Nebraska Early Development Network

Technical Assistance Guidebook

Nebraska Early Development Network

Babies can't wait

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Contents

Introduction

Section 1: Overview 1-1
Section 2: Comprehensive Child Find System 2-1
Section 3: Services Coordination 3-1
Section 4: Referral 4-1
Section 5: Intake 5-1
Section 6: Post-Referral Screening 6-1
Section 7: Initial Evaluation and Assessment of the Child 7-1
Section 8: Eligibility Determination 8-1
Section 9: Guidance on Family-Directed Assessment Practices 9-1
Section 10: Interim Individualized Family Service Plan (IFSP) 10-1
Section 11: Initial Individualized Family Service Plan (IFSP) and Implementation 11-1
Section 12: Ongoing Assessment 12-1
Section 13: Periodic IFSP 13-1
Section 14: Annual IFSP 14-1
Section 15: Transition Planning and Implementation 15-1
Section 16: Reference 16-1

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1 Overview

Introduction

Procedures described in this manual meet requirements for implementation of the *Individuals with Disabilities Act, Part C – Early Intervention Program for Infants and Toddlers with Disabilities* (IDEA-2004) and are based on the *Nebraska Department of Education and Health and Human Services Administrative Codes 92 NAC 52 and 480 NAC 1.*

Background information

Nebraska has provided early childhood special education services to children birth to 5 years of age since 1978. Nebraska is one of five states with a "birth mandate" law. Birth mandate means a free and appropriate public education (FAPE) is provided to children from birth to age 21. States with birth mandates may not charge parents for early intervention (EI) and/or special education services.

Federal legislation was first proposed to support nationwide early intervention services for infants and toddlers in 1986, as an amendment to the Education of All Handicapped Act (P.L. 94-142). The *Part C – Early Intervention Program for Infants and Toddlers with Disabilities* was reauthorized in 1997 and again in 2004 under the Individuals with Disabilities Improvement in Education Act (IDEA 2004).

Early Development Network definition

In Nebraska, Part C services to infants and toddlers have been designated as the Early Development Network (EDN). EDN is a family-centered, community-based and culturally competent system of early intervention services [§43-2502.03 – 43-2502.04].

Infrastructure

The Co-Lead Agencies for EDN are the Nebraska Departments of Education (NDE) and Health and Human Services (DHHS), which have administrative, programmatic, and fiscal oversight, ensuring that regulations and guidelines are followed [§43-2505].

Interagency Planning Region Teams (PRTs) were established by NDE and are responsible in assisting in the planning and implementation of the Early Intervention Act in each local community or region [§43-2512].

The infrastructure of the EDN system is supported through LB 520 and the Nebraska Early Intervention Act of 1993.

Core components offered at no cost

All children in the EDN system are to receive, at no cost to the family, the following:

- Screenings, evaluations, and assessments;
- Services coordination;
- Individualized Family Service Plan (IFSP) development and reviews; and
- Needed early intervention services.

Appropriate EI services are provided year-round to families with eligible infants and toddlers (birth through August 31, following their third birthday) who have a developmental delay or a high probability of experiencing developmental delays.

EDN family-centered services

Family-centered practice guides the design and implementation of EDN services for infants, toddlers, and families; these services are philosophically and procedurally different from IDEA Part B Special Education services (for children ages 3-21). EDN services are designed to build the family's capacity in various ways.

The following researched-based principles are the foundation of the EDN (Family-Centered Practices and Provision of Services in Natural Environments):

Principle	Family Centered Practices
1	The overriding purpose of using family-centered practices is family empowerment, which directly influences the well-being and development of the child.
2	Mutual trust, respect, honesty, and open communication characterize the family-provider relationship.
3	Families are active participants in all aspects of decision-making. They are the ultimate decision-makers in the amount, type of assistance, and support they seek to use.
4	The ongoing work between families and providers is focused on identifying family concerns (priorities, hopes, needs, goals, or wishes) and finding family strengths, services, and supports that will meet the family's needs.
5	Efforts are made to build on and use the family's informal community support systems before relying solely on professional, formal services.
6	Providers across all disciplines collaborate with families to provide resources that best match what the family needs.
7	Support and resources need to be flexible, individualized, and responsive to the changing needs of families.
8	Providers are cognizant and respectful of families' culture, beliefs, and attitudes as they plan and carry out all interventions.

EDN family-centered services (continued)

Principle	Provision of Services in Natural Environments[1]
1	Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
2	All families, with the necessary supports and resources, can enhance their children's learning and development.
3	The primary role of a service provider in early intervention is to work with and support family members and caregivers in children's lives.
4	The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles, and cultural beliefs.
5	IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
6	The family's priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
7	Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

EI services criteria

Principle	EI services means developmental services that:
1	Are provided under public supervision;
2	Are selected in collaboration with parents;
3	Are provided at no cost;
4	Are designed to meet the developmental needs of the eligible infant or toddler and the needs of the family to assist appropriately in the infant's or toddler's development, as identified by the IFSP team, in any one or more of the following areas: • Physical development, including vision and hearing, • Cognitive development, • Communication development, • Social or emotional development, or • Adaptive development;

EI services criteria (continued)

Principle	EI services means developmental services that: (continued)
5	Meet the standards of the state and the requirements of Part C of the IDEA;
6	Include the identified services on the following pages;
7	Are provided by qualified personnel;
8	To the maximum extent appropriate, are provided in natural environments*, including the home or community settings in which children without disabilities participate; and *More information about natural environments can be found at the end of this section.
9	Are provided in conformity with an IFSP that meets Part C requirements/rules and are based on peer-reviewed research to the extent practicable.

EDN services provided

Services Coordination is the only EDN service that all children and families receive. EI services made available to eligible infants and toddlers include the following [92 NAC 52-003.09A]:

- Assistive technology devices and services;
- Audiology services;
- Family training, counseling, and home visits;
- Health services;
- Medical services only for diagnostic or evaluation purposes;
- Nursing services;
- Nutrition services;
- Occupational therapy;
- Physical therapy;
- Psychological services;
- Sign language and cued language services;
- Social work services;
- Special instruction;
- Speech-language pathology services;
- Transportation services and related costs; and
- Vision services.

Note. Post-referral screenings, initial evaluation or assessments, and ongoing assessments are also provided to families at no cost as a part of the IFSP process [92 NAC 52-006 and 52-007].

Additional EI services requirement

The services listed above ***do not constitute an exhaustive list*** of the types of EI services that may be provided. There is nothing in the state regulations that prohibits the identification in the IFSP of another type of service as an EI service, provided that the service meets the nine criteria for EI service requirements on page 1-4.

"Other services"

Both early intervention and "other services" may be needed by the child/family in order to achieve their IFSP outcomes. To the extent appropriate, the IFSP must include medical and "other services" connected to a child's outcomes in order to meet the child's needs, but are not required under IDEA, Part C.

In addition, there can be agencies or programs involved with the family that provide services that ***are not*** linked to an IFSP outcome. These agencies or programs should be documented with family information on the IFSP.

Documenting "other services"

"Other services" ***must be*** documented on the IFSP service page. This includes identifying medical and other services that the child or family needs or is receiving through other sources. However, because these services are not required, funded, or monitored under IDEA, Part C, these "other services" are not required to meet the 30-day timeline for initial service provision.

EI services offered at no cost

All children in the EDN system are to receive, at no cost to the family, the following services:

- Screenings, evaluations, and assessments;
- Services coordination;
- IFSP development and reviews;
- Needed early intervention services (does not include "other services"); and
- Transition planning for exiting EDN.

Early intervention services listed on the IFSP as an EI service must be provided at no cost to the family. Nebraska is one of five states with a "birth mandate" law. States with birth mandates may not charge parents for any of those services. Birth mandate means states with a requirement that FAPE be provided to children from birth to age 21, which includes special education services.

Year-round services

EI services provided by the school district or approved cooperative may not be interrupted, modified, or otherwise changed for reasons unrelated to the child's needs, such as service provider availability or scheduling [92 NAC 52-007.07A].

Federal indicator of timely services

Data about timely services are collected and reported annually in a Federal indicator in order to show regional and state performance of this requirement (Indicator C1). All states collect data on all new services provided within the state's definition of timely delivery of services, which are reported in Nebraska's Part C Annual Performance Report (APR). Nebraska has defined timely services as:

> *Timely services are measured per child within 30 days from the date of parental consent for the services listed on the initial IFSP and all subsequent IFSPs [92 NAC 52-007.04D].*

Parents' consent to or decline of EI services

Parents have the right to agree to all or some of the recommended services. Only the services that parents consent to on the IFSP are provided to the child/family. If a parent does not provide consent for a particular EI service or withdraws consent after initially receiving the service, that service cannot be provided. Parents may also decline all EI services recommended by the IFSP team.

Natural environment definition

The term *natural environment* means settings that are natural or typical for a same-aged infant or toddler without a disability, and which may include home or community settings. EI services, when provided in settings other than the natural environment that are most appropriate, must be determined by parent and the IFSP team only when EI services cannot be achieved satisfactorily in a natural environment. Intervention should be embedded into the child's natural routines [92 NAC 52-003.22 and 52-007.04C2] and daily activities as much as possible in order to promote the child's learning. If the intervention cannot be provided in natural routines and daily activities, a plan should be made for how and when the intervention will become part of the natural routines and daily activities.

Settings	Definitions
Home	Principal residence of family/caregiver
Community	Childcare, preschool, library, grocery store, park, restaurants, community centers
Other	Not home- or community-based: for example, hospital, residential facility, clinic, center/classroom for children with disabilities

Natural environment requirements

There are four requirements that service coordinators and service providers must implement related to services in natural environments.

Services must be provided in natural environments.

To the maximum extent appropriate to the needs of the eligible child, early intervention services are to be provided in a natural environment.

Setting other than a natural environment.

The provision of EI services for each eligible child may occur in a setting other than a natural environment only if the parent and IFSP team determine that EI cannot be achieved satisfactorily for the child in a natural environment. This decision must be based on the evaluation results, as well as the assessment of the child and family, and is meant to achieve the outcomes on the IFSP.

Exceptions to natural environments.

The provisions regarding natural environments do not apply to services listed in an IFSP that are intended to meet the needs of a parent or other family member and not the needs of the child, such as participation of a parent in a parent support program.

Justification for other setting in an IFSP.

For each EI service to be provided to the child, the IFSP team shall determine if the child's needs are being met in a natural environment. If the team determines that a specific service for the child must be provided in a setting other than a natural environment, such as a center-based program that serves children with disabilities or another setting appropriate to the age and needs of the child, a justification must be included in the child's IFSP.

Federal indicator of natural environments

Data about natural environments are collected and reported annually in a Federal indicator in order to show regional and state performance of this requirement (Indicator C2). All states collect data on the primary setting of EI services and have set targets, which are reported in the Nebraska *Part C APR*.

Federal indicator of timely and accurate data

Data about IFSP procedural requirements are collected and reported annually to the U.S. Department of Education. Information on timely and accurate data is reported in Indicator C14 in Nebraska's *Part C APR*. Accuracy of IFSP data is important because local, state, and federal stakeholders make decisions based upon the indicator information. School districts or approved cooperatives are monitored annually about the timeliness and accuracy of the data they provide.

2 Comprehensive ChildFind System

Introduction

The Nebraska Departments of Education and Health and Human Services, as co-lead agencies, ensure that (a) all infants and toddlers with disabilities in the state who are eligible for early intervention (EI) services are identified, located, and evaluated; and (b) an effective method is developed and implemented to identify children who are in need of EI services [92 NAC 52-006].

ChildFind for Early Development Network (EDN) and the identification of eligible infants and toddlers are year-round requirements conducted by the Planning Region Teams (PRTs), school districts, and services coordination agencies.

Collaborative partnerships needed

In addition, the co-lead agencies and PRTs collaborate with state and community partners to ensure that the child find system is coordinated with agencies responsible for administering various education, health, social service programs, and tribes/tribal organizations that receive funds under Part C, including the following [34 CFR 303, 302(c)]:

- ChildFind, which is authorized under Part B of the Individuals with Disabilities Improvement in Education Act (Special Education);
- Maternal and child health agencies (Maternal and Child Health Bureau, or Title V);
- Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT);
- Developmental Disabilities Assistance and Bill of Rights Act, administered by the Department of Health and Human Services;
- Early Head Start;
- Head Start;
- Supplemental Security Income (SSI) program;
- Medicaid;
- Child protection and welfare programs, including programs administered by the Department of Health and Human Services;
- Childcare programs;
- Programs that provide services under the Family Violence Prevention and Service Act;
- Early Hearing Detection and Intervention (EHDI) system; and
- Children's Health Insurance Program (CHIP).

ChildFind system components

The EDN comprehensive child find system in Nebraska is based on the following [§43-2507]:

- Public awareness, including access to EI materials;
- A central directory of services that are accessible to the general public; and
- Comprehensive identification and referral procedures.

Pre-referral activities: Public awareness program

Public awareness materials are available to inform the public of the EDN system. Materials are provided to agencies and organizations having a direct interest in early intervention to help locate and refer potentially eligible infants and toddlers from birth to 3 years of age. Materials distributed include information about:

- Child development;
- The referral process;
- Availability of EI services;
- EDN central point of contact; and
- The central directory.

Funding for public awareness materials are provided to assist in the comprehensive child find system through the Annual Support/Systems Change Grants administered by PRTs.

Public awareness materials - online access

A host of online resources about EDN are available to the public at edn.ne.gov.

Central directory of services

A central point of contact and directory was developed for ease of public access to EDN information and services.

The statewide point of contact, Nebraska ChildFind, provides a toll-free number that is available statewide to link callers to information about EDN services.

The *Early Development Network Referral Resource Directory* provides the central point for contact for EDN referrals at the state and local level. The Early Development Network Services Coordination Agency is the local central point of contact within each PRT.

Resource	Access
Statewide EDN central point of contact	Toll Free: 1-888-806-6287 childfind.ne.gov
Statewide EDN central directory	edn.ne.gov

3 Services Coordination

Introduction

The overall purpose of Early Development Network (EDN) services coordination is to assist and enable an eligible infant or toddler and the child's family to receive the services and rights, including procedural safeguards, required in NDE 92 NAC 52 and DHHS 480 NAC 1 state regulations.

Definition

Services coordination is an active, ongoing process that involves:

1. Assisting parents of infants and toddlers with disabilities in gaining access to, and coordinating the provision of, the early intervention (EI) services;
2. Using family-centered practices in all contacts with families; and
3. Coordinating the other services identified in the Individualized Family Service Plan (IFSP) that are needed by, or are being provided to, the eligible infant or toddler and that child's family.

Appointment of Services Coordinator

A Services Coordinator shall be appointed to a family immediately after a referral is received. Continuity of services for the child and the child's family shall be a consideration in the determination of whether a change is made in the Services Coordinator at any time following the initial appointment. See Section 5: Intake, page 5-2, *Services Coordinator assigned*.

Role of Services Coordinator

Services Coordinators serve as a representative of the EDN system of EI services. They have five major roles:

1. Partner with each family in continuously seeking the appropriate services, resources, and supports necessary to benefit the development of each child being served for the duration of the child's eligibility.
2. Assist the family in accessing EI services and resources from a variety of formal and informal community agencies or providers.
3. Facilitate communication among EI service providers across agencies, resulting in a more coordinated and responsive delivery system.
4. Use family-centered practices in all contacts with families.
5. Ensure the development and implementation of the IFSP within required timelines.

Family-centered principles and practices

The relationship between the Services Coordinator and the family demonstrates family-centered practice as described in Section 1, pages 1-2.

Federal indicator family outcomes

Survey data from families in EDN are collected and analyzed to assess the impact of EI services on families. Data are reported annually in order to show regional and state performance. All states collect data on a family survey and have set targets. Each Planning Region should meet the state target, which is reported in the *Part C APR, Indicator C4*. Nebraska collects Indicator C4 data using the Early Development Network Family Survey. The EDN system uses this indicator as a general means to evaluate the overall effectiveness of its services coordination system.

Services Coordinator responsibilities

Each eligible infant and toddler and their family must have one Services Coordinator who is responsible for:

1. Coordinating all EI and other services required under EDN across agency lines; and
2. Serving as the single point of contact for carrying out the specific services coordination services listed in the following table.

	Services Coordinator Responsibilities
1	Explaining the system of services and resources known as EDN.
2	Assisting parents of infants and toddlers with disabilities in obtaining access to needed EI services and other services identified in the Individualized Family Service Plan (IFSP), including making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families.
3	Coordinating the provision of EI services and other services (such as education, social, and medical services that are not provided for diagnostic or evaluative purposes) that the child needs or is being provided.
4	Coordinating evaluations and assessments.
5	Facilitating and participating in the development, review, and evaluation of IFSPs.
6	Conducting referral and other activities to assist families in identifying available EI service providers.
7	Coordinating, facilitating, and monitoring the delivery of required services to ensure that the services are being provided in a timely manner.
8	Conducting follow-up activities to determine that appropriate Part C services are being provided.

	Services Coordinator Responsibilities (continued)
9	Informing families of their rights and procedural safeguards.
10	Coordinating the funding sources for required services.
11	Facilitating the development of a transition plan to preschool, school, or if appropriate, to other services.

Services coordination at transition

The Services Coordinator is responsible for initiating discussion with the family about transition within the timelines established by IDEA Part C, which are within 9 months and not fewer than 90 days before the third birthday of the child. Responsibilities include development of a transition plan, as appropriate.

Services coordination activities at the time of transition include:

- Preparation of the child and family for transition;
- Notification to the district that the child is potentially eligible for preschool services under Part B of IDEA;
- Preparation for the transition planning meeting;
- Facilitation of the transition planning meeting; and
- Implementation of the transition plan.

Note: More specific information procedures for transition responsibilities can be found in Section 15: Transition Planning and Implementation.

Minimum services coordination requirement

Services coordination varies among families and within any given family over time. Services coordination frequency and intensity must be responsive to the changing child and family needs.

EDN has established a policy for the minimum amount of services coordination to be provided to each eligible child and their family:

- One face-to-face contact with the child and family every other month; and
- Telephone or written contact occurs in the months in which a face-to-face contact does not occur.

Documentation of services coordination requirements

Ongoing, accurate, and timely documentation of services coordination activities for each child/family is maintained by using the CONNECT Narrative format.

Note: See Narrative Policy (Attachment A) and Billing Policy (Attachment B) for EDN services coordination.

Attachment A

NDE	Infants, Toddlers And Families	DHHS

Early Development Network Policy Bulletin

EDN Services Coordination Narratives

Services coordination is *"an active, ongoing, flexible, individualized process of interaction facilitated by a Services Coordinator to assist a family of an eligible infant or toddler with disabilities within a community . . . to identify and meet the family and child's needs through coordination of informal and formal supports." (480 NAC 1)*

This policy sets forth the following services coordination narrative guidelines.
Services coordination narrative must include dated chronological documentation of the following:

1. Communication with the family, noting the Services Coordinator's location;
2. Communication with service providers;
3. Services Coordinator decisions and actions;
4. Referrals to resources, including, for example, when applications are mailed or items submitted;
5. Services delivery monitoring;
6. Other factual information and services coordination activity relevant to the case.

Documentation must be objective and free from bias.

Narrative Requirements:

For Early Development Network (EDN) Services Coordination, **documentation** of any contact made with a child/family/service provider/agency for the purpose of services coordination is **required** and must be contained in the **narrative** section of the client's EDN case page on **CONNECT**. Documentation of any contact must follow the format prescribed by the CONNECT narrative template to include, but should not be limited to:

- Date, place and type of contact;
- Reason for contact;
- Person (Services Coordinator/agency) completing the contact;
- Person with whom primary contact is made;
- Names/titles of others present/involved during contact;
- Description/outcome of the contact, and;
- Further follow-up needed.

Until further notice, the "Start Time" and "Stop Time" categories of the CONNECT narrative are not mandatory.

The "Goal Progress" and "Service Delivery Monitoring" categories should be completed at least one time per month during the contact in which the Services Coordinator and family discussed the progress of the IFSP outcomes/goals.

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Attachment A

NDE	Infants, Toddlers And Families	DHHS

Early Development Network Policy Bulletin

EDN Services Coordination Narratives

REQUIRED DOCUMENTED CONTACTS/NARRATIVES THAT MUST BE REFLECTED ON CONNECT:

*Assessment activities, including taking child/family history; identifying the needs of the infant/toddler, family strengths and priorities; gathering information from other sources such as family members, medical providers, persons known to the child and educators to form a comprehensive assessment of the family.

*Development and periodic/annual review of IFSP

*Referral and related activities to help infant/toddler obtain needed services and/or linking family with needed service providers to address/achieve goals of IFSP

*Monitoring and follow-up activities necessary to ensure IFSP is effectively implemented and adequately addresses needs of infant/toddler. These activities may be with the family members, providers, etc

QUESTIONS? Contact EDN personnel at DHHS Jessica Anthony Jessica.Anthony@nebraska.gov

Attachment B

NDE	Infants, Toddlers And Families	DHHS

Early Development Network Policy Bulletin

EDN Services Coordination Medicaid Billing Procedures

Services coordination is "an active, ongoing, flexible, individualized process of interaction facilitated by a Services Coordinator to assist a family of an eligible infant or toddler with disabilities within a community to . . . identify and meet the family and child's needs through coordination of informal and formal supports." (480 NAC 1)

In accordance with 480 NAC 1, *"The **Services Coordinator** shall **contact** the family **at least monthly** to review the progress of the IFSP [plan]."* This contact must be face-to-face contact with the family and child at least every other month.

BILLABLE CONTACTS

For Early Development Network (EDN) services coordination, **contact** is an encounter with the family and child that relates to the needs of the particular child and family that are or may be included in their Individualized Family Service Plan (IFSP). For billing purposes, **Services Coordinators** making contacts **must maintain a level of competency** to successfully perform contractual obligations **(EDN Services Coordination Contract, Section III., Scope of Services)**. This applies to the Supervisor(s) as well.

As such, a billable unit is a month in which contact is made with the family and child. The contact **must** be a reasonable attempt to **accomplish** the above objectives and goals of **services coordination**. Such contacts may include but are not limited to the following actions taken with the child and family by the Services Coordinator or Supervisor:

1. Visit informally with the family to gather intake/assessment information and establish rapport;
2. Secure information releases to facilitate sharing of information and notification of the referral source that contact has been made with the family;
3. Identify family needs, strengths and priorities;
4. Assist the family in forming the IFSP team and gaining access to services;
5. Serve as liaison between the family and service providers relative to the needs of the family while at the same time encouraging the family to take this role;
6. Assist the family in identifying gaps in services and relaying that information to the IFSP team and other agencies;
7. Work with the family to develop strengths and skills needed to support the child with the disability;
8. Facilitate and support parents' advocacy skills;
9. Coordinate and chair IFSP team meetings and conduct appropriate follow-up to ensure plan implementation (initial, periodic reviews and others);
10. Facilitate communication between the IFSP team, family and other service providers; and
11. Facilitate problem-solving and the collaboration of team members around the changing needs of the infant or toddler and assist in making needed adjustments to the IFSP and service arrangements with providers.

(continued on reverse side)

Attachment B

NDE	Infants, Toddlers And Families	DHHS

Early Development Network Policy Bulletin

EDN Services Coordination Medicaid Billing Procedures

BILLABLE CONTACTS *(cont.)*

Documentation of any contact made with a client for the purpose of Services Coordination is **required** and must include but should not be limited to:

- Reason for and nature/content of the contact;
- Date, place and/or type of contact;
- Who participated in the contact;
- Services Coordinator/agency involved;
- Outcome of the contact; and
- Further follow-up needed.

All payment requests for Early Development Network (EDN) services coordination (SC) are completed through DHHS's web-based "**CONNECT**" system. Billings are automatically generated monthly for each Services Coordinator based on each coordinator's "open" EDN cases and must be properly completed in accordance with the following guidelines:

1. Each claim (line) of the billing must include ALL of the applicable information requested. Most of this is automatically populated through CONNECT from the "Client" and "EDN Case" records.
2. A maximum of one (1) unit of service per child per month per region may be claimed by a providing agency. If a child moves from one (1) region to another but the child/family continues to be served by the same EDN Agency/Services Coordinator, one (1) of the claims should be submitted by the SC to their supervisor with a "0" Type/Site code and "COMPLETED" by the Supervisor.
3. A separate billing will be generated for each month of service for which the EDN case is "open."
4. At least one (1) contact indicated by the "Type/Site" code for the child and month billed must have been performed by a **Services Coordinator** or Supervisor who **maintains an ongoing level of competency** to successfully perform contractual obligations (EDN Services Coordination Contract, Section III., Scope of Services). (Enter the lowest numbered applicable T/S code.)
5. Please **submit** billing documents in a **timely** manner and on a **monthly** basis. This will help facilitate our budget monitoring of the program and assist your agency with its cash flow.
6. Whenever a claim is made for a month where there was no face-to-face contact with the child and family, a face-to-face contact must be achieved before a subsequent month's claim can be submitted for payment. However, consideration will be made when the services coordination case is closed. If the honest and full intent was to permanently close the case and more than one (1) calendar month lapsed before a referral or request to reopen is made, payment will be considered even though face-to-face contact is not achieved. Written documentation and justification must be attached and accompany the billing.

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Attachment B

7. On the off-month when a face-to-face contact is not required, **phone** communication is the desired form of contact. If timely attempts to communicate by phone are unsuccessful (and documented), or the family requests contact via another modality (documented), **written** correspondence **may be considered** a contact. Written correspondence includes postal mail and interactive electronic modes of communication, such as email and texts. "Type/Site" code "98" should be entered on the applicable claim line when written correspondence is the only contact made during the month. Please include very brief "Notes" with the claim that **explain** the type of correspondence and the circumstances surrounding the client's situation. Please note that mass distribution of blanket mailings, notices, brochures, form letters or general memorandums cannot be construed as "providing Services Coordination" for the purposes of defining billable contacts.
8. On the rare occasion when **no contact** was made face-to-face, by phone or in writing but the contractor feels that services coordination was rendered and wishes to bill for the month, a claim **may be considered** by the Department. A "Type/Site" code "99" ("Other Encounter Not Face-to-Face") should be entered and a very brief "Note" is **required**. The Department will make a determination as to the appropriateness of payment based on the information submitted and received. "Type/Site" code "99" should also be used when "Face-to-Face" contact is required but extenuating circumstance(s) prevented such contact and other Services Coordination (including phone contact) was provided. Contact EDN personnel at DHHS if you have questions regarding this or any billing situation.

Please keep all claim "**Notes**" very short and concise. If the information included in the "**Notes**" section of the claim no longer applies or effects the processing of the claim, please remove it before submitting the claim(s) to DHHS.

It is not expected that the above list addresses all billing questions. Unique situations are bound to occur and will be handled in a collaborative manner by EDN personnel at DHHS on a case-by-case basis.

QUESTIONS? Contact EDN personnel at DHHS Jessica Anthony Jessica.Anthony@nebraska.gov

4 Referral

Referral definition

Referral is a systematic method to link potentially eligible children and families to Early Development Network (EDN).

- Written parental consent is not required to refer an infant or toddler to EDN. However, to adhere to family-centered practices, parents should be informed prior to referring the child.
- A child should be referred to EDN if there is any indication of a concern by a professional or parent.

Coordination of referrals

Referrals may be coordinated through four resources:

- Nebraska's statewide central point of contact, Nebraska ChildFind;
- EDN Services Coordination agencies/offices;
- School districts; and
- Co-lead agencies Nebraska Department of Education [(NDE)] and Nebraska Department of Health and Human Services (DHHS).

Using established procedures, these entities will collect all pertinent information and fax, email, and/or call the local EDN central point of contact (EDN Services Coordination agency) with the referral information. As noted above, referrals may be made directly to the EDN Services Coordination Agency within each Planning Region Team (PRT) Region. Referral data are managed through the EDN Services Coordination Agency's CONNECT computer system to collect and analyze state and regional data to assess the effectiveness of EDN.

Note: The Co-lead agencies and Nebraska Child Find facilitate referrals and are NOT considered primary referral sources (see primary referral sources list on page 4-3).

Redirecting referral information

Co-Lead agencies, Nebraska Child Find, and EDN Services Coordination staff must be prepared to take referral information from any referral source and for any region. If a referral call is received for a child who does not live in the region where the call is received, agency staff should accept the referral information. Agency staff must promptly pass the referral information to the appropriate region. Agencies will not tell the referral source to call the appropriate Agency.

Transfer of the referral information is accomplished by:

If…	Then…	And...
A referral comes into a region other than where the child resides	The receiving agency answering the phone takes the information to begin the intake process	The receiving agency faxes, calls, or emails the information to the appropriate EDN Services Coordination Agency.

Child Referred less than 45 days prior to the 3rd Birthday

Occasionally referrals will be received less than 45 days from the toddler's 3rd birthday. The Co-lead agencies recommend that teams individualize this process with families. The Services Coordinator should contact the family and explain the differences between Part C and Part B, including that if eligible, the child could remain in Part C through August 31st, following the toddler's 3rd birthday. The parent can then determine if they would like move forward with Part C or Part B. If the Parent would like to utilize Part B, the Services Coordinator would gather the parent's permission to make a referral to the appropriate school district.

Primary referral sources

Primary referral sources include but are not limited to the following:

- Parent, family, or other person designated as a parent, including parents of infants and toddlers;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT);
- Physicians (Pediatric, Family, Sub-specialty or General Practice);
- School districts/Approved Cooperatives;
- Hospitals, including prenatal and postnatal care and hospital-based high-risk follow-up programs;*
- Health, including County Public Health, home health agencies, etc.;
- Developmental Disabilities programs;
- Social Security Income (SSI) agency;
- U.S. Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS)/Child Abuse Prevention and Treatment Act (CAPTA) referrals;** CFS Specialist referrals, Foster Care;
- Child care programs;
- Maternal and Child Health program, including the Maternal, Infant and Early Childhood Home Visiting program;
- Early Head Start and Head Start programs;
- Nebraska's Early Hearing Detection and Intervention program at the DHHS Division of Public Health (EHDI);
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program;
- Families and/or provider agencies that are connecting families who have out-of-state IFSPs to Nebraska's Part C/Early Development Network;***
- Homeless family shelters;
- Domestic violence shelters and agencies;
- Supplemental Security Income (SSI) programs; and
- Nebraska's Children's Health Insurance Program (CHIP).

Referral sources: *Hospital Newborn Intensive Care Unit (NICU)

It is common for infants in the hospital (NICU) to be referred to EDN prior to discharge. It is recommended that EDN Services Coordinators contact the hospital liaisons or staff following the referral and initiate contact with the parents after the child is discharged.

The 45 calendar day timeline begins when the child is discharged from the hospital. The EDN Services Coordinator will contact the family when appropriate either before discharge or immediately following discharge.

Referral sources: **DHHS – Division of Children and Family Services/CAPTA

The Nebraska Departments of Education and Health and Human Services have agreed upon department roles and the process used to refer children with substantiated cases of abuse or neglect to EDN.

The agreement includes the following:

Step	Action
1	The Division of Children and Family Services (CFS) of DHHS provides EDN Services Coordination agencies an automated weekly list of children younger than 3 years of age who have a substantiated case of abuse/neglect.
2	If child is a state ward, an automated state ward notification letter is generated to school district.
3	The EDN Services Coordination agency immediately assigns a Services Coordinator who contacts the family.
4	The EDN Services Coordinator contacts family to set up home visit to discuss EDN program. The Services Coordinator also contacts the foster parent to inform them a referral has been made and to determine if the foster parent has concerns for the child.
5	At the home visit, the EDN Services Coordinator explains program and obtains consent to evaluate child, or family declines to participate.
6	School district determines if a parent represents the child or if a surrogate parent is needed based on Rule 52, and shares the information with the EDN Services Coordinator.
7	School district begins the process of eligibility determination for early intervention services.
8	The EDN Services Coordinator notifies DHHS CFS worker of child's early intervention eligibility via email or phone. EDN Services Coordinator sends a copy of the evaluation to the CFS worker if parent has given written consent, or if a court order is received by the EDN Services Coordination Agency in which the court has ordered the evaluation of the child.

Step	Action (continued)
9	If child is found not eligible, the EDN Services Coordinator sends form HHS-6 notification to the family, and school district provides family written notice of ineligibility.
10	If the child is found eligible for early intervention, a meeting will be scheduled to develop the Individualized Family Service Plan (IFSP). The EDN Services Coordinator will invite appropriate representatives (i.e., parents, CFS worker, school district providers, and/or other individuals with special expertise about the child) to the IFSP meeting.
11	The EDN Services Coordinator will send a copy of the IFSP to the DHHS CFS worker and to the court, with parent permission. If evaluation was court-ordered, then the EDN Services Coordinator will explain to the family that a copy of the evaluation and IFSP must be sent to the CFS worker and court. Additionally, the Services Coordinator must provide a copy of the IFSP to the parent.

Note: DHHS Children and Family Services Specialists can also refer children for Early Intervention (EI) services prior to substantiating a finding of abuse/neglect by completing a referral form within the DHHS computer system N-FOCUS. The form is submitted directly from N-FOCUS to CONNECT.

Referral sources: ***Out-of-state

If a child and family move to Nebraska from another state and currently have an IFSP, this is considered a source of referral. (States vary in regulation to implement IDEA Part C; Nebraska's implementation procedure is to consider an out-of-state IFSP as a referral from another source.)

The following steps are used for families moving to Nebraska:

Step	Action
1	Intake/Referral is completed, following intake procedures.
2	Assign a Services Coordinator.
3	Follow Services Coordinator procedures for providing Notice and Consent for Early Intervention Initial Multidisciplinary Evaluation and Child Assessment (EI-2 Form).
4	School district discusses with the family state-to-state variation of eligibility criteria and provision of early intervention services.
5	Review the out-of-state MDT report, IFSP and any record(s) available regarding the child.

Step	Action (continued)
6	To implement early intervention services until Nebraska eligibility is determined, an Interim IFSP may be developed. See Section 10: Interim IFSP, page 10-1.
7	Determine Nebraska eligibility by (1) reviewing medical records, and (2) if needed, conducting a comprehensive multidisciplinary evaluation.
8	Conduct child and family assessment procedures. (See Sections 7 and 9).

Note: The Nebraska IFSP team is to use all timely available evaluation and assessment information from the other state as a starting point for evaluation activities (i.e., do not need to re-administer evaluations or assessments). This use of timely available evaluation and assessment information would be considered "review of existing records." See Section 8: Eligibility Determination.

Referral Sources: In-State – District to District

If a child and family move from one district to another and have an IFSP, this is considered a source of referral for the receiving EDN Services Coordination Agency and school district.

The following steps are used for families moving to a new school district within Nebraska:

Step	Action
1	Referral received.
2	Assign a Services Coordinator.
3	Services Coordinator obtains prior records regarding multidisciplinary evaluation and IFSP from previous EDN Services Coordination Agency.
4	Services Coordinator conducts the Periodic IFSP review within 30 days of receipt of the referral in order to make necessary changes.
5	The IFSP team develops and implements the IFSP and provides early intervention services within 30-days of parental consent.

Use of referral source data

Each year, EDN Services Coordination Agencies and Planning Region Teams collect and analyze sources of referral data. The Child Find data are utilized to determine effectiveness in identifying eligible infants and toddlers, including special populations, such as:

- Native American infants and toddlers;
- CAPTA-referred infants and toddlers; and
- Children whose families are homeless.

After analyzing these data, each PRT develops activities to increase and seek appropriate sources of referrals to reach all children and families who may be eligible for EDN.

Request for records

Referral sources and other agencies may have:

- Child health and medical records;
- Pre-referral developmental and/or specialty screenings, and evaluations; and
- Information about prior and current services.

If reports and records are not available from the referral source at the time of intake, the Services Coordinator seeks to obtain all existing information. A release of information form (EI-3) signed by the parent is required for the exchange of information between agencies. The authorizations are valid for up to one year, unless specified otherwise by the parent on the form.

Follow-up with referral source

Once EDN receives a referral, the Services Coordinator is required to follow-up with the referral source with permission of the family. Communication with the source of referral is important to:

- Obtain records and prior evaluations (in order to reduce duplication),
- Maintain the family's network of support;
- Sustain professional courtesy; and
- Support future referrals to EDN.

Once parental consent is obtained, on form EI-3, Services Coordinators communicate with referral sources regarding the outcome of the referral.

5 Intake

Purpose

The purpose of the intake process is to:

- Share information about the child and the System of Early Intervention (EI) Services;
- Develop rapport with the family;
- Determine if the family is interested in proceeding with the process;
- Begin to identify with the family—their daily routines, activities, and supports;
- Gather information to address the family's concerns and questions about their child's health and development;
- Begin identifying family's resources, priorities, and concerns;
- Offer referrals for immediate needs; and
- Begin the process of determining eligibility for early intervention.

The Early Development Network (EDN) intake process begins on the date of the initial contact with the Services Coordination Agency, school district or approved cooperative from the referring source (e.g., physician, family member, etc.), which is defined as the referral date.

Gather information

Note: 45-DAY TIMELINE BEGINS

During the intake process, personnel responsible for completing intakes are to gather and document the following:

- Date the referral was received;
- Referral source information. Also, if referral source is parent, how they learned about EDN;
- Reason for referral;
- Child demographic information: name, age, family's address, etc.;
- Prior pre-referral screening results, if available;
- Language spoken in the home; and
- Other important information.

Note: The **DATE the referring source contacts EDN is the start date of the 45-day timeline** for completion of evaluation, eligibility determination, and the initial Individualized Family Service Plan (IFSP) meeting.

Note: EDN Services Coordination agencies, school districts/approved cooperatives, the Co-Leads, and Nebraska Child Find, will accept all referrals they receive. Information will be taken from the referral source and promptly transferred to the region of the child's residence. Intake staff should not tell a referral source to call another region, even if the child is not currently living in their regional area. See Section 4: Referral, page 4-2, Redirecting referral information.

Federal indicator of 45-day timeline

√C-7
45-day timeline

Data that measures the timeline between date of referral and the completion of the evaluation and the initial IFSP meeting are collected and reported annually in a Federal report in order to show regional and state performance with the 45-day timeline requirement. All states collect data on the number of children whose evaluation, assessment, and initial IFSP meeting met the 45-day timeline and, if not met, reasons for not meeting the 45-day timeline. Each state is expected to meet the 100 percent target, which is reported in the *Part C APR, Indicator C7*. Nebraska collects this information for Indicator C7 from the IFSP *Intake/Referral* and *Meeting* pages.

Services Coordinator assigned

A Services Coordinator is immediately assigned to each referral to begin the Intake process.

Note: The assigned Services Coordinator may change following determination of eligibility and development of IFSP based on needs of the child and family.

First contacts

The following table provides the nine steps for initial contacts with the family. The steps may vary in sequence, locations, and times.

Step	Action
1	The Services Coordinator contacts the family by telephone, mail, or in person within 7 calendar days, supporting family-centered practices for responsiveness. (In the event that a family cannot be reached, the Services Coordinator must document all attempts to reach the family and continue to try to make contact with the family.) These contacts are documented in the Narrative section of CONNECT.
2	During first contact, most likely a telephone call, the Services Coordinator will: • Introduce self and role in EDN; • Inquire about the reason for referral; and • Schedule first visit, offering the parents a choice in date, time of day, and location. The first visit is to be completed within 7 calendar days of the first contact unless the family requests a delay.

Step	Action (continued)
3	During **the first visit**, the Services Coordinator will provide an orientation regarding EDN including: • Explaining the purpose of EDN; • Explaining a family's right to a Services Coordinator who partners with the family and coordinates services across agencies; • Assisting the family in identifying immediate concerns, with first consideration given to the family's natural and cultural supports. Referral(s) are made to service options within the community as identified through the family assessment process. Services coordination duties may include helping the family to complete forms, make telephone calls, schedule or attend appointments, or support activities that will empower families to meet their needs; • Explaining the procedural timelines, family rights and responsibilities, procedural safeguards, and the need for obtaining the family's written consent and release of information for screening and evaluation by the school district or approved cooperative in order to determine the child's eligibility for early intervention services; • Explaining eligibility criteria and what the evaluation/assessment process will look like; and • Explaining that there are no costs to families for services coordination, screening, evaluation, assessment, and if eligible, early intervention services.
4	The Services Coordinator will *begin the family assessment* process by listening to the family and exploring concerns of the family in order to: • Establish rapport; • Identify child and family strengths, concerns, and desired priorities; • Identify the services and supports needed to enhance the child's development; and • Begin anticipating evaluation needs.
5	After the family is well informed, they will decide whether to proceed with an evaluation or to decline the EDN evaluation at this time. **Note:** With parental consent, the process may start with the District ***conducting a post-referral development screening*** if there was no pre-referral development screening completed prior to the referral and there is no diagnosed physical or mental condition. This *post-referral screening* may help parents decide whether they want to proceed to a full evaluation. See Section 6: Post-Referral Screening.
6	The Services Coordinator will discuss sources of existing records and evaluation/ assessment information needed for the EDN process that have already been obtained and/or need to be obtained.
7	The Services Coordinator will explain and obtain the needed Authorization for Release of Information form.

Step	Action (continued)
8	The Services Coordinator will clarify how the family and team members will communicate in future (e.g., provide contact information; establish preferences for when and how to communicate; etc.).
9	The Services Coordinator will schedule future times the family can meet with the Services Coordinator and evaluators.
10	The Services Coordinator will continue the family assessment process by conducting an interview using a *family assessment tool*. The *initial family assessment* must be conducted within the 45-day timeline if the parents agree to the assessment. See Section 9: Guidance on Family-Directed Assessment Practices.

Inability to contact family

At times, the Services Coordinator is unable to contact parents. The following guidelines describe timelines for considerations of "unable to contact."

With receipt of new referral, the Services Coordinator:

- Makes a minimum of three attempts to contact (i.e., telephone, drive by home) family within 7 calendar days from initial intake/referral;
- Uses a variety of attempts to contact at different times of day and days of week; and
- Documents all attempts to contact family in the Narrative section of CONNECT.

If…	Then…
the Services Coordinator is unable to contact the family within 7 calendar days;	the Services Coordinator mails a letter to the parents, documenting attempts to make contact. the letter requests that the parents call the Services Coordinator.
the Services Coordinator is unable to contact the family within 14 calendar days;	the Services Coordinator mails a second letter indicating the referral will be closed. **Note:** Services Coordinator *should* contact the referral source, if other than parent, to ask for assistance in contacting the family.
the family *does* contact the Services Coordinator within 7-21 calendar days from referral and is interested in EDN;	the Services Coordinator follows procedures beginning with "First contacts" on page 5-2. at initial IFSP meeting, if 45-day timeline is not met due to delay in contact with the family, document reason not met due to family reason/delay on the Concerns, Priorities page of IFSP and in CONNECT Narratives/Notes section of EDN case page.

If…	Then…
the family *does not* contact the Services Coordinator after 21 calendar days from referral;	the Services Coordinator will follow CONNECT procedures for case closure. Services Coordinator informs school district or approved cooperative accordingly.
the family is still interested in EDN and does contact the service coordinator on the 22nd or more days from the date of the referral;	the Services Coordinator assures that previous intake has been closed (as instructed above), and then enters a new intake/ referral on CONNECT.

Scenarios of consent for evaluation

Services Coordinators may encounter a number of situations related to evaluation and signed Notice and Consent for Initial Evaluation and Child Assessment. Guidance for these scenarios is provided in the table below.

If…	Then…
parent requests only one or two developmental areas to be evaluated;	the Services Coordinator explains to the family that all areas are required to be evaluated according to Federal law.
parents have signed consent for a comprehensive, multidisciplinary evaluation and the district/approved cooperative does not provide an evaluation;	the school district/approved cooperative is considered out of compliance.
parent signs consent for evaluation and cannot be found after that (to schedule or complete the evaluation);	the Services Coordinator follows procedures on page 5-5, “Inability to contact family.” the Services Coordinator sends a 2nd letter documenting that the school district will not be conducting an evaluation due to inability to contact family. Note: If the letter comes back as undeliverable, file the returned letter in the child’s record and send a copy to school district or approved cooperative accordingly.

Decline of evaluation

The parent has the right to decline or refuse evaluation for a child. If the parent declines the evaluation, the Services Coordinator makes reasonable efforts to ensure the parent:

- Is fully aware of the nature of the evaluation and assessment;
- Is fully aware that all areas of the child's development are required to be evaluated;
- Is fully aware that EDN services cannot be provided without a comprehensive multidisciplinary evaluation to determine eligibility; and
- Understands that the child will not be able to receive the evaluation unless consent is given.

Services Coordinators are to follow the steps in the table below if a parent declines the evaluation.

Steps	Action
1	Suggest other available community resources and provide contact information for future use, if needed by the family.
2	Inform the person who referred the family to the Early Intervention Program, if any, of the outcome of the referral provided the family has given written authorization. **Exception: Child Abuse Prevention and Treatment Act (CAPTA) and Early Hearing Detection and Intervention (EHDI) referrals**.
3	Provide the family with a copy of the letter sent to the referral contact, if applicable.
4	Complete the following CONNECT data entry and record keeping in order to close the file: *Narratives*, HHS-6, and *case closure* on EDN Case page of CONNECT.

6 Periodic IFSP

Introduction

Comprehensive identification procedures ensure that all children birth to 3 years of age who may be eligible for Early Development Network (EDN) are identified, located, and referred for an evaluation. The process may start with a ***post-referral developmental screening*** if there was no pre-referral developmental screening completed prior to the referral and there is no diagnosed condition. This post-referral screening may help parents decide whether they want to proceed to a full evaluation.

The following section refers to a post-referral screening, which takes place ***after*** a referral is made to EDN.

Note: Parent may request a full evaluation at any time during the post-referral process, regardless of post-referral screening results.

Post-referral screening procedures definition

Post-referral screening procedures means activities that are carried out by the school district to identify, at the earliest possible age, infants and toddlers potentially eligible for EDN, and includes the administration of appropriate instruments by trained personnel.

Note: Screening activities do not alter the 45-day timeline.

Criteria for selection of screening tools

Screening tools vary by those qualified individuals seeking to briefly appraise an infant or toddler's developmental skills. The school district or approved cooperative is responsible for selecting appropriate screening tools based on the following criteria:

- Norm-referenced for birth to 3-year-olds and standardized in administration;
- Valid and reliable;
- May be administered by professional or trained personnel as specified by the publisher;
- Provides input from families;
- Culturally and linguistically sensitive; and
- Can be administered in a reasonable, timely manner.

Post-referral screening

*When a school district or approved cooperative determines screening will be conducted, the following steps should be taken:

Step	Description
1	Services Coordinator provides and reviews Part C procedural safeguards/family rights with parents.
2	Services Coordinator obtains parent signature on *Early Development Network Consent for Initial Screening* form.
3	School district or approved cooperative completes developmental screening.

If…	Then…
screening information indicates child is suspected of having a developmental delay or disability;	a full evaluation and assessment of the child must be conducted by school district or approved cooperative, if parent consents to this activity via the Consent for Initial Evaluation and Child Assessment form. Share written results of screening with family, Services Coordinator, and referral source (if parental consent obtained) [92 NAC 52-009.03B]. See Section 7: Initial Evaluation and Assessment for how to conduct a timely, comprehensive, multidisciplinary evaluation.
screening information indicates child is not suspected of having a developmental delay or disability;	a *Prior Written Notice* (results of screening) reflecting that determination is provided to the parent, Services Coordinator, and referral source (if parental consent obtained) that includes a description of the parent's right to request a full evaluation [92 NAC 52 009.03B].

***Note:** If the parent of the child requests and consents to an evaluation at any time during the post-referral screening process, evaluation of the child must be conducted, even if the infant or toddler is not suspected of having a disability [92 NAC 52-006.03C].

Screening: Important considerations

It is important to note the following considerations:

If…	Then…
an infant's or toddler's medical records indicate the child has a diagnosed physical or mental condition;	the child is eligible for EDN. An initial assessment is required to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. See Section 7: Initial Evaluation and Assessment.
a referral is received from another agency with timely *pre-referral* screening data;	existing timely pre-referral screening information and data are acceptable for consideration and review of the child's development and should not be re-administered. With parental written consent, the team moves to a full evaluation in order to determine eligibility.
an infant or toddler has not been screened before the referral was made (no pre-referral screening), there is no diagnosed condition reported at the time of referral, and the child is not suspected of having a developmental delay;	the school district or approved cooperative (if parental consent has been obtained) may choose to conduct a post-referral screening of the child's development and then share the results with the parent, the Services Coordinator, and referral source (if parental consent obtained) [92NAC 52.009.03B].

Note: Once a referral to EDN has been made, the 45-day timeline begins. Parent's written consent is required for both a screening and an evaluation.

7 Initial Evaluation and Assessment of the Child

Introduction

The Services Coordinator is responsible for providing notice, obtaining parental consent, and coordinating the initial evaluation for the child, and the initial assessment of the child and family (See Section 5: Intake). The following Initial Evaluation and Assessment section defines terms and procedures related to activities that must be completed within 45 calendar days from the date of referral of the child.

The Co-Lead Agencies ensure that each infant and toddler who is referred for evaluation or early intervention services receives a timely, comprehensive, multidisciplinary *evaluation* unless they are otherwise determined eligible through review of medical and other records.

If determined eligible (either through identification of a diagnosed physical or mental condition or by meeting standard deviations outlined in Rule 52) through record reviews, the child receives an *assessment*, conducted by the school district, of the unique strengths and needs of that infant or toddler and the identification of services appropriate to meet those needs. In addition, the Services Coordinator conducts a *family-directed assessment* of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler.

Multidisciplinary evaluation definition

Multidisciplinary evaluation means the involvement of two or more separate disciplines or professions and, with respect to evaluation of the child, may include one individual who is qualified in more than one discipline or profession [Rule 52-003.16A].

Evaluation definition

Evaluation means the procedures used by qualified personnel to determine a child's initial eligibility to begin receiving early intervention services and continuing eligibility [Rule 52-003.07].

Assessment definition

Assessment means the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs, and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility. This includes the assessment of the child and the assessment of the child's family [Rule 52-006.07/480 NAC 1-008]. Initial assessment means the assessment of the child and the family conducted prior to the child's first Individualized Family Service Plan (IFSP) meeting.

Role of evaluation and assessment in determining eligibility

A multidisciplinary evaluation is conducted after the Services Coordinator obtains parental consent using the *Notice and Consent for the Initial Evaluation and Child Assessment form* (EI-2).

A timely, comprehensive, multidisciplinary evaluation is conducted to determine a child's initial and continuing eligibility for Early Development Network (EDN).

Evaluations and assessments are used at different steps in the eligibility determination process. *Evaluation* is a process used to determine eligibility. Once a child is determined eligible, a multidisciplinary *assessment* of unique strengths and needs of that infant or toddler is conducted. In addition, a family-directed assessment is conducted that identifies the resources, priorities, and concerns of the family as well as identifies the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The family and child assessments are critical in that they are the basis upon which the IFSP outcomes are based.

The *Eligibility Determination Decision Flowchart* on page 7-10 provides decision-making rules and processes, which can be extremely helpful in understanding when an initial evaluation is required. It will also be helpful in arriving at accurate answers to the question, "Is this child eligible for EDN participation?"

Questions and decisions to determine eligibility

In order to determine the appropriate Initial Evaluation and Assessment procedures, you must begin the process with this question: *What questions should be asked and which decisions need to be made to determine eligibility?*

The following table uses words to describe the process that is outlined in symbols on the flowchart. Details related to reviewing records, completing initial child and family assessments, and completing initial evaluations are found following this table.

If...	And...	Then...
the child *has* a diagnosed physical or mental condition known to cause later delays;	the diagnosed physical or mental condition is documented in medical or other records that are available for review;	• child is eligible for EDN, • an initial multidisciplinary assessment of the child is conducted by the district/ approved cooperative to identify unique strengths and needs in each of the required developmental areas, helping to identify the early intervention services appropriate to meet those needs, and • a family-directed assessment is conducted by the Services Coordinator in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

If...	And...	Then...
the child *has* an established delay;	the delay is documented in medical or other records that are available for review;	• child is eligible for EDN; • conduct an initial multidisciplinary assessment of the child to identify unique strengths and needs in each of the required developmental areas, helping to identify the early intervention services appropriate to meet those needs; and • conduct a family-directed assessment in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.
the child *does not have* a diagnosed condition or established delay;	a screening *was completed* before the referral to EDN (e.g., physician or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) conducts a screening) that is available for review, and parent consents to a full evaluation;	• conduct initial timely, comprehensive, multidisciplinary evaluation of the child; If child is determined eligible: • conduct an initial multidisciplinary assessment of the child to identify unique strengths and needs in each of the required developmental areas, helping to identify the early intervention services appropriate to meet those needs; and • conduct a family-directed assessment in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

If...	And...	Then...
the child *does not have* a diagnosed condition or established delay;	a pre-referral screening *was not completed* before the referral to EDN, and the *parent wants* and consents to a *post-referral* screening;	• conduct post-referral screening to determine whether the child is suspected of having a disability or a developmental delay. **Note:** A parent can request a full evaluation at any time during the screening process.
the child's *post-referral* screening results indicate a suspected disability or developmental delay; **Note:** Even if screening results do not indicate a suspected disability or developmental delay, the parent has the right to request a full evaluation, in which case you would follow this same process.	parent consents to full evaluation and assessment;	• conduct initial timely, comprehensive, multidisciplinary evaluation of the child; **If child is determined eligible:** • conduct an initial multidisciplinary assessment of the child to identify unique strengths and needs in each of the required developmental areas, helping to identify the early intervention services appropriate to meet those needs; and • conduct a family-directed assessment in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

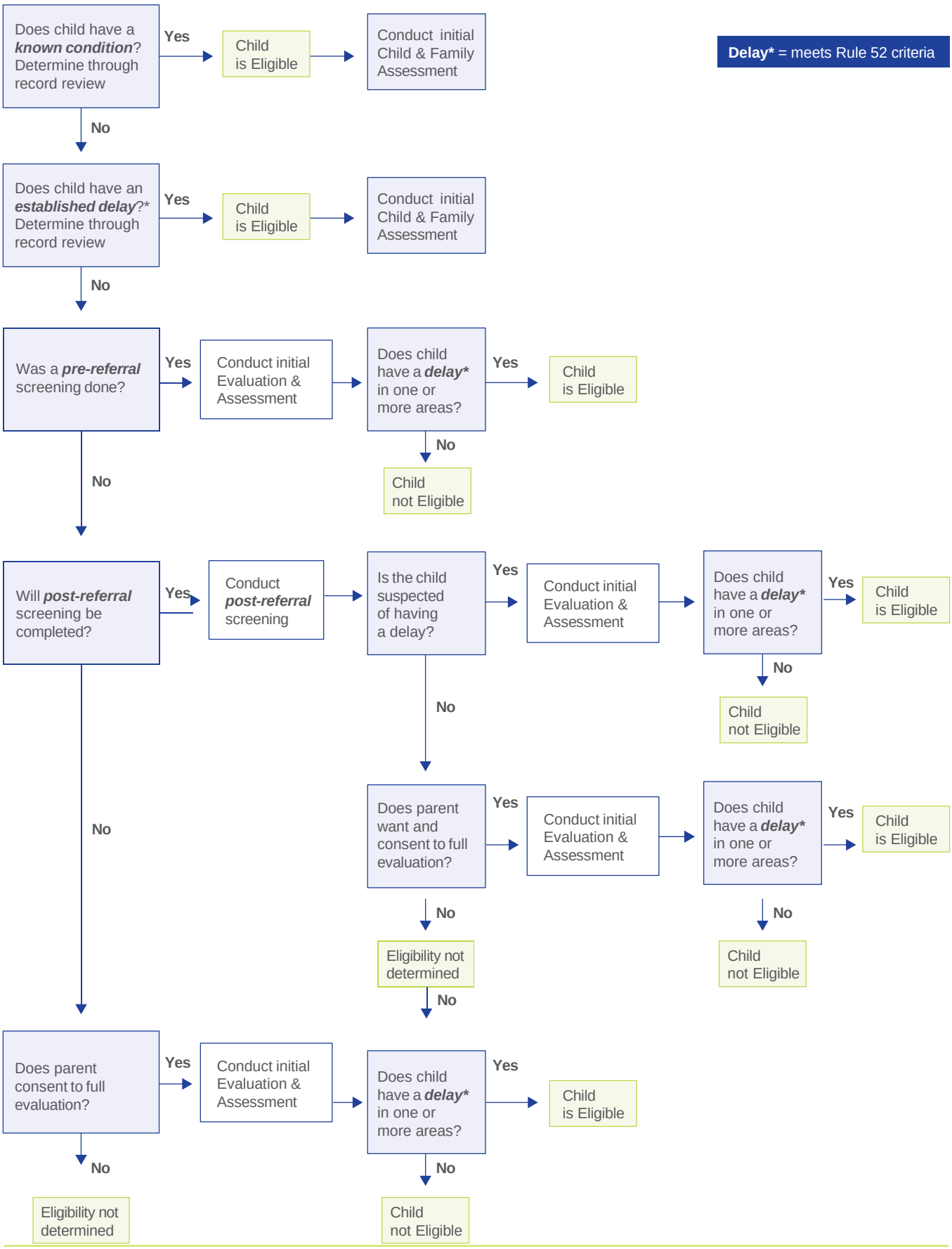
If...	And...	Then...
the child *does not have* a diagnosed physical or mental condition or established delay;	no post-referral screening will be completed, and parent consents to a full evaluation;	• conduct initial timely, comprehensive, multidisciplinary evaluation of the child; **If child is determined eligible:** • conduct an initial multidisciplinary assessment of the child to identify unique strengths and needs in each of the required developmental areas, helping to identify the early intervention services appropriate to meet those needs; and • conduct a family-directed assessment in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.
the child *does not have* a known condition or established delay;	parent does not consent to post-referral screening, and parent does not consent to full evaluation;	• eligibility cannot be determined; and • referral is closed due to lack of parental consent for completing the evaluation process. • Services Coordinator provides family with referrals to other agencies/supports according to the family's needs. • Services Coordinator informs the person who referred the family to the EDN program, if any, by letter of the outcome of the referral if the family has given written authorization. Services Coordinator gives the family a copy of the letter sent to the referral contact. • Services Coordinator sends family the HHS-6 Notice of Action form in adherence to the Department of Health and Human Services (DHHS) regulatory requirements.

Eligibility determination decision flowchart

The *Eligibility Determination Decision Flowchart* on the next page shows the basic evaluation and assessment decisions and actions needed to provide information to determine eligibility and to develop an IFSP for eligible children and their families.

While the flowchart shows the basic questions and decisions that need to be made, it does not show all the multiple questions and decisions that are made by those who are completing the child evaluations as well as the child and family assessments.

Eligibility Determination Decision Flowchart



Comprehensive multidisciplinary evaluation requirements

Multidisciplinary evaluation means the involvement of two or more separate disciplines or professions that *may include one individual* who is qualified in more than one discipline or profession (i.e., [Rule 52-003.16]).

There are a number of requirements that must be met during the evaluation process. School districts and approved cooperatives responsible for the evaluation shall ensure, at a minimum:

- No single procedure is used as the sole criterion for determining a child's eligibility for EDN.
- Procedures must include:
  - » administering an evaluation instrument;
  - » taking the child's history, including interviewing the parent;
  - » identifying the child's level of functioning in each of the developmental areas;
  - » gathering information from other sources such as family members, other caregivers, providers, social workers, and educators, to understand the full scope of the child's strengths and needs; and
  - » reviewing medical, educational, or other records.
- All developmental areas must be evaluated.
- All evaluations must be conducted in the native language of the child, unless it is clearly not feasible to do so.
- All evaluation procedures and materials are selected and administered so as not to be racially or culturally discriminatory.
- Evaluations are conducted by qualified personnel, in a nondiscriminatory manner.
- Timelines are met for completing the evaluation and IFSP meeting within 45 calendar days.
- No cost to parents.

Conduct the initial evaluation

The team conducting the initial evaluation seeks information to determine the child's level of functioning in each of the developmental areas to determine eligibility.

The following areas of development are required to be evaluated:

- Adaptive
- Cognitive
- Communication
- Physical—including vision and hearing
- Social/Emotional

Review of medical, educational, or other records

A member of the multidisciplinary evaluation team (MDT) reviews documents available for the infant or toddler and determines through professional judgment the information relevant to the evaluation. Records that might be reviewed include:

- Pertinent records related to the child's current health status and medical history; and
- Existing child evaluations, assessments, and prior screening reports.

Interview

Members of the MDT interview the parents and other individuals with direct knowledge and understanding of the child and family with respect to the specified developmental areas. The interview process is used to evaluate the family's resources, priorities, and concerns. Should the family choose to participate in the family assessment, it is conducted through a *conversational* interview process using a family assessment tool.

Observe

Team members may observe the infant or toddler in his or her natural environment and through interactions for daily activities such as eating, playing, talking, laughing, crawling, rolling, etc. Other observations may include:

- Observations following adaptations or modifications suggested by the evaluator;
- The child's interaction with family, friends and other professionals; and/or
- Insight and information gathered through observations by family members or other providers.

It should be noted that observations can be used to seek answers to questions regarding the family's interactions, routines that can be used to infuse instructional opportunities, intervention ideas, and intensity of support needed to effect a change in the infant/toddler's performance.

Tests

Tests are a process of gathering direct information through a variety of means and providing a numeric measure of performance. These means may include and are not limited to rubric assessments based on functional skills, functional behavioral assessments, curriculum-based assessments, norm- or criterion-referenced assessments, or performance assessments conducted by observing the child as they complete the specific tasks.

These tests or assessments assist with determining:

- Initial functioning level in all required areas of development;
- The gap between the child's current level and expected developmental or age referenced performance;
- Additional areas where more in-depth evaluation is needed; and
- Other sources to gather needed information.

Types of evaluations

When the evaluation includes administration of tests, the selection of valid and reliable instruments is critical, since decisions about the child's skills and knowledge are based on the integrity of the initial evaluation. The following are descriptions of various types of evaluation.

Diagnostic instrument: Provides information about a child's developmental strengths and concerns compared to other children of the same age; provides a norm-referenced or a criterion-referenced score that is used to determine if a developmental delay is present.

Norm-referenced: A standardized test in which the child's score is compared with other children's scores. Provides information on how a child is developing in relation to a larger group of children of the same chronological age. Items are chosen based on statistical criteria, such as percentage of children who master a particular skill at a certain age or whether the item correlates well with the total test.

Criterion-referenced: A means of determining the level of a child's skills compared with a criterion or with a performance standard. Items are usually sequentially arranged within the developmental domains or subject areas. Numerical scores represent proportion of specific domain or subject area that a child has mastered.

Criteria for selecting evaluation and assessment instruments

Professionals are responsible for selecting evaluation and assessment instruments based on the following criteria:

- Purpose of instrument described and population for which it was designed and validated;
- Data available to indicate the technical adequacy or psychometric properties is well described, and indicates that the instrument is valid (meaning) and reliable (consistent):
  - » The validity of an instrument communicates whether it is measuring what it says it measures (e.g., a "language test" actually measures language development).
  - » If an instrument is reliable, results across examiners, children, and over time can be trusted.
- Standardized administration with clear description of requirements necessary to administer the instrument and training or education level of personnel needed;
- Norm-referenced based on range of age from birth to 3 years;
- Offers multiple developmental domains;
- Provides opportunities to involve families in the evaluation process;
- Cost for use and ongoing data collection is reasonable;
- Time to administer instrument is reasonable;
- Yields a standard score;
- Provides the necessary information to answer the referral concern and the family/team questions; and
- Provides information to help make the decision about a child's eligibility for EDN.

Addressing additional concerns

Teams are required to gather enough information before the initial IFSP meeting so that an appropriate IFSP can be written within 45 days from date of referral. However, additional information may be needed to enhance IFSP outcomes and may be gathered after the initial IFSP meeting.

If the team does not collect the depth of information needed in an area of development (e.g., reason for referral), the team cannot delay meeting the 45-day timeline for the purpose of gathering additional information. See Section 12: Ongoing Assessment, page 12-2, *Additional assessment needs*.

Record review to establish eligibility

A child's medical and other records may be used to establish eligibility *without conducting an evaluation* of the child if those records indicate the child (i.e., [92 NAC 52-006.04A1])

- Has at least 2.0 standard deviations below the means in one of the developmental areas (cognitive, physical including vision and hearing, communication, social or emotional, adaptive); or at least 1.3 standard deviations below the mean in two areas of development; OR
- Meets the criteria for an infant or toddler with a *diagnosed condition* that has a high probability of resulting in developmental delay.

If a child is determined eligible for EDN based on a review of records, the school district or approved cooperative *must conduct an initial assessment* of the child. The school district or approved cooperative must provide a copy of the (MDT) written report to the parents and Services Coordinator.

Initial child assessment introduction

If an evaluation is not required as described above, an assessment is needed in order to gather information to meet the child's and family's needs.

Note: *The Notice and Consent for Initial Evaluation and Child Assessment* is used for parental consent for evaluation and/or assessment of the child.

Purpose of assessment

A multidisciplinary assessment is conducted to identify the child's unique strengths and needs in order to identify services appropriate to meet those needs [92 NAC 52-006.05A2].

Comprehensive multidisciplinary assessment requirements

Multidisciplinary assessment means the involvement of two or more separate disciplines or professions that *may include one individual* who is qualified in more than one discipline or profession [92 NAC 52-003.20A].

There are a number of procedures that must be followed during the assessment process. School districts and approved cooperatives responsible for the initial assessment shall ensure, at a minimum:

- All developmental areas are assessed.
- All assessments are conducted in the native language of the child, unless it is clearly not feasible to do so.
- All assessment procedures and materials are selected and administered so as not to be racially or culturally discriminatory.
- Assessments are conducted by qualified personnel, in a nondiscriminatory manner.
- Timelines are met for completing the assessment and IFSP meeting within 45 calendar days.
- No cost to parents.

[92 NAC 51-006.05-006.05D]

Conduct the initial assessment

The team conducting the initial assessment of the child seeks information to determine the child's level of functioning in each of the developmental areas to identify services appropriate to meet those needs.

The following areas of development are required to be assessed:

- Adaptive
- Cognitive
- Communication
- Physical-Fine Motor
- Physical-Gross Motor
- Health
- Hearing
- Nutrition
- Vision
- Social/Emotional

Minimum standards for comprehensive 45-day assessment process

The comprehensive multidisciplinary assessment of the child's strengths and unique needs, and the family assessment of priorities, resources, and concerns, are conducted within 45 calendar days from the child's referral.

An appropriate assessment instrument containing multiple domains is acceptable to assess the child's developmental areas required for comprehensive assessment, excluding health, nutrition, hearing, or vision.

Required areas for the child's comprehensive assessment include:

Multi-domain diagnostic instrument

- Adaptive
- Cognitive
- Communication
- Physical-Fine Motor
- Physical-Gross Motor
- Social/Emotional
- Health
- Hearing
- Nutrition
- Vision

Other instruments and procedures may be used to assist with the comprehensive assessment of infants and toddlers, including health, nutrition, vision, and hearing, as well as areas of major concern, such as behavior checklists, structured interviews, play-based assessments, adaptive and developmental scales, and curriculum-based instruments.

Addressing additional concerns

Teams are required to gather enough information before the initial Individualized Family Service Plan (IFSP) meeting so that an appropriate IFSP can be written within 45 days. However, additional information may be needed to enhance IFSP outcomes and may be gathered after the initial IFSP meeting. In order to develop a meaningful and functional IFSP, teams must conduct an assessment of the child's functioning within everyday activities.

If the team does not collect the depth of information needed in an area of development (e.g., reason for referral), the team cannot delay meeting the 45-day timeline for the purpose of gathering additional information. See Section 12: Ongoing Assessment, page 12-2, *Additional assessment needs.*

8 Eligibility Determination

Eligibility introduction

Consideration of the child's eligibility for Early Development Network (EDN) services is a focus of the multidisciplinary evaluation team (MDT). As illustrated in the *Eligibility Determination Decision Flowchart* in Section 7: Initial Evaluation and Assessment, on page 7-7, there are different points in the evaluation process where an MDT determines whether a child is eligible for EDN. Infants and toddlers who qualify for Early Intervention will be identified in the category of developmental delay [92 NAC 52-006.04A].

Eligibility Determination

In determining eligibility, the MDT has four choices:

- Child is eligible based on diagnosed physical or mental condition that has a high probability in resulting in future delay [Rule 52-006.04A1];
- Child is eligible based on at least 2.0 standard deviations below the mean in one developmental area or 1.3 standard deviations below the mean in two or more areas (i.e., [92 NAC 52-006.04B1 and 52.006.04B2]);
- Child is eligible based upon Informed Clinical Opinion [Rule 52-006.05B2]; or
- Child is not eligible [92 NAC 52-006.04 to 52-006.04B2].

The purpose of reviewing records and/or completing evaluation processes is to gather evidence to support team decisions regarding eligibility determination. If a review of a child's medical and other records shows evidence that the child has a diagnosed physical or mental condition, then that child is determined eligible for the EDN.

Note: *Informed Clinical Opinion* may be used on an independent basis to establish a child's eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility [92 NAC 52-006.05B2]. Informed Clinical Opinion means the integration of the results of evaluations, direct observations in various settings, and varied activities with the experience, knowledge, and skills, of qualified personnel [303.321(3)(ii)].

The following definitions describe eligibility criteria to guide the team's decision-making process.

Eligibility Criteria	Definition
Diagnosed physical or mental condition	Infants and toddlers referred to the EDN may have a diagnosed physical or mental condition that has a high probability of resulting in a substantial developmental delay in the areas listed below. (Find examples listed on page 8-4.)

Eligibility Criteria	Definition
	Infants and toddlers referred to the EDN may be experiencing a developmental delay that is at least 2.0 standard deviations below the mean in one area of development or 1.3 standard deviations below the mean in at least two or more areas as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: • Cognitive development • Physical development, including vision and hearing; • Communication development; • Social or emotional development; and • Adaptive development.
Eligibility	The infant or toddler who meets either criteria above is considered eligible for EDN services.

Prepare for eligibility determination

Once the record review, evaluation, and assessment are completed, the Services Coordinator schedules the initial Individualized Family Service Plan (IFSP) meeting with the parent and members of the multidisciplinary IFSP team. Information and evaluation results are reviewed to discuss eligibility of the child for the EDN.

Note: Disciplines required to complete reports as mandated by professional licensure must also prepare results to be included with the *IFSP Evaluation and Assessment* page. The results on the IFSP may include a reference to a professional report, but the professional report shall not be a substitute for what is required to be written on the *IFSP Evaluation and Assessment* page.

Infants and toddlers (birth to 3 years of age) are eligible to receive early intervention services coordinated by the EDN, if the child meets one of two eligibility criteria (e.g., known condition or developmental delay).

Preparation for eligibility based on diagnosed condition

Eligibility based on diagnosed condition. Infants and toddlers referred to the EDN may have a diagnosed physical or mental condition that has a high probability of resulting in delays in cognitive; physical, including vision and hearing; communication; social or emotional; or adaptive development [92 NAC 52-006.04A1].

Infants and toddlers with a *diagnosed condition* are eligible to receive EDN services.

- An appropriately qualified professional can submit documentation for the child's diagnosed condition. A child's medical and other records may be used to determine eligibility without conducting an evaluation of the child if those records indicate that the child's level of functioning in one or more of the developmental areas constitutes a development delay or that the child meets the criteria for an infant or toddler with a diagnosed condition [92 NAC 52-006.05B1).
- If a child is determined eligible, meeting the above criteria, then a comprehensive multidisciplinary *initial assessment* must be completed across developmental areas to determine the child's unique strengths and needs for the identification of appropriate services to meet the needs of the child [92 NAC 52-006.05A2].

- A child with a diagnosed condition may or may not have a delay in developmental areas at the time of referral but remains eligible for the EDN.

Note: The child remains eligible for EDN services until August 31, of the child's third birthday.

Physical or mental diagnosed condition list

At the time of referral or within the established 45-day timeline, infants and toddlers with a diagnosed condition are eligible to receive all EDN services. These children may or may not be experiencing a delay in development at the time of referral and evaluation. Diagnosed conditions with a high probability of later delay include, but are not limited to the following:

- Chromosomal abnormalities, including, but not limited to, Down Syndrome, Fragile X, cystic fibrosis, and dwarfism;
- Sensory impairments, including, but not limited to, vision and hearing deficits, Pervasive Development Disorder (PDD), and other Autism Spectrum Disorders (ASDs);
- Inborn errors of metabolism, including, but not limited to, phenylketonuria, hypothyroidism, galactosemia, and sickle cell disease;
- Congenital central nervous disorders, including, but not limited to, spina bifida and microcephaly;
- Other congenital or acquired conditions, including, but not limited to, cleft palate, missing limbs, cerebral palsy, traumatic brain injury, seizure disorders, and physical impairments from birth or accident;
- Behavioral or emotional conditions such as serious attachment disorders;
- Disorders secondary to exposure to toxic substances including drugs and alcohol exposure or fetal alcohol syndrome; and
- Conditions resulting from serious chronic conditions, drug or alcohol exposure, failure to thrive, PDD and other ASDs.

Preparation for eligibility based on developmental delay

Eligibility based on developmental delay. For infants and toddlers who do not have a diagnosed known condition at the time of referral, a 2.0 standard deviation below the mean in one developmental area or a 1.3 standard deviation below the mean in two or more areas is used to establish eligibility for EDN. Areas include cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development [92 NAC 52-006.04A2 to 52-006.04A2C].

- A child's medical and other records may be used to determine eligibility without conducting an evaluation of the child if those records indicate that the child's level of functioning in one or more of the developmental areas constitutes a development delay.
- The delays are measured by appropriate evaluation instruments and procedures to document the required delay in at least one of the development areas listed above.
- The information from the comprehensive evaluation is reviewed by the MDT to determine eligibility.

Note: *Informed Clinical Opinion* may be used on an independent basis to establish a child's eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility [92 NAC 52-006.05B2]. Informed Clinical Opinion means the integration of the results of evaluations, direct observations in various settings, and varied activities with the experience, knowledge, and skills, of qualified personnel [303.321(3)(ii)].

Note: For children with a **diagnosed condition AND** who meet Rule 52 criteria of a developmental delay in at least one previously described developmental area, or in two or more previously described developmental areas, the MDT designates **diagnosed condition** or developmental delay or both as determination criteria for evaluation.

Review eligibility

The MDT is responsible for determining the eligibility of the child. The team means the involvement of two or more separate disciplines or professions that may include one individual who is qualified in more than one discipline or profession. The Services Coordinator is not part of the MDT.

If the child is determined	And the family…	Then…
Eligible	Agrees to EDN services	• The district informs the Services Coordinator that the child is likely eligible and of the need to move forward with the child and family assessment process. • The Services Coordinator contacts the family and informs that the child is likely eligible for EDN services and requests to schedule the IFSP meeting at a time and setting convenient to the family. At this time, the Services Coordinator also schedules a home visit to conduct the child and family assessment. • The Services Coordinator then sends all team members, including the family, a Prior Written Notice advising the purpose of the Initial IFSP meeting is to determine eligibility for EDN services and develop the Initial IFSP. • Before the Initial IFSP meeting, the multidisciplinary evaluation written report is reviewed. Each team member must sign whether they agree or disagree with the results of the evaluation. The Services Coordinator does not participate in signing the Multidisciplinary Team (MDT) report. • The Initial IFSP is developed.

If the child is determined	And the family…	Then…
Eligible (cont'd)	Declines EDN services	• Services Coordinator and the parent (if willing) explore and consider other appropriate community options. • The district provides a Prior Written Notice and the Services Coordinator provides the HHS-6 to the family describing the following: **a.** Child is eligible to receive early intervention services; **b.** Initial IFSP meeting was declined by parent. **c.** Parent was informed that without parental consent, EDN services could not be provided. **d.** EDN case is closed based upon parent's request. **e.** All procedural safeguards available to the family. • Services Coordinator provides information so the family can contact EDN in the future, if needed. • The Services Coordinator informs the person who referred the family to the EDN, if any, by letter of the outcome of the referral if the family has given written authorization. The MDT report will also be forwarded to the referral contact if the family requests this action in writing. • The Services Coordinator gives the family a copy of the letter sent to the referral contact and ensures they received the multidisciplinary evaluation written report. • Services Coordinator assures completion of required CONNECT data entry, including narratives detailing above actions and EDN case closure.

If the child is determined	And the family…	Then…
Not Eligible		• The district contacts the Services Coordinator and informs that the child is likely not eligible and a meeting needs to be conducted with the family to review the eligibility determination. • The Services Coordinator contacts the family and schedules a meeting, at a time and place convenient to the family, to review the eligibility determination. • At this meeting, the team reviews the written report, the district informs the family of the reasons the child is not eligible, and provides the Prior Written Notice to the family, which contains the following required elements: **a.** Statement that the child is not eligible for EDN services **b.** The reasons for taking this action **c.** All procedural safeguards available to the family • The district/Services Coordinator ensures the parent understands the procedural safeguards available through mediation, state complaint, and due process procedures [92 NAC 52-009.03B2C]. • The Services Coordinator will provide the family with referrals to other agencies/supports according to the child's/family's needs. • The Services Coordinator informs the person who referred the family to the EDN, if any, by letter of the outcome of the referral if the family has given written authorization. The MDT report will also be forwarded to the referral contact if the family requests this action in writing. • The Services Coordinator gives the family a copy of the letter sent to the referral contact and the multidisciplinary evaluation written report. • Services Coordinator provides information so the family can contact EDN in the future, if needed. • Services Coordinator assures completion of required CONNECT data entry, including narratives detailing above actions and EDN case closure. • The Services Coordinator sends the family written notice of case closure.

Documentation of circumstances for not meeting 45-day timeline

All circumstances for not meeting the 45-day timeline must be documented by the Services Coordinator in the CONNECT narrative, and if the child is eligible, on the family concerns, priorities, and resources IFSP pages. Circumstances that are considered within reasonable parameters for meeting timeliness compliance include child and/or family reasons and some other reasons.

Although there may be acceptable circumstances for not meeting the 45-day timeline, the state is required to report all IFSPs that missed the 45-day timeline in the Annual Performance Report. However, the state can provide explanations for all IFSPs that did not meet the timeline due to exceptional circumstances. It is critical to:

- Document the appropriate exceptional circumstance in the CONNECT narrative and on the IFSP.

Agency or system circumstances may contribute to missing the 45-day timeline. Agency or system exceptional circumstances must also be documented as described above and are not considered acceptable reasons by the Federal Office of Special Education Programs.

9 Guidance on Family-Directed Assessment Practices

Family-directed assessment purpose

A requirement of the assessment procedures is to identify the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler. Conducting family assessment is the responsibility of the Early Development Network (EDN) Services Coordinator.

The family assessment can assist the Individualized Family Service Plan (IFSP) team in identifying those resources, priorities, and concerns as well as what is important to the family, and what supports and services are needed to best enhance their child's health and development within the family's/child's routines and natural environments. It is *NOT* an evaluation of the family. Family choice is provided in accessing services.

- The family assessment, conducted by a conversational interview and using a family assessment tool, must be voluntary on the part of the family.
- Parents can choose to decline the assessment.
- The Services Coordinator explains the need to learn about the family's resources, priorities, and concerns and asks their permission to record responses on the concerns, priorities, and resources pages of the IFSP. The following table provides guidance on next steps, depending on the parents' decision.

If the family...	Then...
agrees to an assessment of the family's resources, priorities, and concerns	the following requirements must be met: • Conducted by personnel trained to utilize appropriate methods and procedures; • Based on information provided by the family through personal interview/an assessment tool; and • Documented as to the family's identified resources, priorities, and concerns related to enhancing their child's development on concerns, priorities, and resources pages of the IFSP.
agrees to an assessment of the family's resources, priorities, and concerns **BUT** declines documentation in the IFSP	the following requirements must be met: • Conducted by personnel trained to use appropriate methods and procedures; • Based on information provided by the family through personal interview and an assessment tool; and • Indicate completed but did not want recorded on IFSP or within CONNECT Narrative.

If the family...	Then...
declines the family assessment at this time	• Indicate declines on concerns, priorities, and resources pages of the IFSP and CONNECT Narrative.

Guidance from Co-Lead Agencies

The following are practice points emphasized by the Co-Lead Agencies:

- Family assessment is a systemic process and is to be used with all EDN families.
- The family-directed assessment process is an opportunity to embed EDN Family Centered Principles. The ongoing work between families and providers is about identifying family concerns (priorities, hopes, needs, goals, or wishes), family strengths, and the services and supports that will provide necessary resources to meet those needs. Service providers should view the family assessment as an important process which can provide essential information on the family and child—aiding the family's participation in the development of child and family outcomes. For this reason, the "voluntary participation" requirement that allows the family the option to decline should be seen for what it is—a choice provided for families—and not be viewed by service providers that the assessment has little importance or that a decline of the assessment saves the time of having to complete additional documentation. These guiding conversations are necessary to understand and get to know a family. A family may choose not to document these conversations on the concerns, priorities, and resources pages of the IFSP, but should clearly understand why this information is so important to the whole process.
- The process can be an effective means to help the family learn to "effectively communicate their child's (and thus the family's) needs." (One of the three family outcomes measured through the annual Part C/EDN Family Survey.)
- The information gathered during the process is intended to help the team design effective, meaningful, and motivating child and family outcomes for the IFSP.
- The Co-Lead Agencies have endorsed the Routines-Based Interview as an evidence-based tool to be used for family assessment, and when completed together with a service provider, serves as child assessment as well. An additional tool endorsed by the Co-Lead Agencies during family assessment is the Eco map.

10 Interim Individualized Family Service Plan (IFSP)

Interim IFSP requirements

Early Development Network (EDN) services may be provided to a child and family if the school district, based upon professional judgment and available information, has indicated the child may be eligible before the comprehensive multidisciplinary evaluation is completed when the child has immediate identified needs. If services are initiated prior to completion of the evaluation, an interim IFSP is developed. The 45-day timeline must be followed and appropriate documentation completed.

An interim IFSP would be developed in the following scenario:

If...	Then...
a child has obvious immediate needs, and signed parental consent is obtained	develop an interim IFSP and continue to conduct the timely evaluation and child and family assessment. The Interim IFSP will provide information regarding the child's abilities and needs to be used for program planning and eligibility.

Interim IFSP procedures

Steps used by the Services Coordinator to develop the interim IFSP include:

Step	Action
1	During the intake or the comprehensive multidisciplinary evaluation process, discuss with the family the possibility that the child may not be eligible for EDN services.
2	Obtain signed parental consent.
3	Schedule an interim IFSP meeting to address provision of services. **Note:** The IFSP must include the name of the Services Coordinator responsible for implementation of the interim IFSP.
4	Schedule the comprehensive multidisciplinary child evaluation as well as child and family assessment to meet the 45-day timeline requirement for completion of the evaluation and hold the initial IFSP meeting.

Interim IFSP

Examples

May be used to start a child on waiver services or to provide immediate service in exceptional circumstances when it is not possible to complete the child's Multidisciplinary Team (MDT) evaluation and assessment within the required timeline due to child's illness/medical emergencies/ hospitalization.

May be used when a family is moving in from another state where they have been receiving early intervention services and it appears the child will be eligible in Nebraska.

11 Initial Individualized Family Service Plan (IFSP) and Implementation

Introduction and definition

The initial IFSP meeting occurs when the multidisciplinary IFSP team gathers to develop an IFSP for an eligible child/family using information gathered from the initial assessments of the child and family as well as any information from screening, evaluation, and record reviews. Through the IFSP process, families can express their desired outcomes and participate in planning for their child and family.

IFSP team means the involvement of the parent and two or more individuals from separate disciplines or professions and one of these individuals must be the Services Coordinator [NAC 52-003.16B and 480 NAC 1].

At this stage in the IFSP process, outcomes as identified by the family, Early Intervention (EI) and other services recorded in the language of the family on the IFSP, are implemented.

All IFSP members communicate and work collaboratively as they implement the services and monitor the progress made toward achieving the IFSP outcomes.

Families see the IFSP as their plan, with others supporting this in its implementation. The family and all service providers have a clear picture of who, why, where, and what services and supports are included in the IFSP. Coordination continues to be the way of doing business throughout the process [480 NAC 1].

Implementation of EI services

√C1
Timely Service

Service providers implement the services as outlined on the IFSP services page (frequency, intensity, duration, natural environment, etc.). The first service delivery date must be within 30 days after the Consent for Services is signed by the parent.

Note: The initial IFSP meeting date cannot serve as the projected start date or actual first service delivery date for providers, unless their first delivery service log note clearly documents a separate visit providing service to the child and/or family occurred following the initial IFSP meeting. The initial IFSP meeting does, however, serve as the start date for services coordination only.

The Services Coordinator and family coordinates implementation of the IFSP, and the Services Coordinator helps the child and family to gain the services and assistance they need to accommodate their needs in settings most natural and comfortable in daily routines.

The plan is implemented as written by the team members designated on the IFSP.

The Services Coordinator advocates for the family, as appropriate.

The Services Coordinator serves as liaison and mediator between the family, service providers, and agencies.

The Services Coordinator assists the family in dealing with situational changes that effect implementation of the IFSP. This may include calling of partial or full IFSP team meetings which may be at the request of the family or other team members.

If there is a need to change the service frequency, intensity, or duration, service providers are to communicate with the family and Services Coordinator and request a periodic review. Refer to Section 13: Periodic IFSP.

The Services Coordinator, together with the family, is responsible for ongoing monitoring of the plan to determine that appropriate services and supports are being provided according to the IFSP. The Services Coordinator shall personally contact the family at least monthly to review the progress of the plan. This contact must be face-to-face with the family and child at least every other month. If a problem is identified or change indicated, the Services Coordinator shall work with the family to take appropriate action.

Initial IFSP meeting and development process overview

The following table provides an overview of the six stages of the process and requirements for the initial IFSP meeting. Specific implementation procedures follow the overview.

√C1 Timely Services

Stage	Process	Description
1	Prepare for Initial IFSP Meeting	The initial IFSP meeting is held within 45 calendar days of the referral to Early Development Network (EDN) and after all evaluation and assessments have been completed. Services Coordinator provides written notice of the IFSP meeting to the family and other team participants [480 NAC 1]. **√C7 45 Calendar Day Timeline**
2	Begin the Meeting	The meeting is chaired either by the Services Coordinator or the family. Participants are introduced at the beginning of the meeting. The purpose and intended results are reviewed, and the tone and details of the meeting are set.

Stage	Process	Description
3	Review Eligibility	The IFSP team reviews the family's resources, priorities, and concerns identified in the initial family assessment; reviews the strengths and concerns of initial evaluation and child assessment results; and discusses any reviews of medical and other records which were used to determine eligibility of child EI services. **Note:** A child's medical or other records may be used to establish eligibility (without conducting an evaluation of the child) if the records indicate that the child is experiencing a developmental delay in one domain or in two or more domains as outlined in Rule 52 or the child has a diagnosed physical or mental condition that has a high probability for resulting in developmental delay [NAC 52-006.04].
4	Develop the Plan	The family shares with the team the desired goals and priority outcomes for the next year. The IFSP team reviews child and/or family outcomes, based upon family priorities, and determines activities and services needed to achieve those outcomes. Additionally, the team considers ways to accomplish the desired outcomes for the child and family by identifying their strengths and supports; agreeing upon strategies and responsibilities of individual team members in working toward outcomes which can be addressed during the child's daily routines and activities; identifying other community resources or service providers to fill in gaps in the plan that cannot be filled by the existing team; working toward goals beyond the scope of education; determining the need for and responsibilities of ongoing services coordination; discussing timeframes for different responsibilities; making sure that the plan considers all aspects of the child and family supports (i.e., all agencies and providers); and considering whether what is being asked of the family and team members is coordinated and reasonable. The IFSP team determines the frequency, duration, location, and projected start dates for each EI service.

Stage	Process	Description
5	Consent for Services	Parent signs or declines Consent for Services.
6	Finalize IFSP	The Services Coordinator distributes a written copy of the IFSP to each person attending within 7 calendar days of the meeting. Parents must give specific consent for distribution of the IFSP document to any individuals or agencies not on the IFSP team. Additionally, the Services Coordinator distributes a copy of the family assessment to the parent within 7 calendar days of the IFSP meeting.

Procedures and documentation for each stage of the process are described below.

Stage 1: Preparation for initial IFSP meeting

The parents and other IFSP team members must be notified in writing in advance of initial, periodic, and annual IFSP meetings. The following table outlines **Services Coordinator** actions to prepare for the initial IFSP meeting.

Step	Action
1	The Services Coordinator ensures that all evaluations and assessments are or will be completed within 45 days of referral to (EDN).
2	The family and the Services Coordinator meet to prepare for the meeting of the IFSP team. At this time, desired outcomes for the child and family are discussed. Based on the results of the Multidisciplinary Team (MDT) evaluation, other assessments, and the wishes of the family, IFSP team membership is established. The Services Coordinator helps prepare the family for the IFSP meeting and the part they would like to play. The IFSP document should be shared with the family prior to the meeting so that the information can be integrated into the plan. The Services Coordinator chairs the initial meeting unless the family chooses to take this role.
3	The Services Coordinator sets up the meeting in a setting and at a time convenient to the family. The meeting is conducted with accommodation for the native language or primary mode of communication of the family. The Services Coordinator should also ask the family if a cultural representative would be desired as part of the team by the family if the family is not of the dominant culture. **Note:** IFSP meetings must be conducted in settings and at times that are convenient to families and in the native language of the family or other mode of communication used by the family unless it is clearly not feasible to do so.
4	Meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.
5	The Services Coordinator prepares for initial IFSP meeting, gathers paperwork, etc.

Required participants

Each initial IFSP meeting must include the following participants:

- The parent or parents of the child;
- Other family members, as requested by a parent, if feasible to do so;
- An advocate or person outside the family, if a parent requests that the person participate;
- The Services Coordinator;
- A person or persons directly involved in conducting the evaluations and assessments;
- As appropriate, persons who will be providing EI services to the child or family; and
- A representative of the school district or approved cooperative who has the authority to commit resources.

Alternative methods of meeting participation

If the person or persons directly involved in conducting the evaluations and assessments are unable to attend a meeting, arrangements must be made for the person's involvement through other means, including one of the following [92 NAC 52-007.03B and 480 NAC 1-010.06]:

- Participating in a telephone conference call;
- Having a knowledgeable authorized representative attend the meeting; or
- Making pertinent records available at the meeting.

Stage 2: Begin the meeting

The meeting is chaired either by the Services Coordinator or the family and conducted in the native language of the family. The family/Services Coordinator starts the meeting:

- Introduce IFSP team members;
- Review purpose and intended results of the meeting; and
- Set the tone and details of the meeting.

The meeting shall be conducted in accordance with family-centered philosophy and focus on the outcomes desired by the family with input from the whole team. The family chooses if they want to include family outcomes in addition to the goals for the child.

Stage 3: Review eligibility

See Section 8: Eligibility Determination.

At the Initial IFSP meeting, the multidisciplinary evaluation written report is reviewed and signed by all team members to assist in developing the initial IFSP.

Contents of IFSP

There are requirements for the contents of the IFSP located at 92 NAC 52-007 and 480 NAC 1-010.06.

Stage 4: Develop the plan

The IFSP team develops an IFSP for each eligible child, including:

- child and/or family outcomes based upon family priorities and how they will be monitored;
- activities to achieve the outcomes; and
- services needed to achieve those outcomes and enhance the child's health and development and the family's capacity to meet their child's needs.

Completion of the IFSP form (EI-1) is necessary to meet state and Federal compliance monitoring requirements. EI-1 form and instructions for the completion of the IFSP can be found at http://edn.ne.gov.

Stage 5: Consent for services

The parent has the right to decline any or all EI services recommended by the IFSP team. If the parent declines one or more EI services, the Services Coordinator makes reasonable efforts to ensure the parent:

- is fully aware of the nature of the services that would be available;
- understands that the child will not be able to receive the service(s) unless consent is given; and
- understands they may accept or decline any service at any time without jeopardizing other EI services [92 NAC 52-009.03A5a and 52-009.03A5b].

The parent must provide written consent for EDN services. The following scenarios and instructions apply:

If parent...	Then...
gives consent to all recommended services	• Parent checks "Yes" to understanding content of IFSP and giving consent for all services in the IFSP, and signs and dates the IFSP.
gives consent to some services, but declines a specific service(s)	• Parent checks "Yes" to understanding content of IFSP. • Services Coordinator or parent lists any service(s) the parent does want on the consent page of the IFSP. • Parents signs and dates Consent for Services on the IFSP.
is not ready to consent for services at the time of the meeting	• Services Coordinator reviews that services cannot begin until consent is provided. • Services Coordinator schedules a day/time to follow up with the family to obtain consent signature within a week.

If parent...	Then...
does not consent for services at the meeting	• Parent checks “No” to giving consent for all services on IFSP service/ consent page and signs the IFSP. • Services Coordinator and the parents explore and consider other appropriate community options, as appropriate. This is documented in CONNECT narratives. • Services Coordinator documents all services declined by the parent on the IFSP service page. • Services Coordinator describes parental decision to decline services on the HHS-6, Notice of Action, to include case closure and service delivery ending, and provides copy to parent. • Services Coordinator provides information so the family can contact EDN in the future, if needed.

Stage 6: Finalize IFSP

The Services Coordinator finalizes understandings with the family, assures completion of all needed paperwork, and communicates the results of the meeting with parent and identified partners (e.g., physician, referral source). Some of the three steps can be completed at the meeting location or afterwards in another location.

Step	Action
1	Review with the family when each consented EI service is scheduled to begin and address any questions they may have.
2	Discuss with the family who will get copies of the IFSP (referral source; healthcare provider; others with appropriate releases). **Note:** An EI-3 Release of Information form may need to be completed at the meeting (or prior to) to allow for information to be exchanged with providers from outside the network of EDN service providers.
3	Provide at no cost to parents a copy of evaluations, assessments of the child and family, and the IFSP within 7 days of the IFSP meeting. Provide to others for whom the family has signed a release of information, as agreed upon with the family.

Coordinating and monitoring delivery of services

Between IFSP meetings, the Services Coordinator has the responsibility to:

- Facilitate the timely delivery of EI services.
- Coordinate and monitor the delivery of available services.
- Coordinate the performance of evaluations and assessments.
- Coordinate with medical and health providers.
- Assist families in identifying and accessing available resources and services needed and take actions to meet those needs.
- Assist the family in dealing with situational changes that affect implementation of the IFSP. This may include calling of partial or full team meetings at the request of the family or other team members.
- Use family-centered practices in all contacts with families.

Inability to contact family and/or implement IFSP

At times, the Services Coordinator or EDN service providers are unable to contact families whose children have an IFSP and/or are unable to provide EDN services. The following guidelines describe timelines for consideration of "unable to contact."

Note: The following guidelines may be effective in resolving most cases in which IFSP team members are unable to connect with a family. Always use professional judgment on the timelines in these procedures. The intended result of these procedures is that families are engaged in the EDN. Do not exit a child unnecessarily if information suggests that the timelines should be extended.

If...	Then...
the IFSP service provider and/ or Services Coordinator are unable to communicate with families and therefore are unable to provide a service	• IFSP team members must communicate with the Services Coordinator and problem-solve from there. Team members must make repeated and varied attempts, through telephone calls, home visits, and letters, to schedule another appointment. • Additionally, the Services Coordinator will attempt to make contact with the family to determine if there has been a change in the family's circumstances. • Services Coordinator documents all attempts to contact the family on the CONNECT Early Development Network Case Narrative. All IFSP team members must also record their individual attempts to contact the family. • Documentation must reflect attempted contacts were initiated on different days and at different times over a period of at least 30 days. **Note:** Services Coordinator, with appropriate consent for release of information, must contact the primary medical provider or other agencies/providers working with the family to ask for assistance. These contacts must be documented in the CONNECT Narrative. **Note:** If the family is involved with the U.S. Department of Health and Human Services/Children and Family Services (DHHS/CFS) and appropriate consent for exchange of information is signed, the Services Coordinator should contact the child's DHHS/CFS worker/supervisor to obtain current contact information.

If...	Then...
the IFSP service provider and/ or Services Coordinator is unable to contact the family after 1 month of a missed appointment to discuss the continuation of services on the IFSP	• Services Coordinator mails a certified letter to the parents indicating attempts to make contact. The letter requests that parents contact Services Coordinator within 2 weeks to discuss continuation, reduction, or ending of services based upon family's wishes. • The Services Coordinator provides a copy of the letter to the school district or approved cooperative. • Services Coordinator documents all attempts to contact in the CONNECT Narrative and maintains a copy of the certified letter in the services coordination file. All IFSP team members must also record their individual attempts to contact the family.
the family does not contact the Services Coordinator 14 calendar days from the mailed certified letter Or the letter comes back undelivered and there has been no communication with the family	• The Services Coordinator will implement case-closing procedures. » Send the family notice of closing using Form HHS-6, Notice of Action, including: » a clear statement of the action taken; » a clear statement of the reason for the action; » a specific policy reference which supports such action; and » a complete statement of the family's right to appeal for Medicaid services only. **Note:** While the family has the right to appeal for Medicaid services only, the Services Coordinator shall not provide assistance nor serve as advocate or representative in this issue. A copy of the HHS-6 is provided to the district. **Note:** Families can reinstate services provided as part of Free and Appropriate Public Education (FAPE) at any time upon request. » Service delivery ends. » Services Coordinator documents all steps/activities in the CONNECT case narratives and closes the EDN case on CONNECT, specifying the reason for case closure as "Withdrawn by Parent." Case is closed.

If...	Then...
the Services Coordinator receives some type of communication from the family indicating they no longer want EDN services	• The Services Coordinator will implement case-closing procedures outlined previously.
the Services Coordinator receives contact the family is still interested in EDN services	• Services Coordinator schedules next appointment. • IFSP team provides services as recorded in the IFSP.
the family contacts Services Coordinator/ providers after exiting EDN/ case closure has occurred and is still interested in EDN services	• If family contacts the Services Coordinator within 30 days of the most recent case closure, reopen the case by updating the referral date in CONNECT and deleting the close date and reason. (See Section 3, EDN CONNECT Manual, for additional instructions.) • If family contacts the Services Coordinator beyond 30 days of the most recent case closure, complete a new Referral/Intake and indicate that the child was previously in EDN; follow procedures in Section 3: Services Coordination. **Note:** When designing the second multidisciplinary evaluation, the team will need to consider timeliness of prior evaluations and assessment data.

Federal indicator of children served

√C5/C6
Children Served

Data about the number and percentage of children served in Part C early intervention (Early Development Network) are collected and reported annually in a Federal indicator in order to show regional and state performance. All states collect data on the number of children served (children on an IFSP) and have set targets to achieve. Each planning region is to meet the state target, which is reported in the Part C Annual Performance Report available at http://edn.ne.gov.

12 Ongoing Assessment

Introduction

Ongoing assessment by service providers occurs as Early Intervention (EI) services are provided. Ongoing assessment information is used to identify the child's unique strengths and needs and that the EI services are appropriate to meet those needs throughout the period of the child's eligibility.

Purpose of ongoing child and family-directed assessment

The purpose of ongoing child and family-directed assessment is to identify:

- Child's unique strengths and needs;
- The effectiveness of interventions and activities;
- Services appropriate to meet the child's needs;
- Family's changing resources, priorities, and concerns; and
- Supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

Rationale for ongoing assessment

Ongoing assessment information enables the Individualized Family Service Plan (IFSP) team to determine the degree to which the child and family are making progress toward achieving the desired outcomes and whether modifications or revisions of the IFSP outcomes or services are necessary.

Additional assessment needs

As providers and Services Coordinators get to know a child and family better over time and ongoing assessment yields more understandings, new concerns may be identified. If specific expertise from a professional is needed by someone not presently on the IFSP team, the Services Coordinator and provider discusses this with the family. If the family agrees, arrangements are made to schedule an assessment of the child at a time and place convenient to the family. A new consent for evaluation is not needed.

The assessment information is shared with the IFSP team members to determine if new services are needed.

If...	Then...
there is a need for a new service to be added to the IFSP or changes made to existing service provision	the Services Coordinator schedules an IFSP meeting (follow procedures for Periodic IFSP – Section 13 or Annual IFSP – Section 14). **Note:** At the IFSP meeting, the team reviews the assessment results and determines needed outcomes and services. In some circumstances, it may be that newly recommended activities can be provided by a current team member without the services of an additional provider.
there is no need for a new service, nor changes to current service provision	the Services Coordinator documents information for review at the next periodic or annual meeting.

The Services Coordinator ensures the child assessment information is documented in the Child's Present Levels of Development section of the IFSP at the next scheduled IFSP meeting.

Ongoing assessment requirements

- Ongoing assessment is conducted by providers of IFSP EI services and those listed as responsible for the IFSP outcomes.
- Ongoing assessment shall, at a minimum, implement the criteria, timelines, procedures, and activities outlined for each IFSP outcome.
- Verbal or written feedback shall be provided to parents regarding ongoing assessment of their child.

13 Periodic IFSP

Introduction

A periodic review of the Individualized Family Service Plan (IFSP) for a child and the child's family must be conducted every 6 months, or more frequently if conditions warrant, or if the family requests such a review. A review may be carried out by a meeting or by another means that is acceptable to the parents and other participants [92 NAC 52-007.02B].

Periodic review requirements

A periodic review of the IFSP must be held at least every 6 months for the following purposes:

- To determine the degree to which progress toward achieving the outcomes is being made; and
- To determine whether modification or revision of the outcomes or services is necessary.

When periodic review is needed

Periodic reviews may also be conducted more frequently than 6 months if conditions warrant or if the family requests a review. The table below indicates various conditions and whether a periodic review is needed or not.

If...	Then a periodic review is…
parent requests the IFSP team to reconvene	**required.**
service(s) need changes in: • Frequency • Duration • Location	**required.**
team is considering a service be added or ended	**required.**
major changes have occurred in child's abilities, family priorities, concerns or resources	**required.**
an outcome is changed, met or added	**required.**

Options for periodic review

Periodic reviews may be carried out by a face-to-face meeting or by another means if acceptable to the parents and other participants. Other possible ways for conducting periodic reviews may include phone calls, webcam or other electronic processes.

Periodic IFSP review process

The following table provides an overview of the five stages of the process and requirements for the periodic IFSP review. Specific implementation procedures follow the overview.

Stage	Process	Description
1	Prepare for Periodic IFSP Review.	The periodic IFSP review must be held within 6 months of the initial and annual IFSP meeting, or more frequently as needed, and uses ongoing assessment data to assist the team in reviewing the plan. The family and other IFSP members are notified of the periodic IFSP review. **Note:** Either a periodic or an annual review must be held every 6 months.
2	Begin the Review.	Participants are introduced. The purpose and intended results are reviewed, and the tone and details of the meeting are set.
3	Review and Revise the Plan.	The IFSP team reviews child's present levels of development, child and/or family outcomes, progress, the services provided and determines needed changes.
4	Consent for Services.	Parent signs or declines Consent for Services on IFSP.
5	Finalize IFSP.	The Services Coordinator distributes a written copy of the IFSP to each person attending within seven calendar days of the meeting. Parents must give specific consent for distribution of the IFSP document to any individuals or agencies not on the IFSP team.

Stage 1: Prepare for periodic IFSP review

There are three steps to prepare for the periodic IFSP review that involve Services Coordinators, families and IFSP team members.

Step	Action
1	Services Coordinator schedules periodic IFSP review with family and team members. The review can be a face-to-face meeting or by other means acceptable to the family (e.g., conference call). *Exception: Transition conference/Planning see Section 15.*
2	Services Coordinator completes *IFSP Meeting Notice* and sends to all team members including the family, no matter how meeting is held. **Note:** There is no required number of days a notice must be provided; however, the notice must be provided within a reasonable time prior to the meeting. Family centered and collaborative practices indicate notice is timely enough to assure team members' participation [92 NAC 52-009.03B1 and 480 NAC 1].
3	Services Coordinator updates any family information as needed on the IFSP.

Required participants

Required participants in the periodic review must include:

- The parent or parents of the child;
- Other family members, as requested by a parent, if feasible to do so;
- An advocate or person outside the family, if a parent requests that the person participate; and
- The Services Coordinator.

If conditions warrant, provisions must be made for the participation of the following:

- A person or persons directly involved in conducting the evaluations and assessments.
- Persons who will be providing early intervention services to the child and family as appropriate.
- A representative of the school district or approved cooperative who has the authority to commit resources.

Note: Consideration of participants should include all agencies providing direct and ongoing services and others as the family requests.

Alternative methods of meeting participation

For a periodic review, persons directly involved in conducting evaluations are NOT required to attend the meeting unless a condition warrants participation. When conditions do warrant involvement, these alternative methods of participating must be followed if the person is unable to attend in person:

- Participating in a telephone conference call;
- Having a knowledgeable authorized representative attend the meeting; or
- Making pertinent records available at the meeting.

Stage 2: Begin the review

The Services Coordinator starts the review as follows:

- Introduce IFSP team members.
- Review purpose and intended results of the meeting.
- Set the tone and details of the meeting.

Stage 3: Review and revise the plan

The meeting participants do the following:

- Review child's present levels of development and child and/or family outcomes and their progress, based upon ongoing assessment information.
- Determine the effectiveness of activities and services to achieve the outcomes.
- Determine needed changes to the plan to enhance the child's health and development and the family's capacity to meet their child's needs.

Completion of the IFSP form is necessary to meet state and Federal requirements. Steps to be completed are provided in the table below.

Step	Action	Documented on IFSP…
1	Discuss findings from ongoing assessments and the family's current concerns, priorities, and resources.	• Family Concerns and Priorities and Strengths pages • Child's present levels of development pages
2	Revise or update child and/or family outcomes, as needed.	Outcome pages
3	Determine and document progress criteria, timelines, procedures, activities, and next steps for each outcome.	Outcome pages
4	Determine services needed to achieve the outcomes.	Services page. **√C2 Services in NE**
5	Determine where services are to be provided.	Services page

Stage 4: Consent for services

The contents of the IFSP must be fully explained to a parent and informed written consent from a parent must be obtained prior to the provision of early intervention services described in the IFSP.

Note: Any new service added at any meeting is held to the 30-day-timeline standard for timely services. The 30 days is calculated from the date of parental consent to the date that the service is delivered as written in the IFSP and accurately recorded in the service provider log/notes.

Parents have the right to agree to all or some of the recommended services. Only the services consented to by the parents are provided to the child and family. If a parent does not provide consent for a particular early intervention service or withdraws consent after first receiving it, that service cannot be provided.

Stage 5: Finalize IFSP

The Services Coordinator finalizes understandings with the family; assures completion of all needed paperwork; and communicates the results of the meeting with parents and, with consent of parents, identified partners (e.g., physician, referral source). Some of the following steps can be completed at the meeting location or can be done afterwards in another location.

Step	Action
1	Review with the family when each consented early intervention service is scheduled to begin and address any questions they may have.
2	If the child is on Medicaid, the school district or approved cooperative must provide written notification to the child's parent prior to using a child's public benefits or insurance through Medicaid in Public Schools (MIPS) program to pay for occupational therapy, physical therapy, and/or speech language services.
3	Discuss with the family who will get copies of the IFSP (referral source; health care provider; others with appropriate releases). **Note:** An Early Intervention- (EI)-3 Release of Information form may need to be completed at the meeting (or prior to) to allow for information to be exchanged with providers from outside the network of EDN service providers.
4	Provide at no cost to parents a copy of evaluations, assessments of the child and family, and the IFSP within 7 days of the IFSP meeting. Provide to others for whom the family has signed a release of information, as agreed upon with the family.

More information about these procedures can be found in Section 11: Initial IFSP and Implementation.

14 Annual IFSP

Introduction

A meeting must be conducted on at least an annual basis ***to evaluate and revise, as appropriate, the Individualized Family Service Plan (IFSP)*** for a child and the child's family. The results of any current evaluations and other information available from the ongoing assessments of the child and family must be used in determining early intervention services that are needed and will be provided [92 NAC 52-007.02C].

Annual IFSP meeting requirements

The following table provides an overview of the stages of the process and requirements for the annual IFSP meeting. Specific implementation procedures follow the overview.

Stage	Process	Description
1	Prepare for annual IFSP meeting.	The annual IFSP meeting is held no later than one year of the initial IFSP meeting. The family is notified of the meeting. Ongoing assessment information of child and family is gathered. Decisions are made about additional assessments as needed.
2	Begin the meeting.	The meeting is chaired either by the Services Coordinator or the family. Participants are introduced at the beginning of the meeting. The purpose and intended results are reviewed, and the tone and details of the meeting are set.
3	Review IFSP and revise the plan, as needed.	The multidisciplinary IFSP team reviews the effectiveness of the plan and determines needed changes.
4	Review parental rights.	Parental rights are reviewed and a copy provided to the family at the meeting.
5	Consent for services.	Parent signs or declines consent for services.
6	Finalize IFSP.	The Services Coordinator distributes a written copy of the IFSP to each person attending within 7 calendar days of the meeting. Parents must give specific consent for distribution of the IFSP document to any individuals or agencies not on the IFSP team.

Stage 1: Prepare for annual IFSP meeting

There are five steps to prepare for the annual IFSP meeting.

Step	Action
1	• Services Coordinator has discussions with family and other team members about preparing for the upcoming annual review of the IFSP. • If additional assessment by a provider not already on the team is needed for decision making at the annual IFSP meeting, the Services Coordinator makes the necessary arrangements to facilitate the process of obtaining the assessment.
2	Services Coordinator schedules annual IFSP team meeting with family, other team members no later than 1 year of the initial IFSP meeting. **Note:** IFSP meetings must be conducted in settings and at times that are convenient to families and in the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.
3	Services Coordinator provides written notice and sends to the family and other participants early enough before the meeting date to ensure that they will be able to attend. **Note:** There is no required number of days a notice must be provided; however, the notice must be provided within a reasonable time prior to the meeting. Family-centered and collaborative practices indicate notice is timely enough to assure team members' participation.
4	The Services Coordinator ensures the child assessment information is documented in the Child's Present Levels of Development section on the IFSP.
5	Services Coordinator reviews and updates any family information on the Concerns, Priorities, and Strengths pages of the IFSP.

Required participants at annual review

Each annual IFSP team meeting to evaluate the IFSP must include the following participants:

- The parent or parents of the child;
- Other family members, as requested by a parent, if feasible to do so;
- An advocate or person outside the family, if a parent requests that the person participate;
- The Services Coordinator;
- A person or persons directly involved in conducting the evaluations and assessments;
- As appropriate, persons who will be providing early intervention services to the child and family; and
- A representative of the school district or approved cooperative who has the authority to commit resources.

Stage 2: Begin the meeting

The meeting is chaired by either the Services Coordinator or the family. The Services Coordinator starts the meeting and does the following:

- Introduces IFSP team members.
- Reviews purpose and intended results of the meeting.
- Sets the tone and details of the meeting.

The meeting shall be conducted in accordance with the family-centered philosophy and based on the outcomes desired by the family with input from the whole team. The family chooses if they want to include family outcomes in addition to the goals of the child.

Alternative methods of meeting participation

For the participation of a professional who has been directly involved in conducting evaluations, assessments, or medical diagnoses and who is unable to attend the IFSP meeting, arrangements must be made for the person's involvement through other means including [92 NAC 52-007.03B and 480 NAC 1]:

- Participating in a telephone conference call;
- Having a knowledgeable authorized representative attend the meeting; or
- Making pertinent records available at the meeting.

Stage 3: Review IFSP and revise the plan

The IFSP team evaluates the effectiveness of the plan using ongoing assessment and any new evaluation information and determines needed changes.

Completing IFSP forms is necessary to meet state and Federal requirements. Steps and forms to be completed are provided in the table in Stage 5 below.

Stage 4: Review parental rights

The Services Coordinator reviews and provides the *Part C Procedural Safeguards Manual for Parents to the family.*

Stage 5: Consent for services

The parent has the right to decline any or all early intervention services recommended by the IFSP team. If the parent declines one or more Early Intervention (EI) services, the Services Coordinator makes reasonable efforts to ensure the parent:

- is fully aware of the nature of the services that would be available;
- understands that the child will not be able to receive the service(s) unless consent is given; and
- understands they may accept or decline any service at any time without jeopardizing other EI services [92 NAC 52-009.03A5A and 52-009.03A5B].

The parent must provide written consent for EDN Services. The following scenarios and instructions may apply.

If parent...	Then...
gives consent to all recommended services	• parents sign and date that they understand the IFSP and parental rights, give permission to implement the Plan, and give consent for all services in the Plan.
gives consent to some services, but declines a specific service(s)	• Services Coordinator lists any service(s) and the frequency of the service(s) the parents do want on the consent page of the IFSP. • parents sign and date that they understand the IFSP and parental rights, they do not agree with the proposed IFSP as written, but they do consent to the services and frequency listed by the Services Coordinator on the consent page.
is not ready to consent for services at the time of the meeting	• Services Coordinator reviews that services cannot begin until consent is provided. • Services Coordinator schedules a day/time to follow-up with family to obtain consent signature within a week.
does not consent for services at the meeting	• parents sign and date that they understand the IFSP and parental rights; however, they are not giving consent for the services listed on the IFSP services page. • Services Coordinator and the parents explore and consider other appropriate community options, as appropriate. This is documented in CONNECT narratives. • Services Coordinator describes parental decision to decline services on the HHS-6, to include case closure and service delivery ending, and provides copy to parents. • Services Coordinator provides information so the family can contact Early Development Network (EDN) in the future, if needed.

Stage 6: Finalize IFSP

The Services Coordinator finalizes understandings with the family, assures completion of all needed paperwork and communicates the results of the meeting with parent and identified partners. Some of the three steps can be completed at the meeting location or afterwards in another location.

Step	Action
1	Review with the family when each consented EI service is scheduled to begin and address any questions they may have.
2	Discuss with the family who will get copies of the IFSP (referral source; health care provider; others with appropriate releases). **Note:** An EI-3 Release of Information form may need to be completed at the meeting (or prior to) to allow for information to be exchanged with providers from outside the network of EDN service providers.
3	Provide at no cost to parents a copy of evaluations, assessments of the child and family, and the IFSP within 7 days of the IFSP meeting. Provide to others for whom the family has signed a release of information, as agreed upon with the family.

More information about these procedures can be found in Section 11: Initial IFSP and Implementation.

15 Transition Planning and Implementation

Introduction

Early Development Network (EDN) services are provided until August 31st of a child's third birthday or until the child has met all Individualized Family Service Plan (IFSP) outcomes and there is no longer a need for early intervention services. It is essential to anticipate the time when the child will no longer receive early intervention services. Planning for the child's transition is important in order to achieve EDN's mission of enhanced child growth and development and family capacity to meet child needs. At the point of transition, families are aware of and prepare for changes. Families have full knowledge and developed skills so that they will be able to assume a role similar to that of the services coordinator and continue in a process similar to the IFSP. Additionally, a positive and smooth transition is necessary when the family moves from one District to another or from Nebraska.

Purpose and intent

Effective transition promotes linkages with the community system, including informal and formal supports, which will assist with the continued growth and development of the child. Families are involved throughout the transition process for their child. There shall be continuity of services for children during the transition process as children and families move from the EDN system to the school system or other community services.

Note: The transition plan is part of the IFSP and documented on the *IFSP Transition page* and not a separate document.

Federal indicators regarding transition

Data about transition services are collected and reported annually in three Federal indicators in order to show Regional and State performance of IDEA Part C transition requirements (Indicators C8). All states collect data on transition services. The target for transition is 100 percent, which is reported in the *Part C Annual Performance Report*. Nebraska collects information for Indicator C8 on the IFSP Transition page.

The Part C-Annual Performance Report (APR) Indicator #8 includes:

1. Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday, including:
   - 8A Transition Steps and Services;
   - 8B Notification to school district, if child potentially eligible for Part B; and
   - 8C Transition conference (not fewer than 90 days before child's third birthday), if child potentially eligible for Part B.

Discussions with families

Transition from EDN is to be discussed with families from the beginning of the child's eligibility to plan for a smooth change. Families will make an informed decision regarding whether their toddler will remain in Early Development Network/Part C services until August 31st of their toddler's third birthday or if they would like their toddler to transition to Part B services and an Individualized Education Plan (IEP) on their toddler's third birthday.

IFSPweb Tutorial: Transition Planning http://www.ifspweb.org/transition_planning.html is a helpful resource for informing families about the transition process and enhancing their abilities to advocate for their child and family before, during, and after the transition planning process.

Example:

Scenario	Action	Family Decision
Toddler's Date of Birth: November 1st	Transition Conference must be held no later than August 1st (90 days prior to third birthday). Families are provided information on the differences in Part C and Part B.	Family will make an informed decision regarding their toddler remaining in Part C, transitioning to other community services, or transitioning to Part B. This decision is recorded on the Transition Page of the IFSP.

Note: Families may choose for their toddler to transition to Part B at any time between their toddler's third birthday and August 31st of the toddler's third birthday.

Steps and services

Steps and services needed to prepare the child and family for the transition should be incorporated into the IFSP over time, using the IFSP Transition page. The IFSP Transition page can be used as early as the initial IFSP meeting and added to until the child exits.

Dual meeting purposes

IFSP teams follow procedures for the transition planning process, which is completed during initial, periodic, or annual meetings. The transition planning process is not a "type" of IFSP meeting. Requirements for initial, periodic and annual meetings are still applicable even when the meeting purpose is for planning the child's transition.

Transition planning pathway options

Federal regulations outline two transition planning pathways for children and their families, depending on whether they are considering Part B (special education) services after age three (Pathway I) or choosing other community services (Pathway II).

If data suggest child is…	Then IFSP team follows procedures for…
eligible for Part B	transition *from Part C to B* planning process.
not potentially eligible for Part B due to successful completion of all IFSP goals	transition to *other community services* planning process.

IFSP teams analyze and discuss ongoing child and family assessment data to determine which transition pathway the team will follow prior to conducting the meeting where transition planning occurs. Discussions about the data will guide decisions about the transition planning process.

If data suggest…	And…	Then IFSP team…
child has acquired developmental skills comparable to same age peers	IFSP team has no concerns about the child's ability to continue to demonstrate age appropriate skills without specialized educational supports and services	follows procedures for the transition pathway for Transition to *Other Community Services.*
child has acquired developmental skills comparable to same age peers	IFSP team has concerns about the child's ability to continue to demonstrate age appropriate skills without specialized educational supports and services	follows procedures for the transition pathway for Transition *from Part C to B.*
child has not acquired developmental skills comparable to same age peers	IFSP team has concerns about the child's developmental progress without specialized educational supports and services	follows procedures for the transition pathway for Transition

Required meeting timelines

The following outlines the requirements and timelines for holding a transition planning meeting, depending on the pathway chosen by the IFSP team.

Pathway	Requirement	Timeline
1. Transition from Part C to B	Services Coordinators ***must*** convene a transition planning meeting with approval of the family.	***Not fewer than 90 days*** and not more than 9 months prior to the child's third birthday.
2. Transition to Other Community Services	Services Coordinators should ***make reasonable efforts*** to convene a transition planning meeting.	***Not fewer than 90 days*** and not more than 9 months prior to the child's third birthday.

Pathway I, Transition plan requirements

The IFSP transition plan from Part C to B must contain steps to be taken to support the smooth transition of a child from EDN. These steps include, but are not limited to:

- Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition.
- Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting. New settings may include one of the following:
  - » Preschool services under IDEA Part B
  - » Public Pre-Kindergarten
  - » Head Start
  - » Child Care programs
  - » Other appropriate early childhood services.
- Confirmation that Child Find information about the child has been transmitted to the school district to ensure continuity of services from the Part C program to the Part B program, including a copy of the most recent evaluation and assessments of the child and the family and most recent IFSP.
- Identification of transition services and other activities that the IFSP team determines are necessary to support the transition of the child. Assistive Technology must be considered when a toddler is transitioning from early intervention services to preschool, regardless of whether the child currently receives AT services through the IFSP.
- With written parental consent, the transmission of information about the child and family, when needed, to other relevant agencies to ensure continuity of services including evaluation and assessment, and information and copies of IFSPs that have been implemented.
- Development of a transition plan that includes the child's program options for the period from the child's third birthday through the remainder of the school year and the services that may be provided following the child's third birthday.

Collaboration between IFSP team and school district staff knowledgeable about Part B is required in planning transition.

Other Transition Plan Considerations

While this list is not exhaustive, the IFSP team may use the questions below to help guide discussion at the Transition Conference and at subsequent IFSP meetings. The IFSP team should document concerns identified during the discussions.

What locations for services would you like to consider for your child? (Examples include: Head Start, Preschool at the Public School, Preschool at a community preschool, child care centers, Home, etc.) Do you have any questions or concerns about these options?

Would visiting these centers or classrooms be helpful to you?

How is it for you and your child when you separate, such as when your child is dropped off at child care, grandma's house, etc.?

What does play and interaction with other children look like for your child?

What health and medical issues does your child have? Does your child take medications during the day?

Are there diet restrictions, allergies, or preferences that need to be addressed? Will your child need extra assistance with feeding? (For children who are utilizing a g-tube, consider if they are allowed to take any food orally, when they have scheduled feeds, will someone at the school/child care/Head Start, etc. need to be trained in assisting the child with a g-tube feeding, etc.)

Will your child need any extra assistance or time when getting around the classroom, stairs, or playground equipment?

Are there any differences in how your child will participate in classroom activities, including how he or she reacts to sensory materials such as music time, art time, or playground time?

How does your child respond to activities and routines which require sitting in one spot, following directions, picking up toys, etc.?

Are there any skills your child will need to learn to participate in group activities, such as waiting his or her turn, sharing toys, etc.?

Will Assistive Technology be needed after transition? If so, what types of assistive technology may be needed?

How will your child get to preschool? What transportation options are available? If you are unable to provide transportation, what questions or concerns do you have about your child being transported by someone other than you?

What resources are you interested in exploring to help with your child's transition process? (Contact information for PTI-Nebraska, Parent support groups, disability support groups, etc.)

Pathway I, Transition planning process

There are five stages in the transition planning process to plan for Transition from Part C to Part B.

Note: Families may choose for their toddler to transition to Part B at any time between their toddler's third birthday and August 31st of the toddler's third birthday.

Stage	Process	Description
1	Prepare for transition planning and transition conference.	Prior to the transition conference, the services coordinator initiates family discussions about current services the child and family receive, potential services, and other community options. Arrangements for the meeting also occur (meeting location; notice sent; gathering information, etc.).
2	Transition conference.	Participants review progress of IFSP outcomes; determine if outcomes are met and/or next steps; discuss options for future services; the family is provided an annual transition notice; and plans for a smooth transition are determined.
3	Implement transition plan.	The steps and services outlined in the IFSP Transition Plan are implemented.
5	Exit from EDN (Part C).	Final paperwork and communications are completed to end a child and family's involvement with EDN and to facilitate the transition.

Procedures and documentation requirements for each stage of the process are described on the following pages.

Pathway I, Stage 1: Prepare for the transition conference

The following tables provide steps the Services Coordinator must take to prepare for the transition conference, first with the family and then after the discussions.

Step	Action	Notes
1	Discuss changes and vision.	• The Services Coordinator initiates discussions about current services the child and family are receiving, potential services or other community based options and transition outcomes to be added to the IFSP transition page. What will be different? Vision for the future? • The Services Coordinator discusses invitation and involvement of needed school district special education personnel in transition planning.
2	Provide information to the family about the transition process and their rights.	• The Services Coordinator and family review the *IFSPweb Tutorial: Transition Planning* • The Services Coordinator provides the family with information in order for them to make an informed decision at the transition conference regarding whether their toddler will remain in EDN/Part C services until August 31st of their toddler's third birthday or if they would like their toddler to transition to Part B services and an Individualized Education Plan (IEP) on their toddler's third birthday. • The Services Coordinator provides the EDN/IDEA Part C, Parental Rights to the family and ensures the family understands the procedural safeguards related to transition. The school district is responsible for providing a copy of the Part B Procedural Safeguards to the family.
3	Discuss scheduling of transition conference.	• Transition conference ***must*** not be fewer than 90 days and not more than 9 months prior to the child's third birthday. • Recommended to schedule far in advance of the 90 days prior to third birthday, especially for children on Aged and Disabled Waiver program. • IFSP transition conference is completed during initial, periodic or annual IFSP meeting.
4	Determine with the family who should attend.	See Required Participants below.
5	Consider Release of Information form, as appropriate.	A current release of information is needed to share IFSP records with other community programs or agencies that are under consideration.
6	Send meeting notice.	Services Coordinator sends written notice to all invited participants a reasonable time before the meeting to allow them sufficient time to attend [480 NAC 1-010.06B].

Required participants for transition conference

Participants invited to the Transition conference must include:

- Parent(s) of the child;
- Services coordinator;
- Person(s) directly involved in conducting evaluations and assessments;*
- As appropriate, persons who may provide services to the child or family in the future;
- Other family members, as requested by the parent, if feasible to do so;
- An advocate or person outside of the family, if the family requests; and
- A representative of the school district or approved cooperative who has the authority to commit resources. *

***Note:** If necessary, follow alternative methods of meeting participation procedures. (See Section 13: Periodic IFSP or Section 14: Annual IFSP).

Pathway I, Stage 2: Transition conference

The following table provides actions to be taken by the IFSP Team and the Special Education staff during a transition conference.

Step	Action	Notes
1	Share information.	The team, including the parents, shares progress on the IFSP outcomes, determine if outcome is met and/ or next steps, family's vision for their child, the transition process and any concerns.
2	Provide initial Annual Transition Notice.	Services coordinator provides an annual notice to family containing regulatory requirements, and the team assists family in understanding the information contained in this notice [480 NAC 1-011.01].
3	Discuss continuation of EDN services and document family's decision on IFSP.	Family will make an informed decision regarding whether their toddler will remain in EDN/Part C services until August 31st of their toddler's third birthday or if they would like their toddler to transition to Part B services and an IEP on their toddler's third birthday.
4	Consider and document on IFSP Transition Page necessary assessment(s) and timelines for completion.	The team reviews current IFSP information in order to plan for any needed assessment(s). Any outcomes related to transition developed by the family are added to the IFSP/Transition plan.
5	Discuss potential services and document procedures to help prepare child for changes in service delivery or settings (i.e., visit the preschool).	The team discusses potential services for when the child transitions: • Part B special education and support/related services in the least restrictive environment; and • Other community resources and services.

Step	Action	Notes
6	Document confirmation of transfer of records on Transition Plan.	The Services Coordinator documents on the transition plan confirmation that the district is in receipt of the most recent evaluation and assessment information, copies of the IFSP, and other records. Parental consent to transmit these records is required for other community programs and agencies. Services coordinator will inform families whether written consent is needed or not for record sharing to other parties outside of the IFSP team.
7	Discuss who to invite to Initial IEP/Exit Part C Meeting.	• Discuss required participants (page 15-7). • Discuss the inclusion of IFSP team members in the IEP meeting with the family. The services coordinator or IFSP team members may attend the IEP meeting at the request of the parent.
8	Develop a written transition plan. **√ C8A Transition**	• A transition plan must be written, including steps and services to prepare the child for any new expectations and/or skills as well as any supports and training needed for the parent(s), as appropriate. • *Complete all sections of the IFSP transition plan, including timelines for each action step.*
9	Complete Release of Information form, as needed.	• A current release of information is needed to share IFSP records with other agencies and programs that are under consideration (e.g., Head Start). • Obtain parent signature.
10	Finalize IFSP.	• Provide at no cost to parents a copy of evaluations, assessments of the child and the IFSP (which includes the transition plan) within 7 days of the IFSP meeting. Provide to others for whom the family has signed a release of information as agreed upon with the family.

Pathway I, Stage 3: Implement transition plan

The services coordinator monitors implementation of the activities as identified in the child's transition plan. The following table outlines actions for different team members needed for effective transition from Part C to Part B.

Team Member	Action
Family	Participates in steps and services related to child and family as outlined in transition plan.
Services Coordinator	• Monitors all Part C and non-special education transition activities and IFSP services. • Provides information about program(s) and/or available community opportunities. • Other duties as outlined in transition plan. • Prepares for child's exit from Part C.
Other IFSP Team Members	• Provide ongoing assessment information to future service providers, as needed and allowed by consent. • Assist with steps and services as outlined in Transition Plan.

Pathway I, Stage 4: Conduct Initial IEP

The local school district Part B Special Education personnel determine if the child is eligible for Special Education. If the child is eligible for Special Education, the local school district must develop and implement an IEP by the child's transition date. A transition conference can serve as an exiting meeting for Part C/Initial IEP meeting. The Services Coordinator or other IFSP team members may attend the Initial IEP meeting at the family's request.

Pathway I, Stage 5: Exit from Early Development Network (Part C)

Prior to a child's exit from the EDN, the services coordinator finalizes understandings with the family, addresses any questions or concerns, and assures the completion of all required paperwork outlined in the table below.

IFSP Forms	Notes
IFSP Transition Plan	Services Coordinator indicates completed activity dates and final exit date.
Notice of Action Form	**Notes**
HHS-6 Notice of Action	Services Coordinator documents termination of EDN services due to child's transition and related regulation citation on the HHS-6 form and provides a copy to the district.
CONNECT Data Entry	**Notes**
CONNECT Narrative/ case closure	Services Coordinator completes CONNECT Narrative entry and case closure steps on CONNECT EDN case page.

Pathway II, Transition planning requirements

The following are transition planning requirements for children moving from Part C to other community services (non-Part B services).

- Include the family in the transition plans.
- With the approval of the family, make reasonable efforts to convene a conference among the lead agency, the family, and providers of other appropriate services to discuss the appropriate services that the child may receive;
- Establish a transition plan, including, as appropriate, steps to exit from Early Development Network, Part C.

Pathway II, Transition plan requirements

The IFSP must contain steps to be taken to support the transition of the child from Early Development Network. These steps include, but are not limited to:

- Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition;
- Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting;
- With written parental consent, the transmission of information about the child to relevant agency(s) to ensure continuity of services including evaluation and assessment, and information and copies of IFSPs that have been developed and implemented; and
- Development of a transition plan that includes the child's program options for the period from the child's third birthday through the remainder of the school year and the services that may be provided following the child's third birthday.

Required timeline

Services coordinators will make reasonable efforts to convene a Transition Planning Meeting not fewer than 90 days and not more than 9 months prior to the child's third birthday.

Note: Families may decline convening of meeting.

Parent decisions

Parents have a number of options and decisions to make regarding transition planning and next steps. The following table provides common scenarios and the procedures to follow based on the family's decision.

If parent…	Then Services Coordinator …
and other IFSP team members determine child is not potentially eligible for Part B	• indicates child is not eligible for Part B services on IFSP *Transition Plan*. • continues to follow procedures in transition planning process for Pathway II.
declines holding a transition conference	• documents on the IFSP *Transition Plan*: » Attempts to engage family in a meeting; and » Parent decision to decline a meeting. • continues to follow procedures in transition planning process for Pathway II **except** does not convene a formal transition conference.

Pathway II, Transition planning process

There are four stages in the transition planning process for children leaving Early Development Network and moving to other community services.

Stage	Process	Description
1	Prepare for transition planning and transition conference	The Services Coordinator initiates discussion about current services the child and family receives, potential services and other community options. Preparations for the meeting also occur.
2	Transition conference	With parent approval, participants gather to review ongoing assessment data, discuss options for future services, and determine plans for smooth transition.
3	Implement transition plan.	The steps and services outlined in the IFSP Transition Plan are implemented.
4	Exit from EDN (Part C).	Final paperwork and communications are completed to end a child and family's involvement with EDN and to facilitate the transition.

Procedures and documentation requirements for each stage of the process are described on the following pages.

Pathway II: Stage 1: Prepare for the transition conference

The following tables provide steps the services coordinator must take to prepare for the transition conference.

Note: Even if the parent declined convening of transition conference, services coordinator, if possible, reviews the steps with the family without a formal meeting and documents in the CONNECT narrative.

Step	Action	Notes
1	Discuss changes and vision.	The Services Coordinator initiates discussions about current services the child and family are receiving, potential services or other community based options and transition outcomes to be added to the IFSP transition page. What will be different? Vision for the future?
2	Provide information to the family about the transition process and their rights	• The Services Coordinator and family review the *IFSPweb Tutorial: Transition Planning as needed*. • The Services Coordinator provides the EDN/IDEA Part C, Parents Rights, to the family and ensures understanding of procedural safeguards related to transition.
3	Discuss program options and enrollment criteria.	The services coordinator discusses with the family program options including eligibility requirements for community services (e.g., Head Start).
4	Discuss scheduling of transition conference	• Meeting, with parental approval, **must** be at least 90 days and up to 9 months prior to the child's third birthday. • Meeting is completed during an initial, periodic or annual IFSP meeting.
5	Determine with the family who should attend.	Participants must include: • Parent(s) of the child, • The Services Coordinator, and • IFSP service provider(s). Other participants may include: • School district representative; • Other family members, as requested by the parent, if feasible to do so; • An advocate or person outside of the family, if the family requests; and • Persons who will be providing services to the child or family.

Step	Action	Notes
6	Consider Release of Information, as appropriate.	A current Release of Information signed by the family is needed to share information with community service providers/agencies.
7	Gather information.	The Services Coordinator makes reasonable efforts to gather information from current and potential service providers and/or programs.
8	Send Meeting Notice.	The Services Coordinator sends written notice to all invited participants a reasonable time before the meeting to allow them sufficient time to attend. **Note:** Omit Step 8 if parent declined meeting.

Pathway II: Stage 2: Transition conference

The following table provides actions to be taken by the IFSP team during a transition conference.

Note: If parent declined convening of transition conference, if possible, services coordinator reviews the steps with the family without a formal meeting and documents in the CONNECT narrative.

Step	Action	Notes
1	Share information.	The team, including the parents, share progress on the IFSP outcomes, parent's vision for their child, the transition process, and any concerns.
2	Provide initial Annual Transition Notice.	Services Coordinator provides an annual notice to family containing regulatory requirements, and the team assists family in understanding the information contained in this notice [480 NAC 1-011.01].
3	Discuss potential services .	The team discusses potential services for when the child transitions. **Note:** Discussion must include services needed from the child's third birthday through the remainder of the school year (August 31).
4	Discuss parent consent for transfer of records.	• Consent is required to transmit Part C records to community partners, if determined necessary (e.g., Head Start). • If needed, complete *Release of Information* form and obtain parent signature.

Step	Action	Notes
5	Develop a written transition plan. **√ C8A Transition**	• A transition plan must be written, including *steps and services* to prepare the child for any new expectations and/or skills as well as any supports and training needed for the parent(s), as appropriate. • *Complete all sections of the IFSP transition plan, including timelines for each action step.*
6	Finalize IFSP.	Provide at no cost to parents a copy of the IFSP (which includes the transition plan) within 7 days of the IFSP meeting; provide to others for whom the family has signed a release of information as agreed upon with the family.

Pathway II: Stage 3: Implement transition plan

The Services Coordinator monitors implementation of the activities as identified in the child's transition plan. The following table outlines actions for different team members for effective transition from Part C to other community services.

Name	Actions
Family	Participates in steps and services related to child and family as outlined in transition plan.
Services Coordinator	• Monitors all transition plan activities and IFSP services. • Provides information about program(s) and/or available community opportunities. • Assists with steps and services as outlined in transition plan. • Prepares for child's exit from EDN.
Other IFSP Team Members	• Provide ongoing assessment information to future service providers, as needed and allowed by consent. • Assist with steps and services as outlined in Transition Plan

Pathway II: Stage 4: Exit from Early Development Network (Part C)

Prior to a child's exit from the EDN, the services coordinator finalizes understandings with the family, addresses any questions or concerns, and assures the completion of all required paperwork outlined in the table below.

IFSP Forms	Notes
IFSP Transition Plan	Services Coordinator indicates completed activity dates and final exit date.
Notice of Action Form	**Notes**
DHHS-6 Notice of Action	Services Coordinator documents termination of EDN services due to child's transition and related regulation citation on the HHS-6 form and provides a copy to the district.
CONNECT Data Entry	**Notes**
CONNECT Narrative/ case closure	Services Coordinator completes CONNECT Narrative entry and case closure steps on CONNECT EDN case page.

16 Reference

1. Workgroup on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings. (2008, March). Agreed upon mission and key principles for providing early intervention services in natural environments. Retrieved from http://ectacenter.org/~pdfs/topics/families/Finalmissionandprinciples3_11_08.pdf