. Can a service provider other than the service coordinator be reimbursed for attending an Individualized Education Plan (IEP) meeting with the family if the child is still enrolled in Part C at the time of the IEP meeting?

   Response: As indicated in the Practice Manual, service coordinators are expected to make every effort to participate in the initial Individualized Education Plan (IEP) meeting for children transitioning to early childhood special education services if invited by the local school division at the request of the parent. Since reimbursement of service coordinators is not provided on the basis of individual activities, reimbursement is not an issue. There may be situations where it would be helpful for an EI Professional or EI Specialist to participate in an IEP meeting, and providers are encouraged to do so. However, an IEP meeting is not a medically necessary treatment service and would not be covered by Medicaid/FAMIS. DBHDS considers participation in an IEP meeting to be a teaming activity that would not be billed by the provider and would not be reimbursed by Part C.

9. Is it acceptable for students to sign the documentation when they participate in assessments, meetings or services for children?

   Response: The certified early intervention professional who is responsible for the service (assessment, meeting participation or intervention) must sign the documentation. Students may sign below the signature of the certified early intervention professional.

Inactive

10. Can the service provider be taken off after the inactive process has been initiated but before it has been completed? (Rationale: When we have a list of kids waiting for services and a provider has a child who's "no showing" taking a spot on her caseload, that just doesn't seem fair to the family who is waiting. What we've done in the past is put the "no show" child at the top of the list of kids waiting to be assigned and when and if they ever contact us and say they do want to resume services, we assign the next available therapist to the child).

    Response: Once the service provider has been notified by the service coordinator that the case is inactive (which occurs when there has been no contact by the family within 10 calendar days of the letter being sent to the family), then the local system may decide to reassign that provider to another child and family. However, the local system must be able to provide necessary services to the inactive child and family if communication is made at some later point by the family and the family wishes to continue services. Any time children wait for services due to provider unavailability the local system is out of compliance with federal and state Part C requirements.

Foster Care

11. A child is in foster care. We begin the service pathway with the foster parent, concurrently working towards contacting the biological/adoptive parent. If the

biological/adoptive parent responds but doesn't follow through (by missing appointments, not sending forms in a timely manner), can we continue the service pathway with the foster parent? In another scenario, the only biological parent is incarcerated, but "does want to participate", but the process is delayed for obvious reasons. Can we proceed with the foster parent to keep things moving, but continue to communicate with the biological parent? What if the biological parent is in another state and communication through a social worker slows the process down?

Response: Based on the wording of the scenarios in the questions, it sounds like the local system has correctly used the *Notice to Biological/Adoptive Parent* and that the biological/adoptive parent has responded to the notice, asserting his/her rights as a parent. In each scenario, this assertion of parental rights has led to delays in moving through the service pathway. However, as indicated on page 15 of the Practice Manual, as soon as the biological/adoptive parent notifies the local Infant & Toddler Connection of his or her intention to assert the rights of parent under IDEA, the biological/adoptive parent must be presumed to be the parent for early intervention purposes. Local systems are encouraged to collaborate with local Departments of Social Services in identifying strategies to support the biological/adoptive parent in carrying out the role of parent when he/she has chosen to assert his/her parental rights. This collaborative relationship also ensures that DSS stays informed about the biological/adoptive parent's ability to function in this role.

<u>Annual Confirmation of Eligibility</u>

12. If a child has a diagnosis that makes them automatically eligible, page 28, #5 in the Practice Manual states that annual confirmation of eligibility is still required. However, #6 on the same page makes it look like if they still have a diagnosis they are still eligible (as expected). Are there specific diagnoses that, even if the child had that condition initially, if "corrected" or not resulting in problems at the time of the annual, would not make the child automatically eligible? For example, if the child had a diagnosis of cleft palate that had been surgically repaired or prenatal drug exposure that was not causing symptoms, would the child still be eligible at the annual based on their original diagnosis? Some staff here were thinking, because of the wording in the Practice Manual, that even though the child has a diagnosis at the annual that s/he would then also have to show a delay or atypical development to still qualify. I feel certain that this is not the case, but could you clarify?

    Response: #6 on page 28 of the Practice Manual refers to situations where you would need to confirm eligibility at a time <u>other than</u> the annual IFSP and is not applicable to the question posed above. As indicated in #5 on page 28, eligibility must be confirmed for all children, including those with a diagnosed condition, at the annual IFSP. That does not mean that a child with a diagnosis must now show a delay or atypical development in order to remain eligible. In your examples, the child who had a cleft palate or prenatal drug exposure remains eligible at the annual IFSP based on that diagnosis even if the cleft palate was repaired or the drug-exposed infant shows no symptoms.

The confirmation of eligibility determination at the annual IFSP ensures there has been no change in the original diagnosis. Also, remember that endocrine disorders and hemoglobinopathies make the child eligible under Part C in Virginia only if the multidisciplinary team determines that the diagnosis has a high probability of resulting in developmental delay for this specific child since not all disorders within these categories have a high probability of resulting in developmental delay for all children. Based on additional information available at the time of the annual IFSP (e.g., how the child has responded to treatment for the condition), the eligibility team may determine that this diagnosis no longer has a high probability of resulting in a developmental delay for this child.

13. For an annual confirmation of eligibility, in what instances (especially for a child who is receiving service coordination only) would a screening need to be completed again? Would a screening be necessary in all situations?

    Response: As indicated in the text box on page 121 of the Practice Manual, screening would be used for the annual confirmation of eligibility if the child is receiving service coordination only and it is unclear whether the child continues to meet eligibility criteria for a developmental delay or atypical development. A screening would not be necessary if the child had a diagnosed condition that meets Virginia's Part C eligibility criteria. Generally, a screening should not be needed when a provider other than the service coordinator is providing services to the child since that provider's ongoing assessment should provide information about the child's developmental status. The exception may be if the provider has not seen the child for an extended period of time (e.g., due to the child's extended hospitalization/illness or because of a period of inactive status).