



# Child Development Watch Policy Manual



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## Purpose

This document describes the Delaware framework of the coordinated early intervention system for infants and toddlers with disabilities and/or developmental delays and their families. The manual is based on the participation of Delaware in Part C of the Individuals with Disabilities Education Act (IDEA).

The Birth To Three Early Intervention System is designed to assure early intervention services. All components of the system comply with policies under Part C of IDEA. (See Appendix A page 25).

## Overview

The Birth to Three Early Intervention System refers to the entire system of early intervention services throughout Delaware (See Flow Chart page 47). The guiding principles are:

**Family-centered focus** - Delaware is committed to strengthening and supporting families, sensitivity to the family's right to privacy, and respect for multicultural preferences. As the primary influence in the child's life and the most valuable source of information about the needs of the child and family, family members are key participants in each step of early intervention design and delivery. A critical function of service providers should be to enhance and build the confidence and competency of the family so that the family can support their child's development throughout the day as natural learning opportunities occur.

**Integration of services** - The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services and supports should be planned using a collaborative, multidisciplinary, interagency approach. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.

**Universal application** - Families of infants and toddlers with disabilities or developmental delays in all areas of the state should receive comprehensive, multidisciplinary assessments of their young children, ages birth through 36 months, and have access to all necessary early intervention services and supports.

**Cost effectiveness** - The system maximizes the use of third party payment and avoids duplication of effort. Initial evaluation for eligibility and service coordination are provided at no cost to the family. Sliding fee scales may be used when appropriate so that families pay for services based on their ability to do so.

**High quality services** - Service should be provided at the highest standards of quality, with providers being required to meet appropriate licensing and credentialing guidelines.

The Birth to Three Early Intervention System has the responsibility to implement the many components of Part C of IDEA. These may include:

- Assuring compliance with the State's definition of developmental delay
- Developing and updating a central directory of information
- Providing timetables for serving eligible children
- Conducting public awareness
- Providing a child find system
- Conducting evaluation and assessment
- Developing an individualized family service plan
- Developing a comprehensive system of personnel development and personnel standards
- Developing procedural safeguards
- Determining lead agency designation and responsibility
- Developing a policy for contracting
- Ensuring a procedure for timely reimbursement of funds
- Providing data collection

The Department of Health and Social Services (DHSS) is the lead agency in Delaware for Part C under IDEA. The Division of Management Services (DMS) has the administrative responsibility for the Part C Birth to Three Early Intervention System. The Birth to Three office:

- Oversees funding, coordinates training, and provides technical assistance and management to support the system
- Coordinates resource materials, and public awareness information and activities
- Maintains federal and state laws, policies and guidelines, and monitors for implementation

The Division of Public Health (DPH) within DHSS has the operational responsibility for Child Development Watch (CDW), the program that carries out Part C in Delaware (See Appendix B page 48). Child Development Watch is responsible for:

- Identification of potential eligible children and their families
- Service coordination for eligible families
- Evaluation for eligibility and family assessment
- Developing and maintaining the Individualized Family Service Plan
- Referring for service provision
- Preparing for and carrying out transition

Child Development Watch is a multi-agency program. Team members include professionals from DPH, DMS, the Division of Developmental Disabilities Services (DDDS), and the Division for the Visually Impaired (DVI) within DHSS; the Division of Family Services (DFS) within the Department of Services for Children, Youth and Their Families (DSCYF); the Department of Education (DOE) and the family. The Interagency Agreement for the Delaware Early Intervention System under Part C of the Individuals with Disabilities Education Act specifies the roles and responsibilities of the participating agencies and provides guidance (See Appendix A page 47). CDW works collaboratively with Christiana Care Health

System and the Alfred I. duPont Hospital for Children, as well as other public and private facilities and agencies. The family and the child's primary care physician are full team members.

## **Mission**

The mission of Child Development Watch is to enhance the development of infants and toddlers with disabilities and/or developmental delays and to enhance the capacity of their families to meet the special needs of these young children. This mission has been adopted by the Interagency Coordinating Council and Delaware Health and Social Services.

Child Development Watch is part of the comprehensive, coordinated early intervention system that empowers families and provides resources to enable children to reach their maximum potential. The system provides long-term benefits to children, families and the Delaware community. Such an effort reflects the national and state goal for "Education 2000" that all children start school ready to learn.

## **I. Community Outreach and Identification**

Infants and toddlers with a disability and/or developmental delay are identified through various activities, which include Child Find, Public Awareness, Early Identification and Screening and Central Intake.

### **A. Child Find**

Child Find ensures that all infants and toddlers in Delaware who are eligible for services under Part C are identified, located and evaluated. These activities are coordinated across agencies. The Integrated Services Information System (ISIS) is in place to track which children are identified as potentially eligible for early intervention. Once a child is identified, the referral is assigned to a service coordinator within two working days.

### **B. Public Awareness**

Public awareness provides information to the general public about the Child Find system. Information is provided to primary referral sources such as families, hospitals, physicians, social service agencies, childcare programs, education agencies, and other professionals. Information is provided through brochures, pamphlets, the *Growing Together Portfolio*, the *Family Guide*, a public service announcement, press releases, a video, and the *Central Directory of Services for Young Children with Special Needs*.

### **C. Early Identification and Screening**

Screening activities help to identify children with disabilities and/or developmental delays and usually are conducted by the primary care provider and/or social service agencies. The screenings are performed with reliable and valid procedures that identify children in need of further evaluation. With parental consent, the screening information is shared with Central Intake as a referral to Child Development Watch.

## **D. Central Intake**

Central Intake is located within the Division of Public Health.

For New Castle County  
2055 Limestone Road  
Wilmington, DE 19808  
(302) 995-8617 or (800) 671-0050

For Kent and Sussex Counties  
18 North Walnut Street  
Milford, DE 19963  
(302) 422-1335 or (800) 752-9393

Referrals are taken on a standard referral form and information is entered into ISIS. Central Intake staff has access to multiple databases for verification of information and avoidance of fragmentation or duplication of services. Central Intake staff obtains complete and accurate information from the referral source to assist with the assignment of service coordination.

## **II. Personnel**

In Delaware, personnel in early intervention are expected to meet the highest requirements that apply to their profession or discipline. Please refer to the Matrix of Personnel requirements for state of Delaware (See Delaware Personnel Standards and Guidelines Matrix page 77).

As an interagency program, Child Development Watch has participating staff from various state agencies and private providers. A Clinic Manager at each location is responsible for day-to-day supervision of all staff at their location. For shared staff, Interagency Agreements explain their duties related to their home agency and their duties related to CDW. Clinic Managers support the performance review process for the home agency. The Division of Public Health is responsible for program implementation and provides administrative guidance when flexibility is not possible in personnel issues.

A new CDW staff member is provided on the job training and supportive coaching. CDW provides ongoing professional development through funded statewide trainings, on site workshops and participation in conferences. Training calendars and events are coordinated with provider partners to facilitate sharing of resources and to increase participation. For CDW staff, day-to-day supervision and support is provided by the Clinic Manager or designee. Principles of active listening, mutual respect and coaching are tenants of supervisory practice. Supervisors are expected to provide support to direct service personnel as required.

### **III. Service Coordination**

Service Coordination begins with the activities carried out by a Service Coordinator to assist the family in determining the eligibility of their child for Child Development Watch. The Service Coordinator assists the family in understanding the CDW program and their rights and procedural safeguards (see Appendix C). The Service Coordinator supports the family's role as the primary influence in the life of their child and as an integral team member. As the child is determined eligible, the Service Coordinator helps the family understand the process and the findings. When the child's needs are determined, the Service Coordinator helps the family understand these needs as they relate to daily life and helps the family understand their role in meeting these needs. The Service Coordinator helps the family determine their resources and strengths which would enhance their child's natural learning opportunities. The Service Coordinator assists in determining family priorities and obtaining the supports needed for families to participate as fully as desired in the development of their child.

Each child and family eligible for Child Development Watch will be provided a Service Coordinator who is responsible for coordinating all supports and services across agency lines. This person serves as a single point of contact in helping parents to understand and obtain the services and assistance they need.

#### **A. Specific service coordination activities include:**

1. Coordinating the performance of assessments and evaluation for eligibility
2. Developing with the family their priorities, concerns and resources
3. Facilitating and participating in the development, review, and evaluation of individualized family service plans (IFSP)
4. Assisting families in determining their active role in the plan
5. Assisting families in identifying available service providers
6. Coordinating and monitoring the delivery of available services
7. Informing families of the availability of advocacy services
8. Coordinating with medical and health providers
9. Facilitating the development of a transition plan to preschool services, as appropriate

Service Coordination assignment occurs when the child is referred through Central Intake to Child Development Watch. Service Coordination assignment is made within two working days from the receipt of the referral to Central Intake.

Since family empowerment is a desired outcome, the Service Coordinator works with the family to enhance the family's capability of negotiating service systems and obtaining resources in response to family needs. The activity of service coordination should strive to enhance the family's ability to coordinate their own services.

The Service Coordinator must meet the requirements for their discipline, including any licensure or certification standards that make one eligible to practice in Delaware. Service Coordinators are expected to complete 15 hours of Child Development Watch Service Coordination Training and required periodic updates.

## **B. Core competencies of Service Coordinators are:**

1. Sharing a family-centered philosophical framework for service coordination
2. The ability to collaborate with families
3. The ability to demonstrate cultural competence
4. The ability to plan interventions with families
5. The ability to collaborate with professionals
6. An understanding of the roles and responsibilities of the service coordinator
7. Knowledge of federal and state laws and policies that apply to early intervention
8. Knowledge of resources, services, supports and payment systems for early intervention
9. Skill in accessing resources, services and supports in a manner that helps families and encourages the self-sufficiency of the family
10. The ability to monitor and evaluate the implementation of services and supports
11. Knowledge of and skill in child and family advocacy

The service coordination assignment may change during the time the child is eligible for Child Development Watch. The service coordination assignment may change when the child and family's needs may better be served by a different professional on the team. For example, a child's medical condition stabilizes and improves, but the family's social needs require more expertise and the Service Coordinator changes from a nurse to a social worker. In addition, service coordination may change based upon the request of the family.

## **IV. Evaluation and Assessment**

### **A. Definitions of Evaluation and Assessment**

"Evaluation" means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for participation in early intervention services. This includes determining the status of the child in each of the developmental domains.

"Assessment" means the ongoing process used by appropriately qualified personnel throughout the period of a child's eligibility to identify:

1. The child's unique strengths and needs and options, such as services, appropriate to meet those needs
2. The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability and/or developmental delay

### **B. Scope of the Evaluation for Eligibility**

An evaluation to determine eligibility for early intervention services includes:

1. A review of pertinent records related to the child's current health status and medical history
2. An evaluation of the child's level of functioning in each of the following areas of development:
  - a. Physical (including vision & hearing)

- b. Cognitive
  - c. Communication
  - d. Social or emotional
  - e. Adaptive/ Self Help
3. A determination of the unique needs of the child in terms of each of the five developmental areas including the identification of supports and services appropriate to meet those needs
  4. A determination of the resources, priorities, and concerns of the family related to enhancing the development of the child

### **C. Team Composition**

The assessment of each child shall be conducted by a multidisciplinary team of qualified personnel trained to utilize appropriate methods and procedures for assessing infants and toddlers. The multidisciplinary team shall include the family. The Service Coordinator may be one of the qualified personnel.

Multidisciplinary team members may include the following qualified personnel:

1. Audiologists
2. Family Therapists
3. Nurse/Nurse Practitioners
4. Nutritionists
5. Occupational Therapists
6. Orientation and Mobility Specialists
7. Pediatricians and other physicians
8. Physical Therapists
9. Psychologists
10. Social Workers
11. Special Educators
12. Speech Language Pathologists

The team may also include an interpreter or a person familiar with the child and family's cultural background.

### **D. Evaluation Measures**

The multidisciplinary evaluation team shall use appropriate procedures and activities to determine a child's eligibility to receive early intervention. Multiple sources of information shall be used in the assessment process.

Evaluations shall be administered in the child's native language or other mode of communication unless it is clearly not feasible to do so. Evaluation materials and tools shall reflect respect for cultural values and lifestyles. Any evaluation procedure or material shall be selected and administered so as not to be racially or culturally biased.

Evaluation tools may include:

1. Standardized tests
2. Rating scales
3. Developmental profiles
4. Other instruments and tests that meet acceptable professional standards
5. A review of pertinent records related to health status and medical history
6. Clinical judgment of the professionals using parental input and opinion
7. Observations of the child including those made by the family

## **E. Eligibility Criteria**

There is no financial eligibility criteria for children and families participating in Part C. Infants and toddlers birth to three years of age with a disability and/or developmental delay are eligible for early intervention provided through Child Development Watch. Children are eligible based on an established condition, a developmental delay or by clinical judgment.

1. Established Condition - an established condition is one with a high probability of developmental delay including, but not limited to the following:
  - a. Chromosomal Anomaly
  - b. Genetic Disorder
  - c. Severe Infectious Disease
  - d. Neurological Disorder
  - e. Congenital Anomaly
  - f. Sensory Disorder
  - g. Severe Adjustment, Socio-Affective and Other Atypical Disorder
  - h. Severe Toxic Exposure
  - i. Medically Fragile
  - j. Chronic Medical Illness
  - k. Low Birth Weight/Small For Gestational Age
  - l. Growth Deficiency

The presence of an established condition must be confirmed by certified professionals. A multidisciplinary assessment, including available current evaluations, is required to develop the Individualized Family Service Plan (IFSP).

Entitlement under the definition of established condition continues as long as the specific established condition exists (within Part C age limits). If at the time of a follow-up eligibility evaluation it is found that successful intervention has resolved the established condition, Part C entitlement based on that definition would end. Such a child may be entitled to Part C under a developmental delay criteria, or clinical judgment; however, a new eligibility determination would be required.

Certain established conditions have life-long effects such as a Chromosomal Anomaly. It is the responsibility of the Service Coordinator to work closely with the family and the multidisciplinary assessment team to determine which early intervention services are needed for an individual child. It is possible that a specific child with an established condition is developing at a normal rate, and there are no early intervention services identified as needed.

An IFSP would be developed reflecting that no services are currently needed with a review scheduled in at least six months.

2. Developmental Delay - a developmental delay is a 25% delay in one or more of the following domains: physical, cognitive, communication, social/emotional or adaptive. Verification shall be determined by a multidisciplinary team based on substantiation of a significant difference between the age expected level of development (based on gestational age) and current level of functioning.
3. Clinical Judgment - the multidisciplinary team determines the child's eligibility with written justification included in the child's evaluation report.

Children in Delaware who are Deaf or Hard-of-Hearing, Visually Impaired, Deaf/Blind or Autistic are entitled to FAPE (free, appropriate public education) from birth. The services provided to these children are referred to as "Birth Mandate" under Part B of IDEA. These children are entitled to Part C early intervention services birth to three years of age as well as to Part B services. These children have a dual eligibility for Part C and Part B. When a child is found to have one of these conditions, a referral is made to the child's School District for determination of Part B eligibility. (DOE Administrative Code <http://www.state.de.us/research/AdminCode/Education/Frame.htm> Title 14, Delaware Administrative Code, Education, 925 Children with Disabilities: 4.2 Definitions and General Eligibility/Exit Criteria)

## **F. Ongoing Evaluation/Assessment**

Part C eligible children will receive an annual, five-domain evaluation for the determination of continued eligibility. An assessment tool will be used to determine a quantitative as well as a qualitative measure. The assessment determines the current level of functioning for the child, facilitates writing the annual IFSP and provides input for transition planning. The child should have ongoing assessments including a determination of the current needs at least every six months. Assessments should be completed more frequently if indicated by the child's needs.

The overall goals of the child assessment process are to identify:

1. Current abilities and needs of the child
2. Intervention strategies that are appropriate and take into consideration the constantly developing, changing child

Because the assessment is an on-going process and the IFSP reflects this, the IFSP becomes a dynamic document that will be frequently modified based upon the changing status of the child. The child assessment process requires frequent updates with the family. With parental permission, information from the child needs assessment may be shared as part of the IFSP process.

## **G. Identification of Family's Resources, Priorities and Concerns**

Family concerns, priorities and resources are integrally related to enhancing the development of the child. Determination of these strengths and needs is an ongoing process that begins within 45 days of the consent for treatment and prior to development of the IFSP. Although participation in the family assessment process is voluntary the family's concerns, priorities, and resources, as related to the development of the child, provide direction for the IFSP.

The assessment process:

1. Is conducted by personnel trained to utilize appropriate methods and procedures
2. Is based on information provided by the family through a personal interview
3. Incorporates the family's description of its strengths and needs related to enhancing their child's development

The family assessment should begin prior to the preparation of the IFSP and within the 45 days period between the consent for treatment and the preparation of the IFSP. However, the family assessment, like the child assessment, is an ongoing process. The family assessment process can and should continue throughout the duration of contact with the family and child.

Whenever possible both parents and/or any significant others (e.g. grandparents, siblings) should participate in the family assessment process. Because many areas may be involved in this assessment, the process may take several sessions. These sessions can be conducted by telephone, in the home, at the CDW site, or at any other location or means convenient to the family. In addition, the family assessment like the IFSP can be updated at any time.

Based upon the preference of family and the relationship between the family and the Service Coordinator, the family assessment may be done using an informal personal interview or a formal questionnaire. Sensitivity to family preferences is fundamental in determining the most appropriate interactive approach. The family assessment should always be completed in a non-judgmental manner. It should be directed by the family's style and priorities. The family assessment provides a means for the Service Coordinator to begin to establish a trusting and respectful relationship with the family.

General topics in the family assessment include:

1. The family's concerns for their child
2. The family's dreams for their child
3. What the family feels it needs in order to help their child
4. What the family members see as their strengths, their support systems, and their own resources
5. Available resources
6. Family supports
7. Daily routines

Since the family assessment clarifies the concerns, priorities and resources of the family, it forms a natural foundation for the IFSP. Families may choose to share information from the family needs assessment to be a part of the development of the IFSP.

## **V. IFSP**

The development of the IFSP is provided at no cost to the parents. Under the Part C federal mandate, the IFSP must be completed in forty-five (45) calendar days. This time period begins when the parent signs the Child Development Watch Part C consent form.

The IFSP is based on the clinical assessment of functioning in the five developmental domains and the family's concerns, needs, priorities and resources that may influence the child to improve developmental outcomes. Whereas the multidisciplinary evaluation is the "one point in time" series of tests or procedures used to determine initial or continuing eligibility for early intervention services, assessment is the continual process used to determine the evolving and changing needs of a child. Assessment is an on-going process that occurs before, during, and after the evaluation process. Assessment combines information across settings among all service providers in order to obtain a more complete picture of the abilities and needs of the child and family. It is the responsibility of the professional team working with the child to share information that contributes to the assessment process.

The IFSP is designed to address the child's developmental needs and the needs of the family as they relate to the child's development. The plan focuses on outcomes to meet these needs. Team members share ideas on how these outcomes can be met. Ideas may include things that the family and others important in the child's life can do to encourage development. At the IFSP meetings, methods to encourage development are discussed. These would include options such as early intervention services as well as other community resources and supports.

### **A. Purpose**

The purpose of the IFSP is to identify and organize formal and informal resources to facilitate families' goals for their children and themselves. The IFSP is a promise to children and families - a promise that their strengths will be recognized and built on, that their needs will be met in a way that is respectful of their beliefs and values, and that their hopes and aspirations will be encouraged and enabled. The IFSP is an evolving process of interaction, collaboration, and partnership between families and professionals. It is a living, fluid document that can be modified any time.

The definition of family is an individual process, dependent upon individual family variables. The family may include, but not be limited to birth parents, adoptive parents, guardians, siblings, aunts, uncles, grandparents, and significant others.

### **B. Preparation**

It is the responsibility of the Service Coordinator to assist the family in preparing for the IFSP meeting, including an orientation to the IFSP process prior to the initial IFSP team meeting. Participants in the IFSP are the family, assessment team, service provider, primary care physician, service coordinator and other persons the family may desire. The meeting will be held at a time and place convenient to the family. Written notice will be provided to the family and other participants at least 10 working days before the meeting.

The family is encouraged to participate actively in the discussion and is the primary decision-maker in the process of IFSP development. Parents are responsible for the final decision in determining whether they, their child, or other family members will accept or decline services.

Unique cultural characteristics and preferences of families should be taken into consideration in IFSP planning. The contents of the IFSP must be fully explained to the family and the family must sign the IFSP to indicate informed written consent before the provision of early intervention services.

### **C. Content**

The IFSP is primarily the family's roadmap for addressing the needs of their child. It is written in family friendly language and addresses the family's goals for their child. While the IFSP may also serve as a document for insurance or other purposes, the focus of the document must be that it is meaningful and comprehensive to the family.

The IFSP includes the following information:

1. Information about the child's status based upon professionally acceptable objective criteria including a statement of the child's present level of:
  - a. Physical development including vision, hearing, and health status
  - b. Cognitive development
  - c. Communication development
  - d. Social or emotional development
  - e. Adaptive development
2. Family information including a statement of the family's resources, priorities, and concerns related to enhancing the development of the child
3. Outcomes including a statement of the major outcomes expected to be achieved for the child and family, and the criteria, procedures and timelines used to determine:
  - a. The degree to which progress toward achieving the outcomes is being made
  - b. Whether modifications or revisions of the outcomes or services are necessary
4. Early intervention services including a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the stated outcomes
5. Other supports and services, to the extent appropriate, along with the steps that will be undertaken to secure those services through public or private resources

There are other services that a child or family need, but are not covered under Part C. The listing of these non-covered services does not mean that these services must be provided. By listing these services the IFSP provides a comprehensive picture of the child's early intervention, medical, and health needs which is useful to both the child's family and the Service Coordinator. It is also appropriate for the Service Coordinator to assist the family in securing non-covered services.

Routine medical services such as immunizations and "well-baby" care need not be included unless the child needs these services and the services are not otherwise available or being provided.

6. Dates and duration of services include the projected dates for completed referral to provider agencies, initiation of services and the anticipated duration of those services
7. The Service Coordinator is named on the IFSP. The Service Coordinator is responsible for assuring implementation of the IFSP and coordination with other agencies and persons
8. Transition plans to provide a smooth progression from CDW to school district or other services at age 3. The transition plan describes steps taken to facilitate the transition of the three-year-old child when exiting CDW to preschool services under Part B or other services (See Transition page 23)

**D. Required IFSP meetings include:**

1. The initial IFSP meeting that is held after the child has been evaluated for eligibility for the first time
2. Periodic IFSP review for a child and family is conducted every six months or more frequently if conditions warrant, or if the family requests such a review. The purpose of the periodic review is to determine:
  - The degree to which progress towards achieving the outcomes is occurring
  - Whether modifications or revisions of the outcomes or services is necessary

This review may be carried out by a meeting or by other means that is acceptable to the family and other participants

3. An annual meeting to evaluate the IFSP. The results of any current evaluations and any other information available from ongoing assessments of the child and family will be used in determining what services are needed

All IFSP meetings should be conducted:

- a. In a setting and at times that are convenient to families and mutually agreed upon. This could include evening meetings and might occur at the family's home or in another location that is comfortable to the family.
- b. In the native language of the family or other mode of communication used by the family.

Parents will be informed of their right to have family members or other advocates present at the IFSP meeting. The meeting arrangements will be made and written notice provided to the family and other participants 10 days prior to the meeting.

## **E. Interim IFSP**

There are two situations in which an Interim IFSP is needed:

1. When services must begin before a five domain evaluation for eligibility is completed; or
2. When an evaluation cannot be completed within 45 days due to exceptional circumstances, such as illness of the child

The Interim IFSP is intended to accomplish two specific purposes:

1. To facilitate the provision of services in the event the child has obvious immediate needs that are identified, even at the time of referral, such as when a physician recommends that a child with cerebral palsy begin physical therapy as soon as possible
2. To ensure that the requirements for the timely evaluation and assessment are not circumvented

The interim IFSP documents the reasons why an interim IFSP is necessary. The Interim IFSP is temporary.

The Interim IFSP includes:

1. The name of the Service Coordinator who will be responsible for the implementation of the IFSP and coordination with other agencies and persons
2. The early intervention services that have been determined to be needed immediately for the child and/or for the child's family
3. Documentation by the Service Coordinator, when appropriate, that the 45-day time requirement for completing the evaluation and assessment has not been met. Parental signature would indicate knowledge of, and agreement to the delay in completing the evaluation

## **VI. Service Provision**

Early intervention services are defined in Child Development Watch as services that are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development in their unique family culture. Services are based on the individual outcomes the IFSP is designed to achieve. Services are provided in natural environments identified by the IFSP team. Through the IFSP, the family is recognized as the primary interventionist for the child. To enhance this process, early intervention services are embedded into the daily routines of the child and family to the greatest extent possible for the individual child.

The purpose of early intervention is to support the family to develop confidence and competence to enhance the development of the child. Early intervention services are selected in collaboration with the family and are provided under public supervision by qualified personnel. Family members and other caregivers are encouraged to support the child's development spontaneously and as part of regular daily routines as natural learning opportunities occur.

The services are based on the child's IFSP and are provided through service provider agencies that maintain agreements with the Birth to Three office. Services are funded maximizing the use of third party payments and a system of payment by families including a schedule of sliding fees, as appropriate, and state and federal funds. No child is denied services due to inability to pay.

To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. These are settings in which natural learning opportunities occur. Natural environments are settings that are normal/natural settings for peers without disabilities. Natural environments are not created. Natural environments exist as the settings where peers without disabilities are located. Supports may be needed to add the child to the natural/normal setting, rather than to add peers to a setting created for children with special needs. The IFSP team would provide for these supports when developing the plan.

The Service Coordinator is responsible to ensure discussion of natural environments when service provision is addressed in the IFSP meetings. Careful discussion of the pros and cons of supports needed are documented as part of the decision-making process. When services cannot be provided in a natural environment, the IFSP team must develop a plan of the steps and supports needed to move services into a natural environment setting.

#### **A. General Role of Service Providers**

To the extent appropriate, service providers in each area of early intervention are responsible for:

1. Consulting with families, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services
2. Developing competence and confidence in families and other caregivers in the provision of services so that families can support the child's development during daily routines and activities
3. Participating in the multidisciplinary team assessment of the child and family
4. Collaborating in the development of the IFSP so that goals and outcomes are functional for the family and meet their priorities and concerns
5. Embedding services into the daily routines and activities of the child and family to support natural learning opportunities
6. Coaching families to support their child's development

#### **B. Role of the family**

As the primary interventionists, family members are participants in service delivery. The provider supports the family with coaching and training to enhance the natural learning opportunities that occur routinely and spontaneously in the child's life. Services are integrated into the family's unique culture of activities and routines.

Families decide how to integrate services into their lives. In some families, the family members will be the primary persons interacting with the child to enhance development. In other situations, the family may choose to have activities demonstrated to them or work with the other professionals in a team approach to meet the child's needs.

### **C. Early Intervention Services**

Early intervention services may include the following:

Please note that service coordination is not included as it is a service that all infants and toddlers receive through Child Development Watch.

#### **1. Assistive Technology**

Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified or customized, that is used to maintain, or improve the functional capabilities of children with disabilities. Assistive technology service means a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. These services include:

- a. The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment
- b. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices
- c. Selecting, designing, fitting, adapting, applying, maintaining, repairing, or replacing assistive technology devices; Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs
- d. Training or technical assistance for a child with disabilities or, if appropriate, the child's family
- e. Training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities

#### **2. Audiology**

- a. Identification of children with auditory impairment using a risk criteria and appropriate audiological screening techniques
- b. Determination of the range, nature, and degree of hearing loss and communications function, by use of audiologic evaluation procedures

- c. Referral for medical and other services necessary for the habitation or rehabilitation of children with auditory impairment
- d. Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services
- e. Provision of services for prevention of hearing loss
- f. Determination of the child's need for individual amplification including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of the devices

### **3. Family Training, Counseling, and Home Visits**

Services provided by social workers, psychologists, or other qualified personnel to assist the family in understanding the special needs of the child, and enhancing the child's development.

### **4. Health Services**

Services necessary to enable a child to benefit from the other early intervention services described in this section during the time that the child is receiving other early intervention services. Such services as:

- a. Clean intermittent catheterization, tracheotomy care, tube feeding, the changing of dressing or ostomy collection bags, and other health services
- b. Consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other early intervention services

**Health Services does not include the following:**

- a. Services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of the hydrocephalus)
- b. Services that are purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicines or drugs for any purpose)
- c. Devices necessary to control or treat a medical condition
- d. Medical - health services (such as immunizations and regular well baby care) that are routinely recommended for all children

### **5. Medical Services only for Diagnostic or Evaluation Purposes**

Services provided by a licensed physician to determine a child's developmental status.

## **6. Nursing Services**

- a. The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems
- b. Provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development
- c. Administration of medications, treatments, and regimens prescribed by a licensed physician

## **7. Nutrition Services**

- a. Conducting individual assessments in:
  - 1) Nutritional history and dietary intake
  - 2) Anthropometric, biochemical, and clinical variables
  - 3) Feeding skills and feeding problems
  - 4) Food habits and food preferences
  - 5) Developing and monitoring appropriate plans to address nutritional needs
  - 6) Making referrals to appropriate community resources to carry out nutrition goals

## **8. Occupational Therapy**

Services intended to address the functional needs of a child related to performance of self-help skills, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include:

- a. Identification, assessment, and intervention
- b. Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills
- c. Prevention or minimization of the impact of initial or future impairment delay in development, or loss of functional ability

## **9. Physical Therapy**

- a. Screening of infants and toddlers to identify movement dysfunction
- b. Obtaining, interpreting, and integrating information appropriate to program planning, to prevent or alleviate movement dysfunction and related functional problems
- c. Providing services to prevent or alleviate movement dysfunction and related functional problems

## **10. Psychological Services**

- a. Administering psychological and development tests, and other assessment procedures
- b. Interpreting assessment results
- c. Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development
- d. Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling

## **11. Transportation**

Providing transportation to a family as well as reimbursement for travel (e.g. taxi, common carrier or other means) and related costs (e.g. parking expenses) that are necessary to enable infants and toddlers with disabilities and their families to receive early intervention services.

## **12. Social Work Services**

- a. Making home visits to evaluate a child's living conditions and patterns of parent-child interaction
- b. Preparing a social or emotional developmental assessment of the child within the family context
- c. Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents
- d. Working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services
- e. Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services

## **13. Special Instruction (Early Childhood/ Special Instruction)**

- a. The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction
- b. Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan

- c. Providing families with information, skills, and support related to enhancing the skill development of the child
- d. Working with the child to enhance the child's development

#### **14. Speech-language pathology**

- a. Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills
- b. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills
- c. Provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills

#### **15. Vision Services**

- a. Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities
- b. Referral for medical or other professional services for the habilitation or rehabilitation of visual functioning disorders, or both
- c. Communication skills training, orientation and mobility training for all environments, visual training, independent living skills, and additional training necessary to activate visual motor abilities

### **VII. Transition**

Transition is the movement of a child and family from one program or environment into another. Soon after the family's entry into CDW, the service coordinator will begin the discussion about the eventual transition out of the program. Transition is a process, not a single event. Transition involves change for children, families, agencies and staff. Planning for the changes can help to ease the stress for everyone involved and will make the new program or setting more successful. Transition planning helps to assure continuity of programming and minimize family disruption. Families are an integral partner in the transition planning and supports, such as convenient scheduling, transportation and interpreter services, should be available to the family.

#### **The timeframes for exiting are specific:**

- Children who turn three between May 1 and August 31 have the option of remaining with CDW until the beginning of their school district's school year in the fall

- Children who turn three between September 1 and December 31 have the option of starting services through their school district at the beginning of the school year, or remaining in early intervention services until their third birthday
- Children who turn three between January 1 and April 30 and are eligible will transition from CDW to school district services on the child's third birthday

Some children exiting CDW may enter community preschool or local Head Start programs. Other families may choose to participate in community activities available for toddlers.

Some children may be eligible for preschool services provided by their local school district referred to as Part B or special education services. Families may choose to participate in these services. Regardless of the choice or combination – community preschool, Head Start, community activities, local school district services – transition planning facilitates the process for the child and family.

Transition planning identifies the current needs of the child and explores future options for addressing these needs when the child exits CDW. The transition plan provides details about what steps are needed and who is responsible for each step so that successful transitions can occur for the child and family.

The Service Coordinator is knowledgeable of many community resources and how to determine eligibility for Preschool (Part B) special education services. With parental consent, CDW children transitioning to school district services are referred to their school district six months prior to the child's third birthday or the date the child is eligible to begin Part B services. For children exiting at the beginning of the school year in the fall, referral would be made six months prior to the beginning of the school year in the child's school district.

Information required for a referral may include:

- A copy of the Child Development Watch referral form with the child's identifying information
- Results of the child's most recent developmental assessment
- A copy of the IFSP
- Pertinent therapy records
- Recent assessments from early intervention providers
- Any other information to determine and provide educational and related services

### **Transition Conference**

At least 90 days and no more than 180 days before the child is due to exit CDW the Service Coordinator schedules a transition conference in which a representative from the school district joins the family, the Service Coordinator, the service provider and others to develop the transition plan as required by federal regulations. It is required that notice of the transition conference be sent to the family and other participants 10 days prior to the conference. The purpose is to determine the child's needs, explore options to meet those needs and make a plan for the supports necessary to prepare for the transition. The participants will:

1. Discuss how the child is functioning currently
2. Review past and present services
3. Discuss the adequacy of those services in meeting the child's needs
4. Explore the options to meet the child's needs
5. Determine steps needed prior to starting school district or other services (such as immunizations, site visit, additional evaluations, etc.)

A transition conference does not determine the specific services or programs to be provided by the school district. A transition conference describes the child's needs, how the needs have been met in the past, explores options how to meet the needs in the future, and develops a plan of the steps to be taken by the family, Service Coordinator, school district representative, etc. to prepare for the change. A transition conference may also be an IFSP meeting since the Transition Plan is a part of the IFSP. If this is the case, only one notice needs to be sent. This notice of the transition conference also serves as the IFSP meeting notice. As required, this notice must be sent out to the family and other participants 10 days prior to the conference.

The Individual Education Plan (IEP) team determines eligibility for Part B services. The IEP team is composed of parents, a regular education teacher, a special education teacher or provider, and a representative from the school district who has the authority to commit resources from the school district. The parent may invite the CDW Service Coordinator to attend the IEP meeting. The IEP will state the child's eligibility, classification needs, and the goals and objectives to meet the needs. The final step in the planning is placement – the location where the goals and objectives written on the IEP are carried out.

# Appendix A

## Interagency Agreement for the Delaware Early Intervention System Under Part C of the Individuals with Disabilities Education Act

**DATE: October 2001**



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*Signatures*

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Cari DeSantis, Secretary Date  
Department of Services for Children, Youth & Families (DSCYF)

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Valerie Woodruff, Secretary Date  
Department of Education (DOE)

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Vincent P. Meconi, Secretary Date  
Department of Health & Social Services (DHSS)

## **Purpose Statement**

The purpose of this agreement is to ensure collaboration in the continuation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for infants and toddlers with disabilities and/or developmental delays who are eligible under Part C of the Individuals with Disabilities Education Act (IDEA). Part C of IDEA, which is administered by Delaware Health and Social Services, provides funding and management to support a statewide, comprehensive, coordinated system of early intervention services for infants and toddlers with disabilities and/or developmental delays and their families. Child Development Watch (CDW) carries out the operations of the Part C Birth to Three Early Intervention System. This system is designed to ensure the availability and accessibility of early intervention services for all eligible children and their families.

The agencies involved in this agreement are: The Department of Health and Social Services (DHSS) - including the Division of Public Health (DPH), the Division of Management Services (DMS), the Division of Developmental Disabilities Services (DDDS), the Division for the Visually Impaired (DVI), and the Division of Social Services (DSS) Medicaid Program; the Department of Education (DOE); and the Department of Services for Children, Youth and Their Families (DSCYF) - including the Division of Family Services (DFS) and the Division of Child Mental Health (DCMH).

This agreement specifies the roles and responsibilities of the participating agencies and provides guidance for its continuation. All parties to this agreement are referred to as agencies. Each agency was represented on the Interagency Agreement Task Force. The membership of the task force is included in Appendix A.

State departments have authority to manage the provision of services through contracts, grants, policies and procedures, or regulations. It is the intent of this agreement to ensure the following:

1. The continuation of an interactive, cooperative relationship at the State level which results in effective and efficient services and supports for eligible infants, toddlers and their families, and minimizes duplication of such services and supports.
2. Cooperative fiscal planning which will maximize utilization of available funds in providing services and supports to the eligible population of infants and toddlers with disabilities and/or developmental delays and their families.

## **Intended Outcomes**

It is agreed that the potential benefits from cooperation among the State departments include the following:

1. Availability of services for children and families;
2. Maximum utilization of funds and resources;
3. Increased coordination among Departments in order to minimize unnecessary duplication of effort;
4. Increased collaboration with respect to shared expertise and planning based upon priorities, resources and concerns identified by the families of eligible infants and toddlers;
5. Increased ease of access for families seeking services and supports from multiple systems; and
6. Increased satisfaction of families with respect to early intervention services and supports.

### **Vision To Guide Program Implementation**

The mission of this statewide effort is to enhance the development of infants and toddlers with disabilities and developmental delays, and to enhance the capacity and abilities of their families to meet the special needs of these young children.

A comprehensive, coordinated early intervention system that empowers families and makes available resources to enable their children to reach their maximum potential would provide long-term benefits to the children, their families and the Delaware community. Such an effort reflects the national and state goal that all children start school ready to learn.

Principles of the program:

- \* **Family-centered focus** Delaware has a commitment to strengthening and supporting families. As the primary influence in the child's life and the most knowledgeable source of information about the needs of the child and family, family members should be included in each step of service design and delivery. A key function of service providers is to enhance and build the capacity of the family to meet their own needs. Furthermore, the program must be sensitive to the family's right to privacy and to multi-cultural differences.
- \* **Integration of services** The needs of infants and toddlers and their families require the perspectives of various disciplines; thus, services should be planned using a collaborative, multidisciplinary, interagency approach. Services and supports should occur in settings most natural and comfortable for the child and family. The development of a natural system of supports within a family's community should be promoted at all times. Existing services and programs, both public and private, should be supported with appropriate linkages promoted.
- \* **Universal application** Families throughout Delaware with infants and toddlers with disabilities or developmental delays should receive comprehensive, multidisciplinary assessments of their young children, ages birth through 36 months, and have access to all necessary early intervention services.

- \* **Cost effectiveness** The system should maximize the use of third party payment, and avoid duplication of effort. When appropriate, families are expected to pay for the cost of services based on their ability to do so.
- \* **High quality services** should be provided at the highest standards of quality, with providers being required to meet appropriate licensing and credentialing guidelines.

**Authority**

The responsibilities and objectives delineated in this agreement are derived from the following federal legislation that requires collaboration with other related federal and state initiatives:

- .. Part B and Part C of the Individuals with Disabilities Education Act (IDEA), Amendments of 1997;
- Delaware Law to Amend Chapter 2 of Title 16 of the Delaware Code Subchapter II - Infants and Toddlers Early Intervention Program;
- .. Public Law 100-146, The Developmental Disabilities Assistance and Bill of Rights Act;
- .. Title XIX, Medicaid, of the Social Security Act;
- .. Title V, Maternal and Child Health Block Grant, of the Social Security Act;
- .. Title IV, Child Welfare, of the Social Security Act;
- .. The WIC Program - The Women, Infants and Children's *Special Supplemental Nutrition* Program;
- .. The Child Care and Development Block Grant and the Child Welfare At-Risk Child Care Program, both enacted under OBRA'90;
- .. The Head Start Act; and
- .. The Americans with Disabilities Act of 1990.

**Mutual Objectives**

It is agreed that each agency will support the attainment of the following mutual objectives:

1. To coordinate the provision of services and to ensure the availability of all necessary services to eligible children and their families;

2. To participate in the IFSP (Individualized Family Service Plan) process as needed for children and families with whom the agencies are involved;
3. To participate in and provide information, on a timely basis, to the state ISIS (Integrated Service Information System) data system, and to supply data on Part C eligible children so that accurate and unduplicated counts can be given to the U.S. Department of Education;
4. To participate in the design and provision of cooperative interagency and multidisciplinary training opportunities for parents and service providers;
5. To provide appropriate information to the Birth to Three Central Directory of services;
6. To collaborate on and participate in Birth to Three public awareness activities;
7. To include parents as active participants in policy development, program development and service provision for their child with disabilities;
8. To provide early intervention services in accordance with Delaware Child Development Watch Policies and Procedures and Child Development Watch Standards; and to assure the quality of service providers and service delivery in providing comprehensive early intervention to Part C eligible children;
9. To support participation in and representation on the State (ICC) Interagency Coordinating Council, committees and task forces by their appropriate staff; and to consider the recommendations of the ICC;
10. To develop and support joint budget requests to the state legislature to ensure the maximum utilization of existing resources and to assist in securing additional state resources as needed;
11. To develop and support policies to ensure services in natural environments, to the maximum extent possible;
12. To follow the procedural safeguards developed for the Part C Birth to Three Early Intervention System under Part C of IDEA;
13. To share information in accordance with confidentiality requirements and in accordance with the Delaware state interagency agreement related to confidentiality;
14. To support development and use of appropriate interagency forms and procedures;
15. To collaborate on the development of policies to ensure that traditionally underserved groups including minority, low-income, and rural families are meaningfully involved in the continued planning and implementation of the Birth to Three Early Intervention System and that these families have access within their geographic areas to culturally sensitive services;
16. To support policies and procedures for a comprehensive system of personnel development.

## **Agency Responsibilities**

The ultimate responsibility for the Part C Birth to Three Early Intervention System rests with the lead agency, the Department of Health and Social Services with the advice and assistance of Delaware's Interagency Coordinating Council. However, each agency agrees to continue existing responsibilities already under their agency and to participate in the overall coordination and implementation of services. The following narratives describe the specific roles and responsibilities currently held by each agency.

### **DEPARTMENT OF HEALTH & SOCIAL SERVICES**

#### ***Services in the Division of Management Services***

The Division of Management Services (DMS) is the administrative office for the Part C Birth to Three Early Intervention System under IDEA (Individuals with Disabilities Education Act). This office provides funding, coordination of training, technical assistance and management to support the statewide, comprehensive, coordinated system of early intervention services for infants and toddlers with disabilities and/or developmental delays and their families. This office is responsible for developing and coordinating resource materials, public awareness information and activities, maintaining federal guidelines and securing federal and state funding.

#### ***Services in the Division of Developmental Disabilities Services***

The Division of Developmental Disabilities Services (DDDS) offers services as part of Child Development Watch to any child, birth to three and their family, who is at extremely high risk for developmental delay or with an established condition, as outlined in the Memorandum of Understanding approved between DDDS, DMS and DPH. These services, provided by Developmental Nurse Specialists, include family service coordination, neuro-developmental assessment, intervention for developmental and/or medical problems, and facilitation of the role of parents as primary advocate and teacher for their child. The Developmental Nurse Specialists also serve as consultants to other service coordinators, physicians, and public and private agencies.

#### **Respite**

DDDS offers different types of respite experiences depending on the needs of the individuals and family requesting the service.

Respite is a term used to identify a situation in which an individual who meets the criteria of the Division is given a period of temporary relief or rest. They experience a social/recreational experience in the community while their family is afforded a period of relief from the daily care responsibilities. The length of the respite is pre-determined according to the family's need and the availability of resources.

Respite mainly takes place in the private home of a DDDS screened and qualified provider. However, a provider may come to the family's home to care for the individual or the family may choose their own provider. Any infant, child or adult who meets the criteria of the Division and who is a resident of Delaware is eligible for the program. Requests for services may be made through the Intake Coordinator or the regional respite coordinator of DDDS.

### Residential Services

Under the Omnibus Budget Reconciliation Act of 1987 (OBRA), DDDS will work with a family who is referring a child for long-term care outside the home. DDDS is responsible for determining if the child is eligible for placement, could benefit from specialized services and is nursing home appropriate. DDDS would provide case management, which advocates for services the child needs and coordinates the services the child receives. For children under three, the OBRA case manager and the Child Development Watch service coordinator work together to provide services.

### ***Services in the Division of Social Services Medicaid Program***

Delaware Medicaid pays for medically necessary services that are ordered by a physician for persons determined to meet the Medicaid eligibility requirements. Services for which reimbursement is available are those that are approved in the State Plan for Medical Assistance. These services may be provided as part of the basic benefit package of the Diamond State Health Plan (Medicaid managed care), or they may be provided through the Medicaid fee-for-service system.

Under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), reimbursement for non-state plan covered services may be obtained if the services are medically necessary, are the result of an EPSDT screen, and are allowable under Section 1905(a) of the Social Security Act. Reimbursement may require prior authorization from a managed care organization or from the Medicaid Program.

Medicaid eligibility determinations are made by the Division of Social Services and, in the case of Supplement Security Income (SSI) recipients, the Social Security Administration. Recipients are eligible as "categorically needy". Medicaid will not pay for care or services rendered before the beginning date of eligibility or after the end date of eligibility.

By Federal regulation, Medicaid is the payer of last resort. If a recipient has access to other health insurance, that payment source must be utilized before Medicaid reimbursement can be made. The existence of Part C funds notwithstanding, Medicaid is obligated to pay for allowable services covered through the EPSDT Program.

Medicaid is required to establish interagency collaborative activities with related agencies and programs in order to address the goals of:

- Containing costs and improving services by reducing service overlaps or duplications, and closing gaps in the availability of services;
- Focusing services on specific population groups or geographic areas in need of special attention; and
- Defining the scope of the programs in relation to each other.

Agencies and programs with which Medicaid is required to coordinate include Title V programs, state agencies responsible for administering health services and vocational rehabilitation services, Head Start, WIC, school health programs (including IDEA), and social services programs under Title XX. Linkages with these programs may be made via managed care organizations or directly with the Medicaid Program.

Federal regulations permit Medicaid to pay for services provided to Medicaid beneficiaries under Title V and for those Medicaid allowable services covered in an IEP or an IFSP. Medicaid allowable services prescribed in an IFSP are deemed to be medically necessary when authorized by the Primary Care Physician of a child eligible for the Child Development Watch program.

### ***Services in the Division of Social Services Delaware Healthy Children Program***

Children in families with incomes too high to qualify for Medicaid may qualify for the Delaware Healthy Children Program (DHCP). The DHCP is a low cost, non-Medicaid, non-entitlement health insurance program for uninsured children under age 19. Children who have been uninsured in the six months prior to application and whose family income is between 100% and 200% of the federal poverty level may be eligible for the Delaware Healthy Children Program. Children in families with income less than 100% of the federal poverty level must be enrolled in Medicaid. The DHCP allows for some income disregards, so families slightly over the limit should still apply.

Families can file an application by calling 1-800-996-9969. Proof of income, child's age, and social security number are required. The application process can all be done by mail.

There are low cost monthly premiums based on family income. Premiums are \$10, \$15, or \$25 per family per month (not per child). Children are guaranteed 12 months of coverage if premiums are paid. There are incentives to prepay premiums. There are no co-pays or deductibles except for a \$10 co-pay for inappropriate use of the emergency room.

Families may choose one of two managed care organizations to provide comprehensive health benefits that include: well-baby and well-child checkups, immunizations, hospital care, physician services, lab, x-rays, medical equipment, therapy services, emergency ambulance services, and limited mental health services. Prescription drugs and more extensive mental health services are provided as a wraparound benefit. Because the DHCP is not an entitlement program, there is no EPSDT mandate as there is in the Medicaid program. Reimbursement of services may require prior authorization from the child's managed care organization.

The Division of Social Services makes eligibility determinations for the Delaware Healthy Children Program. The monthly premium must be paid for coverage to begin.

### ***Services in the Division for the Visually Impaired***

The Division for the Visually Impaired (DVI) provides diagnostic, educational, service coordination and social work services for infants suspected or diagnosed of having severe visual impairment. Upon referral, DVI collects medical information and conducts functional visual evaluations. A representative from Division for the Visual Impaired may serve as the qualified professional on the team determining initial eligibility.

Other services provided to infants birth to three include:

- Direct educational intervention such as vision stimulation, instruction in self-help skills, tactile stimulation, and pre-Braille;

- Family counseling relative to the visual handicap;
- Orientation and mobility on a pre-skill level; and
- Parent training in areas related to developmental skills and blindness.

### ***Services in the Division of Public Health***

The Division of Public Health (DPH) is the official health agency of the state with a broad mission “to protect and enhance the health of the people of Delaware”. This mission is carried out through health surveillance, planning, policy and standard setting, program evaluation and health care system development to assure adequate service accessibility. DPH partners with primary care providers and community health care providers such as community health centers to augment the continuity and comprehensiveness of the community services and to enhance the early case finding/outreach and prevention aspects of the services. DPH directly provides clinical services related to infectious disease screening, diagnosis, treatment, contact tracing and service coordination for all citizens regardless of income or insurance status (i.e., Tuberculosis, STD). Other clinical services provided by DPH include dental services for Medicaid-eligible children and immunizations for uninsured and underinsured children. It also acts as an alternative source of community based care for sensitive services for which some individuals seek health care outside of the traditional private sector or separate from their medical home (i.e. family planning, HIV counseling and testing). Public Health’s clinical services are provided at multiple State Service Centers strategically located throughout the state. DPH also provides home visit assessments and on-going intervention services to pregnant women at risk (Smart Start program) and enhanced care for children (Kids Kare program). DPH does have a contract with the Medicaid Managed Care Organizations for reimbursement of some of the clinic and home services. DPH coordinates with primary care providers for any aspects of medical or clinical care that it provides. Many DPH services are offered through collaborative arrangements with other public and private health care providers such as the Christiana Care Health System and the duPont Hospital for Children.

*Child Health Services:* DPH promotes a primary medical home with a primary-care physician (PCP) for all children in Delaware. However, realizing that this is ideal is not always achievable, DPH provides child health services directed toward health promotion and disease prevention in order to reduce childhood mortality and improve health status of Delaware's children. DPH provides these services to those children who do not have or are unable to utilize a PCP. Child Health Clinic Services place priority on a number of health promotion and disease prevention activities. One of the priorities is well child health assessment using screening guidelines developed for the EPSDT program and a continuous well child program with emphasis on health counseling, education, and routine immunizations. Another priority includes the evaluation, treatment and/or referral of significant health problems identified by parent or screening procedures.

DPH provides immunizations to clients of all ages and lead screening for children birth to five years of age. Billing for these services is based on a sliding scale fee; no one will be refused service due to inability to pay. Children who are covered by Medicaid and other third party insurers are encouraged to obtain this service through their primary care provider. This service also includes health education and parenting education and is one component of Child Find under the Birth to Three Early Intervention System.

*Child Development Watch:* DPH has the operational responsibility for Child Development Watch (CDW) that screens, assesses, determines Part C eligibility, provides family service coordination and ensures implementation of the Individualized Family Service Plan (IFSP) process. CDW works collaboratively with the Christiana Care Health System and the duPont Hospital for Children. In addition to DPH personnel, team members include staff from the Division of Developmental Disabilities Services (DHSS), Division of Family Services (DSCYF), and Department of Education (DOE). Each child's primary care physician is also a full member of the team.

*Special Supplemental Nutrition Program for Women, Infants and Children (WIC):* This is a federally funded supplemental food and nutrition program that benefits infants, children up to age five and pregnant, breastfeeding, and post-partum women with low to moderate incomes. WIC provides nutrition education, nutritious foods, and referrals to other health care programs. Program eligibility criteria include: age, income, and nutritional risk such as anemia, inadequate diet or abnormal weight.

*Children's Specialty Services:* DPH offers diagnostic and short-term treatment services for some special needs for children especially in Kent and Sussex Counties where geographic access is limited. These services include neurology, cardiac, genetics, audiology, and ophthalmology. The genetic services include genetic counseling for the family and special formulas for children with inborn errors of metabolism such as PKU. DPH participates as part of the cleft palate/oral-facial clinical team in conjunction with duPont Hospital for Children. The oral facial clinic covers orthodontic treatment if needed.

*Public Health Nurse Home Visit Services:* Public Health Nurses provide home based nursing evaluations, health education, family support and service coordination to families at high risk for poor health status including mothers with high-risk pregnancies (Smart Start Program) and families with at risk children (Kids Kare Program). All families referred are eligible within the limits of service capacity. Medicaid is billed when available. At some sites, the team may include medical social workers, psychology consultation, and nutrition consultation.

*Kids Kare:* DPH provides a multi-disciplinary support program for vulnerable families with children who have been found to be biologically, nutritionally, psychosocially, or environmentally at risk, factors that are highly correlated with a probability of delayed development. A care plan is developed based on the needs of the family determined by risk factors identified at an initial home visit assessment. The families receive support, teaching and coordination of services in their home from Public Health nurses, social workers, and /or nutritionists. Services are available for low-income families who have Medicaid or who are uninsured. Children up to the age of 21 may be referred but priority is given to those children who are between the ages of birth to six. Children referred to this program may show signs of developmental delay but do not meet the eligibility requirements for the Part C Early Intervention System.

*Smart Start:* is a perinatal program, which addresses the education and support needs of the mother, prenatally, and her infant up to 90 days postpartum. Infants born to mothers not enrolled in Smart Start would receive care through Kids Kare, not Smart Start. DPH is one of several providers of this service to Medicaid women. DPH will provide the service to women who are uninsured.

*The Home Visiting Program:* This program offers all first-time parents an initial post partum/newborn home health nurse visit linked to continuing parent education and support services as needed and available. The program is administered by DPH and became available statewide on October 1, 1995. Parents enroll in this program when they sign consent after delivery. DPH has contractual arrangements with home care

agencies to reimburse for visits to uninsured or underinsured families. Families with insurance may receive this visit as a benefit of their coverage. DPH Community Services Team also provides home visiting services to high risk families enrolled in the program. The following agencies partner with DPH and offer ongoing parent education and support to interested families: Department of Services for Children, Youth and Their Families Office of Prevention and Early Intervention; Department of Education, the University of Delaware Department of Individual Family Studies, CHILD, Inc., Children and Families First; Parents as Teachers; and Perinatal Association. In addition to home visits, DPH provides coordination for families enrolled in the program through tracking of information, networking with partner agencies, and conducting parent satisfaction interviews.

*Lead Poisoning Prevention Services:* The Childhood Lead Poisoning Prevention Act requires health care providers to order screening of all children at or around 12 months of age and for children who are at high risk for lead poisoning. In addition, DPH Office of Lead Poisoning Prevention Protocols require that all children who are at high risk for lead poisoning including all those receiving Medicaid or enrolled in the WIC Program be screened at 12 months and 24 months of age. Those who are enrolled in these programs and do not have evidence of such screening should be screened before they are 71 months of age. In addition, these criteria apply to other high risk children who live in one of the twenty zip codes in the state that have been identified as high risk areas for lead poisoning. The State law also requires that public and private child care and preschools require documented proof of blood lead screening prior to enrollment or continued enrollment. Children entering kindergarten during the 2003-2004 school year and thereafter will also be required to have documented proof of a blood lead screening prior to enrollment. Lead screening is a required component of EPSDT for all children (up to five years of age) receiving this service through their primary care provider or through DPH clinics. A home visit is made when a child is confirmed to have an elevated blood lead level. The purpose of the home visits is to conduct a family assessment and develop a care plan. An individualized care plan includes the following: detailed education pertaining to lead poisoning, nutrition counseling, other referrals if indicated and collaboration with the child's primary health care provider. Home visits are conducted by a team that may include Public Health Nurses, Licensed Practical Nurses, Social Services Specialists, and/or Environmental Health Specialists.

*Preschool Diagnostic and Developmental Nursery:* The Preschool Diagnostic Developmental Nursery (PDDN) provides early intervention services to infants and toddlers, age birth to three, and their families under the direction of Child Development Watch. Service delivery reflects a multidisciplinary team approach, and includes services such as special instruction, physical therapy, speech therapy, social work, and consultation services. Services are carried out in small group settings; however, goals and objectives are individualized to meet the developmental needs of each child as well as the needs of the entire family.

## **DEPARTMENT OF EDUCATION**

The Delaware Department of Education is the lead agency for ensuring the provision of special education and related services consistent with the Individuals with Disabilities Education Act (IDEA) for children with disabilities, ages three through twenty-one and those children birth to three who are visually impaired, deaf and hard of hearing, deafblind and/or autistic.

Consistent with Federal and State Law and The Administrative Manual for Special Education Services, the Delaware Department of Education has the following responsibilities regarding services for infants, toddlers and their families, ages birth to three:

- facilitating the development of a comprehensive statewide service system for children birth to kindergarten and their families through the leadership and collaborative efforts of the 619 Coordinator and the Part C Coordinator.
- assuring the Child Find System, including public awareness, screening and evaluation for those children who are visually impaired, deaf and hard of hearing, deafblind and/or autistic.
- assuring the provision of a free appropriate education to children birth to three whom are visually impaired, deaf and hard of hearing, deafblind and/or autistic.
- assuring the implementation of policies and procedures for a smooth transition of children from Child Development Watch to Preschool Programs (3-5yrs).
- monitoring Local Education Agency (LEA) programs and other agency programs serving children with disabilities.
- participating in interagency collaborative efforts to ensure a comprehensive statewide service system for young children with disabilities and their families.

## **DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & FAMILIES**

The Department of Services for Children, Youth and Their Families (DSCYF) provides comprehensive services to abused, neglected, dependent, delinquent, and mentally ill or emotionally disturbed children, youth, and their families. Through its prevention and outreach efforts, the Department attempts to identify families at risk of developing such problems and provides supportive services to reduce that risk.

DSCYF includes four divisions: Family Services, Child Mental Health Services, Youth Rehabilitative Services, and Management Support Services. Services which are currently provided to client groups which would potentially or actually include children covered by the Birth to Three Early Intervention System are described below. Most of these services, however, are accessible only to clients who meet eligibility criteria which are determined by law, by availability of funding, or by program definitions. None of these services is available to children who do not meet these criteria.

### ***Services in the Division of Family Services***

- Investigation of complaints of abuse, neglect, and dependency, including risk assessment
- Treatment services to support the family and reduce risk when a complaint is founded
- Family preservation services to prevent placement of the child
- Foster care services when the child cannot remain in the care of her/his family
- Prevention and early intervention services including behavioral health consultation to Head Start programs statewide and child care providers. (Programs include I Can Problem Solve, Infant Toddler Mental Health, Positive Behavior Supports, and Training of the Trainer)

- Reunification services to reunite families and children after foster care
- Termination of Parental Rights/Adoption services for children who cannot return home
- Support of training for child care providers through the Office of Child Care Licensing

### *Services in the Division of Child Mental Health Services*

- Full range of mental health and substance abuse evaluation and treatment for which eligibility criteria apply

### **INTERAGENCY RESOURCE MANAGEMENT COMMITTEE**

The Interagency Resource Management Committee (IRMC) has the responsibility to consult and advise the lead agency in setting program eligibility standards and to allocate state funds for the Part C Birth to Three Early Intervention System. The IRMC may advise on the use of other funds specifically designated for the program.

### **Financial Matters**

According to 34 CFR 303.124, Part C Federal funds are to be used to supplement and increase the level of State and local funds expended, and in no case to supplant or replace State and local funds. In addition, medical or other assistance available under Title V or Title XIX of the Social Security Act cannot be reduced nor can eligibility under these programs be altered. Except as provided in 34 CFR 303.527, Birth to Three funds may not be used to satisfy a commitment for services that would otherwise have been paid for from other public or private sources but for the enactment of Part C. Accordingly, agencies agree to ensure the continued provision of available resources to deliver early intervention services and supports to eligible infants and toddlers and their families.

Maximum use will be made of all third party funding sources, including Medicaid and Delaware Healthy Children Program. State planning efforts will continue to support and facilitate such financing arrangements. Determination of specific agency responsibility for the provision of entitled services under Part C is based upon the provisions of this agreement and individual agency's eligibility criteria. The Department of Health and Social Services, as lead agency for Birth to Three, is ultimately responsible for ensuring the availability of services to which an eligible child and family are entitled including the provision of a multidisciplinary evaluation and assessment and service coordination, the development of the Individualized Family Services Plan (IFSP) and the availability of services included in the IFSP.

Children eligible under Part C who are also eligible for a free appropriate public education (FAPE) under Part B of IDEA will receive services in accordance with Child Development Watch Policies and Procedures. This includes children who are visually impaired, deaf and hard of hearing, deafblind and/or autistic according to The Administrative Manual for Special Education Services.

The DPH and DMS staff will work to enroll service providers who agree to provide services to eligible children and families, to implement Child Development Watch Policies and Procedures, and whenever possible, to encourage providers to participate in the Medicaid managed care provider network. Through this process, Delaware will ensure that early intervention services under Part C are available throughout the state either through public agencies or through vendor agreements and contractual arrangements with public and private providers.

### *Fees*

All screening, Child Find, evaluation and service coordination activities must be available at no cost to the family. Fees are also not charged for staff time related to the development of the Individualized Family Service Plan (IFSP) or the provision of procedural safeguards. Fees may be charged for other services in accordance with sliding payment schedules under federal or state statute. For those children also eligible for a Free Appropriate Public Education (FAPE) under DOE, FAPE services remain available at no cost.

### **Provision of Services Under Part C**

All agencies agree to collaborate in the provision of services to eligible children and their families. Services are only provided with parental consent and are provided in a family-focused manner with emphasis on the concerns, priorities and resources of the family.

The programmatic flow chart in Appendix B portrays the delivery of services under Part C. It is the intent of the agencies involved to move toward the provision of a seamless system of services for eligible children from birth through entry into kindergarten characterized by continuation of services and minimal disruption or burden to the family.

### *Individualized Family Service Plan (IFSP) and Direct Services*

All early intervention services included in the IFSP must be made available to eligible children and families. A child and family will have a service coordinator who assists the family to access the process from referral to Child Development Watch through the development of the IFSP and with the receipt of services. Definitions of services are included in the Part C Public Law and Federal Regulations. Services may be provided by state or local agencies in accordance with each agency's eligibility requirements and availability of resources. This is in accordance with the provisions of this agreement. Some services are made available through contractual vendor arrangements with public and private providers. The lead agency, the Department of Health and Social Services, remains ultimately responsible for building and ensuring capacity and availability of early intervention services among public and private providers under Part C.

### **Child Find and Service Coordination**

#### *Assurance of System*

The Department of Education and the Department of Health and Social Services are jointly responsible for the Child Find system as defined in the IDEA. Given the parallel requirements under Part B and Part C of the IDEA, the lead agency for Part C (DHSS) and the lead agency for Part B (DOE) accept joint

responsibility as described for ensuring the location, identification and evaluation of all infants and toddlers potentially eligible under Part C or Part B. These two state agencies remain ultimately responsible for Child Find.

The Department of Education assumes responsibility for Child Find activities for those children who are visually impaired, deaf or hard of hearing, deafblind and/or autistic as described in the State Plan and The Administrative Manual for Special Education Services. The Department of Health and Social Services assumes responsibility for Child Find activities for all other children birth to three. In addition, agencies agree to provide information to Child Development Watch through the Division of Public Health, which serves as the central point of contact for the Birth to Three system.

### *Operation of System*

The Child Find system will be cooperatively operated through Child Development Watch and Local Education Agencies. Public Awareness information is disseminated routinely to LEAs concerning services in Child Development Watch. Referrals are commonly made between Child Development Watch and LEAs.

Potentially eligible infants and toddlers are referred to Central Intake in Child Development Watch. Upon referral, a family service coordinator is appointed to assist the family through the completion of the multidisciplinary evaluation and assessment, and upon determination of eligibility, the development and implementation of the IFSP.

Liaison staff from signatory agencies agrees to participate with the families in the interagency Child Development Watch team process through which Child Find is conducted and the service coordinator assigned. Any child believed to be potentially Part C eligible will have a multidisciplinary assessment provided as needed. Parents of these potentially eligible children will be requested to sign a Part C /CDW Consent Form. An IFSP will be developed and implemented for all eligible children. These activities are coordinated through the Child Development Watch interagency team. The makeup of the interagency teams is agreed upon by the agencies and corroborated through the shared allocation of positions and resources. The Part C Birth to Three Early Intervention System provides additional administrative and fiscal support. Existing obligations have been used as the basis for the following explanations of shared Part C responsibilities:

**The Division of Developmental Disabilities Services** participates in all Child Development Watch activities including referrals, multidisciplinary assessments and service coordination for children particularly those with severe conditions. They also provide consultation in their area of expertise to other team members.

**The Department of Education** participates with Child Development Watch in the hiring and supervision of liaisons between DOE, the schools and Child Development Watch to ensure that transition from CDW to Public School Programs is provided. These individuals will also serve as family service coordinators for some children in Child Development Watch. Children who are birth to three and visually impaired, deaf and hard of hearing, deafblind and/or autistic are eligible for FAPE under Part B and eligible for Part C services.

The **Division of Family Services** employs liaisons between DSCYF and Child Development Watch to ensure that all DFS children potentially eligible for Part C services are referred to the program for assessment and early intervention services, in addition to those services which they receive through DFS. These liaisons will also serve as family service coordinators for some children who are in DFS care.

The **Division for the Visually Impaired** participates in the interagency team, and provides family service coordination for children for whom visual impairment is the primary disability. DVI also determines eligibility as part of the Multidisciplinary Team process for all visually impaired children.

The **Division of Public Health** is responsible for the operations of the Child Development Watch (CDW) teams which includes management of monetary and personnel resources of the teams. In addition to program management, it provides family service coordination and ensures Child Find for all potentially eligible children. It provides screening activities for those children who are uninsured or underinsured through well child clinics at state service centers. Other screenings are provided by primary care physicians or by other agencies serving potentially eligible children. All screening activities under the Birth to Three Early Intervention System must meet EPSDT standards.

The Integrated Service Information System (ISIS) is the data system for the Part C Birth to Three Early Intervention System. Information regarding screening, assessments, and services for all children referred to Child Development Watch will be entered into ISIS on a timely basis.

### **Transition**

All Part C early intervention and Part B preschool providers will participate in transition planning conferences arranged by Child Development Watch service coordinators for those children who may be eligible for Part B services. This process is designed to ensure that there is minimal disruption or burden to the family in the provision of services for a child during this time. All transition activities will be in keeping with the goal of providing a seamless system of services for children birth through entry into kindergarten. Every effort will be made by Child Development Watch to work with families to ensure the availability of appropriate services for any children that exit Child Development Watch and are determined not to be eligible for Part B preschool services.

In order to allow maximum time for all necessary planning activities related to transition, the family service coordinator under Child Development Watch for a particular child, believed to be potentially Part B eligible will refer that child to the local education agency, with parental permission, at least 90 days prior to the child's third birthday. This can occur anytime as early as 180 days prior to the child's birthday depending on the point in the calendar year when a child will turn three years.

Following the transition referral, family service coordinators and local education agency staff will work with the family to develop and implement a transition plan in accordance with CDW Policies and Procedures. Evaluations and assessments that have been completed for Part C purposes within the past 6 months do not have to be repeated unless it is determined appropriate for that child and family.

All Part B eligible children are entitled to receive services in accordance with their Part B IEP/IFSP as of their third birthday. However, in order to ensure a transition that is appropriate for the child and family, there may be different points of entry into the Part B system. The following apply:

- The responsibility for children who become three years of age during the time between January 1 and April 30 (inclusive) will transfer from Part C to Part B on the child's third birthday;
- At the parent's request and based upon the IFSP, children determined eligible for Part B who turn three years of age between May 1 and August 31 (inclusive) may continue to receive services through Part C through August 31 of that year; and
- At the parent's request, Part C eligible children who become three between September 1 and December 31 (inclusive), and are determined eligible for Part B services, may receive services through Part B beginning on the first day of the school year in their district of residence.

### **Supervision, Monitoring and Evaluation**

#### *Supervision and Monitoring*

The Department of Health and Social Services as the lead agency is responsible for ensuring that programs and activities receiving assistance under Part C are administered, supervised, and monitored in accordance with Part C regulations. DHSS will carry out this by planning and implementing supervision and monitoring activities through an interagency approach with strong linkages to current activities.

Since most agencies have compliance and monitoring systems already in place, Part C compliance issues will be addressed wherever possible through already operative systems. The agencies have agreed to participate in the interagency system that focuses on providing identified services, training, technical assistance, planning, supervision and monitoring activities which coordinate with existing compliance and monitoring in their agencies. The overall organization and performance of Part C supervision and monitoring will be the responsibility of the Birth to Three management staff in the lead agency.

#### *Evaluation*

An interagency evaluation process is facilitated by the University of Delaware, Center for Disabilities Studies. This process will be used as one component of the evaluation and monitoring to be conducted for the Birth to Three Early Intervention System. All agencies in this interagency agreement agree to use the interagency evaluation process whenever appropriate.

### **Personnel Development**

A Comprehensive System of Personnel Development (CSPD) is a component of both the Department of Health and Social Services Birth to Three Early Intervention System Plan and the Department of Education's (SEA) State Plan for activities and responsibilities under the IDEA. A single Partner's Council For Children with Disabilities (PCCD) committee, appointed by the Secretary for Education, exists in Delaware to facilitate a number of activities, which support the following:

- provide for adequate and appropriate pre and inservice training
- include procedures to ensure an adequate supply of personnel
- provide for acquiring and disseminating significant information derived from research and demonstration projects

The Training Administrator for the Part C Birth to Three Early Intervention System will serve on the committee to ensure that the training needs, personnel development and promising practices associated with the Birth to Three Early Intervention System are adequately addressed. Interagency collaboration and joint planning are supported and endorsed by the PCCD Bylaws.

### **Due Process Hearing**

The Department of Education and the Department of Health and Social Services agree that there will be a single due process system to support all children covered by the IDEA. Responsibility for training hearing officers is a joint responsibility using the training process developed through the Department of Education.

### *Mediation*

The Department of Education and the Department of Health and Social Services agree that joint responsibility will be taken for the development of a mediation system. The Department of Education has taken the lead in initiating the training in conflict resolution and mediation skills. Child Development Watch and other staff under Part C have been and will continue to be included in all aspects of training.

### *Educational Surrogate Parents*

Guidelines for the appointment of an “Educational Surrogate Parent” will be the same for children eligible for services under Part C and Part B of the IDEA. Those guidelines are outlined in the Department of Education’s Administrative Manual for Special Education Services, Child Development Watch Policies and Procedures Manual and the Part C Procedural Safeguards.

### **Procedures To Resolve Disputes Regarding Program And Fiscal Issues**

1. All attempts shall be made to resolve disputes at the lowest possible level, and each agency will use its own dispute resolution procedures to resolve disputes.
2. Disputes that cannot be resolved at the program or agency level shall be referred to the appropriate agency’s Division Directors of the Department of Services for Children, Youth and Families; Department of Health and Social Services and/or appropriate Director of the Department of Education. Those individuals or their designees will together review the issue and make a determination as to how the dispute should be resolved. This decision shall be shared in writing with the parties involved in the dispute within thirty business days of receipt of the request for a determination.
3. If the dispute cannot be resolved as described in #2 above, the dispute shall be referred in writing to the appropriate agency’s Cabinet level State Secretaries or their designees. Their

joint decision shall be shared in writing with the parties involved in the dispute within thirty business days of the referral to them.

4. If the dispute can not be resolved as described in #3 above, the dispute shall be referred in writing to the three signatories of this agreement; the Secretaries of the Department of Services for Children, Youth and Families and the Department of Health and Social Services and the Department of Education. Their joint decision shall be shared in writing with the parties involved in the dispute within thirty business days of the referral to them.
5. When disputes are under consideration, the lead agency shall: (a) assign financial responsibility to an agency or will see that services are paid for in accord with "payor of last resort" provision; (b) reassign financial responsibility upon the resolution of a dispute if the lead agency determines the original assignment of financial responsibility was inappropriate; and (c) make arrangements for reimbursement of expenditures incurred by the agency originally assigned responsibility.
6. The lead agency is ultimately responsible for dispute resolution. To the extent necessary to ensure compliance with its actions, the lead agency will refer dispute resolutions to the Governor and will implement procedures to ensure that timely services are provided pending resolution of disputes.

### **Reauthorization Schedule And Negotiation Procedures**

This Interagency Agreement shall be effective immediately upon the written signatures of all parties and will remain in effect until a new agreement is signed. This Agreement shall be reviewed annually and reauthorized at least every five years by the Department of Education, the Department of Health and Social Services, and the Department of Services for Children, Youth and Their Families. Renegotiations of any portion of this Agreement may occur at any time for good cause, upon the written request of any of the participating Departments.

*INTERAGENCY TASK FORCE*

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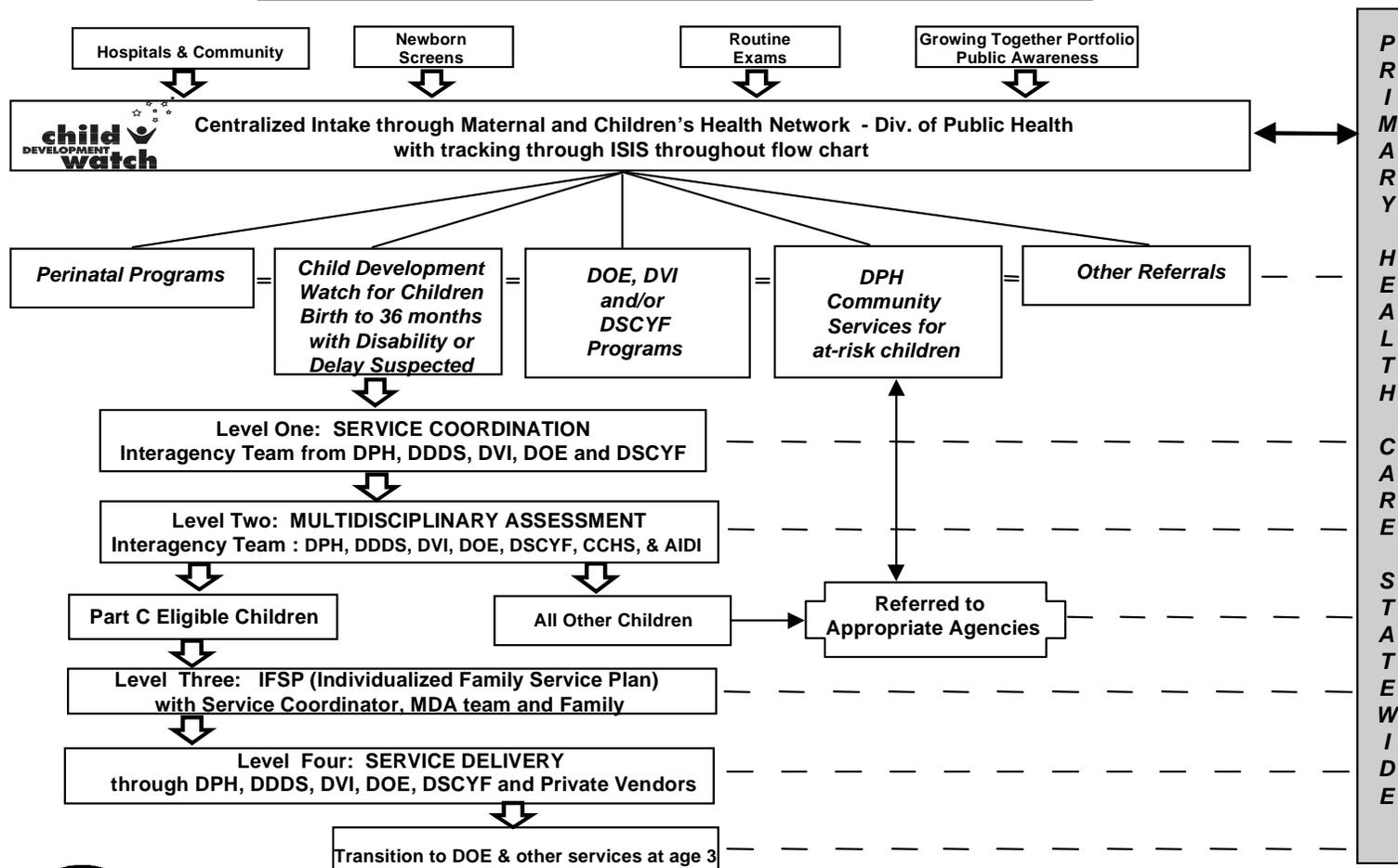
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Beth MacDonald, Chair  
Interagency Coordinating Council

## Part C Model Flow Chart within Delaware Health Network



DPH = Div. of Public Health  
 DOE = Dept. of Education  
 DDDS = Div. of Developmental Disabilities Services

DSCYF = Dept. of Services for Children, Youth & Families  
 DVI = Div. for the Visually Impaired  
 ISIS = Integrated Service Information System

AIDI = duPont Hospital for Children  
 CCHS = Christiana Care Health System  
 MDA = Multidisciplinary Assessment





DELAWARE HEALTH  
AND SOCIAL SERVICES  
Division of Public Health

## Appendix B

# Standards for the Early Intervention Services Delivery System as Provided

by

Child Development Watch



November 2003

STANDARDS FOR EARLY INTERVENTION  
SERVICES DELIVERY SYSTEM AS PROVIDED  
BY CHILD DEVELOPMENT WATCH

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Delaware Personnel Standards and Guidelines Matrix

Glossary

Committee Members

# **STANDARDS FOR THE EARLY INTERVENTION SERVICES DELIVERY SYSTEM AS PROVIDED BY CHILD DEVELOPMENT WATCH**

These standards were developed to guide Child Development Watch and its providers to meet Part H, Individuals with Disabilities Education Act (IDEA) regulations and to provide services in a way that best meets the needs of families with infants and toddlers having developmental delays or disabilities.

This document includes a glossary of the terminology used in developing the standards. Noted are definitions for principle, standard and indicator which form the groundwork for the development of the document. A principle is "a fundamental truth, law, doctrine or motivating force" upon which we will base our operations. The Standards are "the optimal level of practice or the commonly accepted level of practice." The listed indicators are the means of determining whether a standard has been met. Indicators can be divided into three categories: those that are required by law, regulations or state policies; those required by program policy; and those that while considered to be "best practice" are not required but will be attempted.

While some of the indicators may be included in employee performance plans, this document was not developed to measure an employee's individual performance. The purpose of having principles, standards and indicators is to establish benchmarks to evaluate the service delivery system developed for infants and toddlers with disabilities or delays and their families. This document will be used internally to evaluate Child Development Watch on a regular basis and also to provide information, as appropriate, to outside evaluators. These standards are consistent with the evaluation process as required by the Interagency Resource Management Committee (IRMC) as developed by the University of Delaware Center for Disabilities Studies (CDS) and the Part H, IDEA Self-study.

# I. Community Outreach and Identification

## Community Outreach includes:

- **Public Awareness Activities**
- **Early Identification and Screening**
- **Central Intake Referral System**

## Principles

- A. Community Outreach efforts are carefully planned, interagency, family-centered, culturally sensitive and, when appropriate, targeted to specific groups.
- B. Public Awareness activities enhance public knowledge about issues related to infants and toddlers with, or at risk of, disabilities and/or developmental delays with an emphasis on prevention methods and early intervention services.
- C. Child Find early identification and screening are coordinated across agencies and identify potentially eligible young children through primary referral sources who know when and how to contact Central Intake in Child Development Watch.
- D. Central Intake is easily accessible and effective as a single point of entry to early intervention screening, assessment, and services.

## Standard

- 1. Public Awareness provides information to the general public and primary referral sources, such as parent and families of infants and toddlers, hospitals, physicians, local education agencies, social service agencies, child care programs and other professionals in order to reach the appropriate audience.**

## Indicators

- 1a. Child Development Watch staff collaborate with the DHSS Division of Management Services, community agencies and other state agencies with input from parents, families and the Interagency Coordinating Council in developing and implementing public awareness activities.
- 1b. Staff distribute marketing materials (i.e., brochures) when participating in community events and when visiting schools, physician offices, hospitals, community health care agencies, managed care organizations, etc.
- 1c. Press releases for newspapers, radio, television and other local media are made when appropriate.
- 1d. Staff participates in scheduled local health fairs and other community organized events.
- 1e. A list of potential speakers including parents, professionals, and other community agency advocated is available to community groups.

## **Standard**

- 2. Written, visual, and verbal information is culturally sensitive and appropriate for the targeted audience.**

### **Indicators**

- 2a. Press releases and any other materials developed and used by Child Development Watch staff are culturally sensitive and in the language spoken by the persons in the targeted communities.
- 2b. Speakers, who can speak the language of the people in the community, are recruited when making presentations.
- 2c. Staff are trained in cultural awareness and how to communicate effectively with the families in the area to be served.

## **Standard**

- 3. Public awareness addresses prevention of disabilities and developmental delay, how to access appropriate screening services, the needs of infants and toddlers with disabilities and/or developmental delay, and the services available.**

### **Indicators**

- 3a. Staff share the Family Guide which provides the necessary information and referral procedures for accessing available services to families and community agencies.
- 3b. Open houses are held where information on early intervention activities is shared with parents, professionals and community groups.
- 3c. Outreach displays are available which include materials on early childhood development, how to prevent developmental delays, appropriate screening services and, referral information at community functions where families with small children are likely to attend.
- 3d. The *Central Directory of Services for Families with Children who have Special Needs* is distributed to families at intake and when it is revised.
- 3e. Public awareness materials such as brochures, the Family Guide, the *Central Directory of Services for Families with Children who have Special Needs*, and the Child Development Watch videotape are made available to the public.

**Standard**

- 4. Screening activities identify infants and toddlers with disabilities and/or developmental delays, as early as possible. The process also identifies those children who are at-risk for developmental delay due to environmental, socio-economic or physical conditions.**

**Indicators**

- 4a. Staff uses reliable and valid screening procedures to identify children who are in need of an assessment.
- 4b. Staff work with other agencies to avoid fragmentation and duplication of screening efforts.
- 4c. Basic referral information about children is shared between agencies with parental consent so that parents do not receive repeated requests for information concerning their child.
- 4d. Screenings are conducted in a child's "natural environment" setting in which children without disabilities participate.

**Standard**

- 5. Toll-free telephone numbers are available to the general public, to health and other professionals, and to families to request information, to make referrals and to gain access to services.**

**Indicators**

- 5a. Telephone numbers are promoted widely through community outreach and promotional materials.
- 5b. Telephone numbers are available at no cost to the caller (i.e., 1-800).

**Standard**

- 6. All referrals are received with complete and appropriate information in a timely and courteous manner.**

**Indicators**

- 6a. Staff take referral calls in a courteous manner.
- 6b. Staff taking referral calls receive training on appropriate referral taking procedures.
- 6c. Staff assure that accurate and completed information as provided by the referring agency is obtained by using a standardized referral form.
- 6d. Individuals taking referrals have access to information on current services and resources available in their service area (including the most commonly asked questions from parents and professionals).

**Standard**

- 7. An organized system of documentation is utilized to assure timely and appropriate disposition and follow up of referrals.**

**Indicators**

- 7a. Central Intake documents referrals on a standardized form and/or directly enters information into a computerized tracking system.
- 7b. Central Intake fields all referrals to the appropriate personnel within two business days of the referral.
- 7c. Service coordinators are assigned based on the needs of the family and child.

**Standard**

- 8. Timely and appropriate feedback is provided to the referral source indicating the acceptance and/or disposition of the referral.**

**Indicators**

- 8a. The referral source is notified of the disposition of the referral within one month of the referral date.
- 8b. If at the time of referral, the family has transitioned to another service, refused services or moved out of state, the referral source is notified.
- 8c. The primary care provider is notified if the family has transitioned to another service, refused services or moved out of state.

## II. Personnel

This section refers to:

- **Standards that relate to all staff working within organizations serving young children. These standards would include everyone who works within Child Development Watch and its provider agencies.**
- **Standards that relate to staff who provide early intervention services. These standards refer to those individuals who provide actual services such as nurses, family service coordinators, social workers, speech and language pathologists, child development specialists, psychologists, and nutritionist. Assessments are considered to be part of the services provided.**

### Principles

- A. Staff are prepared to work in partnership with all families.
- B. Staff providing early intervention services have knowledge, training, and experience in working with infants and toddlers with disabilities and/or developmental delays.
- C. Staff providing early intervention services are prepared to work in multidisciplinary and transdisciplinary teams and settings.

### Standard

1. **Staff treat families with respect, understanding families' current situations, values, and beliefs, and acknowledge that families' backgrounds may be different than their own.**

#### Indicators

- 1a. Staff provide follow-through with services they have indicated they will address.
- 1b. Staff support and encourage family members to share what they know about their child.
- 1c. Staff are accessible to families and respond to their inquiries.
- 1d. Staff acknowledge families' plans for their children and themselves and assist families in implementing those plans.
- 1e. Staff provide information to families as soon as possible.
- 1f. Staff maintain confidentiality and discretion when sharing information.

**Standard**

- 2. Staff use a variety of communication techniques in providing information to the family based on how that family can best understand information provided.**

**Indicators**

- 2a. Staff write and speak using jargon free language when communicating with families.
- 2b. Staff providing early intervention services explain and define to the family in everyday language any medical, technical, or disciplinary specific terms which relate to their discipline.
- 2c. Staff share complete and unbiased information with the families they are serving.
- 2d. Staff use active listening and other appropriate communication skills with family members and other service providers.
- 2e. Staff interact with families in ways that are responsive to their preferred mode of communication, which may include translation both oral and written in their native language or sign language.

**Standard**

- 3. Staff recognize that more than one agency or organization may be necessary to provide support and services to families of young children with disabilities and work effectively with the staff of those agencies or organizations to ensure optimal early intervention services for families.**

**Indicators**

- 3a. Staff, with permission of families, keep other agencies and organizations informed of the services being provided for the support and development of the child and family.
- 3b. Staff support other agencies and organizations as they serve families and their young children with disabilities and/or delays.
- 3c. Staff speak of a family and other staff, agencies, or service providers with respect.

**Standard**

- 4. Staff providing early intervention services recognize that families are complex and have interactive systems with their own established values, structures, and functions.**

**Indicators**

- 4a. Staff providing early intervention services understand the concepts of family systems and coping systems and apply them to their work.
- 4b. Staff providing early intervention services understand the importance of parent-child interaction during the early years of a child's development.

- 4c. Staff providing early intervention services recognize the different styles of adult learners and tailor their information sharing to fit those styles.
- 4d. Staff providing early intervention services know about and respect the differences in family values, beliefs, attitudes, expectations, and parenting practices across cultures.

### **Standard**

- 5. Staff providing early intervention services are willing to work as a team by including families as part of the team, accepting differences in skills and approaches of other team members, and by sharing their roles with other team members.**

### **Indicators**

- 5a. Staff with specialties help other team members, including parents, acquire skills related to their area of expertise. For example,
- By providing team members with suggestions regarding techniques that can be used with a child during daily routines;
  - By communicating regularly with other team members about how their area of specialty may help a child's overall development;
  - By incorporating their specialty knowledge with the knowledge of all other team members.
- 5b. Parents are invited to team meetings and encouraged to attend when their child is being discussed.
- 5c. Parents are invited to speak first in a team meeting, providing their perspectives and describing their observations prior to the reports of other team members.
- 5d. Staff providing early intervention services explain to families that they may make recommendations based on their different experiences and training.
- 5e. When staff providing early intervention services have multiple perspectives about any aspect of assessment, program planning, intervention, or evaluation of services, they are open with families and one another about those perspectives and work to form a consensus.
- 5f. Staff providing early intervention services are knowledgeable of team process and team dynamics including the ability to set common goals and carry out agreed upon strategies.
- 5g. Staff providing early intervention services are knowledgeable of and use strategies to promote team collaboration including consensus decision making.
- 5h. Staff providing early intervention services are knowledgeable of the different team model (e.g., multi-, inter-, trans-) of assessment, program planning, and implementation and the drawbacks and benefits of each type as well as the situations when each type might be used.

**Standard**

- 6. Staff who provide early intervention services meet the highest requirements in Delaware which apply to their profession or discipline.**

**Indicators**

*(see attached matrix of Personnel requirements of the state of Delaware.)*

- 6a. Staff providing early intervention services meet the requirements according to "Delaware Personnel Standards and Guidelines Matrix" as approved by the Interagency Coordinating Council.

**Standard**

- 7. Staff providing early intervention services for children birth to three have knowledge, training, and experience in early intervention and child development.**

**Indicators**

- 7a. Staff who provide early intervention services have the preferred course work in best practice as defined in "Delaware Personnel Standards and Guidelines Matrix" as approved by the Interagency Coordinating Council.

- 7b. Staff providing early intervention services have experience in serving children birth to three with disabilities and/or developmental delays consistent with that outlined in "Delaware Personnel Standards and Guidelines Matrix" as approved by the Interagency Coordinating Council.

- 7c. Staff have participated in training to:

- Work in teams that include multiple disciplines and agency perspectives;
- Understand and appreciate family-centered, culturally appropriate approaches;
- Understand how to access community resources, technology, and technology training, where appropriate; and
- Be knowledgeable and skilled in the use of assessment instruments;
- Know when and how to apply clinical judgment, when providing assessments and making evaluation decisions.

- 7d. Staff providing early intervention services understand the normal growth and developmental sequence, including ranges of variability, in the areas of communication, social/emotional development, adaptive development, physical development, cognition, health and nutrition.

- 7e. Staff providing early intervention services are familiar with how different disabilities may influence individual infants' and toddlers' developmental skill acquisition and behaviors.

- 7f. Staff providing early intervention services understand how risk factors may affect a child's development.

- 7g. Staff providing early intervention services possess the skills necessary to interact with and respond to infants and toddlers.

### III. Service Coordination

Service coordination is defined as: the activities carried out by a service coordinator to assist the family in determining the eligibility of their child for Child Development Watch services, in understanding their rights and procedural safeguards, and in identifying which services they need and desire, and helping them to obtain those services.

#### Principles

- A. Service coordination is process that assists families in obtaining early intervention services and other services identified in the Individualized Family Service Plan.
- B. The service coordinator coordinates the provision of early intervention services and other needed services. Other needed services may include medical services for other than diagnostic and evaluation purposes, day care services, housing and other economic needs.
- C. Service coordination is a process that facilitates the timely delivery of available services.
- D. The Service Coordination process continuously seeks the appropriate and desired services and situations necessary to benefit the development of each eligible child.

#### Standard

1. **Each child and the child's family is provided with one service coordinator. The service coordinator is a person who has knowledge about early intervention services and community resources for infants and toddlers with developmental delays and their families.**

#### Indicators

- 1a. One service coordinator is assigned to each family based on the discipline which can best serve the needs of the child and family.
- 1b. Service coordinators receive ongoing training in early intervention services and available community resources.
- 1c. Service coordinators meet all standards as outlined in the preceding Personnel section.

#### Standard

2. **Service coordinators inform families of their rights under IDEA.**

#### Indicators

- 2a. Service coordinators provide written information and verbal explanation to families about procedural safeguards under IDEA and continue to keep families informed about their rights.
- 2b. Families are assigned a new service coordinator at the parent's request or if a service coordinator from a different discipline can better meet the needs of the child and the family.
- 2c. Families are informed of any information which is pertinent to their child.

- 2d. Service coordinators acknowledge and facilitate families' right to invite persons of their choosing to be a part of their IFSP planning teams and help to determine which professionals will be on the IFSP team.
- 2e. Service coordinators identify gaps in the provision of services and notify supervisors within one week of identification. In addition to the total lack of needed services, gaps can include waiting lists for services, transportation problems, and access problems due to inappropriate geographical distances and of time of day of service delivery.
- 2f. Service coordinators are aware of circumstances that prevent the provision of early intervention services in a timely manner, (E.g., lack of financial resources, inappropriate referral for evaluation) and where possible, attempt to address and alleviate those circumstances.
- 2g. Service coordinators, with permission of families, seek out other agencies and organizations to be part of the early intervention team and to ensure non-duplication of services.
- 2h. Service coordinators identify and discuss with each family the outcomes they have identified for their children and their family and the array of options available to them to meet these outcomes.
- 2i. Parents are provided with information on available opportunities for their children to interact with typical children.
- 2j. Parents are given information about advocacy organizations including the Parent Information Center (PIC) which can assist them in understanding their rights.

### **Standard**

#### **3. Service coordinators support and strengthen family function.**

##### **Indicators**

- 3a. Families participate in the coordinating process for their child.
- 3b. The IFSP reflects family input, desires and abilities and uses the family's wording.
- 3c. Service coordinators support the parent in promoting the child's development, and the parent's decision-making authority as part of the team.
- 3d. Service coordinators build on the families' natural support systems by assisting the parent to identify social and personal supports and agencies and other organizations that may meet identified outcomes.

## **Standard**

### **4. Service coordinators respect the uniqueness of each family.**

#### **Indicators**

- 4a. Service coordinators provide information in the native/preferred language of the family, or arrange for translation services as warranted.
- 4b. Service coordinators acknowledge and respect the differences in family values, beliefs, attitudes, expectations, and parenting practices across cultures.
- 4c. Service coordinators acknowledge families' mechanisms for coping.
- 4d. The values, beliefs, priorities, and aspirations of the family guide the interactions between the family and service coordinator.
- 4e. Meetings are held at a time and a place convenient for the family.

## **Standard**

### **5. The service coordinator is responsible for:**

- **Ensuring the development and implementation of the IFSP as described in the standards for the IFSP,**
- **Servicing as the single point of contact for Child Development Watch,**
- **Assisting the family in identifying their priorities, concerns and resources,**
- **Coordinating and integrating services,**
- **Ensuring communication with the multidisciplinary assessment team, and**
- **Facilitating the development of a transition plan as appropriate.**

#### **Indicators**

- 5a. Service coordinators inform families of the purpose and process of service coordination.
- 5b. Service coordinators inform families about and link them to community resources and services.
- 5c. Service coordinators assemble the multidisciplinary multi-agency team best suited to meet child and family needs. This team includes the family, the primary care physician, agencies and individuals providing services.
- 5d. Service coordinators facilitate and advocate for family involvement in all decision making.
- 5e. Service coordinators ensure that desired and appropriate referrals are made.
- 5f. Service coordinators maintain communication among all team members, including providing information in the native/preferred language of the family.
- 5g. Service coordinators provide reports to referral sources and primary care physicians in a timely manner.

- 5h. Service coordinators ensure the development of a transition plan in a timely manner as described in the Transition section of these standards.
- 5i. Service coordinators facilitate referrals to desired follow-up services.
- 5j. Service coordinators promote, encourage and empower families to be independent by enhancing families' abilities to work with other agencies.
- 5k. Service coordinators make referrals to the Educational Surrogate Parent Program for any child who may be eligible based on the Part H Procedural Safeguards.

## **IV. Evaluation and Assessment**

### **Definitions of evaluation and assessment.**

- (1) Evaluation means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility.
- (2) Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify –
  - (i) The child's unique strengths and needs and the services appropriate to meet those needs; and
  - (ii) The resources, priorities and concerns of the family and the supports necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

Part-H Federal Regulations Section 303.322

Initial evaluation and ongoing assessments include at least the following: administration of developmental testing instruments, interviews with families and other major caregivers, review of data, and observation. In many situations, other specialized evaluations may be recommended.

### **Principles**

- A. Initial evaluation and assessment in early intervention assists families and professionals in identifying outcomes for young children with disabilities and/or developmental delays and their families.
- B. Initial evaluation and assessment in early intervention is achieved by collecting information through the use of multiple sources and multiple settings.
- C. Initial evaluation and assessment procedures and decisions are made by families and professionals collaborating to make the best possible decisions for young children with disabilities and/or developmental delays.
- D. The assessment process identifies specific child and family needs and concerns that can be addressed through intervention services such as instruction, therapy, or changes in the child's circumstances. This process is designed to assist family members and service providers in identifying interventions that support families in achieving their identified outcomes and monitors the progress toward those achievements.
- E. The assessment process allows for the monitoring and regular appraisal of the early intervention services being provided to the young child with a disability and their family.

## **Standard**

### **1. The initial evaluation and ongoing assessment activities are complete and accomplished in a timely manner.**

#### **Indicators**

1a. The assessment process:

- Assists the family in identifying the child's unique strengths and needs.
- Assists the family in identifying their priorities, concerns and resources.
- Assists the family in identifying the supports and services necessary to enhance their capacity to meet the developmental needs of their young child with a disability.
- Assists the family in obtaining the services and assistance they desire.

1b. The initial evaluation and the ongoing assessments address the five developmental domains.

- Cognitive development
- Communication development, including expressive, receptive and pragmatic skills
- Physical development including both fine and gross motor, and vision and hearing
- Adaptive development, and
- Social/emotional development

1c. The initial evaluation of each child and assessment activities, including the identification of family concerns, priorities and resources are completed within 45 days after the parent consents to services.

1d. If the child's or family's situation prohibits the completion of the evaluation, assessments of the family plan, these activities are postponed until the family is ready for them to occur; however,

- The circumstances are documented; and
- An interim plan is developed.

1e. The assessment process is an ongoing process allowing the child's development to be appraised as needed at multiple points in time.

1f. The assessment process should also include a comprehensive review of past history including other therapies and medical needs.

## **Standard**

- 2. Families are equal members of the assessment team and participate in each step of the evaluation and assessment process to the extent that they so desire.**

### **Indicators**

2a. Informed consent is obtained at each appropriate step of the process

These steps include:

- The initial Child Development Watch consent (Part H consent);
- Consent to share information with other agencies (i.e. ISIS consent form, other agency consent to share forms);
- Consent to release information to other agencies.

2b. Evaluation and assessment reports and recommendations are clear, concise and jargon free, and written at a level that a parent understands.

2c. Parents are adequately notified about all assessment procedures and meetings and provided with the opportunity to participate.

## **Standard**

- 3. The initial evaluation and assessment process is sensitive to cultural differences.**

### **Indicators**

3a. Tests and other evaluation materials and procedures are administered in a culturally appropriate manner including being conducted in the native language of the parent and child or using other appropriate modes of communication, when feasible.

3b. Assessment and evaluation procedures are selected and administered so as to be racially or culturally discriminatory.

3c. Information is gathered from several sources, instruments, settings, and occasions, to provide a valid description of the whole child, including his status or progress.

## **Standard**

- 4. The assessment process is conducted in settings comfortable for the child and family and is designed to promote the observation of optimal behavior and skills.**

### **Indicators**

4a. Assessments are especially adapted to accommodate a child's physical or sensory needs and abilities.

4b. Assessments are conducted in settings most appropriate for the child and may include:

- The availability of developmentally appropriate toys
- Comfortable setting such as home or day care
- Parental involvement

**Standard**

- 5. The assessment process is multidisciplinary and includes family members and appropriately trained personnel using current, accepted procedures.**

**Indicators**

- 5a. Assessments are multidisciplinary and involve two or more discipline or professions in the provision of evaluation and assessments. It is not the needs of the program (i.e., funding, time) which determine the disciplines involved but the needs of the child and family.
- 5b. As indicated by the family's concerns and the child's needs, specialized evaluations such as physical therapy, occupational therapy, speech therapy, nutrition, vision, audiology, and mental health are obtained in a timely manner.

## V. Individualized Family Service Plan (IFSP) Process

### **Definition of Individual Family Service Plan and IFSP.**

Individualized Family Service Plan and IFSP mean a written plan for providing early intervention services to a child eligible under this part [Part H] and the child's family.

Part-H Federal Regulations Section 303.340

### **Principles**

- A. Infants and toddlers are uniquely dependent on their families for their survival and nurturance. This dependence necessitates a family-centered approach to early intervention.
- B. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centered early intervention.
- C. Early intervention systems and strategies must reflect a respect for the racial, ethnic, and cultural diversity of families.
- D. Respect for family, autonomy, independence, and decision making means that families must be able to choose the level and nature of early intervention's involvement in their life.
- E. Family/professional collaboration and partnerships are the keys to family-centered early intervention and to successful implementation of the IFSP process.
- F. The IFSP is more than just a document. It is a process consisting of gathering, sharing, and exchanging information between families and staff to enable families to make informed choices.
- G. An enabling approach to working with families requires that professionals re-examine their traditional roles and practices and develop new practices when necessary—practices that promote mutual respect and partnerships.
- H. No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families. Therefore, a team approach to planning and implementing the IFSP is necessary.

### **Standard**

- 1. The Individualized Family Service Plan (IFSP) is a collaborative, comprehensive, interagency document which includes the expertise of the family, the service coordinator and other relevant persons.**

#### **Indicators**

##### ***Collaboration***

- 1a. Goals and objectives are a product of the collaboration of families and professionals.
- 1b. The scheduling of the development of the IFSP is announced to all potential team members with sufficient notice to allow them to attend or participate in all meetings.

- 1c. Each initial meeting and each annual meeting to evaluate the IFSP includes the following team members: parent(s) of the child, other family members, advocates or other person as requested by the family, the service coordinator, person directly involved in evaluations and assessments, and as appropriate, persons who will be providing services to the child or family.
- 1d. If a person listed above is not able to attend a meeting, arrangements are made for that person's involvement through other means, such as a telephone call, having a representative or making pertinent records available before the meeting, and written reports of the meeting's proceedings if desired and indicated.
- 1e. The IFSP and any revision are available to IFSP team members with opportunity for input.
- 1f. With parental consent, service coordinators will receive a copy of the IFSP or portions of the IFSP.

### **Standard**

- 2. The IFSP is a family-centered process which reflects the families' resources, priorities and concerns as related to the development of their child. It is scheduled at a time and place accessible and convenient to the family, and is written in language which is understandable and comfortable for the family.**

#### **Indicators**

##### ***Family-centered***

- 2a. Goals and outcomes include those identified by the family.
- 2b. Family resources, priorities and concerns are considered first when planning services.

##### ***Accessible and convenient***

- 2c. The meeting time and place is negotiated among the family and other team members. A written memo is then sent to all team members.

##### ***Understandable and comfortable language***

- 2d. Language used in the IFSP is explained fully and written in lay terms whenever possible.
- 2e. Children are referred to by name.
- 2f. 'People first' language is used. This means that instead of putting an adjective before the person in order to describe the individual, the individual is mentioned first (i.e., child with a disability rather than disabled child).
- 2g. Meetings are shared in the native language or other mode of communication used by the family. Special arrangements are documented.
- 2h. Verbal information and written materials are explained, translated or read aloud when necessary.

**Standard**

**3. The IFSP must be timely, written and complete.**

**Indicators**

***Timely***

3a. The IFSP is developed within 45 calendar days after the parent has signed the Child Development Watch Part H consent form, or there is documentation of any family preference for a delay.

***Written and Complete***

3b. The plan is hand written or typed and includes:

- i. A statement of the child's present levels of physical development (including vision, hearing, and health status), cognitive development, communication development, social or emotional development, and adaptive development;
- ii. With the concurrence of the family, a statement of the family's resources, priorities and concerns related to enhancing the development of the child.
- iii. A statement of the major outcomes expected to be achieved for the child and family and the criteria, procedures, and timelines used to determine progress and modifications of outcomes or services;
- iv. A statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the identified outcomes, including-
  - (aa) frequency, intensity and method of delivering services,
  - (bb) natural environments,
  - (cc) locations of services, and
  - (dd) payment arrangements.
- v. Other services (such as medical services the child needs or services for other family members);
- vi. Dates for initiation and duration of services;
- vii. The name of the service coordinator;
- viii. A transition plan from early intervention services; and
- ix. The signature of the parent.

## **Standard**

- 4. The IFSP is a dynamic, responsive process which is fluid and ongoing with timely reviews.**

### **Indicators**

#### ***Dynamic process***

- 4a. Reviews are carried out through timely meetings or other means acceptable to the family.
  
- 4b. The six-month review documents progress towards achieving IFSP outcomes and identifies needed revisions. This is done earlier than six months as needed or when requested by the family or service coordinator.
  
- 4c. The annual review documents the development of a new IFSP based on an evaluation of the current IFSP with input from all team members, in particular as related to progress and changes needed in the outcomes and services for the child and the family.
  
- 4d. Team members base decisions pertaining to revising IFSPs on family resources, priorities and concerns, assessment results and current child information.
  
- 4e. Family members may request special meetings which may not allow time to notify all IFSP team members.

## VI. Service Provision

### Principles

- A. The delivery of early intervention services is comprehensive, individualized, and flexible in order to reflect the dynamic nature of resources, needs, concerns, and priorities of the individual child and family.
- B. Early intervention is planned and implemented according to best practice methods of child development, service delivery and interagency collaboration.
- C. Services are provided in the child's natural environment and in such a manner as to integrate the child and family within the community.
- D. Families are important members of the team and may participate in service delivery for which they receive training to enhance the service delivery experience.

### Standard

1. **Services are individualized in addressing the needs of the child and family, and are assessment-based, functional and effective.**

#### Indicators

- 1a. Early intervention services and delivery methods reflect individual child and family characteristics, preferences, interests, abilities, resources and health status.
- 1b. Services are based on goals and outcomes which are derived from the assessment process as described in the IFSP, and service delivery is linked to those objectives.
- 1c. Early intervention services are based on, and embedded in, the normal daily routines and activities of children.
- 1d. Progress toward meeting the goals and outcomes is continuously measured and documented as services are delivered. A review is conducted at least every six months as part of the IFSP process.
- 1e. Service delivery is revised as appropriate based on the monitoring of progress and changes in the situation of the family and child.

**Standard**

- 2. Services are planned and delivered to promote optimal child development, effective service delivery and interagency collaboration.**

**Indicators**

- 2a. Training and resources on best practices in child development and service delivery is available and shared with staff.
- 2b. Service delivery efforts encourage interagency collaboration and avoid duplication and fragmentation.
- 2c. Information which facilitates service delivery is shared across agencies in an efficient, timely manner, using ISIS whenever appropriate.

**Standard**

- 3. Support services are provided whenever beneficial to facilitate and enhance the early intervention services.**

**Indicators**

- 3a. Identified needs related to support services, such as transportation and translation, are documented in writing along with the plans to provide those services including payment methods.
- 3b. Service coordinators have easy access to, and training on, information regarding support services.

**Standard**

- 4. Services are provided in the child's natural environments, that is in settings that are natural or normal for the child's age peers who have no disability.**

**Indicators**

- 4a. There is a range of options where early intervention services are provided, and the team and family's rationale for the selection of the service delivery location includes consideration of the child's natural environment.
- 4b. Consideration is given for the time of day services are to be delivered, as well as the length of travel time if the child/family must travel to receive the service.
- 4c. The integration of the child and family in the community is promoted and information is provided on community resources and programs.

**Standard**

- 5. Families are closely involved in the delivery of services to their children and are offered training to enhance the effectiveness of services.**

**Indicators**

- 5a. Families are full participants throughout the process of determining what, how, when and where services are to be delivered.
- 5b. Families are encouraged and supported to be with their children during the delivery of services.
- 5c. Family training is available and offered as a component of all services.
- 5d. Resources, such as books and videotapes, are available to families to provide information related to issues relevant to their child and family.

## VII. Transition

### **Definition of transition**

Transition is any movement from one service to another. Transition may occur at times such as when children enter an early intervention program, when they transfer to different services within a program, and when they enroll in a school or community-based program.

### **Principles**

- A. Transition planning helps make the move smoother by addressing the current and future needs of the family, the child, and the staff of the sending and receiving programs.
- B. Transition planning assures continuity of programming from one setting or point to another.
- C. Transition planning minimizes family disruptions while honoring each family's individual needs and values.
- D. Families may choose to participate in transition planning in various ways, depending upon other issues in their lives.
- E. Transition planning is designed to ensure that the child and family are prepared to function well in the receiving program.
- F. Transition planning makes change less disruptive by helping families understand what will be the same and what will be different in the new setting.
- G. Primary care physicians concerned with children's ongoing care should be aware of and included in the transition process to insure continuity of medical follow-up.

### **Standard**

- 1. Transition planning for changes in a child's situation or service should begin as soon as the possibility exists that a transition will be occurring.**

#### **Indicators**

- 1a. Parents are aware that other transitions may occur such as change in service coordinator or provider.
- 1b. Parents and service providers are aware upon entering Child Development Watch that by the time a child is two years of age, a plan to transition the child to new services will be discussed.
- 1c. Staff encourage and empower families to plan for transitions by helping them to understand differences in service models and to interact with other agencies.

**Standard**

**2. Transition planning for when a child turns three is initiated in a timely manner.**

**Indicators**

- 2a. Planning for transition out of Child Development Watch begins by the child's second birthday.
- 2b. At least 90 days prior to the child's third birthday, planning discussions are held with the parent to discuss plans for their child turning three. At this meeting, parents learn about services provided by the appropriate educational agencies and other private providers.
- 2c. When appropriate, and informed parental consent, local educational agencies are made aware of potential referrals at least 6 months prior to the child's third birthday.

**Standard**

**3. Families choose the extent to which they will be involved in transition planning.**

**Indicators**

- 3a. Families are encouraged to participate in transition planning at appropriate points.
- 3b. Transition planning and activities are clearly described in easily understood terms. Language is explained fully and written in lay terms whenever possible.

**Standard**

**4. Families are given information about their transition options in order to aid their effective participation in the transition process.**

**Indicators**

- 4a. Parents receive information about a range of appropriate service delivery options.
- 4b. Site visits to potential receiving agencies are encouraged and facilitated.
- 4c. Prior to the actual referral, parents understand eligibility requirements, referral processes and intake procedures for options under consideration.
- 4d. Parents understand their role in the program planning process of the new agency.
- 4e. Parents understand their rights and procedural safeguards within the new program.
- 4f. Parents are given information about the Parent Information Center which can assist them in understanding their rights.

**Standard**

**5. Transition plans are developed and implemented collaboratively with families, early intervention services providers, and personnel from receiving agencies.**

**Indicators**

- 5a. With informed parental consent, relevant records are forwarded to the receiving agency at the time of referral.
- 5b. Service coordinators attend initial planning meeting(s) held by the receiving agency.
- 5c. With parental permission, service coordinators notify relevant early intervention personnel, including primary care physicians, of upcoming planning meetings held by the receiving agency.
- 5d. Written transition plans include target dates, time lines and persons responsible for transition activities.
- 5e. Service coordinators follow the child's progress in the new program.

**Standard**

**6. Staff work with other community agencies to assure smooth transitions between sending and receiving agencies.**

**Indicators**

- 6a. Interagency agreements are established to facilitate transitions into and out of early intervention services.
- 6b. Early intervention personnel work with other agencies to clearly define and carry out roles, responsibilities, and time lines related to transition into and out of early intervention.
- 6c. With parental consent, information regarding transition is shared with other members of the multidisciplinary team including primary care physicians.

## DELAWARE PERSONNEL STANDARDS and GUIDELINES MATRIX

Personnel	Highest Entry-Level Academic Degree and/or Recognized Comparable Qualifications	Delaware Recognized Current Standard for Practice *	Guidelines for Part H	Preferred Courseware/Experience for Best Practice
1. Audiologist	Master	Licensure, CCC-A	Pediatric Experience	Pediatric Coursework. Supervised Experience with infants & toddlers.
2. Nurse  Advanced Practice Nurse	Licensure as R.N.  M.S.N.	R.N. <sup>1</sup>  M.S.N.	Nurse with MSN or BSN with 1-3 yrs NICU, PH, Peds or OB experience, training in developmental screening, infant health management.  Nurse with MSN or BSN with 3-5 yrs NICU, OB, Peds, PH experience, advanced training in developmental assessment, knowledge of family dynamics, inter-agency coordination.	Nurse with MSN in PH, MCH, Peds with training & experience in developmental screening, infant health management.  Nurse with MSN in MCH, PH with advanced training in developmental assessment, 1-3 yrs experience in infant evaluations, developmental assessments or early intervention, knowledge of family dynamics, inter-agency coordination.
3. Nutritionist  Dietitian	BS in Nutrition  B.S. Registered Dietitian and Dietetic Internship or Equivalent	B.S. in Nutrition  Registered Dietitian	B.S. in Nutrition  Coursework and/or experience with infants and toddlers with developmental disabilities.	Masters in Nutrition  Masters in Nutrition. Coursework in Pediatrics and Developmental Disabilities. Supervised experience with infants and toddlers with developmental disabilities.
4. Occupational Therapist	B.S. Certification, O.T.R.	Licensure, O.T.R.	Pediatric coursework plus Level II pediatric field work, with supervision by an experienced birth-3 OTR during first year.	Masters with pediatric coursework and 3 yrs supervised experience with specialized courses in treatment approaches.
5. Physical Therapist	M.S. Licensure, L.P.T. or B.S. Licensure, L.P.T.	Licensure, L.P.T.	Pediatric coursework plus Pediatric Affiliation or infant and toddler experience under supervision during first year.	Masters with pediatric concentration. Supervised experience in treatment with infants and toddlers.
6. Physician	Licensure, M.D., D.O.	M.D. or D.O. plus three-year residence. Diagnostician-based certified or board eligible in pediatrics/family practice	State standard	Consultation for appropriate sub-specialist: Board-eligibility or board certification in Infant and Child Psychiatry, Pediatric Neurology, Orthopedics with special interest in Pediatrics, Neonatology, Developmental Medicine, or Clinical Genetics.
7. Psychologist Clinical  School	Ph.D. (including one-year internship)  Masters (60 graduate hour minimum). Licensure and/or certification	Licensure (including post-doctoral supervision)  Licensure and/or Certification	State standard  State standard	Coursework in infant assessment, child/family therapy, child psychopathology, child/clinical specialties. Supervised experience (at least 3 months) specific to infancy. Coursework in assessment, child/family intervention. Supervised experience specific to infant/toddlers/families.

<sup>1</sup> Specialty Standards: Clinical Nurse Specialist, School Nurse, Pediatric Nurse Practitioner, Family Nurse Practitioner, Maternal/Child Clinical Specialist, Neonatal Nurse Practitioner, and other clinical specialties pertinent to the need of the facility.

Personnel	Highest Entry-Level Academic Degree and/or Recognized Comparable Qualifications	Delaware Recognized Current Standard for Practice	Guidelines for Part H	Preferred Courseware/Experience for Best Practice
8. Social Worker	MSW Licensure	Licensure, LCSW MSW	State standard	Coursework with infants/toddlers/families. Assessment and intervention with families of children with disabilities. Supervised experience with infants, toddlers and families in interagency collaboration and inter-system coordination.
9. Special Educator <sup>2</sup> (Early Childhood Special Educator)	Collegiate Professional Certificate with Early Childhood Special Education endorsement	Collegiate Professional Certificate with Early Childhood Special Education endorsement	State standard and supervised experience with infants, toddlers, and their families.	Masters in Early Childhood Special Education. coursework with focus on infants/toddlers/families. Supervised experience with families with infants and toddlers with disabilities.
10. Speech and Language Pathologist	Masters and Licensure	Licensure, CCC-SLP	State standard plus supervised experience with infants/toddlers and their families.	Coursework in parent-infant interaction in context of communication, alternative service delivery model, and oral-motor development/feeding. Supervised experience with infants, toddlers, and families.
11. Family Counselor	Masters and Licensure, LPC	Licensure, LPC	State standard	Coursework in interdisciplinary family counseling with infants/toddlers. Marriage and family specialty.
12. Orientation and Mobility Specialist	MS & AER Certification	B.S. or M.S. and AER Certification	State standard and supervised with infants and toddlers	MS & AER certification, coursework and experience in interdisciplinary programming for infants and toddlers and their families.

\* Must be combined with highest entry-level academic degree column for Part H Birth to Three system in Delaware.

**Para Professionals:**

<u>Nursing</u>	<u>Occupational Therapy</u>	<u>Physical Therapy</u>	<u>Education</u>	<u>Social Work</u>	<u>Other</u>
Licensed Practical Nurse Nurse's Aide	Certified Occupational Therapy Assistant Occupational Therapy Aide	Physical Therapy Assistant Physical Therapy Aide	Teacher Aide	Social Service Specialist	Child Development Specialist Case Manager Family Service Coordinator

<sup>2</sup> Alternative Licensure as: Teacher of the Visually Impaired, Teacher of the Hearing Impaired, Educational Interpreter/Tutor for Hearing Impaired, Early Childhood Education/Child Care.

## GLOSSARY

**Assessment** - The ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the services appropriate to meet those need; and resources, priorities and concerns of the family and any necessary supports to help the family to meet their child's developmental needs.

**Best Practices** – Practices recommended in the field of early intervention and early childhood special education. Although the term seems to imply that a practice or set of practices is appropriate for all children with special needs, it also acknowledges that practices must be based on the individual needs of specific children and their families.

**Child Find** – The system to locate, identify, and refer children with or at risk of having a developmental delay who may be in need of early intervention services or special education and related services.

**Confidentiality** – The protection of personally identifying information.

**Consent** - The parent has been fully informed (in the parent's native language or other appropriate mode of communication) of all information relevant to the activity for which consent is sought. The parent understands and agrees in writing to carrying out the activities for which consent is sought and that consent describes that activity and lists the records (if any) that will be released and to whom. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

**Evaluation** – The process through which a child's eligibility for early intervention services is determined.

**IDEA** – The Individuals with Disabilities Education Act. A federal law which contains requirements for serving children with developmental delays birth through 36 months and with disabilities through 21 years and their families.

**Indicator** – the means of determining whether a standard has been met.

**Individualized Family Service Plan (IFSP)** - A written plan for providing early intervention services to an eligible child and the child's family. The plan must meet the requirements specified in the IFSP section of the policy and procedure manual.

**ISIS** – Integrated Services information System. This is a computerized tracking system for children with disabilities and delays or at risk who are aged birth to eight.

**Multidisciplinary** – The involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

**Multidisciplinary Assessment Team** – A team of individuals with different areas of expertise who observe and test a child to find out his or her strengths or weaknesses. In Child Development Watch, the team always includes the parents, primary care physicians,

and service coordinator. Other disciplines are represented based on the needs of the child but may include other service providers, nurses, therapists, child development specialists, etc.

**Native Language** – A term used with reference to persons of limited English proficiency meaning the language or mode of communication in which a person or family is most proficient.

**Natural Environment** – Setting that is natural or normal for children of the same age who have no apparent developmental delay or disability.

**Part H** – The section of the IDEA, as amended, which sets forth the requirements for a state's early intervention program for eligible infants and toddlers.

**Parent** – A parent, guardian, persons acting as a parent of a child, or a surrogate parent who has been appointed to ensure that the rights of an eligible child for early intervention services are protected. The term does not include the state if the child is a ward of the state, but does include persons acting in the place of a parent, such as a grandparent or step parent with whom the child lives, as well as persons who are legally responsible for the child's welfare.

**People First Language** – Instead of putting an adjective before the person in order to describe the individual, the individual is mentioned first (i.e., child with a disability rather than disabled child).

**Principle** – A fundamental truth, law doctrine or motivating force, upon which others are based. Also a rule of conduct, especially of right conduct.

**Screening** – The ongoing process to determine through easily administered procedures or observations, whether or not a child needs to be referred for a multidisciplinary evaluation/assessment to determine the need for early intervention services.

**Service Coordinator** – The person who carries out the activities that assist and enable an eligible child and the child's family to receive the services, rights, protections, and procedural safeguards that are authorized to be provided under Part H of IDEA.

**Service Coordination** – The functions of the service coordinator, including all coordinating activities across agency lines and serving as the single point of contact in helping parents to obtain the services and assistance they need. Service coordination was normally called case management.

**Standards** – The type, model, or example commonly or generally accepted or adhered to. The optimal level of practice, the commonly accepted level of practice.

**Support Services** - Services which help families gain access to and benefit fully from programs, resources and professionals offered by public and private agencies. Transportation and language interpretation are examples of support services.

**Transdisciplinary** – The involvement of individuals working across disciplinary boundaries to plan and provide integrated services.

**Transition** – The period during which children participating in the early intervention programs and their families receive services to enable them to change smoothly to another program when the child’s needs change, the child reaches the age of three, or the family moves.

## **Child Development Watch Quality Management Committee**

### **Chair**

Joan Powell, DHSS/DPH Early Intervention Services Director

Louis Bartoshesky, MD, Medical Center of Delaware, Dept. of Pediatrics, Geneticist

Nancy Colley, DHSS/DMR/CDW Early Intervention Nursing Supervisor

Sherry Eshbach, DHSS/SPH Sussex County Health Unit Deputy Administrator

Cathie Frost, DHSS/DPH/CDW Clinic Manager

Michael Gamel-McCormick, University of Delaware, Center for Disabilities Studies

Rosanne Griff-Cabelli, DHSS/DMS/Birth to Three Program, Statewide Coordinator

Lora Lewis, DHSS.DPH/CDW Clinic Manager

Meri Jo Montague, DHSS/DMR/CDW Developmental Nurse Specialist

Anita Muir, DHSS/DPH Northern Health Services Deputy Administrator

Kathleen Riddle, DHSS/DPH/CDW Quality Management Coordinator

Deborah Simon, Medical Center of Delaware, Child Development Watch Center Manager

Susan Stine, MD, DuPont Hospital for Children, Dept. of Developmental Services

Martha Toomey, DPI/Exceptional Children’s Team, Early Childhood Specialist

Nancy Wilson, IRMC Policy Coordinator

# Appendix C

## PART C PROCEDURAL SAFEGUARDS

### I. GENERAL RESPONSIBILITY

The Delaware Department of Health and Social Services (DHSS) has established procedural safeguards that meet the requirements of the Individuals with Disabilities Education Act, Part C and ensures the effective implementation of those safeguards by each public agency involved in the provision of early intervention services. All agencies receiving either Part C federal funds or state funds, authorized by the Interagency Resource Management Committee, for early intervention services are required to abide by these safeguard policies and procedures. Any provider not abiding by these policies and procedures will lose program funding.

### II. DEFINITIONS

A. Consent means that:

1. the parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication;
2. the parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any), including physical documents and recorded information, that will be released and to whom; and
3. the parent understands that the granting of consent is voluntary and may be revoked at any time.

B. Destruction means physical destruction or removal of personal identifiers from information so that the information is no longer personally identifiable.

C. Education records means the records covered by the Federal Regulations Implementing the Family Educational Rights and Privacy Act. (FERPA).

D. Native language, when used with reference to persons of limited English proficiency, means the language or mode of communication normally used by the parent of an eligible child.

E. Participating Agency means any agency/institution which collects, maintains, or uses personally identifiable information is obtained.

F. Personally identifiable means that information includes:

1. the name of the child, the infant or toddler's parent or other family member;
2. the address of the child, the parent or other family member;

3. a personal identifier, such as the social security number of the child, parent and other family member;
  4. a description of personal characteristics or other information that would make it possible to identify the child, the parent or other family member with reasonable certainty;
- G. Parent means a natural parent, an adoptive parent, a legal guardian, a person acting as a parent, or a surrogate parent appointed in accordance with Part C regulations. This definition was intended to include persons acting in the place of a parent, such as grandparent or stepparent with whom a child lives, as well as persons who are legally responsible for the child's welfare. The term does not include the State if the child is a ward of the State.
- H. A record is any information recorded in any way, maintained by an agency or service provider, or by any party acting for an agency or service provider. These records include files, evaluations, reports, studies, letters, telegrams, minutes of meetings, memoranda reflecting oral conversations, handwritten or other notes, charts, graphs, data sheets, films, videotapes, slides, sound recordings, discs, tapes, and information stored on microfilm or microfiche or in computer-readable form.
- I. Mediation is an informal process in which an impartial person helps parties in conflict resolve their differences and find solution satisfactory to all sides.

### III. NOTICE TO PARENTS

- A. Agencies must give adequate notice to fully inform parents about their safeguards under IDEA, including:
1. a description of the extent the notice is given in the native language of population groups in the state;
  2. a description of the children on whom personally identifiable information is maintained, types of information sought, methods used to collect information (including sources to be used) and uses of information;
  3. summary of policies and procedures participating agencies must follow regarding storage, disclosure to 3<sup>rd</sup> parties, retention and destruction of personally identifiable information; and
  4. a description of all rights of parents and children regarding this information including FERPA and IDEA rights.
- B. NOTICE PRIOR TO ANY ACTION
1. Before any major Child Find activity, notice will be published in the newspaper or other media with circulation adequate to notify the Parents throughout the state.
  2. Written prior notice must be provided to the parents before:
    - a. any proposal to initiate or change the identification of a child, or
    - b. a refusal to initiate or change the identification of a child.
    - c. This notice may consist of a "consent to an evaluation" form.

3. Written prior notice must be received by the parents of an eligible child ten- (10) working days before a public agency or a service provider:
  - a. proposes to change the evaluation or the placement of their child, or to initiate or change the provision of appropriate early intervention services to the child and the child's family or
  - b. refuses to initiate or change the evaluation or placement of their child, or the provision of appropriate early intervention services to the child and his or her family.
4. Agencies and providers shall maintain a copy of the notice and documentation of notification.

#### C. CONSENT OF NOTICE

1. The content of the notice must be in sufficient detail to inform the parents about:
  - a. the action that is being proposed or refused;
  - b. the reasons for proposing or refusing the action;
  - c. the information upon which the proposal or refusal is founded;
  - d. the parent's right to refuse to consent to the action, including any consequences for parent or child if the parent refuses to consent;
  - e. the parent's right to appeal the proposal or refusal to act, including a description of the method of making such an appeal, whether activities to which the parents object will be delayed pending the appeal, and whether activities sought by the parent will be implemented pending the appeal; and
  - f. all procedural safeguards available under the Part C statute and regulations.
2. The notice shall be:
  - a. written in language understandable to the general public; and
  - b. provided in the parent's native language, unless it is clearly not feasible to do so.

COMMENT: Efforts to accomplish this requirement shall include, but shall not be limited to, a comprehensive translator search which may range beyond the geographic area served by the agency or provider and inquiries to the lead agency which shall maintain a resource list of translators.
  - c. If the native language or other mode of communication of the parent is not a written language, the public agency or designated service provider shall take steps to ensure that:
    - (1) the notice is translated orally, or by other means, to the parent in the parent's native language or other mode of communication;
    - (2) the parent understands the notice; and
    - (3) there is written evidence that the requirements of this paragraph have been met.
  - d. If the parent is deaf or blind, or has no written language, the mode of communication shall be that normally used by the parent (e.g., sign language, Braille, or oral communication).

#### D. NOTICE TO NATURAL PARENT:

When the natural parent is known, that parent should also receive notices of actions taken by the "acting parent".

#### E. NOTICE OF PARENT RIGHTS:

Parents shall be informed that they have the following rights:

1. the right to a comprehensive, multidisciplinary evaluation, including assessment, within forty-five (45) calendar days of the receipt of referral by the Part C Birth to Three Early Intervention System;
2. the right to appropriate early intervention services for their child and family;
3. the right to refuse evaluations and assessments, and services;
4. the right to ten (10) working days advance notice before a change is made or refused in the identification, evaluation, or placement of their child, or in the provision of services to the family;
5. the right to confidentiality of personally identifiable information;
6. the right to review and seek correction of records;
7. the right to be invited to and to attend and participate in meetings in which a decision is expected to be made regarding a proposal to change the identification, evaluation, or placement of the child or the provision of services to the child or family;
8. the right to utilize an advocate or lawyer in any dealings with the Part C Early Intervention System; and
9. the right to utilize administrative and judicial processes to resolve complaints.

#### F. HOW PARENTS SHALL BE INFORMED OF THEIR RIGHTS

1. Written notice of parents' rights shall be provided when:
  - a. the family has initial contact with the early intervention system;
  - b. the initial evaluation and assessment is proposed or refused;
  - c. the eligibility determination is made;
  - d. the IFSP is being developed or reviewed; and
  - e. a change in services or placement is proposed or refused.
2. The notice shall be in the language of and by means understandable to the parents.  
COMMENT: In addition, the parent should be informed verbally of any of the actions listed above.

#### G. INFORMING PARENTS OF RIGHTS PERTAINING TO PART B:

Parents should be informed of their rights relating to the Part B system in enough time to permit the parents to ensure that the child, if eligible, will receive appropriate Part B services in a timely fashion.

### IV. PARENT CONSENT

#### A. WHEN INFORMED CONSENT MUST BE OBTAINED

1. before conducting initial and subsequent evaluations and assessments, including family assessments;
2. at the time the IFSP is developed or reviewed, Parents shall be required to sign the IFSP as evidence of that consent;

3. before initiating early intervention services at any time prior to the development of the IFSP; and
4. before a significant change in identification, placement, evaluation or assessment, or in the amount or type of services.

#### B. INFORMED PARENTAL CONSENT TO AN EVALUATION OR ASSESSMENT

1. the parent understands the purpose of the evaluation or assessment and the procedures to be employed;
2. the parent understands any burdens a parent or family may bear as a result of the assessment or evaluation; and
3. the parent understands the possible adverse consequences of refusing to consent to an assessment or evaluation procedures.

#### C. INFORMED PARENTAL CONSENT TO THE PROVISION OF SERVICES

1. the parent understands the purpose of each service to be provided and how the service will be provided;
2. the parent understands the cost (if any) that parents or family may incur for the services;
3. the parent understands any burdens that parents or family may bear as a result of each proposed services; and
4. the parent understands the possible adverse consequences of refusing proposed services.

#### D. PARENTS RIGHT TO DECLINE SERVICE

1. The parents may determine whether they, their child, or other family members will accept or decline any Part C early intervention service in accordance with State law without jeopardizing other early intervention service under Part C.
2. Providers may not refuse to perform an evaluation or assessment procedure or deny a service because parents have refused to consent to another procedure or service.

COMMENT: an evaluation, assessment, or service could only be withheld if the procedure or service would have no validity or be ineffective without the refused procedure or service. This situation, however, would be rare.

#### E. ENCOURAGING PARENT CONSENT IF CONSENT IS NOT GIVEN

1. Reasonable efforts shall be made to ensure that the parent:
  - a. is fully aware of the nature of the evaluation and assessment or the services that would be available; and
  - b. understands that the child will not be able to receive services unless consent is given.
  - c. activities may be pursued that are designed to encourage parents to consent to recommended assessment or evaluation procedures and recommended services that they have refused, including:
    - (1) providing parents with relevant literature or other materials;

- (2) offering parents peer counseling;
- (3) periodically renewing contact with parents, on an establishing time schedule, to determine if they have changed their minds about the desirability of recommended procedures or services.

COMMENT: Any efforts to encourage parent consent shall be sensitive to the family and respect parent decisions.

#### F. OVERRIDE POLICY FOR INITIAL EVALUATIONS

1. The agency may only override parents' refusal to consent to an initial evaluation if that refusal constitutes medical abuse or neglect, where such abuse and neglect are required to be reported under state law.
2. A parents' refusal to consent to an evaluation is not by itself cause to suspect abuse or neglect.

#### V. SURROGATE PARENTS

##### A. WHEN SHOULD A SURROGATE BE APPOINTED

1. The state is mandated to appoint a surrogate parent when:
  - a. Custody has been awarded to the Department of Services for Children, Youth and their Families or other State agency by the Family Court; or
  - b. if no parent can be identified;  
COMMENT: It is unlikely that many infants or toddlers will be without someone who fits the definition of parent.
  - c. if the whereabouts of a parent cannot be discovered after reasonable efforts; or reasonable efforts include, but are not limited to, telephone calls, letters, certified letter with return receipt requested, or visits to the parents' last known address.
  - d. the rights of the natural parents have been terminated by Family Court, no guardian has been appointed, and the infant/toddler has not been adopted (wards of the state).
2. A surrogate parent may be appointed by voluntary written consent to the appointment by the parent which is revocable at any time by the parent with written notice to the Department of Health and Social Services.

##### B. CRITERIA FOR SELECTION OF SURROGATES

1. The lead agency ensures that the surrogate parent is selected as permitted by state law (Delaware Code Title 14 §3132).
  - a. has no interest that conflicts with the interests of the child he/she represents;
  - b. has knowledge and skills that ensure adequate representation of the child;
  - c. is not an employee of any agency involved in the provision of early intervention or other services to the child;
    - (1) A person, who otherwise qualifies as a surrogate parent, shall not be considered an employee of a public agency solely because he/she is paid by a public agency to serve as a surrogate parent.

- (2) Foster parents are not considered employees for the purposes of this requirement.
  - (3) A foster parent may serve as a surrogate parent so long as the foster parent is planning on being the child's foster parent for the foreseeable future or to adopt the child.
    - (a) has familial, social, and/or cultural ties to child, whenever possible.
2. Method for determining whether a child needs a surrogate parent:
    - a. Anyone can notify the Educational Surrogate Parent (ESP) Coordinator that a child may be eligible. Most often it will be either an employee of the Department of Services for Children, Youth, and Their Families or Child Development Watch that become aware of the need.
    - b. A referral form is completed. The original is sent to the ESP Coordinator and a copy is sent to the Division of Management Services. A determination is then made regarding the child's eligibility based on the above criteria (V.A.1).
    - c. The ESP Coordinator selects a potential ESP for the child from the list of certified people. After the recommendation is reviewed and approved by the Department of Health and Social Services the surrogate parent is appointed to represent the child.

#### C. RIGHTS AND RESPONSIBILITIES OF A SURROGATE

A surrogate parent has all the rights of a natural or adoptive parent as they pertain to Part C and shall represent a child in all matters relating to:

1. evaluation and assessment of the child;
2. the development, implementation, annual evaluation, and review of the IFSP;
3. the ongoing provision of early intervention services; and
4. any other rights under Part C.
5. A surrogate parent shall maintain standards of practice as outlined in the Educational Surrogate Parents Manual.

#### D. TERMINATION

1. A surrogate may be replaced only when:
  - a. he/she wishes to relinquish surrogate responsibilities; or
  - b. the Department determines that the appointment will be terminated based on the material failure of the surrogate to discharge his/her duties or maintain confidentiality.
2. If the surrogate is terminated, the surrogate has a right to appeal through the established appeal process described under Section VIII of this document.

#### E. TRAINING/ASSISTANCE

1. The Educational Surrogate Parent Program and the Department of Health and Social Services shall provide initial training for surrogate parents.
2. All surrogate parents are required to take the initial training provided for surrogate parents.
3. Surrogate parents shall be provided follow-up training and assistance in performing their duties when necessary or upon request.

## F. COMPENSATION

1. Surrogate parents shall be reimbursed by the Department of Health and Social Services for all reasonable and necessary expenses incurred in pursuit of their duties.
2. Reasonable and necessary expenses include, but are not limited to, mileage for attendance at meetings concerning the child, long-distance telephone calls concerning the child's services, photocopying of the child's records.

## VI. CONFIDENTIALITY OF INFORMATION

- A. All confidentiality policies and procedures meet Part B confidentiality requirements of information with some modifications to the definitions.
- B. All personally identifiable information concerning a child, the child's parent, or another family member is confidential.
  1. Parental consent must be obtained before personally identifiable information is
    - a. disclosed to anyone other than officials of participating agencies collecting or using the information under Part C of the federal Individuals with Disabilities Education Act, subject to paragraph 2 of this section; or
    - b. used for any purpose other than meeting a requirement under Part C.
  2. An agency or institution subject to Part C regulations may not release information from early intervention records to participating agencies without parental consent unless authorized to do so under FERPA.

## C. CONSENT TO DISCLOSURE

1. Informed consent must be obtained before any disclosure of confidential information, except in the following circumstances:
  - a. public agency or service provider may disclose confidential information to its employees who have a legitimate need for access to the information;
  - b. confidential information may be shared among employees within a division of state government on a need to know basis, but only between divisions in compliance with individual Departmental guidelines on interagency sharing of information; or
  - c. disclosure of confidential information may be made:
    - (1) to authorized representatives of the Controller General of the United States, the U.S. Secretary of Education, or a state agency responsible for the administration of the Part C program when the disclosure is in connection with an audit or evaluation of the Part C program or for ensuring the program's compliance with legal mandates, and the representatives to whom the disclosure is made protect against further disclosures and destroy the information when no longer needed;
    - (2) to organizations conducting studies to develop, validate, or administer predictive tests, to administer financial aid programs, or to improve Part C services; and
      - (a) the study is conducted in a manner that does not permit personal identification of parents, children, or family members; and

- (b) the information is destroyed when no longer needed for the purposes of the study;
- (3) to accrediting organizations to carry out their functions;
- (4) to comply with a judicial order of lawfully issued subpoena and a reasonable effort has been made by the disclosure to notify the parents in advance of compliance;
- (5) To the eligible child's parent.
- d. Each time a disclosure is made in circumstances #2-5 above:
  - (1) the parent must be informed of that disclosure as soon as is possible; and
  - (2) the disclosure must be recorded in the child's record and include the name of the party to whom the information was disclosed, the date of disclosure, and the purpose of disclosure.

#### D. SEEKING CONFIDENTIAL INFORMATION

1. A public agency or service provider must have informed parental consent to seek confidential information unless:
  - a. it is legally required to do so; or
  - b. the information is necessary to respond to a health or safety emergency.
2. Parents may be asked to sign a general release that would allow agencies or providers to seek or provide confidential information from others as long as:
  - a. parents are informed of their right to refuse to provide such authority and notification of that right appears on the written release form.
  - b. the release form lists those from whom the information may be sought and specifies what types of information may be sought from each;
  - c. parents are given the opportunity to limit the information that might be released and the parties from whom information may be released;
  - d. the release is revocable at any time, parents understand that, and it is so stated on the release form; and
  - e. the release is limited to one year or until the development or review of the IFSP, whichever comes first.
3. Each disclosure of confidential information pursuant to a general release shall be recorded in a child's record.

#### E. RELEASE OF SENSITIVE INFORMATION

1. Parents must give specific release for any disclosure of sensitive information. Sensitive information includes, but is not limited to, information pertaining to sexual or physical abuse, mental health treatment, HIV status, or a child's parentage.
2. There should be a space provided on the release form where parents can indicate information that they do not want released without their written consent.

#### F. RELEASE OF INFORMATION TO THOSE WHO WILL SERVE THE CHILD UPON TRANSITION FROM THE PART C SYSTEM

Parents must give informed written consent for the release of information to the public school system or any other agency or provider that may serve their child upon transition from the Part C System.

#### G. SECONDARY DISCLOSURE OF CONFIDENTIAL INFORMATION

1. An agency, may, without parental consent, make a secondary disclosure of confidential information obtained from another party only if such a disclosure is both:
  - a. permitted under the terms of the original disclosure made to the agency or provider; and
  - b. either:
    - (1) permitted by policy F.2., above; or
    - (2) consistent with a general release provided by the parents that meets the requirements for general releases.

#### H. AGENCY RESPONSIBILITY FOR MAINTAINING CONFIDENTIALITY

1. All agencies are required to protect confidentiality of personally identifiable information at the collection, storage, disclosure, and destruction stages.
2. Each agency or provider must designate one person to be responsible for ensuring the confidentiality of personally identifiable information;
3. All persons collecting or using personally identifying information or using personally identifying information must receive training and instruction regarding state policies and procedures.
4. Each agency or provider must maintain, for public inspection, a current list of the names and positions of employees who have access to personally identifiable information.

#### I. DESTRUCTION OF RECORDS

1. The Health and Social Services Department shall inform parents when personally identifiable information collected, maintained, or used under Part C is no longer needed to provide early intervention services to the child.
2. The information must be destroyed at the request of the family. The Department can keep information demonstrating that at one time they served the child and family including the name, address, phone number of the child.
3. When the family requests that information be destroyed, the Department should remind them that the records may be needed by the child or parent for social security, health or other purposes.

## VII. RIGHT TO REVIEW AND CORRECT RECORDS

### A. ACCESS

1. Participating agencies must presume that the parent has the authority to inspect/review records relating to their child unless it has been advised that the parent does not have the authority under state law.
2. The parents of eligible children must be afforded the opportunity to examine, inspect, and review records regardless of source regarding their child or family that relate to:
  - a. screening, evaluation, assessment, eligibility determination, and the development and implementation of the IFSP;
  - b. the filing of individual complaints dealing with the child or family; and
  - c. any other area under the Part C regulations involving records about the child and the child's family.
3. Parents shall not be refused access based on the identity of the agency of provider maintaining the records.
4. Parents may be refused access to the following records:
  - a. records of service, supervisory, and administrative personnel that are kept in the sole possession of the maker of the record and are not accessible or revealed to any other person except a temporary substitute for the maker of the record;
  - b. records of a law enforcement unit of a public agency or private provider; and
  - c. records relating to an individual who is employed by an agency or provider that are made and maintained in the normal course of business, that relate exclusively to the individual in that individual's capacity as employee, and that are not available for use for any other purpose. This subparagraph does not apply to records relating to a parent who is employed as a result of the parent's status as a recipient of services or as a result of the parent's child receiving services.
5. If any record includes information on more than one child, parents of those children have the right to inspect and review only the information relating to their child or to be informed of that specific information.
6. Each agency must keep a record of all parties obtaining access to records collected, maintained, or used (except access by parents and authorized employees of the agency), including:
  - a. the name of the party requesting access;
  - b. the date of access; and
  - c. purpose of access.

### B. RIGHTS RELATED TO REVIEWING RECORDS

1. The right to review a record includes:
  - a. the right to explanations and interpretations of the record;
  - b. the right to obtain a copy of the record; and
  - c. the right to have a representative of the parent's choosing review the record.

2. When a parent asks to review a record, the agency or provider maintaining the record must comply with a request within ten (10) working days.
3. When a request for records is made in connection with an IFSP meeting or formal hearing to resolve a complaint the agency or provider shall provide the records prior to the meeting or hearing at least five (5) days before the proceeding.
4. An agency or provider may not charge a fee to search for or retrieve a record.

#### C. PARENT REQUEST TO AMEND A RECORD

1. A parent may request that information in a record be amended, including deletion, if:
  - a. that information is inaccurate or misleading; or
  - b. that information violates the privacy or other rights of the parent's child or family.
2. When a parent requests in writing to the Department that a record be amended, the agency or provider must act on that request within ten (10) working days from the time the request is received.
3. If the agency or provider refuses to amend the records as requested, it must:
  - a. inform parent (s) of the refusal in writing; and
  - b. advise the parents in writing that they may appeal the refusal and how to invoke the appeal process. The parents have the right to appeal through mediation or the formal hearing process.
4. If the parent chooses not to appeal, or loses the appeal, the parent may place in the files of the agency or provider maintaining the contested record a corrective state commenting on the information and/or setting forth the parent's reasons for disagreeing with the decision on appeal. The agency or provider must:
  - a. maintain that statement along with the contested record as long as the record is maintained; and
  - b. provide that statement along with the contested record if the record or information is ever disclosed to any party.
5. If the parent wins the appeal, the agency or provider must:
  - a. amend the record
  - b. inform parents in writing.

#### D. INFORMATION ABOUT THE MAINTENANCE OF RECORDS

1. The Division of Management Services must provide parents with information about the types and locations of records collected, maintained, or used by public agencies or private providers relating to:
  - a. screening, evaluation, assessment, eligibility determinations, or the development and implementation of the IFSP;
  - b. Individual complaints dealing with children or families; and
  - c. any other area under Part C regulations involving records about children and families.
2. Each public agency and private provider must maintain and provide to parents, upon request:
  - a. a list of the types and locations of records collected, maintained, or used by the agency or provider relating to:

- (1) screening, evaluation, assessment, eligibility determinations, or the development and implementations of IFSPs;
- (2) individual complaints dealing with children or families; and
- (3) any other area under the Part C regulations involving records about children or families; and  
the title and address of the person to whom requests to review such records should be made.

## VIII. IMPARTIAL PROCEDURES FOR RESOLVING INDIVIDUAL CHILD COMPLAINTS

### A. SYSTEM ASSURANCE

1. The Department of Health and Social Services ensures that a system has been established and is operating for conducting formal hearings that:
  - a. addresses parent's complaints about identification; screening; evaluation; assessments; eligibility determinations; the development, review, and implementation of the IFSP; and the failure to respect parents' procedural rights;
  - b. provides parents a clear and easy-to-use method of requesting a hearing; and
  - c. is capable of resolving through a single proceeding a complaint involving two or more agencies or providers.
  - d. meets the following requirements as required by §99.22 of FERPA, and
    - (1) the hearing will be held within a reasonable time after it has received the request for the hearings from the parent;
    - (2) The parent is provided with a notice of the date, time and place, reasonably in advance of the hearing;
    - (3) the hearing will be conducted by an individual who does not have a direct interest in the outcome of the hearing;
    - (4) the parent will have a full and fair opportunity to present evidence relevant to the issues raised. The parent may be assisted or represented by one or more individuals of his or her own choice, including an attorney;
    - (5) the decision will be made in writing within a reasonable period of time after the hearing;
    - (6) the decision will be based solely on the evidence presented and must include a summary of the evidence and the reasons for the decision.

### B. DUE PROCESS REQUEST

1. Parents may initiate the request for a hearing on any issue that is in dispute by filing a written complaint with the Division of Management Services.
2. Parents shall be offered assistance by the Division of Management Services in filing the complaint.

### C. RESPONSE TO A FILED REQUEST FOR DUE PROCESS

1. The Division of Management Services shall:
  - a. respond within 7 days of receiving the complaint by:

- (1) notifying the parents of low cost legal advocacy services;
- (2) notifying parents of their rights related to the hearing process;
- (3) notifying parents of the option of mediation, including a description of the mediation process and its voluntary nature; and
- (4) appointing an impartial hearing panel.

#### D. PARENT RIGHTS

1. Parents have the following rights with regard to the hearing process:
  - a. the right to be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services;
  - b. the right to present evidence, and confront, cross-examine, and compel the attendance of witnesses;
  - c. the right to prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five (5) days before the proceeding;
  - d. the right to obtain a written or electronic verbatim transcription of the proceeding; and
  - e. the right to obtain written findings of fact and decisions.

#### E. CRITERIA FOR APPOINTING HEARING OFFICERS

1. Knowledge of the provisions of Part C and of the needs of and services available to eligible children and their families; and
2. be impartial, meaning that:
  - a. they may not be employed by any agency or program involved in the provision of early intervention services or in the care of the child; and  
COMMENT: A person who otherwise qualifies under this section is not an employee solely due to being paid by the agency to implement the complaint resolution process.
  - b. they may have no other conflict of interest, either personal or professional, that might impair their objectivity.

#### F. RESPONSIBILITIES OF HEARING OFFICERS

1. Listen to the presentation of relevant viewpoints about the complaint, examine all information relevant to the issues, and seek to reach a timely resolution of the complaint; and
2. Provide a record of the proceedings, including a written decision.

#### G. MEDIATION

1. Parents or service providers may request mediation at any time during the complaint process by putting the request in writing to the Department of Health and Social Services. Both parties must sign the request for mediation as an indication of their willingness to engage in mediation.

2. Parents may:
  - a. not be required to participate in mediation as a condition of having a formal hearing;
  - b. choose to pursue both mediation and a formal hearing, with the formal hearing proceeding within the time limits prescribed; and
  - c. accept or reject a request for mediation by an agency or provider.
3. Upon receipt of the request for mediation the Division of Management Services shall:
  - a. promptly appoint an impartial mediator who will schedule a meeting within ten (10) working days of his/her appointment at a time and place mutually convenient to all involved parties; and
  - b. provide all parties with a copy of a handbook that outlines the mediation process.
4. Mediation shall be provided at no cost to either party and in accordance with the process outlined in a mediation handbook.

#### H. CONVENIENCE OF PROCEEDINGS

1. Hearings shall:
  - a. occur at a time and place convenient for the parents; and
  - b. be concluded within 30 days from the time of receipt of the complaint with a written decision being mailed to each party.

#### I. DECISIONS

1. are enforceable by the Department of Health and Social Services;
2. shall be maintained by the Department of Health and Social Services in a central file, which is accessible to the public and has all personally identifiable information deleted;
3. that determine that the information in records is inaccurate, misleading, or violate privacy/rights of the child must be:
  - a. amended, and
  - b. parents must be informed in writing of that decision.

#### J. PROVISION OF SERVICES DURING PROCEEDINGS

1. While any proceedings are pending, including mediation, the child and family must continue to receive the early intervention services that were being provided before the complaint was filed, unless the family and agency or provider agree otherwise.
2. If the complaint involves an application for initial services, the child and family must receive all services that are not in dispute.

#### K. CIVIL ACTION:

Parents who are aggrieved by the final decision of the formal hearing system may challenge the decision by bringing a civil action in state court within 30 calendar days of the decision or in federal court where there is no time limit.

# GLOSSARY

**Adaptive development** - The development of self help skills such as feeding, sucking, etc.

**Annual IFSP Review** - A conference of the child's team, which is conducted every 12 months, to update the Individual Family Service Plan (IFSP) and revise it as needed. The results of any current evaluations and information from the on-going assessment are used in determining what are the child's needs, as well as the family priorities, strengths and concerns.

**At-Risk** - Children who are at-risk of having substantial developmental delays if early intervention services are not provided. Risk factors can be biological or environmental.

**Assessment** - The on-going process used by qualified personnel trained to utilize appropriate methods and procedures throughout the period of the child's eligibility for early intervention services; collecting and bringing together of information about a child's learning needs used to determine assignment to special programs or services; a process using observation, testing, and test analysis to determine a child's strengths and weaknesses to plan his or her educational program.

**Assessment Team** - A team of individuals from different areas of expertise who observe and test a child to determine his or her strengths and weaknesses.

**Case Manager** – The original term used in Part C of IDEA for a service coordinator and having the same functions.

**Child Identification** - Delaware's efforts to locate, identify, and refer children from birth through 36 months with or at risk of having a developmental delay who may be in need of special education and related services.

**Child Development Watch (CDW)** - The program in Delaware which identifies children birth to 36 months with possible developmental delay or disability for evaluation and provides determination of eligibility, multidisciplinary assessment, and service coordination.

**Clinical Opinion/Judgment**- The judgment of a qualified professional based upon experience, training, and assessment of an infant or toddler, regarding the child's developmental status.

**Cognitive Development** - The child's mental processes of perception, memory, judgment, and reasoning.

**Communication Development** - Acquisition of communication skills, during pre-verbal and verbal phases of development; receptive and expressive language, including spoken and sign language means of expression; the use of augmentative communication devices; and speech production and perception. It also includes oral-motor development, specifically those neuromuscular and structural conditions affecting pre-speech oral-motor development, speech and sound production, and feeding and swallowing processes. Related to hearing, the term included development of auditory awareness; auditory, visual, and kinesthetic skills; and auditory processing for speech or language development.

**Confidentiality** - The protection of information which may identify a client to provide privacy.

**Consent** - The parent has been fully informed (in the parent's native language or other appropriate mode of communication) of all information relevant to the activity for which consent is sought. The parent understands and agrees in writing to carrying out the activities for which consent is sought and that consent describes that activity and lists the records (if any) that will be released and to whom. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

**Days** - Calendar days.

**Development** - The progressive and orderly changes in a child's motor, cognitive, language, social, and adaptive abilities that results in the organization of complex systems of competencies. Development increases with maturity, growth, and experience and interaction with the environment.

**Developmental Delay** - A significant variation in normal development in one or more of the five domains as measured and determined measured and determined by appropriate diagnostic instruments and procedures administered by the multidisciplinary team.

**Developmental Disability** - Children birth to 36 months of age who are in need of special education and related services because of a significant delay or deficit or at risk of having substantial developmental delays in one or more of the following areas of development: cognitive, communication, social/emotional, physical and adaptive.

**Document** - To place a written notation about an event in a child's record or to otherwise record it.

**Due Process** - The regular administration of a system of laws which must conform to a fundamental and generally accepted legal principles and applied without favor or prejudice to all.

**Early Intervention Services** - Services that 1) are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development; 2) are selected in collaboration with the family; 3) are provided under the supervision of DHSS by qualified personnel, in conformity with an Individualized Family Service Plan; and 4) meet the standards of the state.

**Early Intervention Specialist** - Professionals trained to provide early intervention services. This includes audiologists, family therapists, nurses, nutritionists, occupational therapists, orientation and mobility therapists, physical therapists, pediatricians and other physicians, psychologists, social workers, special educators, and speech and language pathologists.

**Eligible Infants and Toddlers** - Individuals from birth to 36 months of age who need early intervention services because they are experiencing developmental delays in one or more of the five domains or are at risk of developmental delay (e.g. screening, evaluation)

**EPSDT** - The Early Periodic Screening, Diagnosis and Treatment Program of Title XIX of the Social Security Act. In Delaware it is administered by the Dept. of Public Health.

**Evaluation** - The process through which a child's eligibility for early intervention services is determined.

**Family** - A basic unit in society typically composed of adults and children having as its nucleus one or more primary nurturing caregivers cooperating in the care and rearing of their children. Primary caregivers may include, but are not limited to: parents, guardians, siblings, grandparents, extended family members, and others defined by the family.

**Family Assessment Tool** - An instrument which records professional observations and conclusions beyond information provided directly by the family and/or which compares one family to other families.

**Frequency** - The number of days or sessions that a service will be provided.

**ICC** – The Interagency Coordinating Council required by Part C of IDEA.

**IDEA** – The Individuals with Disabilities Education Act, a federal law which contains requirements for serving children with developmental delays birth through 36 months and with disabilities through 21 years, and their families.

**Individualized Family Service Plan (IFSP)** – A written plan for providing early intervention services to an eligible child and the child's family. The plan must meet the requirements specified in the IFSP section of the policy and procedure manual.

**Interagency Agreement** – A document signed by authorized representatives of at least two agencies outlining mutually agreed upon responsibilities to perform certain duties under specified conditions.

**Intensity** – The length of each session of early intervention service and whether the service is provided on an individual or group basis.

**Integrated Services Information System (ISIS)** – A data system to track which children are identified as potentially eligible for early intervention, their assessments, services and plans.

**Lead Agency** – The Department of Health and Social Services has been designated as the lead agency for Part C of IDEA in Delaware.

**Local Educational Agency** – The local public school district.

**Location** – The place in which early intervention services are offered (e.g. home, hospital, child care center).

**Multidisciplinary** – The involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

**Native Language** – A term used with reference to persons of limited English proficiency and means the language or mode of communication normally used by the parent of an eligible child.

**Natural Environments** – Settings that are natural or normal for children of the same age who have no apparent developmental delay. The primary natural environment for an infant or toddler is the home. If the child spends large portions of the day in a child care setting, early intervention services can be delivered in that setting.

**Part C** – Formerly Part H is the section of IDEA which sets forth the requirements for a state's early intervention program for eligible infants and toddlers.

**Parent** – A parent, guardian, persons acting as a parent of a child, or a surrogate parent who has been appointed to ensure that the rights of an eligible child for early intervention services are protected. The term does not include the state if the child is a ward of the state, but does include persons acting in the place of a parent, such as a grandparent or step-parent with whom the child lives, as well as persons who are legally responsible for the child's welfare.

**Periodic Review** – The review of the IFSP that must happen every six months or more frequently if conditions warrant or the family requests it.

**Permission** – Verbal authorization from a parent to carry out a function.

**Personally Identifiable** – Information that includes the name of the child, the child's parents, or other family members; the address of the child; a personal identifier, such as the child's or parent's social security number; or a list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.

**Physical Development** – A child's vision, hearing, gross and fine motor development, quality of movement, and health status.

**Primary Referral Sources** – Parents, physicians, hospitals (including prenatal and postnatal care facilities and programs) child care programs, local educational agencies, public health care providers, and community programs that have identified a child as needing an evaluation and/or early intervention services.

**Privacy** – Freedom from the intrusion of others in a family's affairs.

**Procedural Safeguards** – The requirements set forth by IDEA, as amended, which specifies families' rights and protections relating to the provision of early intervention services and the process for resolving individual complaints concerning these rights.

**Qualified** – A person that has met state approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which the person is providing early intervention services.

**Records** – Reports, letters or other documents that are collected, maintained or used by the agency in screening, evaluation, and development of the IFSP and/or in the delivery of services.

**Referral** – The direction of a family into the early intervention system for assistance in obtaining information, evaluation, assessment, and needed support services.

**Screening** – The ongoing process to determine through easily administered procedures or observations, whether or not a child needs to be referred for a multidisciplinary evaluation/assessment to determine the need for early intervention services. Screening is not diagnostic; it merely identifies some children as possibly having developmental delays or disabilities.

**Service Coordinator** – The person who carries out the activities that assist and enable an eligible child and the child’s family to receive the services, rights, protections, and procedural safeguards that are authorized to be provided under CDW.

**Service Coordination** – The functions of the service coordinator, including all coordinating activities across agency lines and serving as the single point of contact in helping parents to obtain the services and assistance they need. Service coordination was formerly called case management.

**Social or Emotional Development** – A child’s affective state and ability to interact with people.

**Tracking** – A system designed to follow a child to prevent a child from being lost to the health, education, and social service systems. Tracking assists in the early identification of children in need of special services. In Delaware, ISIS is the tracking system.

**Transition** – The period during which children participating in the early intervention programs and their families receive services to enable them to change smoothly to another program when the child’s needs change, the child reaches the age of three, or the family moves.

**Transportation** – The cost of travel and related costs that are necessary to enable an eligible infant or toddler and the child’s family to receive early intervention services.