

INSTRUCTIONS FOR IFSP PAGE 1

IDENTIFYING INFORMATION, SIGNATURES

1. **Child's Name** - The child's complete legal name, written last name first. The child's name should be written **last name first** throughout the IFSP document. Do not use nicknames and/or abbreviations. If the child is/was known by another name, write **AKA** and the other name below the (*last*) or (*first*) sections of the line.
2. **EI Number** - The child's EI number as issued by the NYC EIP.
3. **Child's DOB** - Child's date of birth in month, date, year (2 digits) order. For example, March 25, 2008 would be written 03/25/08.
4. **Today's Date** – Write the date on which the IFSP meeting is being held. This date will appear at the top of each page of the IFSP.
5. **Gender** – Check the box for male (M) or female (F).
6. **IFSP Meeting** - Check the appropriate box to indicate whether the IFSP is an Interim, Initial, 6 Month, etc. Also check the *Amended* box if this is an amended IFSP, so that it is clear which IFSP period is being amended. If the Transition Plan is developed or the Transition Conference is held as part of the IFSP meeting, check the box for *Transition Plan* or *Transition Conference* in addition to the IFSP period.
7. **Date of Initial IFSP** – Write the date on which the initial IFSP meeting is (or was) held. If this is an Initial IFSP, this will be the **same** date as **Today's Date** in the upper right hand corner. For all other meetings, always write the date the initial meeting was held.
8. **Effective Dates** – At the initial IFSP, write the effective dates of the 6 Month Review and Annual IFSP.
 - *The effective date of the 6 month IFSP is the day after the end date of the initial IFSP*
 - *The effective date of the annual IFSP is the day after the end date of the 6 month IFSP*(Refer to the schedules in the Appendix.)
9. **Mother's/Guardian's Name** – The biological or adoptive mother's/guardian's name.
10. **Father's/ Guardian's Name** - The biological or adoptive father's/guardian's name.
11. **Child's Address/Apartment Number** - The complete address where the child resides. If the address is a *private residence*, write **PH** next to *Apt. #*. Be sure to include the borough of residence or city (for Queens) and the zip code. (**NOTE:** This is the address of the foster parent if the child is in foster care. Block out the name, address and phone number of the foster parent before the IFSP is given to the biological parent or advocate.)
12. **Parents' Language** – The dominant language spoken by the family. Indicate more than one language if two languages are regularly spoken in the home. Indicate if parent/guardian uses sign language primarily. This information is used, in part, to determine if accommodations will be needed for future reviews
13. **Home Phone #** - Indicate N/A if there is no telephone.
14. **Alternate Phone #** - An alternate daytime telephone number at which a family member can be reached.
15. **Cell Phone #** - Indicate N/A if there is no cell phone.

16. **Foster Care Information** - Indicate whether the child is in foster care, the names of the foster parent/surrogate, the foster care agency and the caseworker involved, and the *agency* address, telephone and fax numbers. (See NOTE for #12 above.).
17. **Ethnicity/Race** – Check the appropriate box for **both** *Ethnicity* and *Race*. (**NOTE:** This is a federal requirement which *must* be completed.) Parents should be asked to check the boxes that they are most comfortable with. **More than one racial designation for a child can be selected.** If the parent refuses to complete this information, write this on the form.
19. **Participant’s Name and Signature** – Each person attending the meeting, including any interpreter, prints and signs his/her name to indicate his/her presence.
21. **Agency-** The employer of each person present, except the parent/guardian, who may write “N/A” in this section or leave it blank.

NOTE: In an emergency situation, in which a clinician can only participate in the meeting via telephone, the EIOD must document the clinician’s name, title/discipline, Agency name and that the individual was “available by phone.”

MEDICAL INFORMATION

1. List relevant diagnoses or conditions, e.g., cerebral palsy, autism, Down syndrome, failure to thrive, etc. Write the diagnoses in words; do not use the ICD 9 codes.
2. List relevant medical alerts such as allergies, medications or other information that the interventionist should know.

INSTRUCTIONS FOR IFSP PAGE 3

DAILY ROUTINES AND ACTIVITIES

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on – List the daily activities that are difficult for the family/caregiver, such as bath time, meal time, nap time, family outings, etc. For example, does the child really enjoy playing with other children yet find it difficult due to a communication delay? Does the child become upset at the shopping mall or on the street when there are a lot of people and noise? Include those activities or routines about which the parent has concerns, such as bathing, mealtime, sleeping, or transitioning from one activity to another.
2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority) - List the parent's concerns in order of in which you would like them addressed

Resources:

This page must be completed by the ISC with the parent prior to the IFSP meeting.

1. **Where does your child spend most of his/her time during a typical day?** - Select the settings where the child spends the most time, e.g., home, day care, a relative's home, a babysitter's home, a playgroup.
2. **Day Care/Caregiver Information** –Complete the caregiver's or program's name, address, and telephone number.
3. **If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare?** Select the individual who assists with child care that the parent wants to be involved in the Family Service Plan. These individuals' participation in the Service Plan may be direct (working with an interventionist) or indirect (learning new skills from parent/caregiver). For example, a parent may request that the interventionist work directly with the child's babysitter (direct) and the parent may also want assistance to learn how to show the child's grandmother speech games to use with the child when they visit the grandmother's home (indirect).
4. **What language does your child hear most of the day?** – List the language that the child hears or uses during most of the day. This may be different from the dominant language of the parent (e.g., an English speaking child may have a Spanish speaking babysitter.)

INSTRUCTIONS FOR IFSP PAGE 4
FUNCTIONAL OUTCOMES

1. **Today's Date** – The date of the initial or annual IFSP meeting at which the outcomes are developed.
2. **Date of Review** – The date of the 6, 18 or 30 month review meeting at which the IFSP outcomes are reviewed.
3. **Functional Outcomes** – The outcomes, recorded on page 4, represent one of the most important aspects of the IFSP meeting. Outcomes are statements of the changes or results that are expected to happen for the child and family as a result of EI services. All team members at the IFSP meeting should collaborate in developing these outcomes. The outcomes should be related to the child's developmental needs, the family's concerns and geared toward the child's ability to function during the everyday activities outlined on page 3. For example, "Johnny will be able to sit without support during dinner." The team may also develop outcomes for the family, especially to guide services such as Family Counseling. For example, "*Mr. and Mrs. Bowen will learn about Down syndrome and what to expect for their child in order to explain the condition to their friends and family*"

Specify changes that are expected to occur over the next six months. If necessary, use a second page to list additional outcomes. For example, "*Thomas will be able to communicate his needs by pointing or with words instead of screaming so that the family can visit relatives.*" The outcomes should be unique to the family and give enough information to the interventionist(s) working with the child and family. This will allow the interventionist(s) to develop therapeutic goals and coach family members or caregivers in the activities that can be applied throughout their daily routines. Interventionists will document how they have involved the family in the **Session** and **Progress Notes** (Refer to *Service Delivery Chapter.*) If desired, family members and caregivers can document their use of the activities or techniques in which they have been coached by the interventionist on a calendar or other tool. (See sample calendar and other suggestions in the *Service Delivery Chapter.*)

4. **Objectives:** List the objectives associated with the Functional outcomes. Objectives are short term goals that should be achieved in order for the child to reach the functional outcome. For example,
IFSP Functional Outcome: Ida will be able to pick up small bits of food from like raisins and cheerios with either hand using the thumb and index figure without resting her arm on the table so that she can feed herself every day during meal time.

Objective: Ida will pick up a Cheerio with fingers using a scraping movement.
Objective: Ida will pick up a Cheerio with the side of her finger and thumb
5. At the **Six Month Review** meeting, write the date of the review meeting on a copy of the *Outcomes* page from the prior IFSP. Review the outcomes and discuss the child's and family's progress toward the outcomes. Check the appropriate box next to each outcome to indicate whether the outcome should be *continued*, *revised*, or *discontinued*. Write the dates of the **Progress Notes** for the relevant service type and method.

Write new or revised outcomes for the next six month period on a new functional outcomes page.

NOTE: When a new service is added or an Assistive Technology device is authorized, whether at a six month review or an amendment meeting, a new outcome(s) is required. This outcome will guide the interventionist in working with the family and/or using the AT device with the child and family and can be documented on a new *Outcomes* page.

6. **Signatures** – The parent(s) and the EIOD must sign this page at the 6 Month IFSP Review meeting or the Amendment meeting to indicate agreement with the outcomes for the next six month period. The person who writes the information on this page must also sign (i.e., the OSC or EIOD). This is particularly important for the OSC who may be conducting the review meeting without the EIOD being present.

INSTRUCTIONS FOR IFSP PAGE 5

SERVICE PLAN

This page describes the ways in which the interventionist(s) may involve the family and coach them in activities to practice in their daily routines. Use language that is clear and understandable for the family. The plan should address how the outcomes might be achieved.

1. **Are all services being provided in the child's natural environment?** – Check *yes* or *no*. If *no* is checked, explain why the services cannot be delivered where the child spends most of his/her time. Please note that the rationale needs to be as specific, detailed and developmentally sound. This information is required by the Individuals with Disabilities Education Act (IDEA).
2. **Is any service being provided in a group setting without typically developing peers?** – Explain why the IFSP team agrees that this is the appropriate plan for this child. For example, does the child have special needs that can best be met in a structured group developmental setting?
4. **If the family is unable to be present during therapeutic sessions with the child, how will the service provider assist the family in learning ways to improve the child's functioning in his/her natural environment.** – For example, the interventionist may use a notebook to communicate with the family about the skills on which s/he is working and how the family might practice those skills during the child's natural routines; phone calls can be arranged at regular times; emails can be exchanged, etc. When appropriate, Family Training sessions can be arranged on a regular basis (monthly, bi-monthly etc.) at the center or in the home to teach parents/caregivers/siblings to help the child generalize his/her new skills during daily routines. The parent may be interested in having the interventionist attend a monthly family meeting to explain the child's status and give suggestions that various family members can incorporate into the child's and family's routines.

INSTRUCTIONS

SERVICE AUTHORIZATION DATA ENTRY FORM

This form records the information necessary for data entry into the KIDS system of the services authorized for the child and family through the Early Intervention Program. Indicate all authorized services, including service coordination, assistive technology services, respite services, special instruction, family support and therapeutic services. Indicate transportation services on the **Transportation Service Data Entry Form**. Indicate specific assistive technology **devices** on the **Assistive Technology Device Data Entry Form**. (NOTE: This form may be completed by the Assistive Technology Unit.)

Document authorizations for *each* provider on a *separate* **Service Authorization Data Entry Form**. For example, if occupational therapy will be delivered through ABC agency and speech services and service coordination will be delivered through DEF agency, complete two **Service Authorization Data Entry Forms**, each with the appropriate *Provider Information*.

1. **Child Information** – The child’s EI number, name, and date of birth as recorded in all other places on the IFSP.
2. **Effective Date of IFSP** – For an initial IFSP, this is the date that the IFSP meeting takes place. (NOTE: If the meeting was convened but the IFSP was not completed at that meeting, use the date that the first meeting took place.)

For a Six Month Review or Annual IFSP, the effective date is the day after the end date of the existing IFSP.

For an amendment to an IFSP, use the effective date of the *current* IFSP.

3. **End Date of IFSP** - 26 weeks after the effective date of the IFSP **unless the child turns 3 before that date:**

If a child turns 3 before the 26 week end date of IFSP, the end date of the IFSP must be the day before the child’s third birthday. For example, the effective date of IFSP may be 1/1/10, and the end date of a 26 week IFSP would be 6/30/10. However, if the child’s third birthday is 4/15/10, the end date of IFSP would be 4/14/10.

If the child has been found eligible for services by the Committee on Preschool Special Education (CPSE) and an IEP form is presented at the IFSP meeting, the end date of the IFSP may be 26 weeks after the begin date if the parent requests that the child remain in EI. Under no circumstances, however, can the child continue to receive services beyond August 31 (for children turning 3 between January 1 and August 31) or December 31 (for children turning 3 between September 1 and December 31). A child may not receive services from both EI and CPSE at the same time. (For further information, see the policy on *Transition*).

If the child is found eligible for services by the CPSE after the begin date of IFSP, but before the child’s third birthday, and the parents wish to continue EI services until the age-out date, a new **Service Authorization Data Entry Form** must be written to extend the service from the third birthday to the age-out date. In the example above, if the services end 4/14/10 because the child turns 3 on 4/15/10, the new form will *add* the service from 4/15/10 until 6/30/10. **Note that under no circumstance can the service extend beyond the 26 week end date of the IFSP.** If the parent chooses to remain in EI until the child ages out on 8/31/10, services can be continued at the next IFSP from 7/1/10 to 8/31/10.

4. **Type of IFSP** – Check the appropriate box to indicate if the IFSP is an interim, initial, 6 month or annual IFSP. If the IFSP is a 6 month or annual, also check the appropriate month (6, 18 or 30 month or 12, 24, or 36 month).

If this is an amended IFSP, check **both** the appropriate box indicating the type of IFSP **and** the box indicating amendment to IFSP. Write the **effective date of the amendment**. For example, if an initial IFSP dated 1/1/09 is being amended on 5/20/09, check the box for *Initial* and the box for *Amendment to IFSP* and write 5/20/09 next to *Dated*.

5. **Provider Information** – For all types of IFSPs, each provider agency that will provide services to the child or family must have a separate **Service Authorization Data Entry Form**. For each provider, include the following information:
 - The Provider Agency Name and Provider EI Number as listed in the Provider Directory
 - The name of the contact person at the provider agency who can respond to questions about the child’s program and his/her telephone and fax numbers
 - The name of the child’s currently assigned OSC, the SC’s #, telephone and fax numbers.

6. **Service Provider not identified at time of IFSP for the following services (Pended)** - List all the services where a provider was not identified during the IFSP meeting. The Frequency (how often) and duration (how long) should be included. Write the date by which the OSC will identify the provider. The date must be within 2 weeks of the IFSP date.

7. **EIOD Signature and Name** – The EIOD’s signature, printed name, and the date s/he actually signed the form. This date may be different from the *Effective Date of IFSP*. **No payment can be made by the Early Intervention Program to a service provider if the Service Authorization Data Entry Form is not signed by the EIOD.**

8. **Insurance Information-** Medicaid or private insurance information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child’s Medicaid number, as well as insurance Company Information.

9. **Services** – Refer to the **Service Authorization Data Entry Key** for instructions on the codes. **No information should be written in this section other than the specific information indicated.** List each service type to be provided by the service provider agency indicated in *Provider Information*. There are five numbered “service lines” on each **Service Authorization Data Entry Form**. Only one *Service Type* may be written on each service line. Therefore, if more than five services are to be offered by a given provider, use additional forms. Each service line contains the following information:
 1. **Service Type and Code Letter** – The name of the *Service Type* and its corresponding *Code Letter* as listed.
 2. **Method** – The *Method* by which the service is delivered and its corresponding *Code Letter* as listed.
 3. **Location** – The *Location* of the service and its corresponding *Code Letter* as listed.
 4. **Begin** – The date that each service is authorized to start. The *Begin* date can be any date **after** the *Effective Date* of IFSP for an initial IFSP or any date **on or after** the *Effective Date* of IFSP for a 6 or 12 month IFSP. The *Begin Date* should reflect the actual date that the service is expected to begin. **NOTE: A provider will not be reimbursed for any service delivered prior to the *Begin Date*.**
 5. **End** – The date on which the service will end. If the service is to be delivered for the duration of the IFSP, write the same date as the *End Date of IFSP*. If the service is to end before the *End Date of IFSP*, write the actual date the service will end. **NOTE: A provider will not be reimbursed for any service delivered after the *End Date*.**
 6. **Mins (Minutes)** – How long each session/visit is expected to last, e.g., 30 minutes, 45 minutes, etc.
 7. **Days** – The number of days per week the service will be provided. (**NOTE:** If the frequency is less than weekly, e.g., every two weeks or once a month, write this across the days and weeks boxes, e.g., 2xmonth, 1xmonth. If a particular number of units is authorized for the duration of the IFSP, indicate that clearly, e.g., 8 units during 26 week IFSP)
 8. **Weeks** – The number of weeks the service will be provided, not to exceed the total number of weeks in the IFSP.

9. **Units** – The total number of units authorized for the service type, determined by multiplying the number of days by the number of weeks, e.g., 2x26=52 units, or 1x month=6 units. The number of units may also be the total number of units agreed upon in the *Service Plan*, such as 8 units of Social Work during the IFSP period.

For **Service Coordination**, do not fill in columns *Method*, *Location*, or *Days*. Write the number of minutes authorized per week in *Mins* (Column 7), e.g., 30 minutes. A unit of service coordination is equal to 15 minutes. Calculate the number of units by multiplying the number of minutes divided by 15 times the number of weeks, e.g., 30/15=2x26=52 units. Consult the **Service Authorization Data Entry Key**.

10. Waiver Code –

- a. For Initial and Annual IFSPs: If the line of service violates a billing rule and requires a waiver, write the appropriate Waiver Code. More than one Waiver Code can be placed in a box if the authorization on the service Authorization violates more than one billing rule. EIOD must approve the use of the waiver by initialing the waiver box and inserting the start date of the waiver.

Note: This column replaces the former Waiver Form. No additional form is needed to indicate a waiver of the billing rules.

b. For Review and Amendment IFSP (a waiver has been added to an existing service authorization): the EIOD will write the start date for the waiver on the **Service Authorization Form**, check the box on the top for *Amendment* and put in the date of the amendment, and sign with his/her initials. This situation may occur when a new service is authorized for a child resulting in a violation of the billing rules. For example, a child may already have a PT, OT, and special instructor providing services on the day the parent is available. If ST is added, all four services must be given a waiver of the billing rules, which in this case would be *waiver code #1*. If there is room on the original **Service Authorization Data Entry Form** to add the new service for the same provider agency, the EIOD will indicate the new start date(s), waiver code(s), and initial the *Waiver Code* box.

11. **Status** – Check **Add** if the service line is being added; check **End** if the service line is being terminated. It is **necessary** to check the appropriate box for authorizations at every IFSP period.
12. **Bilingual Request**- Check if bilingual is preferred by the IFSP team. If bilingual services can not be located, a monolingual therapist is acceptable. Please notify the EIOD. The **Service Authorization Form** does not need to be resubmitted.
13. **Prescription Needed**- If Occupational Therapy (OT), Physical Therapy (PT), or Nursing was authorized at the IFSP, check to indicate that services cannot begin until a prescription from a physician is received.

INSTRUCTIONS FOR IFSP PAGE 5B

CO-VISIT

Page 5A documents required information when a co-visit is authorized. This page is for documentation purposes only and is *not* used for data entry. Co-visits may be authorized at an IFSP or as an amendment to the IFSP. **In most cases, the EIOD will complete this page.** To request authorization of a co-visit as an amendment, the SC should follow amendment procedures and include Page 5A completed through *Frequency*. The EIOD will check the appropriate *Authorization* box.

1. **Check the purpose of co-visit(s)** - Check all that apply. If the third box is checked, *Family Training* must be authorized as the service type. This will usually involve authorizing additional lines of service.
2. **Participants** – Check boxes to indicate all participants in the co-visit. Note that the parent or caregiver will always be a participant if the service is home/community or if the second or third boxes are checked. (Co-treatment in an EI center does not require the presence of the parent/caregiver.) Use the **Other** box to indicate the discipline of any other interventionist who may attend the co-visit.

Indicate the number of providers in the same discipline. For example, if there are two Special Instructors who will be attending the co-visit list it as: **SI 2**

NOTE: If two interventionists of the same discipline are attending the co-visit, *even if no additional units are required*, a waiver of the billing rules must be given. Indicate this on the **Service Authorization Data Entry Form** by writing the correct *Waiver Code*.

If Family Training is authorized for the co-visit, check FT and indicate the number and disciplines of the participants. For example, check FT – 4 SI, 1 ST, and 1 OT.

3. **Method** – Check the box for the method that will be used for the co-visit.
4. **Location** – Check if the co-visit will take place in the home, center or other location (specify).
5. **Frequency** – Describe the frequency for which the co-visit is authorized. This can be the number of co-visits per month, bi-monthly, once every three months, etc.
6. **Authorization** – Check the appropriate box to indicate if interventionists will use their existing authorized units for the co-visits or if additional units will be authorized. Indicate if a waiver of the billing rules is required by checking “yes” or “no”. If “yes” is checked, remember to write the *Waiver Code* on the **Service Authorization Data Entry Form**.
7. **Comments** – Use this space to describe any other factors relevant to the co-visit.

NOTE: Co-visits do not necessarily require additional service authorizations. An interventionist can use a session from an existing line of service in collaboration with another interventionist. For example, the IFSP may authorize one visit per week for PT and one visit per week for SI and a monthly co-visit with the child and family. In this case, the PT and SI bill under the code for their own service when billing for the co-visit.

NOTE: In all situations, each interventionist must write his/her own **Co-Visit Session Note**, and include information about the co-visit in the **Progress Note** for the respective service.

INSTRUCTIONS FOR IFSP PAGE 6

SERVICE PLAN: TRANSPORTATION, ASSISTIVE TECHNOLOGY, AND RESPITE SERVICES

These are additional services that may be required by the family and may not necessarily involve an interventionist. These needs include transportation, assistive technology, and respite services. The need for any of these services should be reviewed at *every* IFSP meeting.

1. **Transportation** - The team should review the family's transportation needs related to implementation of the service plan and check the appropriate box. **NOTE:** As per NYS DOH regulations, consideration shall first be given to provision of transportation by the parent of a child.

The IFSP team should explore all options **in the order they are listed**. Is transportation needed at all? If so, is the caregiver able to transport the child either by public transportation or by private car? If the family is requesting reimbursement for public transportation or for mileage accrued, note as such.

If the caregiver is unable to transport the child to the location of service provision, **the reason for this inability must be clearly documented on this page**. For example, "The family/caregiver works during the day, the child stays at the home of a caregiver who cannot leave the building to transport the child to the location of service." "The family does not have a car or other means to transport the child to the EI center." The EIOD should determine the validity of the reason and proceed to consider whether a school bus or car service is an appropriate option.

If car service is authorized, a responsible adult must accompany the child. Any special transportation needs (such as a nurse accompanying the child) must be noted; these needs should be supported by and described in the MDE summary as well as in written documentation supplied by one of the child's medical providers.

2. **Assistive Technology** - The team should discuss and review the need for AT devices and/or services as per the evaluations and MDE summary and include in the plan as needed. Children with visual and hearing impairments and/or motor delays should *always* be considered for AT equipment.

List the names or categories of AT equipment that may assist the child in using EI services to achieve his/her outcomes. Specific devices may include hearing aids, orthotics, or adaptations to commercially available equipment, such as an infant seat or chair for a child with severe tone or muscle issues.

Explain how the AT device will assist in achieving the functional outcome. When specific types of equipment (make, model #) are determined, a request with documentation as outlined in the Policy on *Assistive Technology* *must* be submitted to the EIOD in the Regional Office or the Assistive Technology Unit.

Check the appropriate box to indicate the status of the child's need or potential need for assistive technology. Check the box "Not applicable" if there is no need for assistive technology.

- 3. Respite Services** - The team should review the statement defining respite services with the family, emphasizing that respite is a temporary service. (If the family needs ongoing or long-term services, the OSC should assist them in accessing other supports in the community.) Check the appropriate category indicating whether a parent/guardian has expressed a need for EI respite services. Note here whether the respite application is attached or whether the application is to be submitted at a later date. Respite applications should be sent to the EI Regional Office of the borough in which the child resides.

Indicate whether the family is eligible or has applied for other sources of respite, such as through OMRDD. If the family has applied, give the date of the application and current status.

NOTE: The OSC is responsible for obtaining the services specified on page 6 and ensuring that the rest of the IFSP is implemented as agreed upon by the participants at the IFSP meeting.

INSTRUCTIONS
ASSISTIVE TECHNOLOGY DEVICE
DATA ENTRY FORM

This form records the information necessary to authorize assistive technology *devices*. (**NOTE:** Assistive Technology *services* are authorized on the **Service Authorization Data Entry Form.**) This signed form authorizes payment for the assistive technology (AT) device(s) to the contracted provider agency, who will in turn reimburse the AT vendor. In addition, this form identifies the codes necessary for medical insurance billing.

This form is completed by an EIOD in the Assistive Technology Unit or the Regional Office who authorizes the device(s) after receiving and approving a completed Assistive Technology Specification Request. A copy of the signed **Assistive Technology Device Data Entry Form** must be sent to the provider agency, the service coordinator and the Regional Office for filing in the child's case record.

1. **Effective Date of IFSP** – For an interim or initial IFSP, this is the date that the IFSP meeting takes place. For a Six Month Review or Annual IFSP, the effective date is the day after the end date of the existing IFSP. For an amendment to an IFSP, use the effective date of the *current* IFSP.

2. **End Date of IFSP** - 26 weeks after the effective date of the IFSP **unless the child turns 3 before that date.**

NOTE: This date should be the same as the end date of IFSP on the **Service Authorization Data Entry Form**. See Instructions for that form. For an interim IFSP, the end date of IFSP is 45 days from the date of the child's referral to EI, even though the end date of the authorization (see # 11 below) may be different.

3. **Child Information** – The child's EI number, name, and date of birth as recorded in all other places on the IFSP. Include the child's borough of residence.

4. **Provider Information** – For each provider, include the following information:

- The provider agency name and Provider EI Number as listed in the Provider Directory.
- The name of the contact person at the provider agency who can respond to questions about the child's program and his/her telephone and fax numbers.
- The name of the child's currently assigned OSC, SC ID #, telephone and fax numbers.

5. **Type of IFSP** – Check the appropriate box to indicate if the IFSP is an interim, initial, 6 month or annual IFSP. If the IFSP is a 6 month or annual, also check the appropriate month (6, 18 or 30 month or 12, 24, or 36 month).

If this is an amended IFSP, check **both** the appropriate box indicating the type of IFSP **and** the box indicating amendment to IFSP. Write the **effective date of the amendment**. For example, if an initial IFSP dated 1/1/09 is being amended on 5/20/09, check the box for *Initial* and the box for *Amendment to IFSP* and write 5/20/09 next to *Dated*.

6. **EIOD Signature and Name** – The EIOD's printed name, signature and the date s/he actually signed the form. This date may be different from the *Effective Date of IFSP*. **No payment can be made by the Early Intervention Program to a service provider if the AT Device Data Entry Form is not signed by the EIOD.**

7. **Vendor, Catalog or Dispensary** – The name of the vendor, catalog or dispensary from whom the device will be ordered.

8. **Category/Service Code** – The *category* is Assistive Technology and the *Service Code* is I for all AT devices. Thus this section has already been completed.

9. **CPT/HCPCS Code** – CPT- 4 codes are used to describe medical procedures and are maintained by the American Medical Association. HCPCS codes are established by the Centers for Medicare and Medicaid Services to identify items, supplies and non-physician services not identified within the CPT- 4 coding system. Refer to the reference manuals published by these institutions for the correct coding.
10. **AT Item/Device Description** – The generic or commercial name of the device and components that are authorized for purchase.
11. **Begin and End Dates** – The *Begin* and *End* dates enclosing the period during which the device is to be delivered to the child/family.

NOTE: Although services authorized at an Interim IFSP meeting, including AT services, must end on the 45th day after the child’s referral to the EI Program, AT devices may be authorized for a period of 6 months to allow sufficient time for delivery.
12. **Quantity** – The number of component parts needed for the completed device (e.g., 2 for bilateral orthotics).
13. **Cost** – The discrete cost of each component needed for the completed, assembled device which is included in the listed price on the ordering invoice as quoted by the vendor. The cost for “for profit” agencies may include taxes or surcharges; however, these charges are usually exempted. Shipping and handling may be included as a *separate* item.
14. **Total Cost** – The total cost is the listed price on the ordering invoice which includes all component costs and the base unit comprising the completed, assembled device.
15. **Status** - Circle *Add* if the AT Item/Device is being added for the first time at an initial, 6 or 12 month or amended IFSP. Circle *End* if it is being terminated from the IFSP.

INSTRUCTIONS

TRANSPORTATION SERVICE DATA ENTRY FORM

This page documents the discussion and authorization of transportation to a service delivery site for child and/or caregiver, if needed. There must be a separate Transportation Service Data Entry Form prepared for each provider (unless there is a bus company contract change, see #6 below) that will indicate an amount to be reimbursed for a transportation-related service. For example, if a child will be transported by a school bus provided by the transportation vendor, Smith Bus Company, and if, in addition, the child's father will be reimbursed by the Early Intervention service provider, LMN Developmental Center, for subway fare when he attends a weekly family support group, two **Transportation Service Data Entry Forms** must be completed. One form will be filled out for the bus company and another for the EI service provider.

1. **Child's Name, EI #, DOB** – Write the identifying information for the child as it appears on all other IFSP pages.
2. **IFSP:** Check the appropriate box for type of IFSP and write in the *Effective* and *End* dates of the IFSP period. **The EIOD will print his/her name, sign and date this form upon completion, indicating that the service is authorized.**
3. **Transportation Provider Information** – Either the bus company or the service provider agency that receives payment for car service, mileage, or public transportation and reimburses the family/caregiver. Include the provider name, provider EI contract # (as listed in the provider directory), agency contact person, and telephone and fax numbers of the transporting agency.
4. **Destination Information** - The name of the agency of destination, i.e., where the child/family is to be transported, agency EI contract #, site address, name of transportation coordinator, telephone and fax numbers.
5. **Service Coordinator** - Provide the SC information as indicated.
6. **Data Entry Unit Only – For Bus Contract Change** – This section will be completed by Data Operations staff when there is a change in the bus contract information that does not involve a change in the authorized service. The SC should **not** submit a new **Transportation Service Authorization Data Entry** form. No action is required by the SC or the EIOD/Regional Office.
7. **Transportation Service Type** – Check the box for *Bus* or *Other*. Write the code for the mode of transportation to be reimbursed.
 - 1 = Public Transportation
 - 2 = Taxi/Car Service
 - 3 = Mileage
 - 4 = Parking
 - 5 = Toll
 - 7 = School Bus
 - 8 = Nurse Accompaniment
 - 9 = Other
8. **Companion Accompanying Child** – If authorized, write the name of the person(s) who will accompany the child on the school bus or car service. Indicate the reason for accompaniment on the school bus. (***The parent or another adult over age 18 must accompany the child for car service.***)_The other information in this section applies to parents/caregivers who will:
 - always accompany their child on the bus, or
 - accompany their child on a school bus to an EI facility for the first few days of the child's attendance at the center, or
 - **occasionally but regularly** accompany the child on the bus in order to attend a Family Support Group, Parent-Child Group, or participate in a session at the EI facility.

INSTRUCTIONS FOR IFSP PAGE 7
SERVICE COORDINATION ACTIVITIES

The Service Coordination section includes a list of regularly performed tasks for the Ongoing Service Coordinator (OSC) and the family's/caregiver's selection of an OSC. If additional follow-up activities are required of the OSC, check the applicable boxes.

1. **Service Coordinator Information** – The name of the OSC, SC ID number assigned by NYC EIP, telephone number, email address and name and number of provider agency by whom the SC is employed, as selected by the parent from the list of choices presented at the IFSP meeting.

If an OSC provider has not been identified by the end of the initial IFSP meeting (i.e., services are pending), the family/caregiver may select the ISC as the OSC to help locate a provider(s). Once a provider is located, the family/caregiver may wish to change service coordinators. If the parent selects a new OSC, follow the EIP procedure for changing the SC.

The parent must sign on this page to indicate that s/he has been given options and has selected the OSC.

NOTE: Before a SC can be designated or assigned, s/he must have applied for and received a SC ID number from the Early Intervention Program. In addition, a provider will not be reimbursed by the EIP for the services of the OSC until the *Start Date* for Service Coordination listed on the **Service Authorization Data Entry Form**.

2. **Ongoing SC should** - Check the applicable boxes for OSC F/u activities.
 - a. **Assist family in identifying and applying for Public Programs** – List the programs for which the family may be eligible, such as Child Health Plus or other medical insurance programs offered through Health Care Access and Improvement (HCAI), WIC, Lead program, housing etc.
 - b. **Assist family in identifying and applying for other non-EI services needed by child or family** – List other services that may be needed to support the child and family outcomes, e.g., “work with the local interchurch council to seek funds for child care so that mother can return to work part-time.”
 - c. **Coordinate co-visits; reschedule if necessary** – Check this box if co-visits are authorized. The OSC has the responsibility to coordinate co-visits and to assist in rescheduling as necessary.
 - d. **Locate bilingual services** – If bilingual services have been requested for any of the services authorized, the OSC must make diligent efforts to locate such services. If the OSC is unable to find a provider for the requested bilingual service, s/he must contact the EIOD to discuss alternatives. A monolingual service should not be substituted without the approval of the EIOD.
 - e. **Assist family with transition** – The OSC must assist the family in developing a transition plan for the child whenever a child exits the Early Intervention Program. This includes leaving the program when EI services are no longer needed or when the family moves to another county or state. In these situations, the OSC should help the family access services in the new location. If the child is 2 years old or older, this box must be checked and the OSC must complete pages 7A and 7B.
2. **Primary Health Care Provider** – Name of Primary Health Care Provider, name of Medical Center/Facility, address, telephone and fax numbers.
3. **Permission to Release Copy of IFSP**– The parent will indicate whether s/he wishes to have a copy of the IFSP shared with the child's Primary Health Care Provider by checking the appropriate box, signing and dating the form.
4. **Additional Concerns** – Any concerns discussed at the IFSP meeting (by any participants) that may need follow-up should be described in this section. If billing rules are waived, describe the reasons and specify the circumstances of the waiver(s). If services have been recommended but rejected by the parent, list these services and describe the reason for the parent's rejection of them.
5. **Any further evaluation needed?** – If during the IFSP meeting it becomes evident that another evaluation is needed for additional information, a Supplemental Evaluation can be requested by anyone present. If requested, indicate by checking *yes* and specify what type of evaluation is requested. Explain the reason for the request. A **Request for Additional Evaluation** form should be completed and attached to the IFSP. The OSC must follow-up to assist the family in scheduling the evaluation and ensuring that it takes place in a timely manner.

INSTRUCTIONS FOR IFSP PAGE 7A

TRANSITION PLAN

This page and Page 7B must be completed for any child leaving EI, regardless of his/her age. If the child remains in EI, these pages must be filled out at the IFSP closest to the child's second birthday and updated at each subsequent IFSP review. For a child entering EI after age 2, these pages must be completed at the initial IFSP and any subsequent reviews.

- 1. Information regarding transition** – The parent will sign and date in this box after the information has been explained. If the child no longer requires EI services, the Ongoing Service Coordinator (OSC) will assist the parent to access other early childhood programs as appropriate. If the parent is considering CPSE services, the steps to be taken must be explained and the dates for *Notification*, *Transition Conference* and *Referral* filled in. In addition, write the number of the Department of Education Region and District in which the child resides.

It is important that the parent understand that it is the parent's responsibility to refer the child to the CPSE for initial evaluations. The OSC should assist the family by helping them write the referral letter and mailing or faxing it to the CPSE. The OSC may, if asked by the parent, assist the family with follow-up. The parent must be informed that his/her child will no longer be eligible for EI services after turning 3 unless the child has been found eligible for services by the CPSE. **Include the date on which the child's services will end, i.e., the day before the child's third birthday, in #3 of this section.**

At the parent's request, the service coordinator may attend the CPSE meeting to determine the child's eligibility for preschool special education services.

- 2. Parent has chosen not to** – The parent must indicate by initialing on the appropriate line which steps toward transition s/he has refused. **Include the date, i.e., the day before the child's third birthday, on which the child's EI services will end.** The parent must sign and date in this box if referral to the CPSE has been refused.

INSTRUCTIONS FOR IFSP PAGE 7B

TRANSITION PLAN

This is the second page of required documentation for children leaving EI for any reason and for children who are 2 years of age or older.

1. **What types of setting/services are being considered?** – List the options that have been discussed with the parent and in which the parent shows interest. These may include both government sponsored (e.g., CPSE, OMRDD, Head Start) and private alternatives (e.g., child care, preschool, playgroups).
2. **Date by which steps to prepare the child and family to adjust to a new setting should begin** - Complete the date, either 6 months prior to the child's discharge or when the child is leaving EI before his/her third birthday.
3. **Describe steps to be taken to ensure a smooth transition** –What steps can be taken to assist the transition and the child and family's adjustment to a new setting? For example, SC and interventionists may begin talking to the child and family about changes in services and settings; provide referrals and literature to the family; suggest visiting possible sites or contacting community agencies.
4. **Who will assist?** – List the names of those who might assist, such as current interventionists, staff at the provider agency, community agencies (e.g., ECDC).
5. **Parent's Signature** – The parent should:
 - Complete this part of the form by indicating why the child is leaving EI before the 3rd birthday (e.g., family is relocating, child no longer needs services),
 - Understand the options to refer the child to EI or CPSE depending on the child's age,
 - Sign and date the form.
6. **Update** –At each subsequent IFSP meeting, update the status of the child's progress toward transition by filling in the date on the appropriate line. Refer to the policy on *Transition* for further information.

INSTRUCTIONS FOR IFSP PAGE 8

ATTESTATIONS, CONSENT FOR SERVICES

1. **First Parent's Signature** – Signature of the parent/guardian(s) indicating s/he has read the bulleted points in the box below the child's identifying information and understands his/her rights and responsibilities. *The EIOD must ensure that the parent understands his/her rights in the Early Intervention Program and has received copies of My Family's Rights and the EIP Policy on Make-up Sessions.*
2. **Second Parent's Signature, Agreement with Plan** – Indication of agreement/disagreement with the plan outlined on the previous pages. Check the appropriate box and record any disagreement the parent(s) has with the recommended services on this page. The parent(s) **must sign and date** this form.

If the parents and the EIOD do not agree on any part of the IFSP, the sections of the proposed IFSP that are not in dispute should be implemented. The parents/guardians may exercise their due process rights to resolve the disputed areas. The EIOD and SC must ensure that the parents/guardians understand their due process rights to request mediation or an impartial hearing. The parents/guardians should be referred to the Early Intervention Program's "A Parent's Guide" for information on mediation/due process forms and procedures.

3. **Attestations and Signatures** – The evaluation representative and the EIOD must sign and date the IFSP attestation at the initial IFSP meeting. The EIOD will use the official NYCEIP stamp and sign and date this page for each IFSP, indicating authorization of the plan.