

NYC EARLY INTERVENTION PROGRAM

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____

Race: White Black Native American Asian Other Ethnicity: Hispanic Not Hispanic Unknown

Mother's/Guardian's Name: _____ Father's Name: _____

Child's Address: _____ Apt. No.: _____ Zip Code: _____ Parents' Language: _____

Home Phone #: (____) _____ Alternate Phone #: (____) _____ Cell Phone #: (____) _____

Is child in foster care: Yes No **If yes, please fill out the following information:**

Foster Parent/Surrogate's Name: _____ Agency: _____ Caseworker's Name: _____

Agency Address: _____ Phone #: (____) _____

Does child attend day care (center/family), a babysitter, or another child care program: Yes No **If yes, please fill out the following:**

Name of caregiver, or program: _____ Address: _____ Phone #: (____) _____

IFSP Information (check one): Initial Interim 6 Month 12 Month 18 Month 24 Month 30 Month 36 Month Amended

Date of Current IFSP Meeting: ____/____/____ Projected Dates: 6 Month Review: ____/____/____ Annual Evaluation of IFSP: ____/____/____

Currently Assigned SC: _____ ID #: _____ Agency: _____ Phone #: _____ X _____

PARTICIPANT'S SIGNATURE

ROLE

PROVIDER NAME

By signing above, I hereby certify that all of the information I have provided to the Early Intervention Program and to any other party in connection with the preparation of this Individualized Family Service Plan is true to the best of my knowledge.

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

HEALTH / MEDICAL:

Primary Health Care Provider: _____ Name of Medical Center/Facility: _____

Address: _____ Phone #: (____) _____ Fax #: (____) _____

I give permission for my service coordinator to send a copy of the IFSP and evaluation reports to my child's primary healthcare provider (listed above).

Signed: _____ Date: ____/____/____

If Parent/Guardian/Surrogate chooses to send the IFSP to others working with their child, such as Early Head Start, or Child Care Providers, please complete "Parental Consent to Obtain/Release Information" form.

This section summarizes information about your child's current development (Physical, Cognitive, Communication, Adaptive, Social/Emotional). Include any medical diagnosis, hearing and vision issues, allergies or alerts that the child has.

Parent (Guardian/Surrogate) and evaluation site representative provide a description of what the child is doing and what are the concerns.

Any further evaluations needed? Yes No Specify what type and why:

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

Where does your child spend his or her time? Some of these places may be possible sites for early intervention activities. List some of these places and activities.

Please check the following people who are involved in your child's care and those you would like included in your child's and family's services.

- Mother
- Father
- Step Parent
- Foster Parents
- Grandparents
- Childcare provider
- Siblings
- Others: _____

Where does your child spend most of his/her time?

Describe the people, toys, settings and activities your child finds most engaging or challenging.

What language(s) does your child hear (or use) during most of his/her day? _____

Please provide information about everyday activities, including opportunities for development or problem area. (*Grocery or other shopping, visiting friends/relatives, going out to eat, feeding, bathing, sleeping, childcare, traveling*):

Describe your family's strengths and supports which can help improve your child's development.

NYC EARLY INTERVENTION PROGRAM
DESIRED CHILD AND FAMILY OUTCOME

Child's Name: _____ (Last) _____ (First) _____ E.I. #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

Outcomes: What you want to see happen or change for your child and family as a result of early intervention services.
If needed, attach additional outcome page.

- 1.
- 2.
- 3.
- 4.
- 5.

Plan: Interventionists will work toward the above outcomes by:
Providing appropriate treatment for the child, and teaching caregiver to use what is readily available in order to bring services into the child's daily life. **The interventionists must show that the services they provide fall under FAP (Families as Partners) principles by using an ongoing record of what is taught and how it is taught.** The interventionists should use the FAP calendar or other tool, and the session notes to record these activities. This is then summarized in the progress note.
The family's full participation, including working with the child on activities suggested by the therapist/educator, will result in the best outcome for the child.
List ideas/activities and things families and interventionists will do to achieve the above outcomes. Where?

Who will assist the family in achieving these outcomes? (Be specific.)

If services will not be delivered in the child's natural environment (described on page 3) explain why.

Explain how these services will involve the Family/Caregiver to improve the child's ability to function in his/her natural environment.

**NYC EARLY INTERVENTION PROGRAM
SERVICES NEEDED TO ACHIEVE FAMILY OUTCOMES**

NAME: _____ (Last) _____ (First) _____ EI #: _____ DOB: ____/____/____ DATE OF IFSP: ____/____/____ END DATE OF IFSP: ____/____/____

TYPE OF IFSP (CHECK ONE) Initial Interim 6 Month 12 Month 18 Month 24 Month 30 Month 36 Month Amended

Services Authorized <i>Indicate if bilingual services needed</i>	Outcome # <i>Link each service to an outcome</i>	How often and how long are sessions?	In what setting will this take place and with whom?	Start Date	End Date	PROVIDER INFORMATION
						Agency _____ Contact Person _____ Phone # _____ Fax # _____
						Agency _____ Contact Person _____ Phone # _____ Fax # _____
						Agency _____ Contact Person _____ Phone # _____ Fax # _____

ONGOING SERVICE COORDINATOR

Name _____

Agency _____

Phone # _____ X _____

Fax # _____

Co-visit is needed Yes No

Participants: _____

Frequency: _____

Describe co-visit on page 8 _____

PARENT SIGNATURE _____ DATE _____

EIOD NAME - PRINT _____

EIOD SIGNATURE _____ DATE _____

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

Evaluation of Transportation Needs

Transportation services are authorized to enable an eligible child and the child's family to receive Early Intervention services. As per New York State Early Intervention Program Regulations at 10N.Y.C.R.R., Sec 69-4.19 (b), "...consideration shall first be given to provision of transportation by a parent of a child..." Transportation options are evaluated in the following order.

1. No transportation needed.
2. Caregiver will transport child either by: Public Transportation Private car Is reimbursement being requested? Yes No
3. If the caregiver is unable to transport the child state the reason: _____

The Early Intervention Program will provide transportation by

4. School bus
5. Car Service. If requesting this mode please state reasons why other forms of transportation are inappropriate: _____

6. Are there any other needs (e.g., Nurse on bus)? _____

Assistive Technology

Children with significant motor, hearing, visual or other developmental delays or disabilities may benefit from assistive technology items or devices which enhance their ability to achieve functional outcomes contained in the IFSP. Be sure to include outcomes for AT equipment in the IFSP.

- Form attached Form to be completed Continued assessment needed Child currently has AT equipment Not applicable
- Progress notes should include a description of how Assistive Technology is used as part of the plan to reach functional outcomes.

Respite Services

Respite is short term, temporary care provided by a trained respite worker or nurse. It is intended to provide support to parents and other caregivers who may otherwise be overwhelmed by the intensity and constancy of caregiving responsibilities necessary for their child with special needs. Respite is not a substitute for daycare and the need for childcare is not sufficient alone to justify respite services.

The New York City Early Intervention Program determines the need for respite services based upon the individual needs of the children and families with consideration given to New York State Public Health Laws.

- Does the family express the need for respite services?
- Not at this time Yes Application attached Application pending

**NYC EARLY INTERVENTION PROGRAM
TRANSPORTATION SERVICE AUTHORIZATION FORM**

CHILD'S NAME: LAST _____ FIRST _____ MI _____ CHILD EI #: _____ DOB: _____ / _____ / _____		TRANSPORTATION PROVIDER INFORMATION NAME: _____ PROVIDER EI #: _____ CONTACT PERSON: _____ PHONE: (____) (____) _____ FAX: (____) (____) _____ FOR CONTRACT CHANGES ONLY END: _____ / _____ / _____		DESTINATION INFORMATION AGENCY NAME: _____ AGENCY EI #: _____ SITE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ TRANS. COORD.: _____ PHONE: (____) (____) _____ FAX: (____) (____) _____ FOR CONTRACT CHANGES ONLY-NEW BUS COMPANY:				
<input type="checkbox"/> Initial <input type="checkbox"/> 6 Month <input type="checkbox"/> Annual <input type="checkbox"/> Amended <input type="checkbox"/> Interim		CHECK AS APPROPRIATE: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-Ambulatory <input type="checkbox"/> Wheelchair vehicle <input type="checkbox"/> Needs special safety seat <input type="checkbox"/> Other-Please specify medical or other equipment		NAME: _____ PROVIDER EI #: _____ CONTACT PERSON: _____ PHONE: (____) (____) _____ FAX: (____) (____) _____ BEGIN: _____ / _____ / _____ END: _____ / _____ / _____ WEEKS: _____ UNITS: _____				
<p>NOTE: THE TRANSPORTATION COORDINATOR MUST SEND THIS FORM TO DOT AND THE BUS COMPANY</p>								
TRANSPORTATION			BEGIN	END	DAYS PER WEEK	WEEKS	UNITS	STATUS
Type Code					M T W TH FRI			ADD
For family car estimate mileage:					TOTAL:			TERMINATE
Companion Name: _____					M T W TH FRI			ADD
Alt: _____					TOTAL:			TERMINATE
Reason for accompanying child: _____								
<p>INFORMATION BELOW MAY CHANGE WITHOUT EIOD AUTHORIZATION</p>								
PARENT(S) NAME(S) ADDRESS: _____		PICK UP ADDRESS/STARTING POINT (IF DIFFERENT FROM HOME ADDRESS) _____		EMERGENCY CONTACT NAME: _____ HOME #: (____) _____ WORK #: (____) _____ CELL #: (____) _____		SERVICE COORDINATOR NAME: _____ AGENCY: _____ PHONE #: (____) _____ EXT: _____		
HOME #: (____) _____ WORK #: (____) _____ CELL #: (____) _____		DROP OFF ADDRESS/DESTINATION OF TRIP _____						

**NYC EARLY INTERVENTION PROGRAM
SERVICE COORDINATION ACTIVITIES**

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSF Date: ____/____/____

Service Coordinator Role:

- Assist families in obtaining EI and non-EI services.
- Coordinate and monitor the delivery of all services.
- Facilitate reviews of IFSP every 6 months.
- Inform caregivers of their rights and Procedural safeguards under the Early Intervention Program.
- Obtain insurance information and explain to parents how information will be used by EI.

Transition out of Early Intervention

The service coordinator is responsible for helping the parent identify other early childhood programs if the child is no longer eligible for Early Intervention due to progress, or if the child is three years old.

Other Program(s) to consider:

Early Headstart

Day Care

Private Preschool

Playgroup

Other: _____

EIP-11 (Rev. 5/06)

My Service Coordinator is _____ SC ID # _____

He/She can be reached at # _____ Ext. _____

Provider Agency _____ Provider # _____

Assist family in identifying and applying for:

Insurance (CHIP, Medicaid, etc) Medicaid waiver program

Food stamps, WIC Other _____

Other specific tasks: _____

Transition out of Early Intervention

In order for your child to remain in Early Intervention past his/her third birthday, s/he must be found eligible for CPSE by the day before his/her 3rd birthday: ____/____/____.

When appropriate, and with the parent's written consent, the service coordinator will refer the child to CPSE. Region/District _____ Projected Date of referral: ____/____/____

Parent chooses to have a transition conference. Service coordinator will arrange conference.

Parent chooses not to refer his/her child to CPSE at this time. — Parent is aware that all EI services will end on the day before the child's 3rd birthday.

Comments: _____

**NYC EARLY INTERVENTION PROGRAM
IFSP ATTESTATION AND ADDITIONAL CONCERNS**

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

IFSP ATTESTATION – This page must be signed at the initial IFSP meeting by the evaluation site representative and the EI/OD and attached to the completed IFSP.

EVALUATION REPRESENTATIVE:

I certify that I am qualified personnel as defined in the New York State Early Intervention Regulations, and that I am representing the Multidisciplinary Evaluation Team for the above-named child. I further certify that I have personally evaluated this child and/or have read the complete multidisciplinary evaluation, am knowledgeable about the clinical needs of this child and family, and am able to make appropriate recommendations for services during the IFSP meeting.

Signature: _____

Date: ____/____/____

EARLY INTERVENTION OFFICIAL DESIGNEE (EI/OD):

I certify that the services that I have authorized in this IFSP are based upon the review of the documentation provided by the evaluators and the discussion that took place at the IFSP meeting as documented in the IFSP.

Signature: _____

Date: ____/____/____

Please note: The Early Intervention Official Designee may be contacted by the parent, service provider or service coordinator at any time after this meeting if there are any concerns about the implementation of this plan.

ADDITIONAL CONCERNS – Describe below any concerns (from any members of the IFSP team) that may need follow-up.

- ❖ If co-visits are recommended, use this space to describe the goals of the co-visits and how they will be carried out.

**NYC EARLY INTERVENTION PROGRAM
CONSENT FOR SERVICES**

Child's Name: _____ (Last) _____ (First) _____ EI #: _____ D.O.B.: ____/____/____ IFSP Date: ____/____/____

- I received a copy of **A Parent's Guide** when my child entered Early Intervention. My rights as described in this guide have been explained to me and I understand them.
- I understand that I can request to review my child's file or request an amendment to the file.
- I understand that Early Intervention is a family centered program and that my full participation is necessary for achieving the best outcomes.
- I understand that I may decline a service or services without jeopardizing any other early intervention service(s) my child or family receives.
- I understand that if I have any questions or concerns at any time about services in this IFSP, I should contact my service coordinator or the EI/OD.
- I understand that my child's services will be based on his/her continuing needs and eligibility. I understand that I will be notified of any proposed changes to my child's IFSP, and that I have the right to mediation or fair hearing should I disagree with any proposed changes.

Parent Signature _____ Parent Signature _____ / ____ / ____
Date

- I (We) have participated in the development of this IFSP, and agree to all aspects of this plan. I (we) give permission to the NYC Early Intervention Program to implement this plan.
- I (We) do not agree with some aspects of this plan. I (We) understand that I (we) have due process rights that are described in the **Parent's Guide** and that have been explained at this meeting. I understand that disagreement will not jeopardize other EI services. This is what I (we) do not agree with:

Parent Signature _____

Parent Signature _____

Date: ____/____/____

Print EI/OD Name: _____

Telephone #: (____) _____

EI/OD Stamp

**NYC EARLY INTERVENTION PROGRAM
SERVICE AUTHORIZATION DATA ENTRY FORM**

EFFECTIVE DATE OF IFSP: ____/____/____
 END DATE OF IFSP: ____/____/____
 CHILD INFORMATION:
 CHILD EI #: _____ DOB: ____/____/____
 CHILD'S NAME: _____ (LAST)
 (FIRST) (MIDDLE)
 PHONE: (____) _____ FAX: (____) _____
 SC #: _____

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)
 PROVIDER NAME: _____
 PROVIDER EI #: _____
 CONTACT PERSON: _____
 CONTACT PERSON'S PHONE: (____) _____
 CONTACT PERSON'S FAX: (____) _____
 SC #: _____

TYPE OF IFSP
 Interim
 Initial
 6 Month
 Annual
 Amendment to IFSP
 Dated: ____/____/____

NOTE: The Service Authorization Form is only valid if signed by the EIOD.
 A separate Service Authorization Form must be completed for each service provider.

SERVICE INFORMATION (Must be updated and completed at each IFSP, including amendments). If child is enrolled in a Medicaid Managed Care Plan, include child's Medicaid number, as well as insurance company information.

CHILD MEDICAID ELIGIBLE: Yes No Applied for

CHILD'S MEDICAID OR CIN #: ____/____/____ Lt / Lt / # / # / # / # / Lt
 Lt / Lt / # / # / # / # / Lt

SERVICES (SEE BACK FOR KEY) Data Entry _____ Date: ____/____/____

	1-SERVICE TYPE	2-METHOD	3-LOCATION	4-BEGIN	5-END	6-MINS	7-DAYS	8-WEEKS	9-UNITS	STATUS
1-TYPE										ADD
Code Letter										TERMINATE
2-TYPE										ADD
Code Letter										TERMINATE
3-TYPE										ADD
Code Letter										TERMINATE
4-TYPE										ADD
Code Letter										TERMINATE
5-TYPE										ADD
Code Letter										TERMINATE

<p>1. SERVICE TYPE</p> <p>A Assistive Technology B Audiology C Family Counseling D Health E Nursing F Nutrition G Occupational Therapy H Physical Therapy I Family Support Group J Psychological K Respite Care L Social Work M Special Instruction N Speech/Language O Vision P Service Coordination Q Family Training R Sibling Support Group</p>	<p>2. PAYMENT RATE / METHOD TYPE</p> <p>Z Office/Facility Individual/Collateral Visit A Basic Home/Community Individual/Collateral Visit H Extended Home/Community Individual/Collateral Visit B Basic Group Developmental Visit C Enhanced Group Developmental Visit D Basic Group Developmental Visit with 1:1 Aide G Enhanced Group Developmental Visit with 1:1 Aide E Parent-Child Group F Family-Caregiver or Sibling Support Group</p>
<p>3. LOCATION TYPE</p> <p><u>Group Service Codes:</u></p> <p>A Group 51% TD Group designed for 51% or more typically developing children D Group 50% TD Group designed for 50% or less typically developing children C Group 0% TD Group designed for no typically developing children</p> <p><u>Individual Service Codes:</u></p> <p>B Family Day Care F Hospital Inpatient I Residential Facility K Community Recreation Center E Home G Provider Location (office, clinic, or hospital) O Other M All Group Community Child Care Locations</p>	<p>STATUS</p> <p>(Circle One) <input type="checkbox"/> Add <input type="checkbox"/> Terminate</p> <p>TRANSPORTATION</p> <p>Use Transportation Services Authorization Form for all transportation services.</p>
<p>9. UNITS</p> <p>A unit of Early Intervention Services is a "visit". The total number of units equals the number of visits per week X the total number of weeks.</p> <p><u>Service Type Unit Table</u></p> <p>1 x 26 weeks = 26 units 2 x 26 weeks = 52 units 3 x 26 weeks = 78 units 4 x 26 weeks = 104 units 5 x 26 weeks = 130 units</p> <p>Please refer to Appendix F of the NYC Forms and Procedures Manual for additional calculations.</p>	<p>FREQUENCY AND DURATION CODES</p> <p>4 Begin = Date service scheduled to begin 5 End = Date service scheduled to end (cannot exceed date IFSP ends)</p> <p>6 Mins = Minutes of service per session 7 Days = Number of days per week 8 Weeks = Number of wks of service</p>
<p><u>Service Coordination Units Table</u></p> <p>One unit of service coordination = 15 minutes (¼ hr.)</p> <p>¼ hr. per week x 26 weeks = 26 units ½ hr. per week x 26 weeks = 52 units 1 hr. per week x 26 weeks = 104 units 1½ hr per week x 26 weeks = 156 units 2 hrs. per week x 26 weeks = 208 units</p> <p>Please refer to Appendix F of the NYC Forms and Procedures Manual for additional calculations.</p>	