Early intervention service coordination is a mandated service under [Part C](http://ectacenter.org/partc/partc.asp) of IDEA, provided at no cost to families. Service coordination is defined as an active, ongoing process that assists and enables families to access services and assures their rights and procedural safeguards.

IDEA, definition of Service coordination

|  |  |  |
| --- | --- | --- |
| **§ 303.34 Service coordination services**  **(case management).**  (a) *General.* (1) As used in this part,  *service coordination services* mean  services provided by a service  coordinator to assist and enable an  infant or toddler with a disability and  the child’s family to receive the services  and rights, including procedural  safeguards, required under this part.  (2) Each infant or toddler with a  disability and the child’s family must be  provided with one service coordinator  who is responsible for—  (i) Coordinating all services required  under this part across agency lines; and  (ii) Serving as the single point of  contact for carrying out the activities  described in paragraphs (a)(3) and (b) of this section.  (3) Service coordination is an active,  ongoing process that involves—  (i) Assisting parents of infants and  toddlers with disabilities in gaining  access to, and coordinating the  provision of, the early intervention  services required under this part; and  (ii) Coordinating the other services  identified in the IFSP under § 303.344(e) that are needed by, or are being provided to, the infant or toddler with a disability and that child’s family. | (b) *Specific service coordination*  *services.* Service coordination services  include—  (1) Assisting parents of infants and  toddlers with disabilities in obtaining  access to needed early intervention  services and other services identified in  the IFSP, including making referrals to  providers for needed services and  scheduling appointments for infants and  toddlers with disabilities and their  families;  (2) Coordinating the provision of early  intervention 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;  (3) Coordinating evaluations and  assessments;  (4) Facilitating and participating in  the development, review, and  evaluation of IFSPs;  (5) Conducting referral and other  activities to assist families in identifying available EIS providers;  (6) Coordinating, facilitating, and  monitoring the delivery of services  required under this part to ensure that  the services are provided in a timely  manner;  (7) Conducting follow-up activities to  determine that appropriate part C  services are being provided;  requirements of §§ 303.501 through  303.521 (Payor of last resort provisions).  (Authority: 20 U.S.C. 1432(4), 1435(a)(4),  1436(d)(7), 1440) | (8) Informing families of their rights  and procedural safeguards, as set forth  in subpart E of this part and related  resources;  (9) Coordinating the funding sources  for services required under this part;  and  (10) Facilitating the development of a  transition plan to preschool, school, or,  if appropriate, to other services.  (c) *Use of the term service*  *coordination or service coordination*  *services.* The lead agency’s or an EIS  provider’s use of the term *service*  *coordination* or *service coordination*  *services* does not preclude  characterization of the services as case  management or any other service that is  covered by another payor of last resort  (including Title XIX of the Social  Security Act—Medicaid), for purposes  of claims in compliance with the requirements of §§ 303.501 through  303.521 (Payor of last resort provisions).  (Authority: 20 U.S.C. 1432(4), 1435(a)(4),  1436(d)(7), 1440) |

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

**Referrals**

**Intakes**

**IFSP**

**Transition**

**Exiting**

**Table of Contents**

**Referrals**

1. **Policy**
2. **Procedure**
3. **Service Coordinator responsibilities**
4. Receiving initial referrals
5. Deciding the multidisciplinary team
6. Confirming with the family
7. Assessments to Evaluate

**Decision Tree for Initial Evaluations**

**Intake**

1. **Initial Evaluation**
2. Service Coordinator responsibilities
3. Topics to discuss with families during the Service Coordinator’s first visit

**Eligibility Determination**

1. **Policy**
2. **Procedure**
3. **Service Coordinator/Multidisciplinary team responsibilities**

**IFSP Development and Implementation**

1. **Initial IFSP meeting**
2. Service Coordinator responsibilities
3. Evaluations
4. Prior to IFSP meeting
5. IFSP meeting agenda
6. Data
7. Multidisciplinary team responsibilities
8. **6 month Reviews/IFSP meeting**
9. Service Coordinator responsibilities
10. Evaluations
11. Prior to IFSP meeting
12. IFSP meeting agenda
13. Data
14. Multidisciplinary team responsibilities
15. **Annual IFSP meeting**
16. Service Coordinator responsibilities
17. Evaluations
18. Prior to IFSP meeting
19. IFSP meeting agenda
20. Data
21. Multidisciplinary team responsibilities

**Transition**

1. **Policy**
2. **Procedure**

**a. Service Coordinator responsibilities**

1. Transition Discussion

2. Transition Conference

3. IEP

**Exiting a child from the program**

1. **Service Coordinator responsibilities**

**AEPS Evaluation testing guidelines**

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

**CHECKLIST**

1. **Initial**
2. Evaluation
3. Initial IFSP Meeting
4. **Annual**
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

**Referrals**

* **Referrals**: Referrals for the Up to 3 program can be made by anyone concerned about a child such as a: parent, doctor, daycare provider, DCFS, etc.

1. **Policy:**
2. 45 days to complete evaluations and put an IFSP in place (Target Date)
3. If the family cancels or needs to reschedule an evaluation or the IFSP meeting, the Service Coordinator is responsible to continue contact with the family to reschedule and hold the IFSP meeting as soon as it can be done.
4. **Procedures:**
5. Up to 3 Office Staff administer an ASQ (Ages and Stages Questionnaire) over the phone to help identify areas of concern
6. On Tuesday mornings, Service Coordinators and therapists will sign up for new referrals of children to evaluate and schedule eligibility/IFSP meetings.
7. Annual or 6 month IFSP’s will be scheduled on the First Tuesday two months previous to when they’re due.
8. **Service Coordinator responsibilities**:
9. **Receiving initial referrals**
10. Sign up for new referrals
11. Read through all attached paperwork
12. If there’s an ASQ SE, make sure our Autism Specialist, Janel or Lisa has looked

it over

1. **Deciding the multidisciplinary team**
2. Look at the ASQ results for communication to determine (BLACK, GRAY,

WHITE)

1. Determine all other members of the evaluation team needed by looking at ASQ

scores in the developmental areas addressed and the concerns on the referral

1. **each team member will schedule their own evaluation date and time**
2. Schedule IFSP meeting and check to confirm date and time with other members

of the team

1. **SC Confirming with the family**
2. Call to introduce yourself and confirm evaluation dates and times with the family
3. 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 contac log.
3. In BTOTS, it will not allow you to send multiply appointments on a PWN. You will have to send a PWN for each evaluation date/time for each disciplinary team member evaluating
4. **Assessments to Evaluate**
5. **H.E.L.P:** for children 12 months or younger or developmentally at 12 months or younger
6. **AEPS**: 12 months and older
7. **BDI:** used to determine eligibility on all children referred for initial eligibility and all annuals

Intakes

* **Intakes:** The intake process includes the initial face-to-face visit with the family and the start of information gathering for eligibility determination. The initial visit provides the opportunity to welcome and get to know the family, further describe the Up to 3 Program (which was introduced in the phone call with the family to schedule the visits), and discuss the options and opportunities available to them through the system.

1. **Initial Evaluation** 
   1. **Service Coordinator responsibilities**
2. **Meet with the family face-to-face**
3. Give consistent information about the Up to 3 program using “**Topics to discuss with families during the Service Coordinator’s first visit/Initial Evaluation”.** (on page that follows)
4. **Child’s File**
5. **Complete BDI**
6. **Complete Family assessment**

**5**. **All necessary FORMS are completed**:

**a.** Give copy of Parent rights/Procedural safeguards to family in their native language (WHITE BOOK, Baby Watch, parent rights)

**b.** Obtain parent signature on Consent to Evaluate (PINK SHEET)

**c.** 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)

**d.** Go over parent information on Verification sheet and obtain parent signature (GREEN HALF SHEET)

**e.** Go over and have family fill out Family Interview or Concerns, Priorities, and Resources with caregiver (WHITE SHEET)

**f.** Obtains parent signature on Family Fee form (GREEN SHEET, make sure to get WIC/CHIP/MEDICAID # on form)

**6. Procedure after initial visit:**

**a.** Copy Fee form and turn into Miriam

**b.** Fill out all appropriate paper work for IFSP meeting (see IFSP meeting for forms)

**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 no matter how many visits per month 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 MEDICADE 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**

1. **Policy:**
2. Eligibility determination is made by using results from a developmental screening tool, medical information, parent report, formal/informal observation and written assessment reports if available. The multidisciplinary team must be comprised of the service coordinator and one or more professionals representing at least 2 different disciplines (other than service coordination).
3. **Procedure:**
4. **Service Coordinator/ Multidisciplinary team responsibilities:**
5. Determine Eligibility with the multidisciplinary team by 1 of 3 ways in ranking order:
6. **Medical Diagnosis**
7. **Standard Score (SS)**
8. Needs to be a Moderate Delay for Initial Evaluation (7th percentile or lower), and a Mild Delay for an Annual (16th percentile) to be eligibly by a SS
9. **Informed Clinical Option**
10. If the child has a medical diagnosis, then make that child eligible through medical diagnosis rather than a SS or ICO.
11. If the child is eligible by a SS, then make then eligible by a SS rather than an ICO.
12. Document Evaluation results in appropriate places If a Standard Score, include percentile

**IFSP Development and Implementation**

1. **Initial IFSP meeting:**
2. **Service Coordinator responsibilities:**
3. **ALL testing/evaluating has to be done and completed before IFSP can be held**
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 (top section and all evaluation scores)
9. Strengths and Needs
10. Outcome page (wait to fill out during meeting with family)
11. Service page
12. **IFSP Meeting Agenda:**
13. ALWAYS ask if the family would like another copy of the Parent Rights
14. Go over ALL testing results and scores:
15. 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
16. **NS- Nonsufficient**
17. **AT-mild delay**
18. **Below M= Moderate delay (2 points below cutoff)**
19. **Below S=Severe delay (more than 2 points below cutoff)**
20. Strength and Needs/present levels: Go over concerns and resources, and ask which of those concerns is their top priority for their family
21. Discuss and write goals that relate to the areas of need
22. If you are making or have made an internal referral, put it as a goal that the SC will make a referral to that Therapist/specialist.
23. Discuss and plan services
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 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 fill**
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. AEPS scores and eligibility sheet: Top section, all Evaluation scores
48. Strengths and Needs
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. 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
54. **NS- Nonsufficient**
55. **AT-mild delay**
56. **Below M= Moderate delay (2 points below cutoff)**
57. **Below S=Severe delay (more than 2 points below cutoff)**
58. Strength and Needs/present levels: Go over concerns and resources, and ask of those concerns, which is their top priority for their family
59. Evaluate and rate goals
60. **M = Mastered/Met**
61. **PM = Partially Met**
62. **NM = Not Met**
63. If you are making or have made an internal referral, put it as a goal that the SC will make a referral to that Therapist/specialist.
64. Discuss services and make changes in needed
65. Sign the signature page (everyone attending the meeting)
66. 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
67. **Data**
68. Put visits dates/times/purpose in BTOTS
69. Put through DATA
70. **Multidisciplinary team responsibilities:**
71. **All members on the multidisciplinary team attend if possible**
72. Initial/Annual IFSP: minimum of 2 team members of different disciplinarians required for eligibility
73. 6 months’ review: minimum of 1 person
74. **Prior to IFSP meeting**
75. IF any team members aren’t able to make the IFSP meeting, get recommendations from them: (Recommendation form)
76. Goals
77. Services
78. First visit date
79. **Fill in appropriate sections on the paperwork in the child’s fill**
80. **Annual IFSP meeting**
81. **Service Coordinator responsibilities:**
82. **ALL testing/evaluating has to be done and completed before IFSP can be held**
83. Health, all developmental areas unless parents declined, and other evaluations by other disciplinary team members
84. If child **has a diagnosis**, the nurse will need to review/complete Health assessment, vision, and hearing
85. If **no diagnosis**, the SC will do the Annual Health Assessment, vision, and hearing if trained, or SLP can do hearing and the nurse can check vision if needed
86. **Prior to IFSP meeting**:
87. All forms and documents filled out as much as can be
88. Top section of cover page of IFSP
89. AEPS scores and eligibility sheet: Top section, all Evaluation scores
90. Strengths and Needs
91. Child’s name in correct place on all forms
92. **IFSP Meeting Agenda:**
93. ALWAYS ask if the family would like another copy of the Parent Rights
94. Go over ALL testing results and scores:
95. 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
96. NS- Nonsufficient
97. AT-mild delay
98. Below M= Moderate delay (2 points below cutoff)
99. Below S=Severe delay (more than 2 points below cutoff)
100. Strength and Needs/present levels: Go over concerns and resources, and ask of those concerns, which is their top priority for their family
101. Evaluate and rate goals
102. All goals that are not mastered/met need to be re-written on a new goal sheet along with new proposed goals
103. If you are making or have made an internal referral, put it as a goal that the SC will make a referral to that Therapist/specialist.
104. Discuss services and make changes in needed
105. Sign the signature page (everyone attending the meeting)
106. 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
107. **Data**
108. Put visits dates/times/purpose in BTOTS
109. Put through DATA

**Transition**

1. **Policy:**

1. A Transition Discussion is to be given to the parents prior to the child turning 27 months old.
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. Exit COSF in BTOTS (before the end of the month that they turn 3)
4. Case Disposition
5. If the parents aren’t present, document it on the form
6. Make a copy and mail to parents
7. Put a note on the form saying that you mailed copy to parents with the date / time
8. Document in BTOTS when Case Disposition was completed and mailed to parents
9. Put through Data (only after the child has turned 3)