

REASON FOR DELAY DATA SHEET

CHILD'S NAME: _____

DATE OF BIRTH: _____

REFERRAL DATE: _____

IFSP DATE: _____

Initial: _____

REASON(S) FOR DELAY:

6th Month: _____

- 00 No Delay
- 01 Difficulty Locating or Contacting Family
- 02 Family Unresponsive/Delay Action by Family
- 03 Family Delay - Illness of Child or Parent
- 04 Family Delay - Family Reasons
- 05 Family Delay - Other Reasons
- 06 Foster Care Delay
- 07 Family Moved
- 08 Difficulty Obtaining Translation Services
- 09 Transportation Difficulties
- 10 Weather Delays
- 11 Family Missed Appointments
- 12 Parental Limitations/Scheduling Problems
- 13 Parental Delay in Signing Consent for EIP
- 14 Parental Delay in Choosing Evaluation Site
- 15 Parent Knowingly Chose Evaluation Site with Backlog
- 16 Evaluator Backlog or Delay
- 17 Child was Found not Eligible at First Evaluation
- 18 Evaluation Completed Prior to Referral
- 19 Delay Receipt of Referral by Service Coordinator
- 20 Delay Receipt of Evaluation Report
- 21 Scheduling Problems Due to Service Coordinator's High Case Load
- 22 Scheduling Problem Due to EIO Designee's Full Schedule
- 24 Case was Closed and Reopened

Annual: _____

* NOTE TO SERVICE COORDINATOR: Please submit this form to Operations with the IFSP.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

CHILD'S NAME _____

DATE OF BIRTH: ____/____/____

Anticipated earliest Transition meeting date _____

SCHOOL DISTRICT _____

LAST POSSIBLE DATE OF SERVICES UNDER EI SYSTEM _____ day before child's 3rd birthday

IFSP MEETING DATE: ____/____/____

IFSP PERIOD: FROM: ____ TO: ____

6 MONTH IFSP DUE DATE: ____/____/____

IFSP CATEGORY: Initial Interim 6 Month Annual Amendment

Annual IFSP Due Date: _____

Parent/Guardian Name: _____	Father's Name: _____
Mother's Name: _____	Home Address: _____
Home Address: _____	Home Phone No. of Father: _____
Home Phone No. of Mother: (____) _____	Work Phone No. of Father: _____
Work Phone No. of Mother: (____) _____	Alternate Contact Person: _____
Language Spoken in the Home: _____	Alternate Contact Phone: _____

INDIVIDUALIZED FAMILY SERVICE PLAN PARTICIPANTS (specify discipline or relationship)

Participants	Print Name	Signature	Agency	Phone Number
Parent/Guardian	_____	_____	_____	_____
Parent/Guardian	_____	_____	_____	_____
Surrogate Parent, (if appropriate)	_____	_____	_____	_____
Service Coordinator (Initial/or Ongoing) <small>(Circle one)</small>	_____	_____	_____	_____
Evaluator	_____	_____	_____	_____
DSS (if appropriate)	_____	_____	_____	_____
EIOD	_____	_____	_____	_____
Other	_____	_____	_____	_____

- ATTACHMENTS**
- CPSE Transition Plan
 - Prescriptions
 - Student Information Form
 - Medical
 - Transportation Plan/Parent Reimbursement
 - Mileage Sheet
 - Bus Pass Information Sheet
 - Assignment of Benefits and Medical Information
 - Insurance Information (see attachment)

CHILD'S NAME: _____
Last Name First Name

DOB: _____

CPSE Eligible Date: _____ EIOD Initials: _____

Print Name of OSC: _____

OSC's Phone#: _____ Fax #: _____

Name of EIOD: _____

Interim IFSP Date: _____
 Initial IFSP Date: _____ From _____ To _____
 6 Month IFSP Date: _____ From _____ To _____
 12 Month IFSP Date: _____ From _____ To _____
 18 Month IFSP Date: _____ From _____ To _____
 24 Month IFSP Date: _____ From _____ To _____
 30 Month IFSP Date: _____ From _____ To _____
 No Change

Type of IFSP	Service / Type	Method	Location	Start Date	End Date	Mins/ Sess	Freq Xwk Xmo	Units	Provider	OSC Initials Date	EIOD Initials Date	OPS Initials Date	Effective Cancellation Date	OSC Initials Date	EIOD Initials Date	OPS Initials Date
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															
	Service: _____ Code: _____															

Assistive Tech Device(s)

Transportation Service:

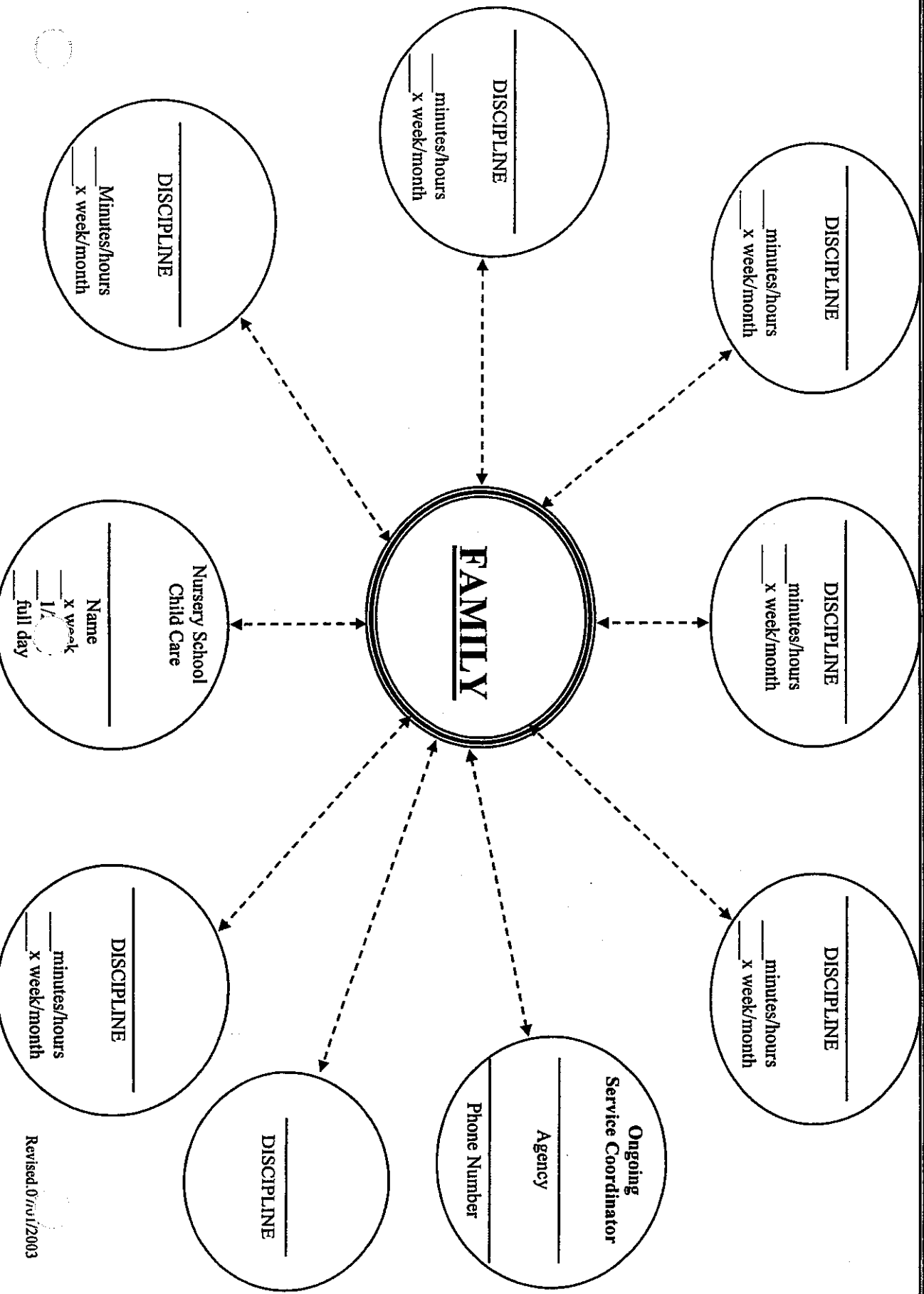
Regular Bus: EIOD Initial/Date: _____ Provider: _____
 days / week, Start / End Date: From _____ to _____ Cost / month \$ _____
 Special Bus: EIOD Initial/Date: _____ Provider: _____
 hours / week, Start / End Date: From _____ to _____ Cost / hour \$ _____
 Bus Pass, Parent Mileage Reimbursement. Submit application to EI Operations accordingly R.B OPS Initial/Date: _____ S.B OPS Initial/Date: _____

Revised 8/05

IFSP SERVICES WORKSHEET

- Interim
 Initial
 Review
 Annual
 Amendment to _____

Child's Name: _____ DOB: _____ IFSP Date: _____ End Date: _____
 (With parental consent and Westchester County Department of Health approval, this intervention plan is subject to change based on child's continuing development and results of intervention.)
 Parent/Guardian Signature: _____ Date: _____
 Ongoing S.C. Signature: _____ Date: _____



CHILD'S NAME: _____

DATE OF BIRTH: _____

IFSP DATE: _____

Domain/Other Family-Child Services

Possible Therapists

Desired Functional Outcomes for Child and Family

What would you like to have happen or changed for your child or family in this domain in the next 6-12 months?

Parent Participation

During which of the following activities will your family be most available to practice suggestions from the teacher/therapist? (Mealtime, bathing, dressing, playing, bedtime, morning routine, shopping, playground, family outings, weekends)

Persons Responsible for Implementing Strategies/What They will Do

1. Parent/Caregiver will participate in intervention sessions when possible and incorporate teacher/therapist suggestions into child's daily routines.
2. Teacher/therapist will utilize child's play activities for individual intervention.
3. Teacher/therapist will model activities for parent/caregiver follow through.
4. Teacher/therapist will record suggestions for follow through in a communication book or by telephone call to parent/caregiver.
5. Teacher/therapist will meet on a regular basis with child, parent/caregiver, and other interventionist to coordinate strategies.

Other: (Note if teacher/therapist should have specialized knowledge in a particular area, i.e., oral motor, medically fragile, severe behavior disorders.)

Settings: (if not most natural environment, explain why)

- Own home/relative _____
- Family child care (Name) _____
- Nursery school (Name) _____
- Childcare Center (Name) _____
- Parent/Child Group _____
- Other (indicate) _____
- E.I. Center (Name) _____
- Rationale for E.I. Center Placement _____

Criteria/Timeline

Due Dates: 3 mo _____ 6 mo _____ 9 mo _____ Annual _____ Other _____

Ongoing service coordinators will distribute progress notes to parents and WCDH service coordinators 10 business days prior to 6 month IFSP review.

Parents/service providers/service coordinators will exchange information through daily logs, phone calls, and home visits.

CHILD'S NAME: _____

DATE OF BIRTH: _____ IFSP DATE: _____

Domain/Other Family-Child Services

Possible Therapists

Desired Functional Outcomes for Child and Family

What would you like to have happen or changed for your child or family in this domain in the next 6-12 months?

Parent Participation

During which of the following activities will your family be most available to practice suggestions from the teacher/therapist? (Mealtime, bathing, dressing, playing, bedtime, morning routine, shopping, playground, family outings, weekends)

Persons Responsible for Implementing Strategies/What They will Do

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5. Teacher/therapist will meet on a regular basis with child, parent/caregiver, and other interventionist to coordinate strategies.

Other: (Note if teacher/therapist should have specialized knowledge in a particular area, i.e., oral motor, medically fragile, severe behavior disorders.)

Settings: (If not most natural environment, explain why)

Own home/relative _____

Family child care (Name) _____

Nursery school (Name) _____

Childcare Center (Name) _____

Parent/Child Group _____

Other (indicate) _____

E.I. Center (Name) _____

Rationale for E.I. Center Placement _____

Criteria/Timeline 6 Months Other

Ongoing service coordinators will distribute progress notes to parents and WCDH service coordinators 10 business days prior to 6 month IFSP review.

Parents/service providers/service coordinators will exchange information through daily logs, phone calls, and home visits.

Child's Name: _____

Date of Birth: _____

IFSP Date: _____

RESPONSIBILITIES OF THE ONGOING SERVICE COORDINATOR (OSC)

- ▶ Ensure that all services listed on the individualized Service Plan (IFSP) begin in a timely manner.
- ▶ Ensure that your child receives all of the services the same number of times per week and for the same length of time as written on the IFSP Services Worksheet.
- ▶ Ensure that there are no gaps in services.
- ▶ Ensure that all of the services continue until the end date of the IFSP unless a signed consent is obtained from parent/guardian.
- ▶ Ensure that all service providers for your child communicate with you and with each other toward a collaborative, and consistent approach with your child.
- ▶ Available by telephone or returning your calls to hear your needs, concerns and possible changes in priority for your child's services.
- ▶ If you or your provider has appropriate rationale, the OSC will work with WCDH towards making appropriate changes in your child's programming.
- ▶ Make referrals to help you to find other services that you or your family may need.
- ▶ Facilitate a formal review of your child's progress with you and the therapists that serve your child at least every six months. Your OSC will collect progress reports from your providers, review the reports and with your input determine the continued appropriateness of the last IFSP.
- ▶ Maintain updated medical information (including new immunizations, recent hospitalizations, etc.), and insurance information and any other relevant child/family information.
- ▶ Help you to prepare for transition of your child into the Committee for Preschool Special Education (CPSE), if appropriate.

I have chosen _____ as
Name Agency

my Ongoing Service Coordinator. I understand the responsibilities of my OSC and will notify the WCDH/IEP Early Intervention Official Designee (EIOD) listed on the cover sheet of the IFSP if I feel the need to talk about my OSC's services or if I wish to change my OSC.

Parent/Guardian Signature

Date

CONSENT TO RELEASE INFORMATION TO EARLY INTERVENTION PROVIDERS OF SERVICE

- I understand that providers delivering services to my child may need to exchange information to facilitate the development and implementation of my child's Individualized Family Service Plan (IFSP).
- I grant my consent for release of the EI Medical Form, Evaluations, IFSP's and Progress Notes to those providers as specified in the IFSP.
- I further understand that this release can be withdrawn at any time upon written notice to my Ongoing Service Coordinator. This release ends on the date of my next scheduled annual IFSP (or if sooner specify date ___/___/___)

Parent Signature

Date

CONSENT TO RELEASE INFORMATION TO OTHER THAN EARLY INTERVENTION PROVIDERS

Pediatrician: Name _____ Address: _____ _____ <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations <input type="checkbox"/> Progress Notes	DSS: Name _____ Address _____ _____ <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations <input type="checkbox"/> Progress Notes
Other: Name _____ Address: _____ _____ <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations <input type="checkbox"/> Progress Notes	Other: Name _____ Address: _____ _____ <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations <input type="checkbox"/> Progress Notes

Parent Signature

Date

Andrew J. Spano
County Executive

Early Intervention Program

Department of Health

Child's Name: _____
Date of Meeting: _____
Date of Conversation with parent: _____

INTERIM
 INITIAL
 6 Month
 ANNUAL
 AMENDMENT

_____ _____ _____ _____ _____
 Date Date Date Date Date

CONSENT FOR SERVICES

Instruction: Initial only those statements that apply:

- _____
Parent Initial

I have been told about the early intervention services that are available for my child and family, and about my rights under this program. I understand the plan that was developed for my child and family. I realize that my permission for the recommended services is voluntary and that I can withdraw my consent at any time.
- _____
Parent Initial

I give permission to the Early Intervention provider(s) to implement this plan. I understand that this is a family-centered program and that I can be included in as many areas of my child's program as I wish.
- _____
Parent Initial

I do not agree with the following: _____
 I understand that I have due process rights that are described in the *"The Early Intervention Program - A Parent's Guide"* handbook and have been explained to me by my Service Coordinator.

3a. I agree to have my child receive only the following services on the IFSP: _____

3b. I do not want my child to receive: _____

3c. I believe that my child should also receive the following services on the IFSP: _____
- _____
Parent Initial

I do not accept the IFSP outlined on the previous pages. I understand that I have due process rights that are described in the *"The Early Intervention Program - A Parent's Guide"* handbook and have been explained to me by the Service Coordinator.

Parent/Guardian/Surrogate Signature (Circle appropriate) _____ Date _____

Parent/Guardian/Surrogate Signature (Circle appropriate) _____ Date _____

Service Coordinator selected by parent(s) _____ Agency _____

Department of Social Services Signature _____ Date _____

Early Intervention Official Designee Signature _____ Date _____

Early Intervention Official Designee Phone Number (_____) _____

Please note: The Early Intervention Official Designee can 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. Service will be authorized contingent on the EIOD's approval. Revised.07/01/2005

CHILD'S NAME: _____ DATE OF BIRTH: _____ IFSP DATE: _____

TRANSPORTATION PLAN

- Parent will provide transportation (parent does/does not) request reimbursement (Circle one)
- Parents cannot provide transportation because
 - other young children at home another disabled family member in the home nature of child's disability
 - parents have medical condition/disability/chronic illness other related problems
- REGULAR BUS transportation will be arranged (Complete transportation SIF)
- SPECIAL BUS transportation will be arranged (Parent/child group) (Complete transportation SIF)
- BUS PASS/BUS TICKET (See Protocol) Parent Mileage Reimbursement (See Protocol)

INCLUSION PLANNING

What our family is doing now: (visiting friends, library, playground, shopping) _____

Future planning for opportunities for our child to interact with other children in the community: _____

ADDITIONAL COMMENTS

Use this section to note informational aspects of the discussions that took place regarding the development of this IFSP

FAMILY RESOURCES AND NEEDS

Child's Name: _____

Date of Birth: _____

IFSP Date: _____

FAMILY RESOURCES

Family Needs	Suggested Family/Community Resources	Who Will Follow Through			
		Family	Ongoing Service Coordinator	Other (Specify)	Timeline
I WANT TO KNOW MORE ABOUT:					
<input type="checkbox"/> Meeting with other families to share information, to learn about a child like mine	Family Connection 493-1343				
<input type="checkbox"/> Information on the child's disability, what it means, working with specialty providers (physicians, etc.)	Family Connection 493-1343				
<input type="checkbox"/> Children with Special HealthCare Needs - information, referral and financial assistance when qualified	CSHCN 813-5328				
<input type="checkbox"/> Local Early Intervention Coordinating Council	LEICC Liaison 813-5094				
<input type="checkbox"/> Finding childcare or play groups in my home or community	Child Care Council 761-3456				
<input type="checkbox"/> Housing, clothing, jobs, food, insurance, child development (a clearinghouse of resource information)	United Way of Westchester and Putnam 949-5355				
<input type="checkbox"/> Assistive technology devices, supplies and equipment	TRAID 493-8213 Ongoing Service Coordinator				
<input type="checkbox"/> Information on child's development and parenting skills	United Way of Westchester and Putnam 949-5355				
<input type="checkbox"/> Resources for non-English speaking families	Minority Outreach Cabrin Immigrant Services Centro Hispanico 949-9300 674-1937 428-3019				
<input type="checkbox"/> Other					

ASSIGNMENT OF BENEFITS AND MEDICAL INFORMATION RELEASE FORM

Child's Name: _____

Address: _____ DOB: _____

_____ Tel: _____

NYS Medicaid #: _____

Primary Insurance: (name) _____ ID#: _____

Primary Care Physician: _____ Tel: _____

Policyholder Name: _____ DOB: _____

Policyholder SS #: _____ Group #: _____

Relationship to Child: _____ Effective Date: _____

Insurance Co. Address: _____ Tel: _____

_____ Employer: _____

_____ Address: _____

City, State

Secondary Insurance: (name) _____ ID#: _____

Primary Care Physician: _____ Tel: _____

Policyholder Name: _____ DOB: _____

Policyholder SS #: _____ Group #: _____

Relationship to Child: _____ Effective Date: _____

Insurance Co. Address: _____ Tel: _____

_____ Employer: _____

_____ Address: _____

City, State

Assignment of Benefits: I hereby assign, transfer and set over to the Westchester County Department of Health, monies and or benefits to which I may be otherwise entitled to from my health insurance carrier, Governmental agencies or others who are financially liable for my child's medical care sufficient to cover the costs of care and the treatment rendered to my child. I also understand that I will not incur any out of pocket expenses for deductibles, and co-pays when insurance policies are accessed for payment of Early Intervention services. I also understand use of third party insurance for payment of Early Intervention services will not be applied against lifetime or annual limits specified in my insurance policy, if such policy is subject to New York State law and regulation. Should my health insurance policy not be subject to New York State law and regulation, I understand that the WCDH will seek reimbursement for services rendered to my child provided that in doing so, any payment for Early Intervention services will not be applied against lifetime or annual limits specified in my insurance policy. I also understand and agree that should I receive any payments from my health insurance carrier to cover the costs of Early Intervention services provided through the WCDH that I will endorse and forward such payments directly to the WCDH at the address below.

Please make check payable and mail to:

Westchester County Department of Health
145 Huguenot Street, 8th Floor
New Rochelle, New York 10801
Attention: Children with Special Needs

Parent / Insured Signature: _____ Date: _____

Release of Information: I authorize Westchester County Department of Health to receive and release to third parties who may be responsible for payment for my child's Early Intervention services any such information as maybe necessary for the completion of financial obligations. I understand that all transactions will observe strict confidentiality. This release of information may be modified or cancelled at any time upon written notification to the Westchester County Department of Health.

Parent / Insured Signature: _____ Date: _____