**Purpose:**

The purpose of this policy is to define the principles and procedures of service coordination within the Utah Baby Watch Early Intervention Program (BWEIP) and to describe the different models and approaches to service coordination that can be used within early intervention programs.

**Definition(s):**

**Utah Department of Health, Baby Watch Early Intervention Program (BWEIP):**

The Utah Department of Health, Baby Watch Early Intervention Program (BWEIP) has been designated by the governor as the lead agency with the single line of responsibility to carry out all the provisions of the part C program under IDEIA.

**Individuals with Disabilities Education Improvement Act (IDEIA):**

The Individuals with Disabilities Education Improvement Act is the federal law set forth by the United States that governs how states and public agencies provide early intervention special education and related services to children with disabilities.

**Individualized Family Service Plan (IFSP):**

An Individualized Family Service Plan (IFSP) is a working document agreed upon by EI service providers and family members to address the special needs of eligible children from birth to three (3).

**Local Education Agency (LEA):**

A Local Education Agency (LEA) refers to the public school district (Part B Preschool Program) where the family resides.

**Service Coordinator:**

A service coordinator is the individual assigned to a child and family who is responsible for coordinating the development of supports and services to assist in the delivery of appropriate EI services.

**Part C:**

Part C of IDEIA supports states in providing EI services for infants and toddlers with disabilities from birth to age three (3) and their families.

**Part B:**

Part B of IDEIA supports states in providing special education and related services to all children and youth with disabilities from ages three (3) to twenty-two (22).

**State Educational Agency (SEA):**

The State Educational Agency (SEA) is the Utah State Office of Education.

**Principles and Procedures:**

**A. Scope of Service Coordination Services:**

1. Service coordination refers to services provided by a service coordinator to assist and enable a child and the child’s family to receive the services and rights, including procedural safeguards under part C of IDEIA.

2. Service coordination services are provided at no cost to the family.

3. Each child and family referred to EI services shall be assigned a service coordinator responsible for:

a. Coordinating all services required under part C across agency lines;

b. Serving as the single point of contact to help parents obtain appropriate services and assistance.

**B. Service Coordination Activities:**

1. Service coordination may include:

a. Assisting parents of eligible children in obtaining access to needed EI services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for the child and their families;

b. Coordinating the provision of EI services and other services such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes that the child needs or is being provided;

c. Coordinating evaluations and assessments;

d. Facilitating and participating in the development, review, and evaluation of IFSPs;

e. Conducting referral and other activities to assist families in identifying available EI providers

f. Coordinating, facilitating, and monitoring the delivery of services to ensure that the services are provided in a timely manner;

g. Conducting follow-up activities to determine that appropriate EI services are being provided, including assuring that the family’s resources, priorities, and concerns are being considered and addressed;

h. Informing families of their rights and procedural safeguards;

i. Ensuring that the provision of verbal and written communications is delivered to the family in their native language or mode of communication, when feasible to do so;

j. Assisting the child and the family with transition from EI services including:

1) Notification to the SEA and LEA no sooner than when the child reaches the age of thirty (30) months and no later than the age of thirty-three (33) months; or thirty-four-and-a-half (34.5) months for a child referred to EI between thirty-three (33) months but before thirty-four-and-a-half (34.5) months;

2) Supporting the family; and

3) Facilitating the development of a transition plan to preschool, school, or, if

appropriate, to other services no sooner than when the child reaches the age of twenty-seven (27) months and no later the age of thirty-three (33) months with information on available service options at:

a) Age three (3);

b) Steps to exit EI; and

c) Any services the IFSP team identifies as needed by the toddler and their family to facilitate a smooth transition.

4) Facilitating in the transition conference with the family, LEA representative, and other members of the IFSP team, as needed.

5). Reporting the early childhood outcomes scores at time of exit from EI services.

**C. Qualifications of a Service Coordinator:**

1. All service coordinators shall have demonstrated knowledge and understanding about:

a. Infants and toddlers with disabilities and/or delays in development;

b. Part C of IDEIA and the relevant regulations from part C; and

c. The nature and scope of EI services available through BWEIP, system of payment for services, and other applicable information.

**D. Models of Service Coordination:**

1. BWEIP supports two (2) models of service coordination:

a. **Primary/Dedicated Service Coordinator**: The assigned individual has sole responsibility to carry out all service coordination responsibilities for the child and the family; This is the model of service coordination that Up to 3 uses.

b. **Direct Service Provider:** The individual who provides direct services such as physical therapy, occupational therapy, speech therapy, or special instruction, also provides service coordination for the child and the family; and/or

c. A combination **of Models of Service Coordination:** An EI program may provide one (1) or more of the above models of service coordination

**Up to 3 program’s Policies, Procedures, and Responsibilities**

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1. **Service Coordinator responsibilities**

**AEPS Evaluation testing guidelines**

1. **Books, Puzzles, and things**
2. **Jumping Ball play**
3. **Magic Show**
4. **Bean Play**
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**CHECKLIST**

1. **Initial**
2. Evaluation
3. Initial IFSP Meeting
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5. Annual Evaluation
6. Annual IFSP Meeting
7. **6-month**
8. 6-month Evaluation
9. 6-month IFSP meeting
10. **Transition**
11. Transition Discussion
12. Transition Conference with school district
13. IEP
14. **Procedures for new referrals:**
15. Up to 3 Office Staff administer an ASQ (Ages and Stages Questionnaire) over the phone to help identify areas of concern. They will schedule the BDI to be completed at home by one of our hourly assessors and document that on the referral report
16. On Tuesday mornings, Service Coordinators and therapists will sign up for new referrals of children to evaluate and schedule eligibility/IFSP meetings.
17. Annual or 6 month IFSP’s will be scheduled on the First Tuesday two months previous to when they’re due.
18. **Service Coordinator responsibilities**:
19. **Referrals and Eligibility**
20. Read through all attached paperwork. IF ASQ scores in the black, a therapist should evaluate in that area. Be sure they have signed up to evaluate and include them in determining an IFSP meeting date and time. All members who evaluate should be at the eligibility meeting and IFSP. They can send recommendations instead, if necessary as long as at least two disciplines are represented by the meeting to determine eligibility.

Eligibility is a team decision including the family and so no single evaluator should tell the parent the child doesn’t qualify.

1. If there’s an ASQ SE with scores above the cutoff, make sure our Autism Specialist, Janel or Lisa has looked it over and identified a test time, if needed.
2. A child is eligible if they have a medical diagnosis and we have the medical records which have been reviewed by our nurse by the time eligibility is determined. If not, and the BDI shows at least one moderate delay, they are eligible by standard scores. If the BDI does not show a moderate delay, the child may be eligible by using the Informed Clinical opinion of our staff following assessment. So, do not say a child is not eligible when the BDI doesn’t show a delay before assessments are complete by other staff members. The health, hearing and vision should also be completed prior to determining eligibility.
3. Assessment must be completed in all areas of development to create an IFSP. The family assessment must also be completed by the time of IFSP, but we complete it before eligibility.
4. Everyone who evaluates and assesses the child will ask about the families concerns and ask follow up questions to identify what part of the family’s life and routines the concern is impacting. IF the evaluator chooses to document this on the visit note, it would be best to put child strengths and needs in the TODAY section of the visit note and concerns and routines in the PLAN section. This information should be documented in the Present Levels of Development portion of the IFSP by the evaluator prior to the eligibility and IFSP meeting.
5. At the IFSP, the Service coordinator facilitates a discussion with the team, including the family, about the strengths and needs and concerns and routines. They ask the family to identify which of those concerns and routines are their biggest priorities and facilitate a discussion to write routine-based outcomes to address child and family priorities.
6. **SC Confirming with the family**
7. Call to introduce yourself and confirm evaluation dates and times with the family by the end of the week you signed up for the referral.
8. Inform family that you will be sending out a letter that will have the

name/date/time/purpose for each appointment.

1. Send out Prior Written Notice of all evaluations scheduled.
2. Or if discussed and confirmed with the family on the telephone, you can send a PWN electronically in BTOTS and document in contact log.
3. In BTOTS, it will not allow you to send multiple appointments on one PWN. You will have to send a PWN for each evaluation date/time for each disciplinary team member evaluating. If the family or evaluator changes evaluation dates after the PWN has been sent, the evaluator will send their own PWN.
4. **Assessments to Evaluate**
5. **BDI:** Every new referral (and annual and exit) will have a BDI completed because it is used to calculate Child Outcome Scores (COS). If the child has a vision loss, a BDI is not appropriate.
6. At initial, the hourly assessors will complete the BDI and score the protocol and put it in the child’s paper file. The service coordinator will put the raw scores into BTOTS in an assessment session and link the assessor’s visit note to the assessment session. For annual and exits, the service coordinator will complete the BDI and enter scores in btots for COS calculation.
7. **H.E.L.P.** for children 12 months or younger or developmentally at 12 months or younger. Sections of this assessment can be completed by the associated therapist or by the service coordinator at if no other therapists are on the team. It can be used for initial, 6-months, or annuals.
8. **AEPS**: 12 months and older.
9. Other assessments can be used in determining Informed Clinical Opinion by therapists, including the PLS, PDMS, CBCL, FEAS, and other assessments listed on the eligibility page of the IFSP.

Intakes

* Intakes: Whoever is the first visitor at the family’s home explains the program a little better and *obtains permission to evaluate and reviews the parents’ rights handout*.
* *Obtain parent signature* for Release of Information (YELLOW/ORANGE SHEET, Physician release of medical records, informing Physician of eligibility for our program, or providing services to the child with another caretaker other than their legal guardian)
* Go over parent information on *Verification sheet* and *obtain parent signature* (GREEN HALF SHEET)
* Complete Family assessment form and interview with parent. Add this information to the concerns, Priorities, and Resources and routines portion of Present Levels of Development.
* Obtains *parent signature on Family Fee form* (GREEN SHEET, make sure to get WIC/CHIP/MEDICAID # on form). Give a copy of the fee form to Miriam to mail to the state for billing.

**Topics to discuss with families during the Service Coordinators first visit:**

* 1. Introduce yourself and explain that you are their service coordinator and will assist the family during the eligibility process and if their child is found eligible you will be the one to help them obtain the services and assistance they need.
  2. Purpose of your visit:
* Answer any questions they have about the program
* Learn about their child and his/her development and family
  1. Discuss with the family that the information you collected today and all information from the early intervention team will be used in determining eligibility.
  2. Eligibility and planning of goals and services will be discussed during the initial IFSP meeting (Individualized Family Service Plan)
  3. Explain the purpose of Early intervention is to support children in developing positive social relationships, acquiring new skills, and assisting children in learning how to get their needs met in the routines and activities that are important to the child and family.
  4. Emphasize that we are a teaching program and provide the parents with the tools, resources, and support necessary to accomplish the goals proposed.
  5. Explain that the parents and caregivers are involved in each step of the process and in each early intervention session.
  6. Explain that some services are available at no cost to families such as eligibility determination, assessments and evaluations, and IFSP planning. The other services will have a monthly payment fee that is determined based on their family size and income, a sliding scale. If the child has WIC, CHIP, or MEDICAID, their payment fee is exempt. However, no family will be denied services because of an inability to pay.
  7. Any information shared about their child and family is kept confidential.
  8. Give opportunity to ask questions and share any information that they feel is important.

**Eligibility Determination**

In staff meeting the Tuesday before the IFSP meeting, each service coordinator reviews upcoming meetings for the week and can remind staff at this time of cancelations, rescheduling, missing PLD information or teaming meetings or other information as needed. (This can more effectively be done individually with team members but SC need to know its ready by the staff meeting.).

**IFSP Development and Implementation**

1. **Initial IFSP meeting:**
2. **Service Coordinator responsibilities:**
3. **ALL testing/evaluating has to be done and completed before eligibility can be determined.**
4. Health, all developmental areas unless parents declined, and other evaluations by other disciplinary team members
5. **Prior to IFSP meeting**:
6. All forms and documents filled out as much as can be
7. IFSP Cover page/signature page (top section)
8. Evaluation/assessment scores cover page and eligibility page (Include all assessments (not just BDI) completed before eligibility meeting as these give a picture of the whole child)
9. Strengths and Needs
10. Outcome page (wait to fill out during meeting with family)
11. Service page
12. **IFSP Meeting Agenda: (Service Coordinator facilitates, but all team participates)**
13. ALWAYS ask if the family would like another copy of the Parent Rights
14. Team reviews ALL testing results and scores, family concerns and routines
15. On BDI, use graph, explain what percentile scores are.
16. On the AEPS, the Percentage given is how much knowledge and skills the child has out of a 100 %. EX: 57%= Child has 57% out of 100% of those skills of what they need to have by age 3
17. **NS- Nonsufficient**
18. **AT-mild delay**
19. **Below M= Moderate delay (2 points below cutoff)**
20. **Below S=Severe delay (more than 2 points below cutoff)**
21. Team discusses strength and Needs/present levels, including family routines and activities and preferences: Go over concerns and resources, and ask which of those concerns is their top priority for their family
22. Team discusses and write goals that relate to the areas of need
23. Team identifies services to address the goals
24. Sign the signature page (everyone attending the meeting)
25. Have parent check the two boxes above the signatures stating that they have participated in the development of their child’s individualized family service plan and that they have received their Parent Rights
26. **Data**
27. Put visit date/time/purpose in BTOTS
28. Put child file through DATA
29. **Multidisciplinary team responsibilities:**
30. **All members on the multidisciplinary team attend if possible**
31. Initial/Annual IFSP: minimum of 2 team members of different disciplinarians required for eligibility
32. 6 months’ review: minimum of 1 person
33. **Prior to IFSP meeting**
34. IF any team members aren’t able to make the IFSP meeting, get recommendations from them: (Recommendation form)
35. Goals
36. Services
37. First visit date
38. **Fill in appropriate sections on the paperwork in the child’s file**
39. **6 month Reviews/IFSP**
40. **Service Coordinator responsibilities:**
41. **ALL testing/evaluating has to be done and completed before IFSP can be held**
42. Health doesn’t need to be assessed
43. All developmental areas unless parents declined, and other evaluations by other disciplinary team members completed
44. **Prior to IFSP meeting**:
45. All forms and documents filled out as much as can be
46. Top section of cover page of IFSP
47. All Evaluation scores
48. Strengths and Needs, concerns, routines,
49. Child’s name in correct place on all forms
50. **IFSP Meeting Agenda:**
51. ALWAYS ask if the family would like another copy of the Parent Rights
52. Go over ALL testing results and scores:
53. Strength and Needs/present levels, concerns, routines: Go over concerns and resources, and ask of those concerns, which is their top priority for their family
54. Evaluate and rate goals
55. **M = Mastered/Met**
56. **PM = Partially Met**
57. **NM = Not Met**
58. Discuss services and make changes as needed
59. Sign the signature page (everyone attending the meeting)
60. Have parent check the two boxes above the signatures stating that they have participated in the development of their child’s individualized family service plan and that they have received their Parent Rights
61. **Data**
62. Put visits dates/times/purpose in BTOTS or complete electronic visit form
63. Put child file through DATA
64. **Multidisciplinary team responsibilities:**
65. **All members on the multidisciplinary team attend if possible**
66. Initial/Annual IFSP: minimum of 2 team members of different disciplinarians required for eligibility
67. 6 months’ review: minimum of 1 person
68. **Prior to IFSP meeting**
69. IF any team members aren’t able to make the IFSP meeting, get recommendations from them: (Recommendation form)
70. Goals
71. Services
72. First visit date
73. **Fill in appropriate sections on the paperwork in the child’s file**
74. **Annual IFSP meeting (similar to initial IFSP except now child is eligible with mild delay and does not need to have moderate delay to stay in service.**
    1. **End all services from previous IFSP and add new start dates as of Annual IFSP date**

**Transition**

1. **Policy:**

1. A Transition Discussion is to be held face to face with the parents prior to the child turning 27 months old regarding the referral notification to Part B. It will go automatically if parents do not opt out by this date.
2. A Transition Conference is to be scheduled and completed before the child turns 33 months old
3. **Procedure:**
4. **Service Coordinator responsibilities:**
5. **Transition Discussion with the family/Referral Notification due by 27 months**
6. At the IFSP closest to the child’s turning 24 months, share with family that At 27 months, child’s name, parent’s name, and address is transferred automatically to the school district listed under child contacts if child is eligible and parents don’t opt out.
7. If not completed at the IFSP, service coordinator schedules a home visit before child is 26 months.
8. Service Coordinator Team Lead gives service coordinators reports monthly of children turning 27 months in the next few months so they can plan when to hold the opt out discussion.
9. Go over pamphlet that is provided for their local school district
   * 1. Documentation
10. OPT OUT form (SC just fills out the top part and dates it and no one signs at the bottom unless parents choose to opt out. Document discussion in box in btots.)
11. Transition Plan (steps 5a-f) form (SC dates when discussed and documents brief discussion in boxes in btots. Reviews preschool preparedness and develops outcomes and services to prepare child for transition. Obtain parent signature on release of information to Part B and include in file/document in btots. Arrange transition conference to occur BEFORE child is 33 months of age. )
12. Eligibility for the school district**:** The school district has their own eligibility criteria that is different from Early Intervention
13. Release of Record form: ALL evaluations, records, and information that Up to 3 has obtained will be sent to local school districts. Parents need to sign this paper form or the electronic version.
14. Or they can sign the Opt Out form and discuss community options available
15. **32 months:**  Discuss 90 day meeting/Transiting conference and schedule it with school district and parent if release has been signed.
16. **By 90 days before 3rd birthday**: Transition conference has to be completed by this date
17. The LEA from the school district will lead the meeting and ask areas of concern from the parents, explain testing that is needed to assess those areas and set up testing date/time and IEP date/time.
18. **IEP with school district to discuss eligibility for services**
19. **Transition Conference / 90 day meeting with family and local school district**
20. **Schedule**
21. Call local school district to set up date/time (each district has certain days and times allotted for 90 day meetings
22. **Logan City**: Kim Barfuss at Riverside Preschool- (435)755-2337
23. **Cache County**: Kelly Garcia –
24. **Box Elder:** Jason Udy at Corrine Early Learning Center in Corrine, UT (435)230-1135
25. Inform family of date and time and their child does not have to attend this meeting and send a Prior Written Notice
26. Prior to meeting, fax child’s IFSP and any other test results they’ve had while with Up to 3
27. AEPS
28. ASQ-SE
29. PLS-5
30. PDMS
31. FEAS
32. CBCL
33. BDI
34. **Meeting**
35. Transition Conference form to fill out during meeting (yellow copy will go to the parents)
36. Obtain copy of the local school districts form
37. IEP date will be scheduled by the school district
38. **BTOTS**
39. Enter visit note
40. Enter Transition Conference information under IFSP tab, Transition Conference and link it to the associated visit note you submitted
41. **Data**
42. File paper work
43. Submit to data
44. **IEP**
45. Goals to rate with parents
46. Case Disposition
47. Service Coordinator will mark the appropriate boxes and sign
48. Obtain signature from parent
49. Obtain a copy of Evaluation Summary from the local school districts testing
50. BTOTS
51. Enter visit note in BTOTS
52. Exit COSF

**f.** Data

**1**.Turn in to data to exit after the child’s 3rd birthday

**4. Transitioning into the community**

**a**. Not eligible to receive services for the school district or parent’s chose to OPT

out

1. Community resources:

**Exiting a child from the program**

1. **Service Coordinator responsibilities**
2. Rate the goals
3. Complete BDI and enter scores in BTOTS before the end of the month that they turn 3 for COS calculation
4. Case Disposition
5. In some cases, this form serves as written notification of exit. If the parents withdrew by phone/text/email or aren’t available for signature, it can be documented on the form and a copy mailed to the parents. Note this on form also
6. Note date records will be destroyed on this form also
7. Document in BTOTS when Case Disposition was completed and mailed to parents
8. Put through Data (only after the child has turned 3)