Table of Contents

This guideline outlines the key purposes, practices and procedures that guide the delivery of early intervention services at PIC, ensuring consistency, quality, and compliance with program standards. It is designed to be a searchable resource that clearly describes service processes, expectations, and procedures for staff. Detailed employee practices and related agency policies can be accessed on SharePoint under Policies and HR General

Overview

Find key timelines, procedures, and staff roles essential to delivering high-quality services. The section includes critical timelines from referral to annual re-evaluation, transition planning, and documentation requirements, as well as decision trees for discharge and exiting. Additionally, it outlines expectations for service delivery, caseload management, travel and mileage, and performance reviews across all staff roles—from direct service providers to administrative and leadership personnel.

Timelines

Child Timeline: Referral to Annual Re-eval

The following document provides a practical overview for ensuring timely compliance with the Part C timeline requirements. It outlines key steps from referral to the development of the Individualized Family Service Plan (IFSP) through Annual Re-evaluation. Adhering to these guidelines supports prompt and effective services for infants and toddlers with developmental needs during their enrollment.

Documents

Child Timeline: Referral through Annual Re-eval

Transition Timeline

This section of the practice guidelines outlines the required steps and timelines for transitioning children from early intervention services to the communit or other agnecies. It includes LEA Notification to ASD, and the need for the Transition Conference. It provides clear guidance to ensure smooth, timely coordination with families, local education agencies and community providers.

Documents

Transition Timeline

Late Referral Timeline

As children who are referred to, or enrolled in ILP and are approaching age three, transition requirements change. The attached document supports staff decision-making depending on the child's age at entry into ILP services.

Documents

Late Referral Timeline

Exiting After Enrollment Decision Tree

This timeline provides an overview and guides the steps and highlights provider responsibilities that apply to children who are enrolled in PIC's services at the time of exit. Post-enrollment processes differ significantly from those used during the referral phase. While the referral process focuses on determining eligibility and initial family engagement, the procedures described here are specific to children who have been enrolled, received services, and are now transitioning through the required exit processes.

Documents

Exiting After Enrollment Decision Tree

Discharge Date Decision Tree

Flow chart that supports the provider in determining the appropriate discharge date for a child exiting PIC's services.

Documents

Discharge Date Decision Tree

Documentation Timeline

Document Timeline and 5 business days

Document	5 business days/7 days	7 days	Notes
Daily Notes	X		
Intake	X		Intake docs need to be e-signed need to be completed in the Admin tab of child's RT file.
Provider Individual Eval	X		Other providers rely on this document to complete the Functional Eval
Functional Eval		X	Complete prior to eligibility meeting to review with family. Will roll to the IFSP, if one is developed.
IFSP initial	X		Complete: • All relevant tabs in the IFSP document • Signature pages listing those present at eligibility/IFSP; list secondary evaluator, even if not present • Service ticket • E-signature pages (and confirm family signed) * Open in tandem with the POC * Complete POC before signing off
POC, Initial	X		• Must be completed before the first visit for billing • Complete with secondary if there is one • Complete with enough time to allow secondary to do POC prior to THEIR first visit. • The doctor has 14 days to sign off, so submit ASAP. Open in tandem with the IFSP
Consult	X		Requesting provider should complete a Consult Request Form and email to the requested provider.
IFSP revision	X		Complete: • All relevant tabs in the IFSP document • Signature pages listing those present at eligibility/IFSP; list secondary provider, even if not present • Service ticket • E-signature pages (and confirm family signed) * Open in tandem with the POC to keep in sync * Complete POC before signing off
POC revisions	X		• Must be completed before the next visit for billing • Complete with secondary if there is one • Complete with enough time to allow secondary to do POC prior to THEIR next visit. • The doctor has 14 days to sign off, so submit ASAP. Open in tandem with the IFSP
Exit		X	Impacts PIC enrolled numbers—exit within 7 days of child's exit
Communication Log		X	Impacts all staff who communicate with clients while provider is away or occupied
Tasks		By specific due date	At least by next visit with family, and if you continue to have a signature problem or a complication with documentation please contact admin ASAP

5 business days

PIC's policy and clinical standard requires that all service notes be completed and signed within **5 business days** of the date of service. While the **final due date** is 7 calendar days from the date of service, **best practice** is to complete documentation on the same day the service is delivered, or at minimum, within the work week in which the service occurred.

This standard is grounded in the following principles:

- **Timely documentation increases the accuracy and quality** of clinical notes.
- **It reduces the number of non-billable events**, such as those resulting from missing Plans of Care or other required elements.
- **It supports the agency's cash flow stability** by reducing billing delays.
- **It allows time for the billing team to identify and correct errors**, ensuring compliance before claims are submitted.

Definition of 5 Business Days:
The five-business-day window begins on the date the service is delivered and ends at midnight on the fifth business day. For example, if a service is provided on a Thursday, the note is due by the following Wednesday at 11:59 PM. Business days exclude Saturdays, Sundays, and observed holidays. However, **non-scheduled workdays (such as Fridays for part-time staff)** still count toward the 5-day timeline, and providers are expected to plan accordingly.

Planned Leave and Closures:
Providers are expected to complete all documentation within the 5-business-day standard even in advance of planned vacation, extended leave, or the winter closure period.

Important Note on Compliance:
Staff who follow the Medicaid 14-day signature guideline should be aware that **this does not meet PIC's documentation standard.** PIC requires adherence to the 5-business-day timeline for internal compliance and operational effectiveness.

Signature, Forms, Documentation, & Verbal Consent Timeline

The following section outlines documentation requirements and timelines for key processes within the IFSP cycle, including intake, evaluation, eligibility determination, initial and annual IFSPs, as well as IFSP revisions. Each of these processes has specific expectations related to provider signatures, required forms, written documentation, and verbal consent. Timely and accurate completion of these elements ensures compliance, continuity of care, and supports billing and program integrity. **Note that while verbal consent is included, it is intended only as a temporary measure—a stop-gap to ensure continuity until written consent is obtained.**

	Intake	Evaluation	Eligible Meeting	Initial IFSP	Revision IFSP	Annual Evaluation	Annual IFSP
Family Signature Forms	Intake Packet: HIPAA Virtual Visits Consent to Eval Consent to Bill Prior Written Notice (PWN) Patient Demographics Release of Information (ROI)		Post Evaluation Packet: Working Together Eligibility Determination PWN	IFSP Packet: IFSP Mtg Signature PWN	IFSP Packet: IFSP Mtg Signature PWN +/- CTB if adding PT/ST/OT AND private insurance	Reevaluation/Annual Packet: HIPAA Virtual Visits Consent to Eval Consent to Bill Prior Written Notice (PWN) +/- Release of Information (ROI)	Post-Evaluation Packet: Working Together Eligibility Determination PWN + IFSP Mtg Signature
Provider Documentation	Intake Note	Functional Evaluation	Daily Note	Initial IFSP	Revision IFSP	Functional Evaluation	Annual IFSP
Verbal Consent	Verbal Consent for Intake Packet if not signed on Date of Service (DOS)		**If Child is Eligible:** Verbal Consent for Post Evaluation Packet **If Child is WNL:** Verbal Consent for	Verbal Consent for IFSP Packet if not signed on Date of Service (DOS)	Verbal Consent for IFSP Packet if not signed on Date of Service (DOS)	Verbal Consent for Reevaluation Packet if not signed on Date of Service (DOS)	**If Child is Eligible:** Verbal Consent for Post Evaluation Packet **If Child is WNL:** Verbal Consent for

	Intake	Evaluation	Eligible Meeting	Initial IFSP	Revision IFSP	Annual Evaluation	Annual IFSP
			Eligibility Determination & PWN if not signed on Date of Service (DOS)				Eligibility Determination & PWN if not signed on Date of Service (DOS)

Caseload

Primary Service Provider Purpose & Practice

How to: Primary Service Provider Assignment

PIC's service delivery approach is a primary service provider/transdisciplinary coaching model.

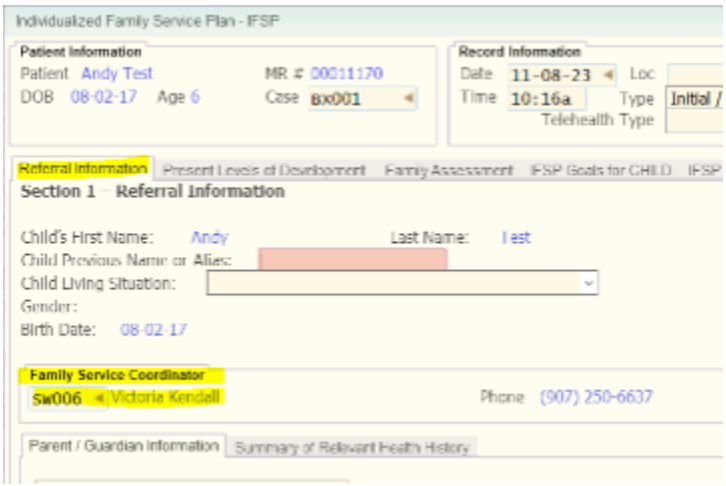
PROVIDER: The primary service provider for a child is initially decided at Team meeting and documented in the RainTree communication log by the referral specialist. One provider is the primary contact for a family who is considered by the team the "best long-term fit". The provider will ideally stay with the family through their journey with PIC and provide the primary service that is needed and family service coordination. This provider model was adopted based on research and ongoing evidence of effectiveness for addressing child development and encouraging parent carryover. The primary service provider element is one of the main tenets of the coaching model.

Rain Tree initial PSP assignment: the team's referral specialist adds communication log note for which provider has been assigned and Team Manager adds role record by end of week.

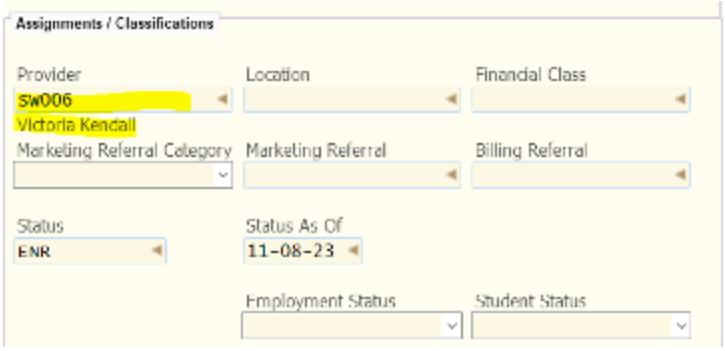
ADMIN: Need an IFSP to update or change the PSP.

1. At the initial IFSP, the provider listed as the Family Service Coordinator on the **Referral Information tab of the IFSP** is who admin will update (if necessary) to be the PSP in the patient demographics.

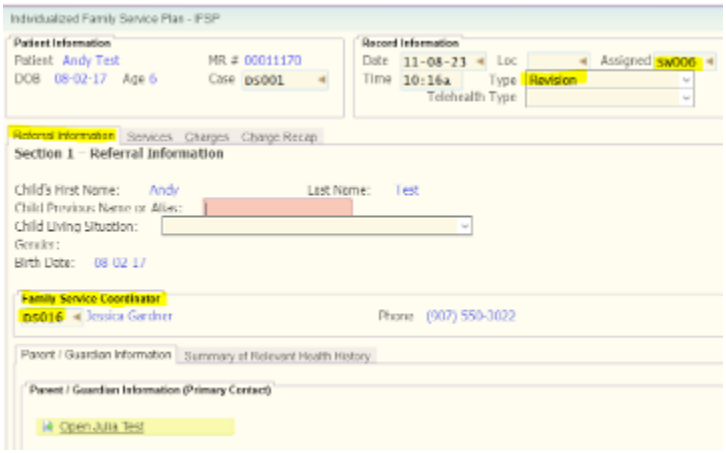
Referral tab of IFSP



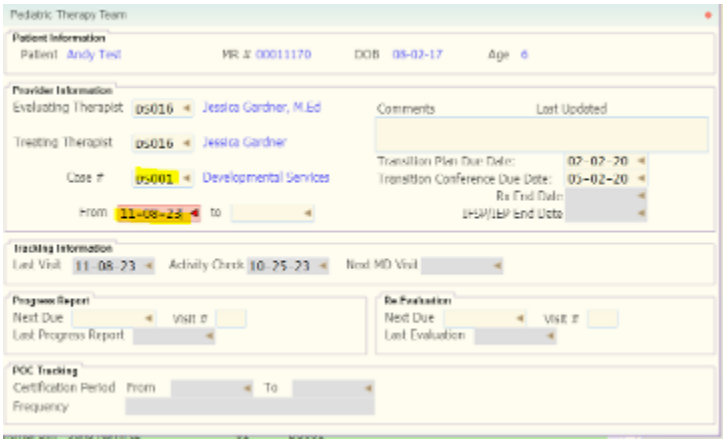
Patient Demographics



2. If the PSP changes, a NEW IFSP is needed to document that. On the Revision IFSP the provider needs to include the Referral Information tab and change the Family Service Coordinator there. This is where Admin will look for the change.



EX: In this example, Victoria can still sign off on the IFSP, but assign Jessica as the new PSP that Admin updates in the Patient Demographics tab. Admin always makes sure anyone on the Services tab has a role record with the start date of the IFSP



Admin double check: The Service Coordination SERVICE provider should be the same provider on the Referral Information tab

Changing Primary Service Provider

Documents

Transfers Among Providers-Purpose, Practice, & Procedure (PowerPoint)

Mileage & Travel

Mileage

Purpose
Motor Vehicle Usage and Drivers Safety

Policy

It is the policy of PIC to safeguard the lives and well-being of its employees, consumers and the public and to protect property by requiring that all motor vehicles be operated on behalf of the agency in a safe, responsible manner and in accordance with local, state and federal laws and regulations.

Practice

Driver Qualifications

1. An employee may only operate a motor vehicle on behalf of PIC if he or she:
    1. Is acting at the direction and with the permission of the Agency; and
    2. Meets all insurance requirements including age and experience; and
    3. Holds a valid driver's license; and
    4. Has an acceptable driving record.

Unacceptable Driving Records

2. Employees will be required to submit copies of his or her driving history as requested. Employees may not operate agency vehicles or their own personal motor vehicle for agency business if they have an unacceptable driving record.
    1. An unacceptable driving record is defined as a driving record that indicates the driver poses an unreasonable risk to employees, consumers or the public including, but not necessarily limited to, a conviction for any of the following violations within the prior 5 years:
        1. Impaired driving while under the influence of drugs, alcohol or a controlled substance or prescription medication; or
        2. Refusal to submit to a breathalyzer test; or
        3. A second violation for reckless driving or careless driving; or
        4. Leaving the scene of an accident; or
        5. Driving with a revoked driver's license.
        6. Other driving convictions may also result in driving restrictions.
3. A current employee who is charged with any of the offenses listed above may not operate an agency vehicle or their own personal motor vehicles for agency business pending resolution of the charge.

Exceptions

4. The Executive Director may include driving restrictions when it is in the best interest of PIC.

Reporting Violations

5. Employees operating their own personal motor vehicles for agency business are required to promptly report all motor vehicle violations to their immediate supervisor whether or not the violation is work related. The immediate supervisor will be responsible for documenting reported motor vehicle violations in the employee's personnel file and discussing with HR and an Executive Director to decide whether or not an exception is able to be granted.
6. Employees are not permitted, under any circumstances to operate personal vehicle for agency business, when any physical or mental condition affects his or her ability to drive safely. This prohibition includes, but is not limited to, circumstances in which an employee is temporarily unable to operate a vehicle safely or legally due to any of the following conditions:
    1. illness,
    2. injury,
    3. medication(s),
    4. emotional conditions,

5. intoxication or
6. any other circumstance that may impair an employees' ability to drive.

Employees are cautioned to follow label warnings and medical advice regarding driving while using medications.

7. **Employees may only use hands-free cell phones or other mobile communication devices while driving any vehicle for PIC business. This includes, but is not necessarily limited to cell phones, mobile phones, Blackberries, PDA's and laptop computers. However, studies indicate that talking on cell phones, even hands-free is distracting and creates a hazard.**
8. While operating a personal vehicle on agency business, employees must obey all traffic rules, drive safely and report any accidents in accordance with this policy.

Accidents

9. In the event of an accident while driving her or his own personal vehicle on agency business, the employee must:
    1. Report the accident to the Alaska State Troopers or local police and then their supervisor, regardless of the amount of damage sustained.
    2. Decline from signing or making any statements regarding responsibility or fault for the accident except to public safety personnel, PIC supervisor, claims adjustor or an attorney for PIC's insurance company.
    3. Obtain names, addresses, phone numbers, license numbers and insurance company contact information of the other drivers involved and the phone number of the public safety officer.
    4. Complete any state required accident (crash) report form and timely file any required Certificate of Insurance with police department where the accident report will be prepared.

Return to work after an Accident

10. An employee will complete the Incident Report as soon as possible and no later than 24 hours after the incident. The incident report will be reviewed by HR and the Executive Director. The reviewer will temporarily authorize or deny authorization for the employee to continue driving.
    1. If the employee is not allowed to continue driving on behalf of PIC, the Executive Director will determine what steps should be taken by the employee to resume driving for PIC.
11. As a general guideline, an Executive Director may determine that an employee who is not at fault may not have to retake the complete drivers' safety training class. Some examples of "not at fault" may include:
    1. If the Employee was determined by Public Safety Personnel to be not at fault in any way, and
    2. If road conditions did NOT contribute to the accident, and
    3. If the Executive Director determines the accident did not involve questionable judgment on the part of the employee.

Auto Insurance

12. Employees who use personal vehicles for work purposes must meet the motor vehicle insurance policy requirements of vehicle insurance policy requirements of the State of Alaska and are encouraged to meet auto insurance policy limits of $100,000/$300,000 bodily injury and $50,000 property damage.
    1. Employees who use personal vehicles for work purposes must show proof of motor vehicle insurance coverage at the time of hire and subsequently, each time their insurance is renewed. Proof of insurance information will be treated confidentially and will be maintained in the employee's personnel file.
    2. Employees are also required to inform their supervisor immediately should his/her required motor insurance coverage lapse, be suspended or terminated. Failure to do so may result in disciplinary action.

Mileage Reimbursement

13. PIC employees who use a personal vehicle for approved business purposes will receive mileage reimbursement for actual mileage incurred for job related travel.
    1. The rate of reimbursement will be set by the Executive Director.
    2. This reimbursement is to assist with the costs of operating and maintaining a vehicle, such as gasoline, oil, depreciation and insurance.
    3. PIC will not accept or pay any mileage reimbursement claims that are submitted later than 6 consecutive pay periods, or 30 days after the close of the fiscal year, whichever comes first.
    4. Employees seeking reimbursement must have a valid drivers license and current proof of insurance in their personnel file.

Vehicle Safety

14. Employees may only drive a personal vehicle for agency purposes if that vehicle is in good and safe driving condition.
15. The driver of the vehicle is responsible for ensuring that safety belts are operable and properly worn by drivers and passengers in all vehicles used for agency business. .

Others in the Vehicle

16. Generally, only PIC employees should be transported in personal vehicles for PIC related purposes or during delivery of agency services.
    1. The Executive Director may grant exceptions to this policy when it is in the interest of the agency to do so.

Parking

17. Employees operating motor vehicles for agency business shall be reimbursed for parking expenses incurred, provided expenses are at least two dollars ($2.00) and a written receipt is submitted.

Discipline

18. Employees who fail to comply with this policy are subject to disciplinary action up to and including termination of employment.

Documents
Mileage Procedure-Fillable Form

Travel

This linked form is used to document and request reimbursement for travel-related expenses incurred during approved work-related activities. To ensure timely processing and compliance with PIC's travel policies, all required fields must be completed accurately. Supporting documentation—such as receipts, mileage logs, and proof of prior approval—must be attached where applicable. Incomplete forms or missing documentation may result in delays or denial of reimbursement. Refer to the PIC Policy and Procedure for Payment while traveling in active work status for additional information.

Documents
Travel Worksheet

Performance Review and Self-Assessment Links by Position

Executive Director

Executive Director Annual Performance Review:

The process of evaluating the performance of the Executive Director falls to the Board of Directors.

At any point in the year, typically near the end of the fiscal year. The Executive Director will submit a self-assessment to the board president in preparation for the performance review. The self-assessment is a document that reflects the accomplishments of the past year or two depending on the board's preference for frequency of the performance review.

The Board President is responsible for completing the review with feedback and consideration from the full board. There is no specific form or specific process as each board uses their own judgement. However, it is recommended that there is some document to include in personnel files and to present to the Executive Director acknowledging the review and its result.

The board president will discuss the annual performance review in an executive session, first with the full board and then with the Executive Director present.

When the board resumes the regular meeting, a motion and vote will be made to present the results of the performance review and any recommended changes to pay or benefits.

Deputy Director

Documents

Self Reflection Yearly Review by Executive Director

Team Managers

Documents

Annual Self Evaluation

Template Evaluation Narrative

Administrative Managers-IT, Finance, and Office

Documents

Self Reflection Yearly Review by Executive Director

Direct Service Providers (BH, DT, PT, OT, ST, and SW)

Documents

Employee Evaluation Grid

Template Evaluation Narrative

Cherish Coordinator

Documents

Annual Self Evaluation

Template Evaluation Narrative

Referral Specialists

Documents

Annual Self Evaluation

Template Evaluation Narrative

Health Information Technicians (HIT)

Documents

Employee Self Evaluation

Support Staff Perf Evaluation

Administrative Support (Data Entry)

Documents

Employee Self Evaluation

Support Staff Perf Evaluation

Prior to Enrollment

Child Find/Reengagement

Purpose
Child Find, a crucial component of Part C legislation, aims to identify, locate, and evaluate children ages birth to 3, as early as possible, to ensure they receive appropriate support and services. PIC has developed and maintains a follow-up process that also supports reengagement for those children whose families disengage from the referral process.

Practice
PIC engages in a range of activities each year to promote awareness of early intervention services, support the evaluation of children, and determine the need for services. These outreach and engagement efforts include: follow-up by the Child Find/CHERISH specialist for children whose families do not respond to or initially decline referrals; participation in local health fairs; coordination and outreach with the local school district; and community resource efforts such as the Diaper Pantry and Swaddle Me, which include early intervention materials and encourage screening. Additional strategies include providing training to OCS, as well as reflective supervision, and materials to help case workers identify children who may need screening, as well as offering the ASQ (Ages and Stages Questionnaire) on PIC's website for families to complete on their own.

Procedure
PIC's participation in Child Find activities is guided by an annual review and planning process led by administrative staff, with input and support from the state, agency leadership, program staff, and the community. These efforts fulfill a requirement outlined in the state grant, which mandates that PIC engage in Child Find activities as part of its legal and contractual obligations.

- The Executive Director, in coordination with staff, participates in various interagency groups to raise awareness of PIC services and develop community partnerships. Agency leadership also creates materials, organizes events, and attends outreach opportunities designed to promote public awareness and generate referrals from parents and key referral sources such as pediatricians, OCS, and NICUs. These referrals are based on a child's potential need for evaluation and early intervention services.
- Staff who wish to participate in current Child Find activities should reach out to administrative leadership for information on active projects. A list of current initiatives is available through the Executive Director. Staff are encouraged to suggest additional Child Find activities and, when possible, offer their expertise to support events. Talk to your manager or the Executive Director if you're interested in participating or proposing a new activity.
- As part of ongoing outreach, the Child Find/CHERISH specialist contacts families who are categorized as "Lost to Follow-Up" or "Decline" within three months of their exit from the referral process to offer continued support and to re-engage.
- Referrals generated from Child Find activities are handled by the Referral Specialists, who initiate the 45-day timeline toward enrollment when appropriate. Staff should contact the Referral Specialists with any questions or to follow up on specific cases.

ASQ Screenings

Purpose
PIC offers the ASQ-3 developmental screening tool on its website (picak.org) for use by parents and other caregivers. This tool helps families monitor a child's developmental progress and identify any areas that may need support.

In most cases, medical home providers, such as pediatricians, administer the ASQ-3 regularly at well-child visits. Some childcare providers also incorporate routine ASQ screenings into their early care practices. These screenings support early identification of developmental concerns and strengthen communication between caregivers and service providers.

PIC providers, in contrast, may use the ASQ in two primary ways:

1. Pre-enrollment, to support families in understanding development and determining whether a referral for evaluation is needed.
2. During-enrollment, as an interim tool to check developmental progress between formal evaluations, when requested by the family or indicated by the PIC provider.

The ASQ supports the following goals:

- Helping families understand if their child is developing skills appropriate for their age.
- Educating families on what developmental milestones to expect.
- Assisting caseworkers and providers in identifying children who may need additional support.

- Facilitating appropriate referrals to PIC or other services when developmental concerns arise.

Procedure
The ASQ-3 and ASQ:SE can be used by both referral sources and PIC providers to support families, depending on the child's enrollment status and needs.

When a family requests an interim ASQ between formal evaluations (for an enrolled child):

- Provide Prior Written Notice (PWN) and obtain Consent to Evaluate.
- Complete the ASQ using a hardcopy from the staff workroom or direct the family to the "For Parents" tab on the PIC website.
- Document results in RT using a Screening Note.
- If the enrolled child scores within normal limits and the parent is considering discharge, PIC may recommend completing a full evaluation sooner than the typical one-year cycle to assess eligibility and ensure appropriate support. In that case, provide a new Prior Written Notice for Evaluation.

When offering an ASQ for a child pre-enrollment:

- Prior Written Notice (PWN) and Consent and Notice of Screening before proceeding.
- Use the ASQ to help determine whether proceeding to an evaluation is advised.
- Document results appropriately, using the Screening Note format in RT.
- For children in OCS custody, ASQs should be conducted in person and are not to replace formal evaluations. They may only be used in addition to, or upon specific request for a screening-only purpose.

Documents
ASQ Practice and Decision Tree

Referral

Purpose
PIC receives about 900 referrals per year from a variety of sources. PIC's Referral Team helps the families of the children who are referred determine if it is an appropriate referral, what they can expect from PIC, and process their information in a timely manner so that children get connected with an early intervention provider for services.

Practice
Referral Specialists review each referral to ensure it is appropriate. Referrals generally come from a qualified provider (Pediatrician, child care) or family/caregiver in the communities that PIC serves including: Anchorage, Girdwood and Whittier, (but *not* Eagle River), as well as the communities of Kokhanok, Iliamna, Newhalen, Port Alsworth, Igiugig, and Pedro Bay. The team then enters the referral information into both Raintree and the State ILP database. When contacting the family, they confirm demographic details and identify the primary concerns. A brief synopsis of each referral is documented in the RT communication log. In addition, the team creates a separate Word document in SharePoint listing all referrals received that week. Referrals are submitted to managers by 10 a.m. on Mondays and assigned to a PIC provider during the team meetings that same week.

Procedure
The Referral Team processes client information according to the established referral procedures. Families are contacted at least three times. Information gathered is processed in a timely manner. Clients are typically called on the same day the referral is received or by the next business day. In general, referrals are processed and assigned within 6–9 days of receipt. If the family cannot be reached after three attempts, the referral source is notified and encouraged to submit a second referral if appropriate. Referrals delayed due to family-related reasons are placed on hold ("pended") and reprocessed as soon as possible once contact is re-established.

Referral FAQs

What questions does referral ask?

If you've thought of it, Referral Specialists likely asks the question. If you do not see information in the referral related to something you see at a visit, the parent likely did not report out the issue. Parents sometimes are in a hurry or do not want to answer, initially. Intake is a great place to follow up.

What to do with a re-referral?

If the child has been discharged and re-referred to PIC, and they contact a provider prior to contacting referral, forward to referral, or take current information and email to referral. Clients who have been discharged will need to go through the process to re-open charts through referral—although this is a shorter process than their initial contact.

Mini-Grants: after it gets approval, what happens next?

After a mini-grant award is approved by the Mental Health, send it to the Exec. Director, Dep. Director or the Finance Manager for a signature. The whole process is outlined here, Next, set an appointment with Julie when she is available (Tu, We, Th). This is an FSC appointment for the provider—it will take an hour at least, and completing the worksheet in the linked instructions is critical to expediting your orders.

Provider confirms worksheet items, shipping, website and totals, or update items prior to meeting with Julie.

How do I get an ROI from OCS?

Contact the PSSU at OCS to get ROIs signed (email is sometimes more efficient).

OCS Placement Search and Support Unit (PSSU)

1-855-603-8637

Press option 2

fcs.ocs.pssu@alaska.gov

When possible, the Referral Specialists will get an ROI and have it in place at referral to team, and will also circle back with OCS to get custody orders which can take some time to be processed at the court.

If you do not hear back from OCS and Referral is not available, you may call the OCS front desk at 907-269-4000, make sure that the OCS worker you have in contacts has not changed and connect to the correct caseworker.

When will I get, or how to I get a custody order from OCS?

It takes at least 30 days for OCS to get custody orders from the court. OCS will share the custody orders upon request and the PIC provider and/or referral may need to follow up about 30 days after child is taken into custody. Custody orders along with an ROI are required for release from both Providence and ANMC records departments.

Documents

Referral Specialists Overview

Intake

Purpose

Intake allows providers and families to begin to build a positive partnership. The service provider gathers client information and shares information about PIC. The goal is to help families orient themselves to our service model, gather family's history, complete intake paperwork, and prepare for evaluations. The following activities usually take place over the course of one visit.

Practice

Intake Practice

Intake allows providers and families to begin to build a positive partnership. The service provider gathers client information and shares information about PIC. The goal is to help families orient themselves to our service model, gather family's history, complete intake paperwork, and prepare for evaluations. The following activities usually take place over the course of one visit.

Action	Reference	EHR Documentation
Describe Program Philosophy/Eligibility • Infants and toddlers learn best where they live and play, through everyday activities and interaction with caregivers.	• Clinical Opinion • Medical Dx	Intake Note Include in note the information gathered and that program description was reviewed.

Action	Reference	EHR Documentation
• All families, with support and resources, can meet the needs of their child. • The PSP role emphasizes support to the family. • Each family' services will be individualized to best meet the needs of the family. • PIC model is reflective of best practices with infants and toddlers, and of the laws and regulations we follow. • Qualify by 50% delay, diagnosis, clinical opinion		
Family and Child Assessment Interview Gather information about family's everyday routines and activities, strengths, pertinent medical and family history.	• Vision Screen • Hearing Screen • For Routines: ◦ Functional interview	Tabs: Objective • Complete Vision and Hearing Screening, or indicate why none Intake • Parent Concerns and Priorities • Home and Resources • Routines • Times • Background Summary • Clinical Observations • Other • Plans • Charges Pediatric Medical History link
Complete Procedural Safeguards Procedural Safeguards acknowledgment forms are signed by the parent to assure that PIC is transparent and they have received information about our processes.	• Patient Demographics form • Acknowledgement of Receipt of PIC Notice of Privacy Practices • Part C Consent to Bill Private Insurance and Medicaid • Parental Prior Written • Notice and Family Rights form (front and back) • Surrogate Parent Form (if child is in state custody) • Share with family 'Stop the Spread of Illness' information sheet	Complete and send to family in Admin Tab on RT. If family does not complete on day of Intake, complete a Verbal Consent note in the Communication Log in the patient chart. Medical record request is submitted to Admin Support to request.
Obtain ROI for Medical Records and other providers/caretakers	Release or Obtain Information	Complete and submit forms in child's permanent file in Admin Tab. Medical record request is submitted to Admin Support admin@picak.org to request immediately following intake.
Set-up Eligibility Evaluation	Prior Written Notice: indicate evaluation is warranted	Appointment in Electronic Health Record in Admin Tabe PWN in Admin Tab

Notes: Background Summary should be a short and concise write-up that addresses the information gathered at the intake interview, and references information from the referral documents. The purpose of this section is to inform a reader about the family concerns, the child's relevant medical history, strengths and challenges, routines or interests, social supports and if necessary any involvement in other services. This should be

written by the provider and NOT copied from the referral specialists. This document supports the providers in developing and justifying an eligibility decision when paired with the evaluation and observations. As well, it informs any future providers about the status of the family and child at intake in relationship to the developmental delay.

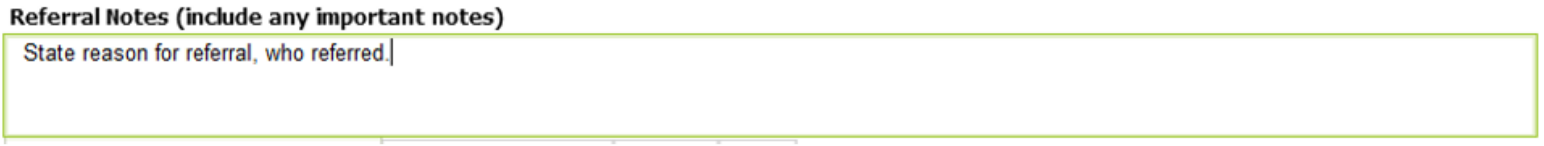
Procedure

Intake Provider Procedure/RainTree Intake Note Guidance

- Note: These directions assume you have an Intake appointment scheduled in your Raintree calendar.
- RainTree Go to DASHBOARD. Double-click on the appointment from the dashboard.
- The Prompt box will appear, click on Check In Appt.
- Work your way through the Intake documentation, and complete every tab. Intake note will appear, enter information following instructions.
- If the parent declined an assessment/evaluation at the Intake, please check the 'Family Declined Family Assessment' checkbox

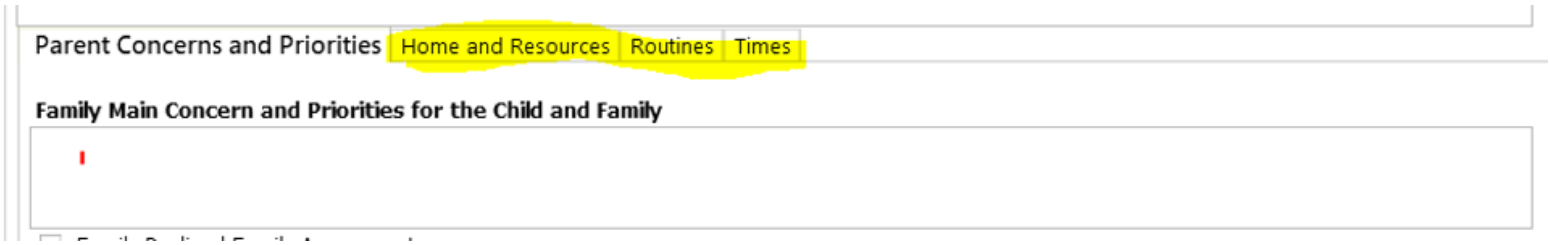
Complete Intake Note in RT using tabs.

***Referral Notes (include any important notes):**

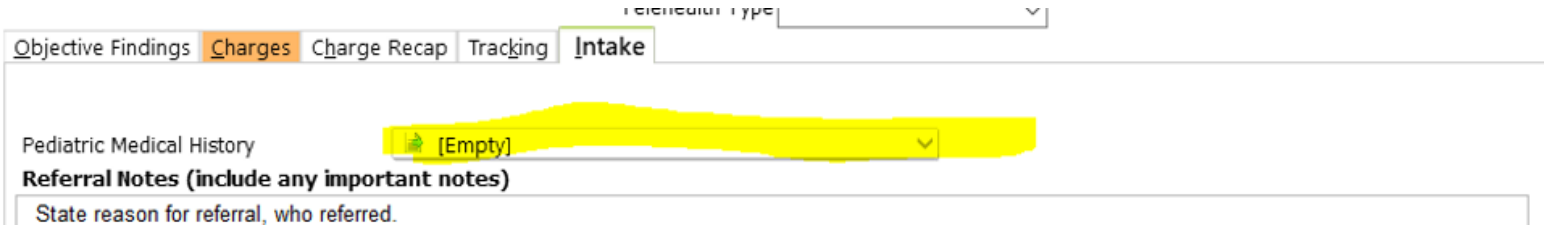


***Family Main Concern and Priorities AND EACH ADDITIONAL TAB for the Child and Family/Home and resources/Routines/Times, Strengths and Challenges:**

***Using the information from the family assessment, complete the following three tabs, for home and resources, routines and times of day that are challenging and easy:**



***Pediatric Medical History: click into the to complete with the family online, or return to the document to complete after the intake home visit:**



***Background Summary AND EACH ADDITIONAL TAB for the Child**

Written a brief summary in narrative format, include the following (in addition to the Ped Med Hx, but no need to repeat):

- Birth History
- Medical Conditions or Concerns
- Family History

***Clinical Observations**

If you had the opportunity to observe the child during the intake visit, what did you see that would inform the evaluation. Include observed information on the following motor skills, learning skills/understand skills, social skills and emotional behavior, self care skills, other (eating, sleeping, dressing, sensory, transitions, temperament)

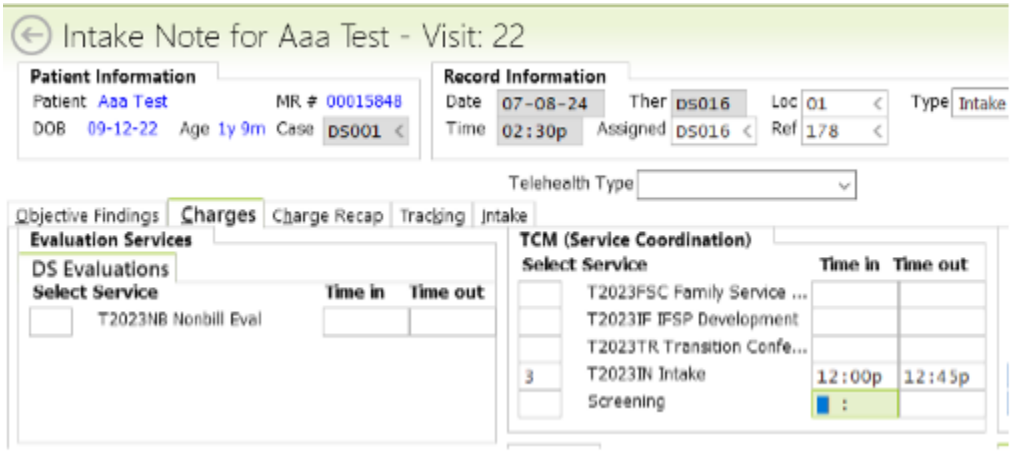
***Other Pertinent Information**

Include information that does not fit in to other areas. Information that is not intended to be disclosed to others, such as mental health information. If you wish for this information to print in the intake note, check the 'Show in Printed Intake Note' box.

***Plans for Further Evaluation: enter the date and time if set.**

Entering Charges

Click on Charges tab and complete with time in/time out (units will calculate):



Then, F10 to Save.

Intake Preview Note will appear

Look to lower left corner of document to save and sign off, click button Click Save and Sign Off button:

The units in the charges tab will go to Billing Review.

If you started through your Dashboard, you'll be taken back to your Dashboard.

Signatures

Have family complete signature forms—send the forms to the family from RT on the Admin tab

Alternatively, take paper forms and have signatures uploaded to client file in RT by Admin staff.

Additional Considerations

What to do when the Intake takes place over 2 days

If an intake takes place over two or more days, the provider will compile the results for all the days within the intake note that is dated the first day the intake was conducted.

Then the provide will complete an FSC note for the additional days, no charges attached.

Documents

Intake Procedure Admin

Developmental Screenings

Purpose

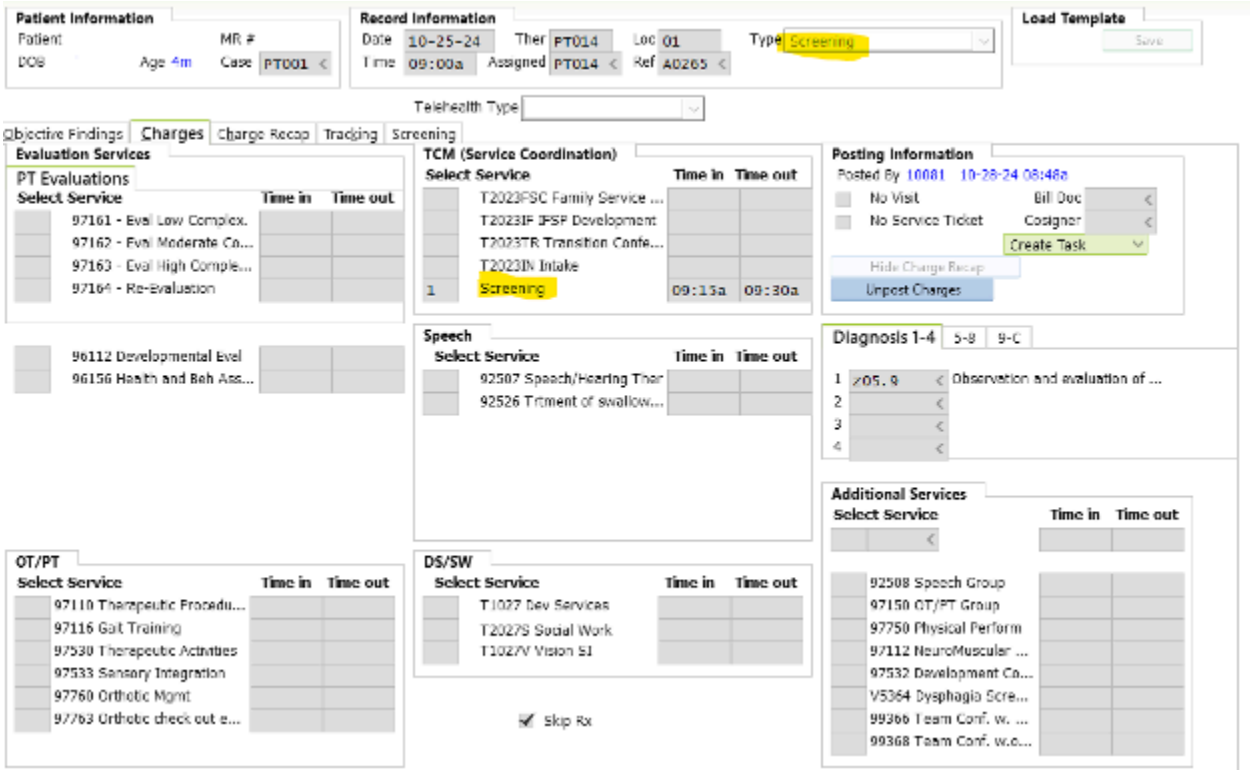
NICU Developmental Screenings Purpose

Referral Specialists review all potential referrals to PIC to assure appropriate referrals are being made. If Referral specialist have a question about if a child should be screened or go directly to evaluation, they will consult team manager(s), then review and determine if the referrals are initially screened in-house, or go to evaluation. Availability of an appropriate provider determines if there is a screen, otherwise referrals go to eval. Screens are assigned in teams. OT, PT are appropriate provider type due to need for a motor therapist. SLP is appropriate only when there is solely a feeding concern. Providers manage the client scheduling and communication.

Procedure

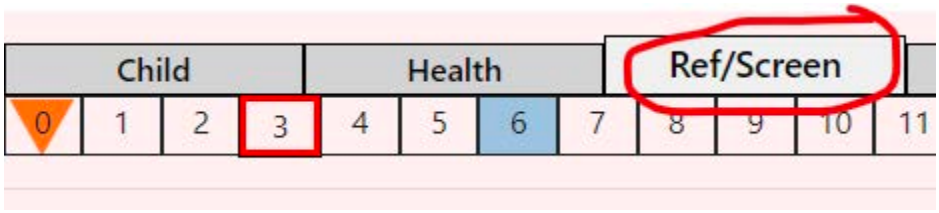
Billing Procedures

No screenings (NICU, developmental, hearing, or vision) are billed out, so the only necessary billing documentation is to list the screening clock times under the Long Term Therapy Note type “Screening”



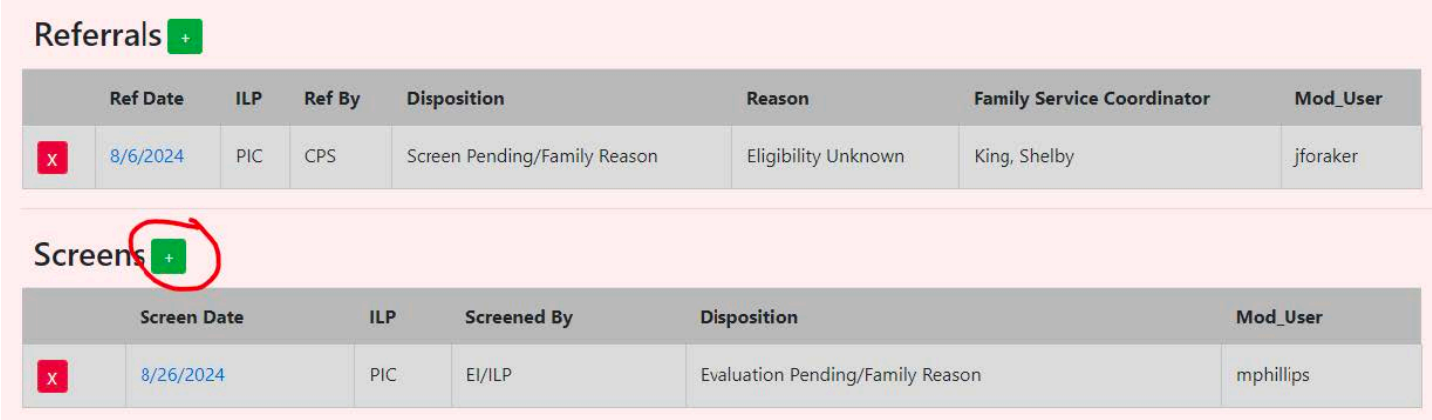
How to- Developmental Screenings Data Entry

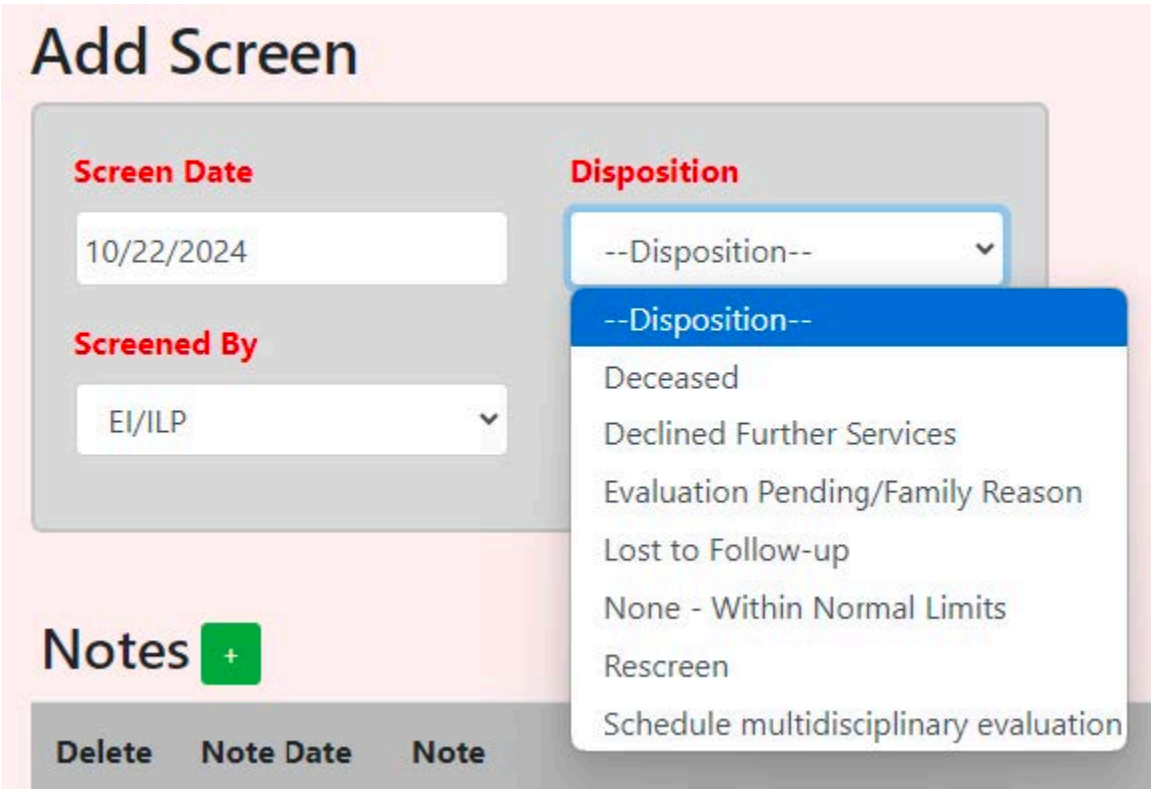
1. Trigger to know to look for a screening? Set up an auto-task to group 10?
2. Once a developmental screening is completed, it needs to be added to the state database under the Ref/Screen tab



   a. If there is a reason to pend prior to the screen, the disposition is updated in the referral.
3. Add the screen in the Screens subheader with the date of service (ex shown below DOS is 10/22/24) by clicking the green square + sign.

a. The “Screened By” will always be EI/ILP





b. The Disposition depends on what the recommendation was in the note, but it generally falls into the following categories:
   1. Declined Further Services: the family doesn’t want to move forward with the PIC process
   2. None- Within Normal Limits: the provider doesn’t recommend a rescreen and the child falls within normal limits at the time of the screening
   3. Refer to team: the provider recommends a full evaluation Disposition --> Schedule multidisciplinary evaluation
   4. Rescreen: the provider recommends rescreening in 1-3 months
      a. If this is the case, then the child will need BOTH the disposition of “Rescreen” AND “Evaluation Pending/Family Reason” with the following reason for pending:
      “The provider recommended that CHILD be re-assessed in # months. The family understands that an evaluation is within their rights, but declines evaluation at this time, preferring to wait # months to rescreen.”
      b. Add the reason for pend, as well as the summary (usually the last paragraph) as a Note with the date as the DOS for the screening.

      Example:

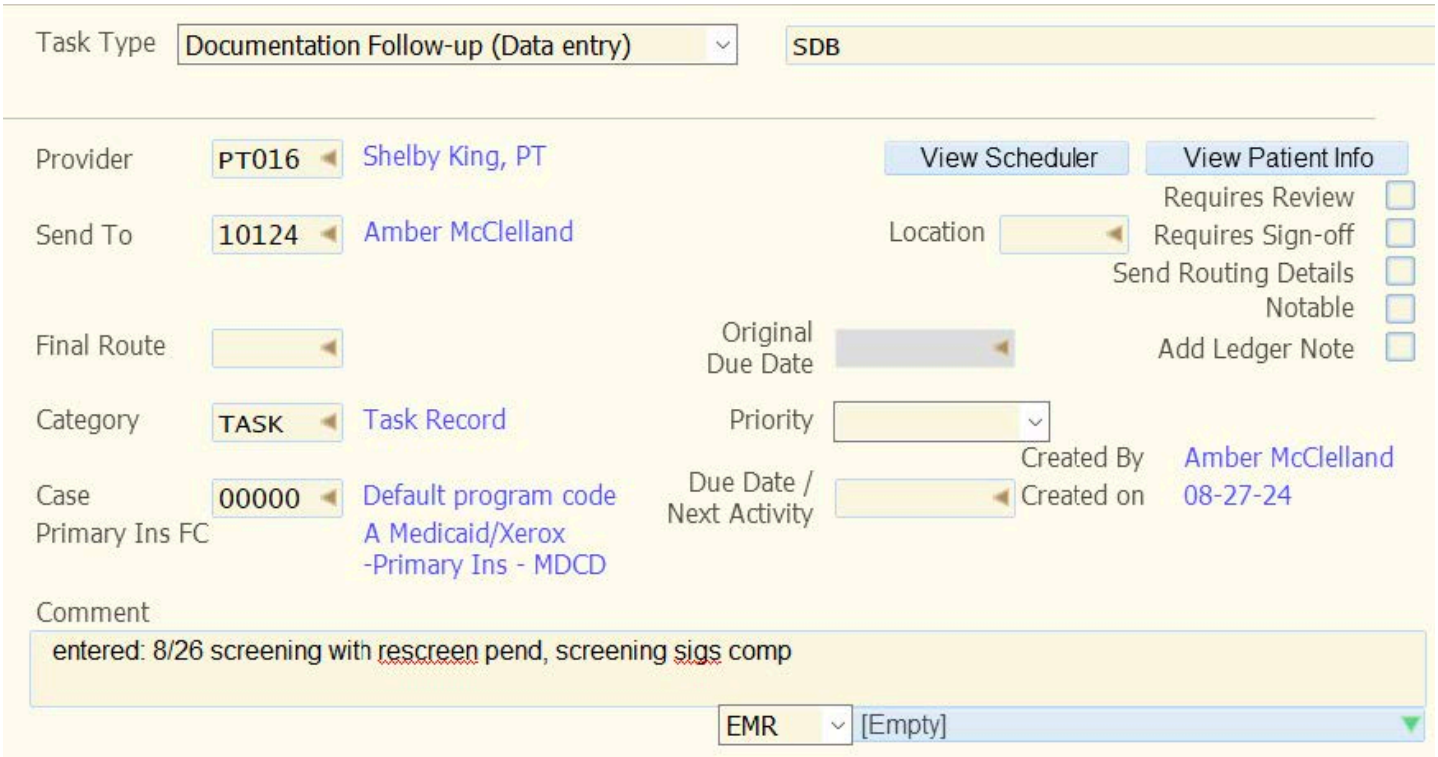
      LAST PARAGRAPH:
      CHILD is a very young infant with a history of drug exposure which puts her at higher risk for developmental delays. CHILD is demonstrating increased extensor tone throughout her body, along with a head-turning preference. Additionally, CHILD

presents with poor repertoire of movement as graded by the General Movements Assessment. It is recommended that CHILD be re-assessed in 1-2 months.

PEND REASON:
The family understands that an evaluation is within their rights, but declines evaluation at this time, preferring to wait 2 months to rescreen.

Make sure the RT status matches the SDB status

4. Signature forms needed:
   a. 1st screening: screening packet, even if 1st screening is WNL, NO PWN is needed.
   b. 2nd screening: PWN and consent to screen



5. Add summary to SDB task
   a. Example: entered: 10/22 screening and rescreen pend, screening sigs comp

Process for Screening NICU Referrals

Team managers/PIC NICU point person review with Prov PT all potential referrals to PIC in advance to assure appropriate referral is being made. Referral specialist and team manager then review and determine if the referrals are initially screened in-house, or go to evaluation (availability of appropriate provider determines if there is a screen, otherwise referrals go to eval). Providers manage the client scheduling and communication.

Conducting the Screening

Team	Procedures
Referral Team	Input client to RT and DB Send list to managers who decide if child is goes to eval or screening within 24 hours of email of request from the referral team Processes family information, and places name on the referral list indicating file goes to eval or screen (provider team assigns the screens) Complete a communication log indicating who the assigned provider is after team meeting **Referral holds on to any child is in the negative age group (under 0 months) and contact the parent **Referral assures that the parent knows that screening is a recommended option and parent can choose eval
Manager Team	Reviews the records at request of the referral team

Team	Procedures
	Complete an FSC daily note for having reviewed the medical record and recommendation to screen or eval Global abbrev: **recreview** Emails referral team indicating send to team with screen or eval Distribute referrals at team At assignment for screening Manager changes “case status” to “on hold” and “on hold until” date three months out: see pics below
Provider	Complete screening packet with family including PWN PWN and Screening consent must be completed at each screening Complete a limited intake and relevant medical history, including but not limited to feeding, sleep patterns, baby’s ability to self-comfort Screen using HINE, ASQ, GMA and head measurement for plagiocephaly, as indicated See actions based on screening results Documentation: RT Screening packet with consent for screening Billing and billing policies Parent rights HIPAA ROIs for providers who are involved Prior Written Notice (if within normal limits and discharging ILP process) Screening note**

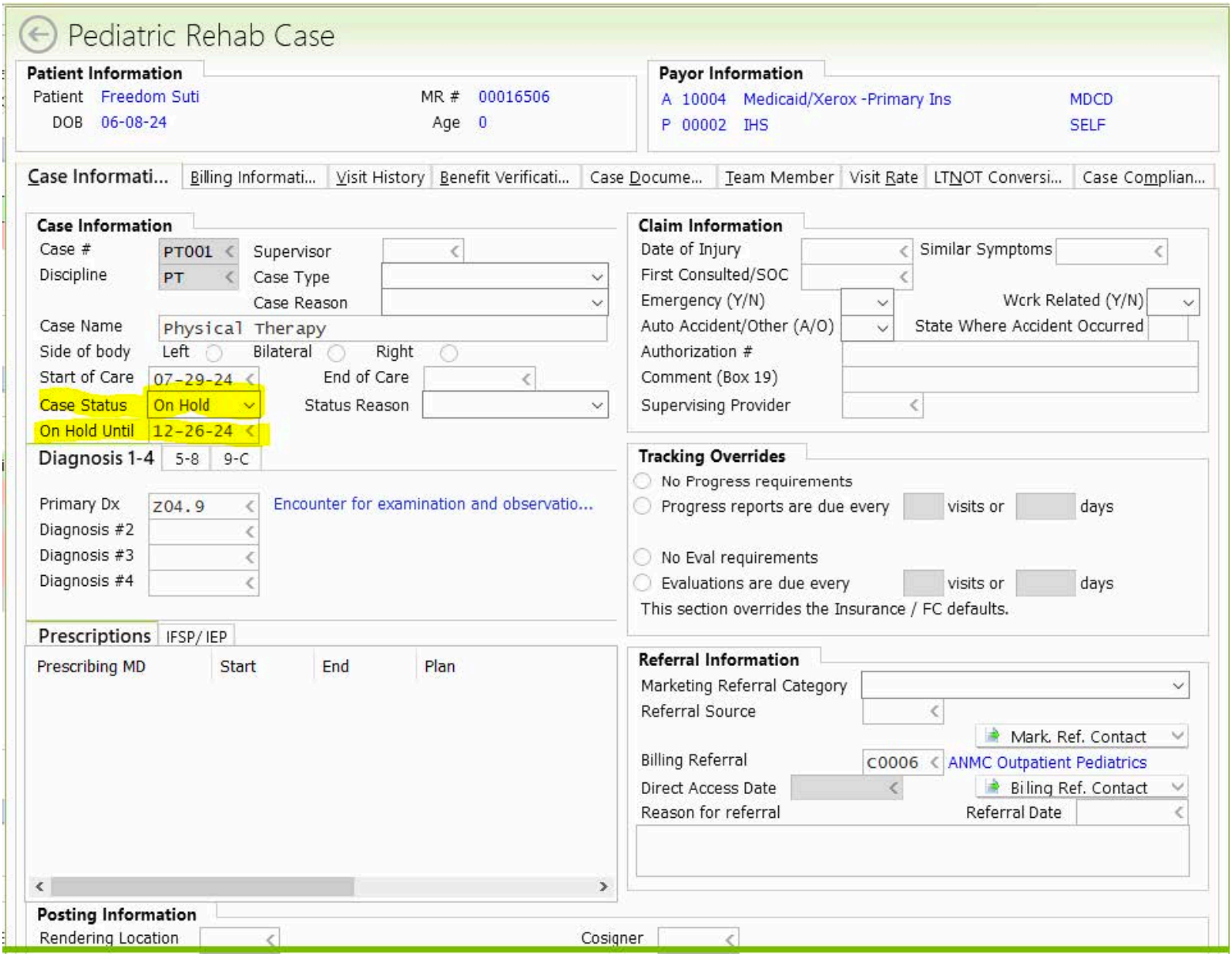
Screening Results

*Whenever possible, the same provider who screened completes the re-screen.

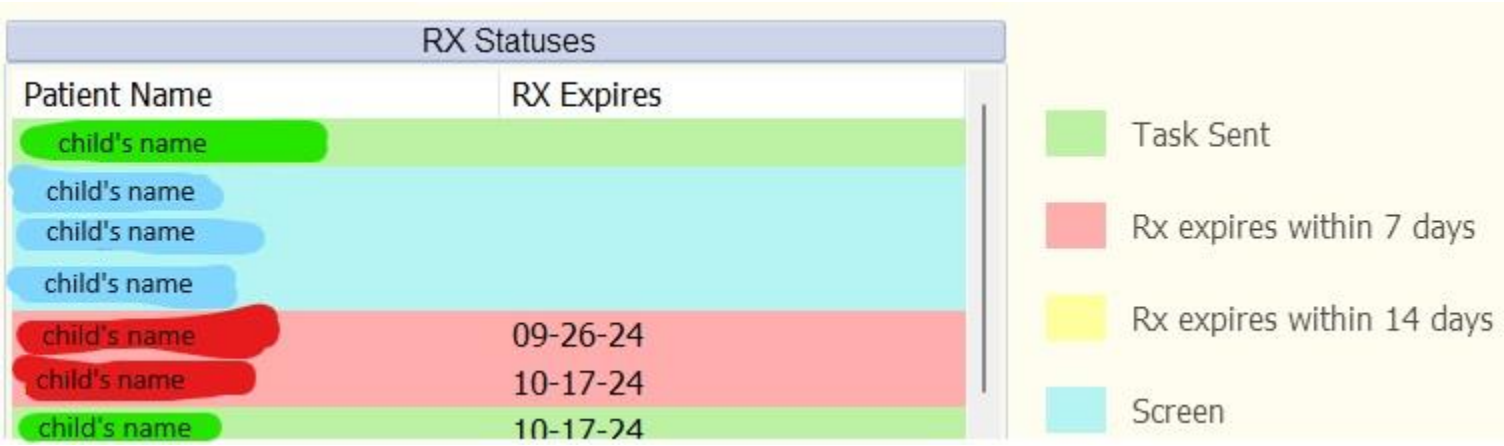
**A screen may be converted to a motor evaluation. Following the motor evaluation, the child is referred to team so that a second discipline can complete the appropriate evaluation of the child. Motor evaluation cannot stand alone—the law requires a child receive a full evaluation prior to being determined ineligible for services.

Picture of how to use the Pediatric Rehab Case to show as a screening on Provider Dashboard

Open a new case on the Child record, select the appropriate case for the provider. Select On Hold in the Case Status dropdown, and set the date approx three months out.



Screenings will appear in blue on the provider's dashboard:



Global abbreviations:

scrn

"the family understands that an evaluation is within their rights but declines an evaluation at this time, preferring to wait no more than 3 months to rescreen."

recreview

Child Status

Pends

Purpose

A child who is in referral or pre-enrollment and whose family or guardian situation (see below) causes delays with a child getting the referral completed, an intake/eval or IFSP completed. In this situation the provider may choose to PEND the child, releasing ILP from 45-day timeline requirements. Despite pending a child, PIC is required to process children to enrollment in a timely manner. Pending means a referral is "on hold" due to family reasons. It formally stops the 45-day timeline.

What is a PEND for?

A child who is pre-enrollment and whose family or guardian situation (see below) causes delays with a child getting the referral completed, an intake/eval or IFSP completed. In this situation the provider may choose to PEND the child, releasing ILP from 45-day timeline requirements. We still need to process children in a timely manner even when children have been pended. Pending means a service is "on hold" due to family reasons.

Practice

There is no need to inform families other than verbally, that their case has been pended and the 45-day timeline has been waived due to family reasons. We do not need to send a letter of pend or notification.

Procedure

Pending/Exempt to 45 Days: the State office will only accept family reasons for exemption for the 45-day timeline. We still need to process children in a timely manner, even when children have been pended. Pending means a service is "on hold" due to family reasons.

Family reasons to pend include:

- Family cancels due to illness of the child, parent or sibling in the home.
- Family cancels for any other reasons and/or asks to reschedule.
- Family no shows.
- Family scheduling difficulties. Examples: family: is/will be out of town; your first available appointment is declined and next available is further out; has limited availability to schedule- "I can only do appt's on Tues & Thurs".
- Family delay responding to provider's attempts to schedule. Example: Provider has reached out to the family at least 3 times across a 2-week period without a response from the family or successfully scheduling.

Unacceptable reason for pend:

- Provider's first available appointment is after the 45 days- this child should be reassigned at Team.
- Provider availability is limited
- Provider cancellation
- Provider out on PTO

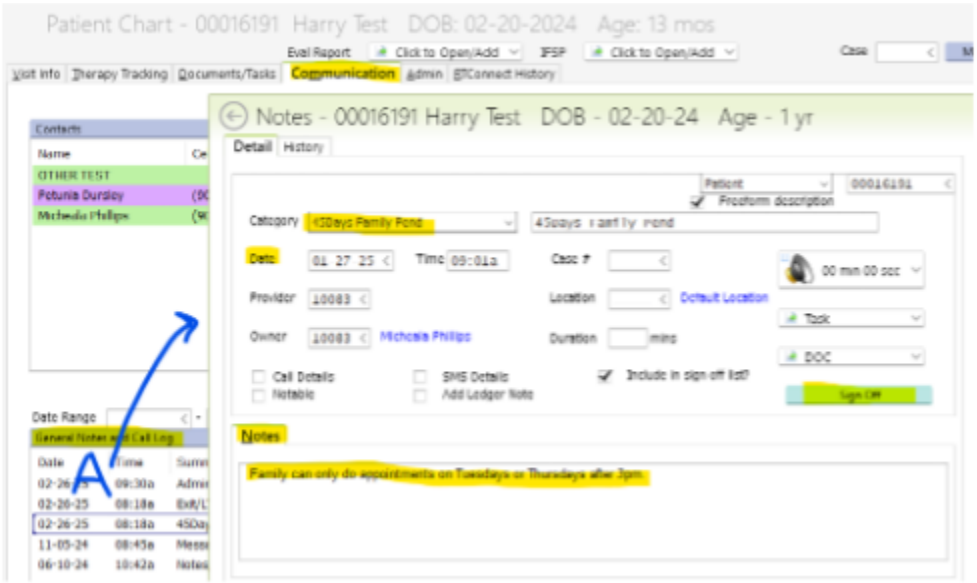
Procedures to Pend for Direct Service Providers

Admin will add the pend for any child who has missed the 45-day timeline IF there is a cancel by family (with a reason provided) or no showed appointment in the visit history. However, this is a retroactive pend added only once the 45-day timeline has been missed and is NOT automatic.

When a child meets the above criteria to be pended, take the following steps:

1. Add a communication log note under the Category “45Days Family Pend” from the drop-down menu.
2. Make sure the date of the comm log note matches the date of the reason for pend (it defaults to the current date).
3. In the Notes section detail the specific reason for the pend. EX: Family is out of town for the next 2 weeks and so intake is scheduled for mm/dd/yy.
4. Sign off on your comm log note.

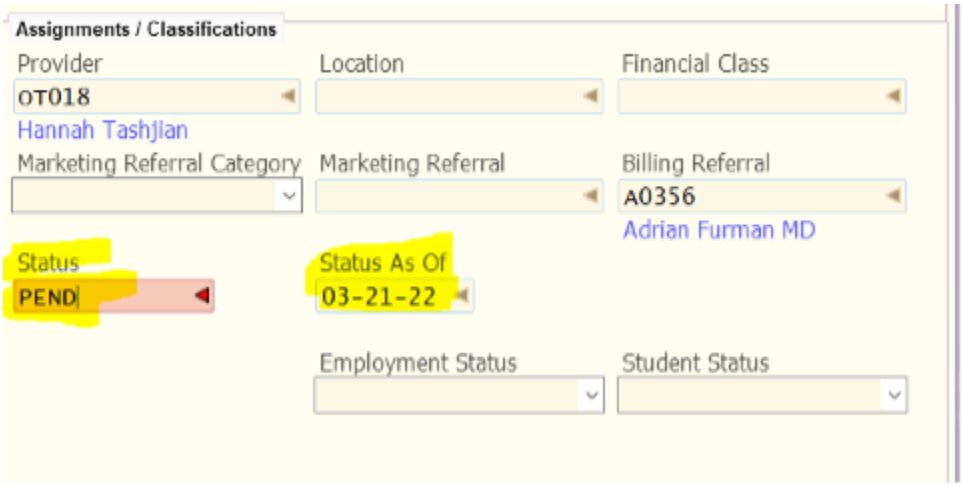
Admin receives an automatic task once the comm log note is signed off, so no further notification is needed.



Procedures to Pend for Admin

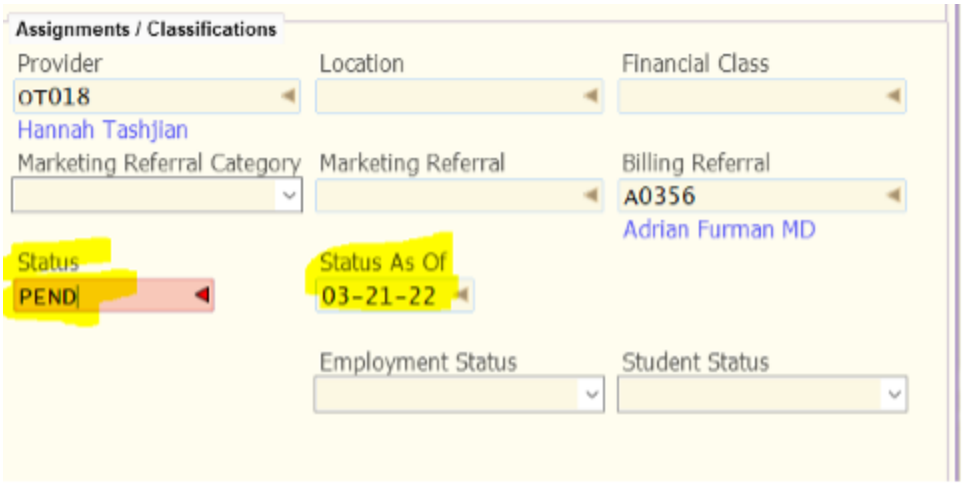
The automated task will come to group 10, with the date and reason for pend provided in the comm log note. It is Admin’s responsibility to ensure the reason given for the pend is a family reason for delay and accepted by the State.

Pend in RT by changing the status of the child in the Patient Demographics tab to PEND and correcting the date to match that of the comm log/visit cancellation.



Note: a child *can* be pended for each and every step of the enrollment process, as long as it’s before IFSP. This includes pending at Referral, Screen, Intake, and Evaluation. However, since once a child is pended, the timeline is put on hold, we don’t require multiple pends. If the pend is over 100 days, review the timeline and see if there are multiple reasons for the delay. This is reviewed in the Reminders Report process by the Office Manager.

For the SDB: If the PEND occurs between Referral and Eval, you will choose the Referral, or if the PEND occurs prior to IFSP but after Eval you will choose Eval.



Referral: To pend for the screen or evaluation appt., use the Referral tab, add a new disposition based on which appt. was pended, for the Screen appt. select 'Screen Pending/Family Reason', for the eval appt. select 'Evaluation Pending/Family Reason.

*In the Notes section, copy the reason for the pend from the comm log, write Pend, the date the child was pended, and the reason."

Screen: To pend for the evaluation appt. after a Screening has been completed, use the Screen tab, add a new disposition of 'Eval Pending/Family Reason'.

*In the Notes section, copy the reason for the pend from the comm log, write Pend, the date the child was pended, and the reason.

Evaluation: To pend prior to the IFSP appt., use the Eval tab, enter the date pended and reason in the Notes section of the state database. For disposition, select 'Enrollment Pending/Family Reason'.

*In the Notes section, copy the reason for the pend from the comm log, the date the child was pended, and copy the reason for the pend from the comm log.

Extended Out of State Family Leave of Absence

Purpose
Children who are either in referral or assigned to a provider and pre-enrolled when a family contacts the provider with request to delay processes due to extended leave will enter into PEND process. If return is not anticipated will be exited from referral or the pre-enrollment process. See also PENDS.

Practice
Providers contact the family and discuss options with them and their circumstance. It is appropriate to let the family know that if they will be out of town for more than a month (or are not sure about their return) we close the referral and ask our Child Find/CHERISH outreach (Dana) to reach out to them when they are expected to return. We will exit them from the process and they can reach out to re-refer. If the family has a return date, we can PEND and potentially schedule an intake. If we lose contact with the family, we can get back to the referral source and have them follow up with the family.

Procedure
- When informed that the family will be out of town for an extended period, inform them that this suspends the 45-day timeline, temporarily.
- If the family has a return date, and an intention to return, we can pend the referral and hold it.
- Provider and family will agree upon contact means, and date for follow-up.
- If the family is not sure when they will return or the time is more than a month, let the family know that we will exit, and they can re-refer with a call at any time up to age three.
- Contact the referral source with a letter to let them know to refer upon client return, if appropriate.

Exit Prior to Enrollment

Purpose
Referred but not enrolled—a child whose family is no longer interested in services will be exited using the State-defined reasons for exiting from referral.

Practice
Often these State-defined reasons for exit from referral are confused with enrollment categories for departure. These are the terms we use for children whose family is no longer interested in referral, intake or additional contacts with PIC:

Lost to Follow Up: After a 10-day letter has been sent, but we haven't heard back from the family.

Decline: The family is not enrolled and is not interested in moving forward with intake, eval or enrollment, family can withdraw from the process at any time.

Not Eligible: The child doesn't qualify for Part C services and the PSP has met with the family to review eligibility.

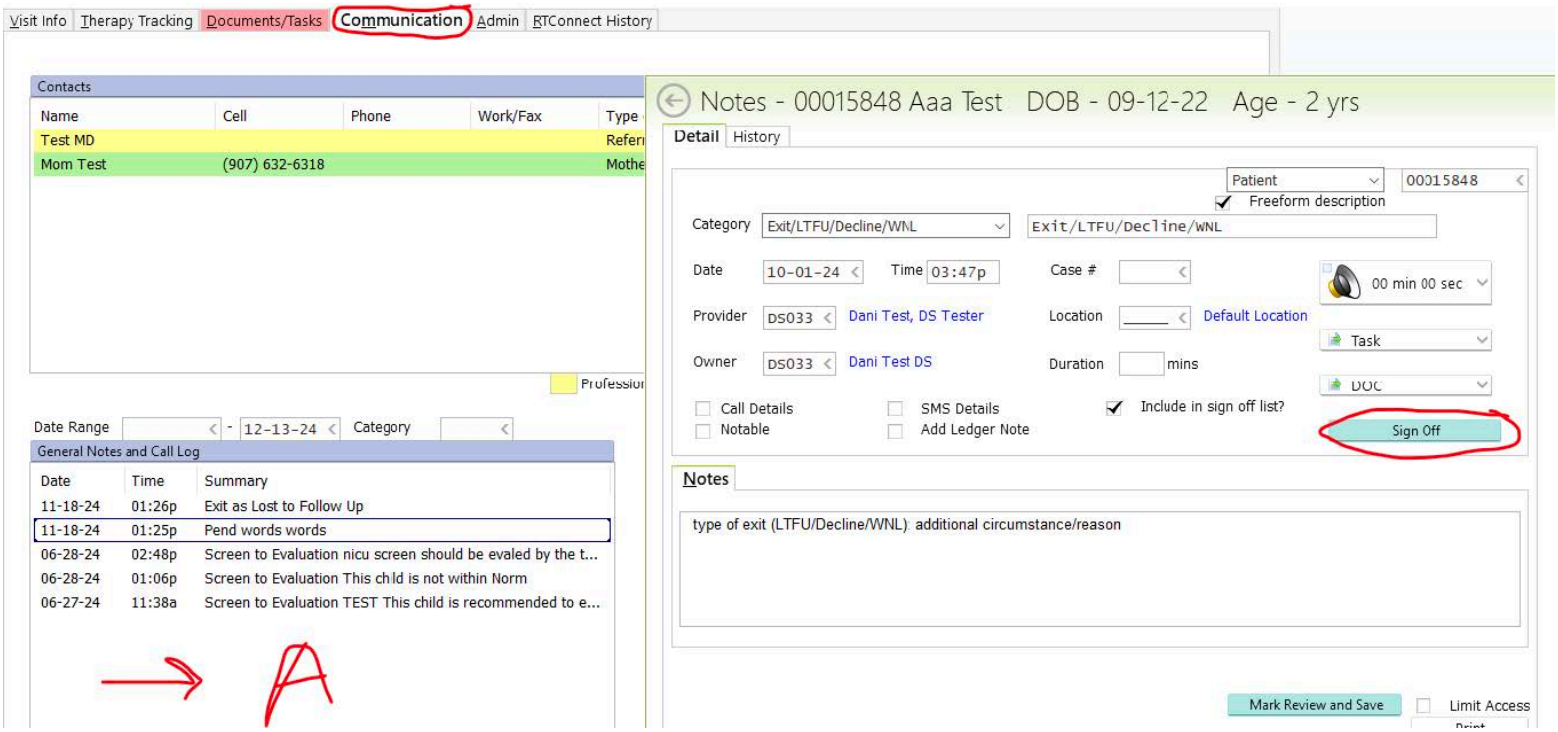
Procedure
Program Documentation- How to exit prior to enrollment

Types of exit status:

Lost to Follow Up: After a 10-day letter (How to 10 day letter.docx) has been sent, but we haven't heard back from the family. Decline: Family is not enrolled and is not interested in moving forward with intake, eval or enrollment, family can withdraw from the process at any time. WNL: Child doesn't qualify for Part C services and the PSP has met with the family to review eligibility.

Steps to Exit

1. Review the child's file to confirm all appropriate documentation has been completed (such as the eligibility meeting if the child is within normal limits).
2. Create a comm log note under the category "Exit/LTFU/Decline/WNL" providing the circumstances of the exit.
    a. LTFU Example: Goofy is lost to follow up. No response from family after 10 day letter was sent on 8/1/24. (The comm log note date would be 8/11/24).
    b. Decline Example: Guardian, Walt Disney, texted PSP to decline further services from PIC at this time for Mickey Mouse. PSP let Walt know that they could refer back to PIC anytime before Mickey turns 3.
    c. WNL Example: Please see daily note 10/1/24 for eligibility meeting, Minnie is within normal limits.
3. Sign off on the comm log note. This triggers a task to be automatically sent to admin. * Note as of December 2024: if you amend your exit comm log note, admin does NOT get a task, so please email admin@picak.org if you need to amend your comm log exit note.



Lost to Follow Up/10-Day Letter

10-Day Letter: Pre-enrolled Child/Notification of Potential Discharge

What is a 10-day letter?

This is a notice sent to families who are pre-enrolled and informs the family or case worker that:

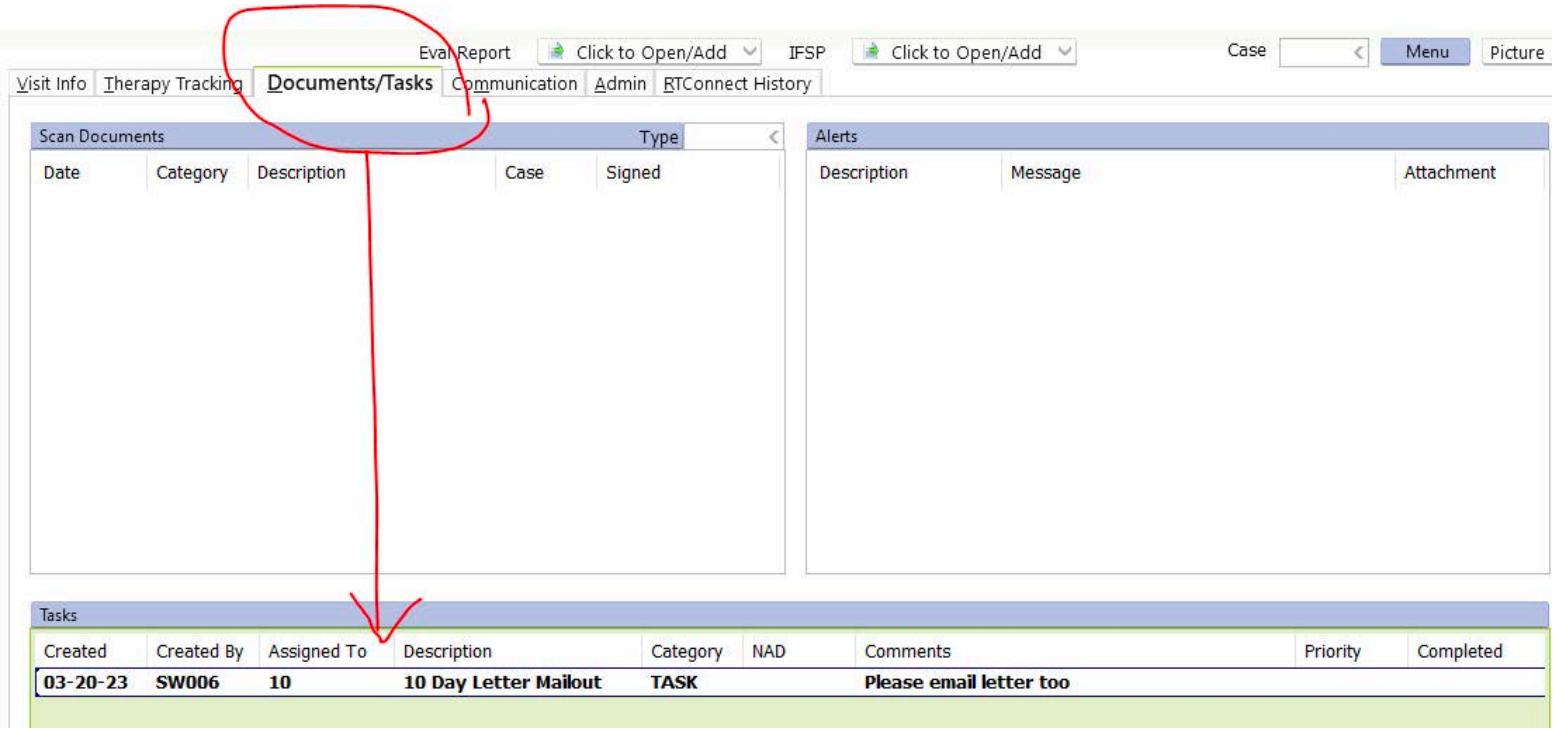
A. they were referred to PIC but we are unable to contact them to complete referral, intake, evaluation or enrollment.
B. they will be discharged from the process if they do not contact us within 10 days of the date of the letter.
C. They are encouraged to contact us in the future and before child's 3rd birthday.

Providers or Referral staff--How to initiate:

- Verify that attempts to contact the family or case worker are in the communication log. Make at least 3 attempts across 2 or more weeks to contact the family, and document
- In RT admin tab, initiate and review 10-day letter for address(es), content (Provider can EDIT THIS LETTER)—addresses need to be verified by provider for accuracy
- When you F10/Save letter: a task is auto-generated for Data Entry to print and mail. You do not need to email admin anymore!!
- If at 10 days there is no further contact, the provider completes the exit process/documentation

**Children who are in OCS custody: create a 10-day letter for the OCS caseworker as well.

Admin will automatically get a task and send out the 10-day letter to the address listed on the letter. No further action is needed from the provider.



Providers Exit at 10 days:

Go to the Communication tab and use the templated note: code LTFU and the following will appear, edit the note—when you sign off the note, it goes automatically to Admin. (Remember to edit!)

The family is being exited due to:

- declining services with this provider. They were encouraged to reengage if needed.
- being lost to follow up. This provider made several attempts to contact the family, see comm log. Family was encouraged to engage in early intervention services, and contact within 10 days of letter, and did not.

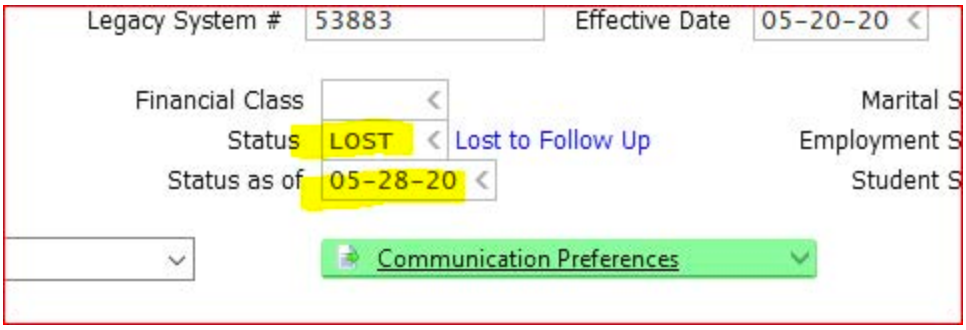
Providers will get a task/reminder sent to them to follow up on the 10-day. If the family exits, complete the exit process and mark complete and the task is filed in child chart. If the family reengages, put a quick note in saying so, and the task will be filed in child chart. The task will be scheduled 10 days out from the 10-day and 30 days from the 30day letter.

- **How to know when admin has completed and what date it was sent?**
  - Admin sends the task back to the provider (final route to themselves so that they can complete the task) with the due date out 10 days and a comment, “This task is coming back to you as a reminder of 10 days. Please exit the child via the comm log if no response from the family.” There is a note in the comm log specifying where the letter was sent and when.

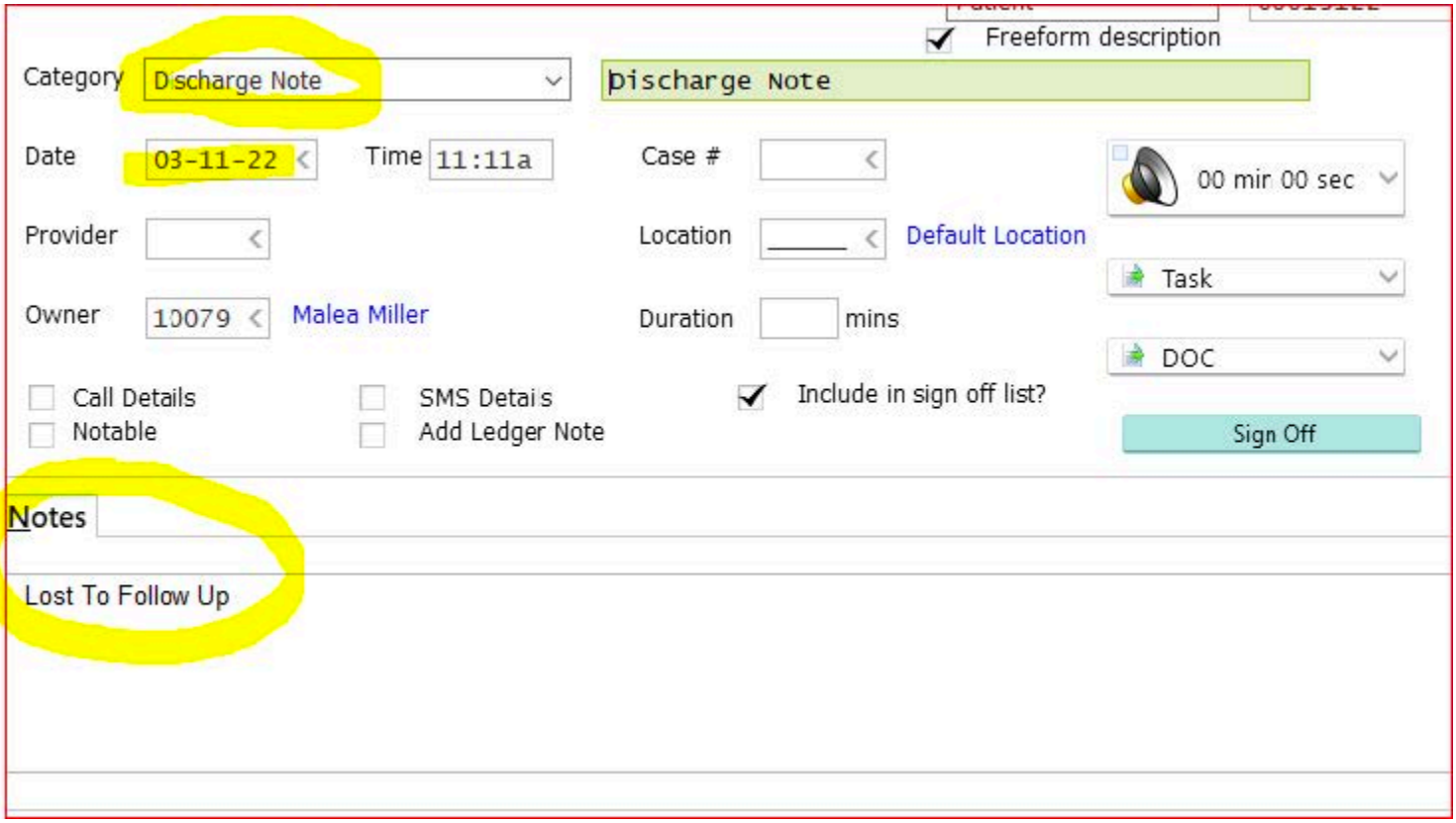
Administrative Staff:

If a family is “Lost To Follow Up” at any time BEFORE an initial IFSP happens then the child is exited with the status of “LOST” in Raintree.

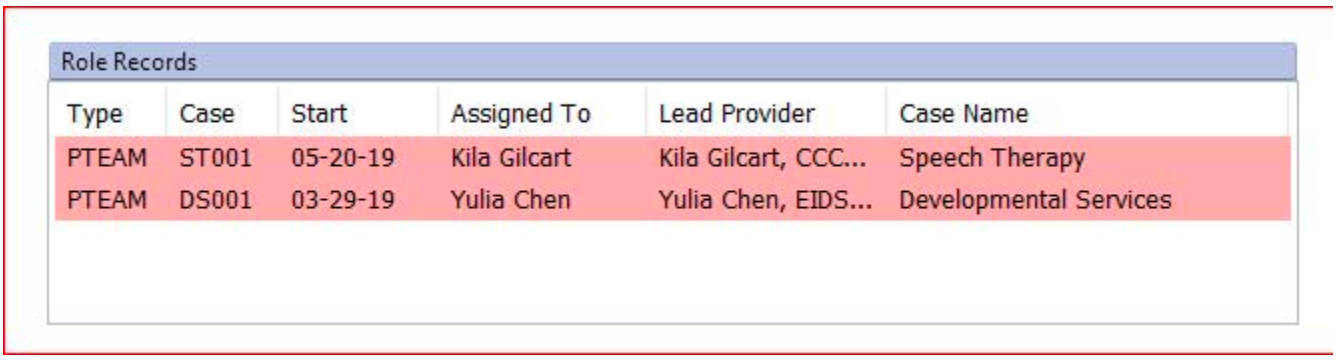
1. CHANGE STATUS TO “LOST” IN PATIENT DEMOGRAPHICS TAB



2. IN PATIENT DEMOGRAPHICS TAB ALSO CHANGE CHILD'S STATUS DATE TO MATCH EXIT DATE FROM WHEN FAMILY WAS LOST TO FOLLOW UP
3. IN "COMMUNICATION" TAB MAKE A CALL LOG NOTE WITH DATE OF EXIT, CATEGORY "DISCHARGE NOTE" AND THE REASON IN THE NOTES BOX



4. IN "VISIT HISTORY" TAB CLOSE ROLE RECORD IF APPLICABLE WITH EXIT DATE



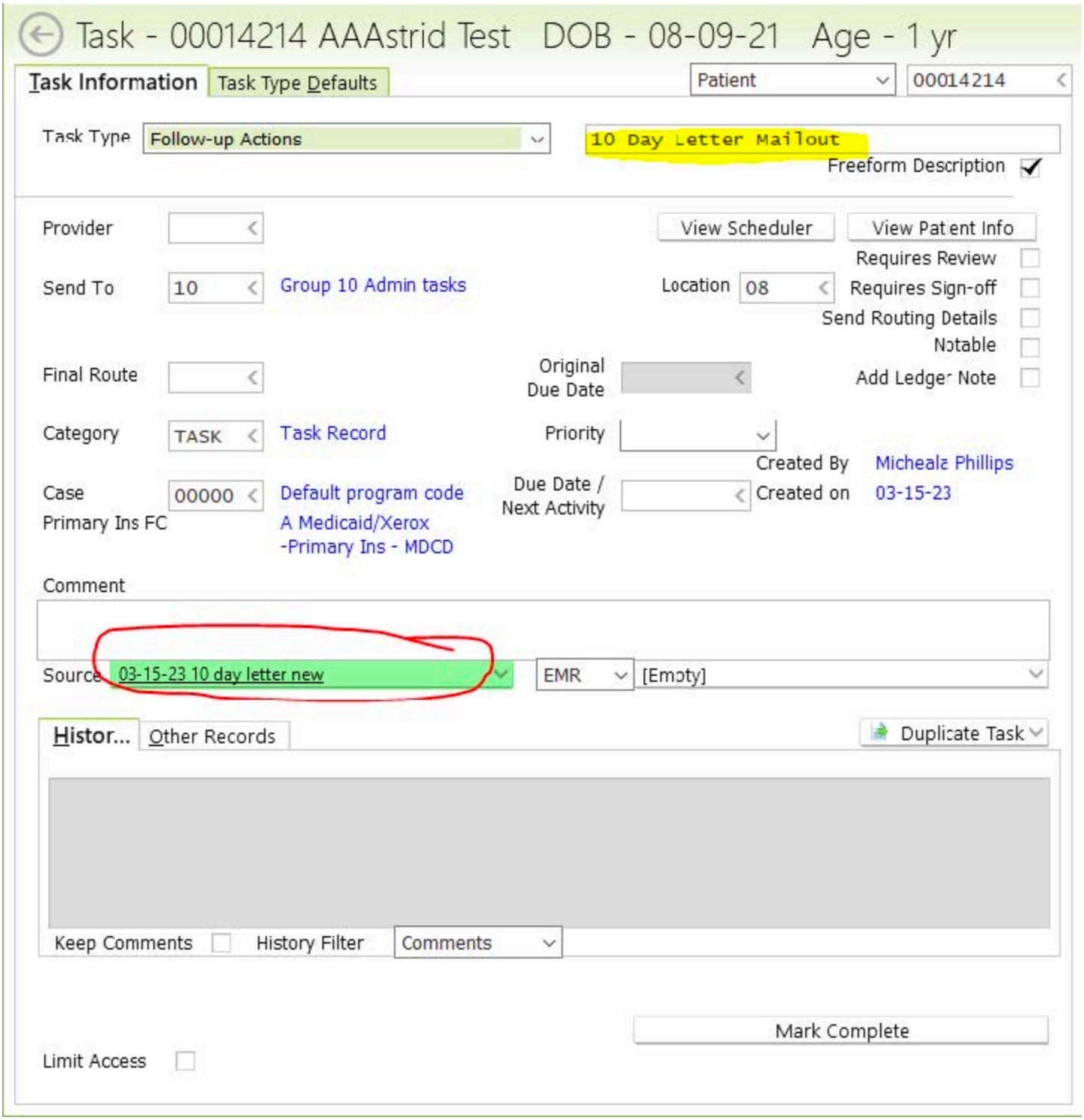
5. IN "ADMIN" TAB CHECK THAT ALL PACKET SIGNATURES ARE COMPLETE OR CLOSED OUT WITH VERBAL CONSENT

6. MAKE A NOTE OF EXIT REASON/EXIT DATE IN THE STATE DATABASE TASK
7. IN “ADMIN” TAB SEND REFERRAL FEEDBACK FORM TO REFERRAL SOURCE TO LET THEM KNOW OF STATUS How to- Referral Feedback Form.docx

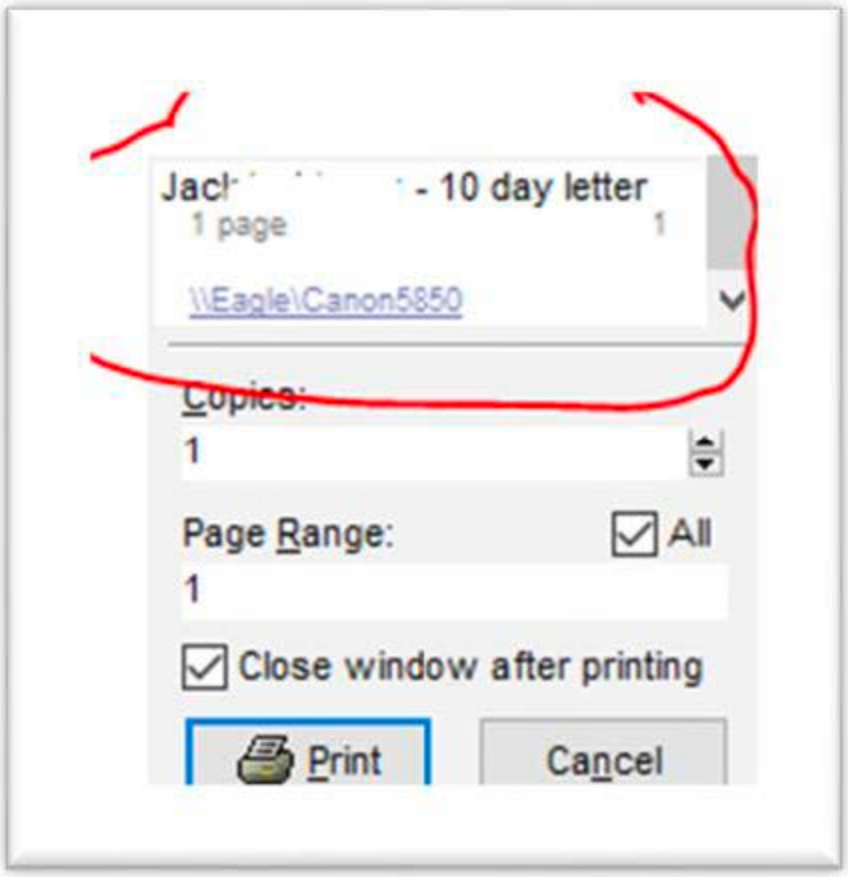
Administrative Staff—How to print and mail letter:

A task will be delivered to Group 10

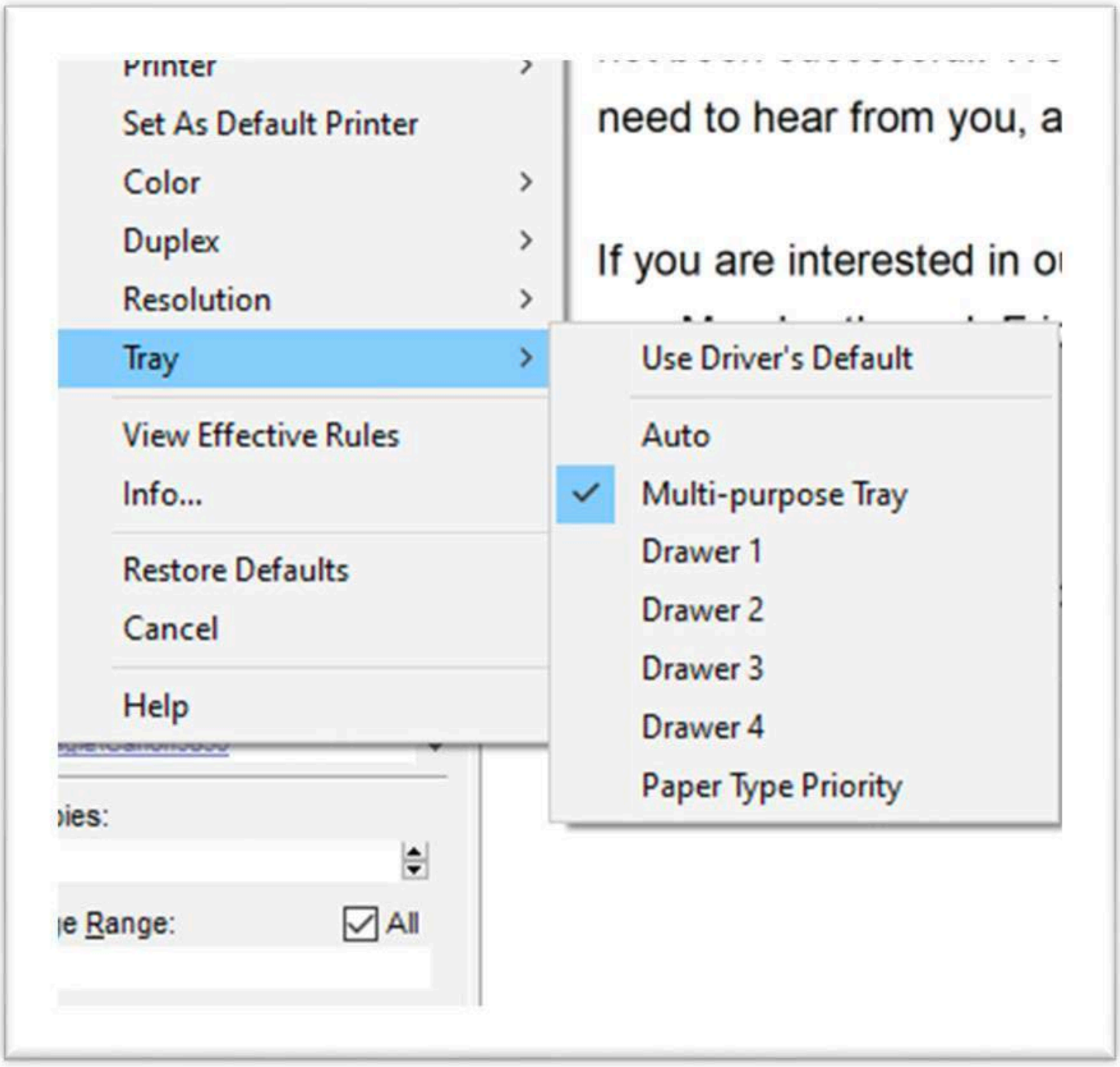
1. Go to Group 10 tasks, open the automated task and print the 10-day letter



2. A RT editable word document will pop up with letter.



3. Control P to print or click printer icon
4. Left click on the //Eagle/Cannon 5850 to select the correct tray: Multi-purpose Tray



5. Then, click “Print”
6. Collect the printed letter, put in envelope and stamp with postage meter
7. The default setting is for a 1st class letter so you can place it on the weigh tray if sending additional papers and you think the envelope might be heavier than typical.
8. Enter Comm Log stating that letter has been mailed, and to whom at what address.
9. For Provider generated letters: send the task back to the provider (final route to themselves so that they can complete the task) with the due date out 10 days and a comment, “This task is coming back to you as a reminder of 10 days. Please exit the child via the comm log if no response from the family”
10. For Referral Specialist generated letters: close out the task.
11. Electronically send referral feedback letter to referral source at the time the ten-day letter is being mailed
12. Children in OCS custody: you need to send OCS caseworker the 10 day letter as well.

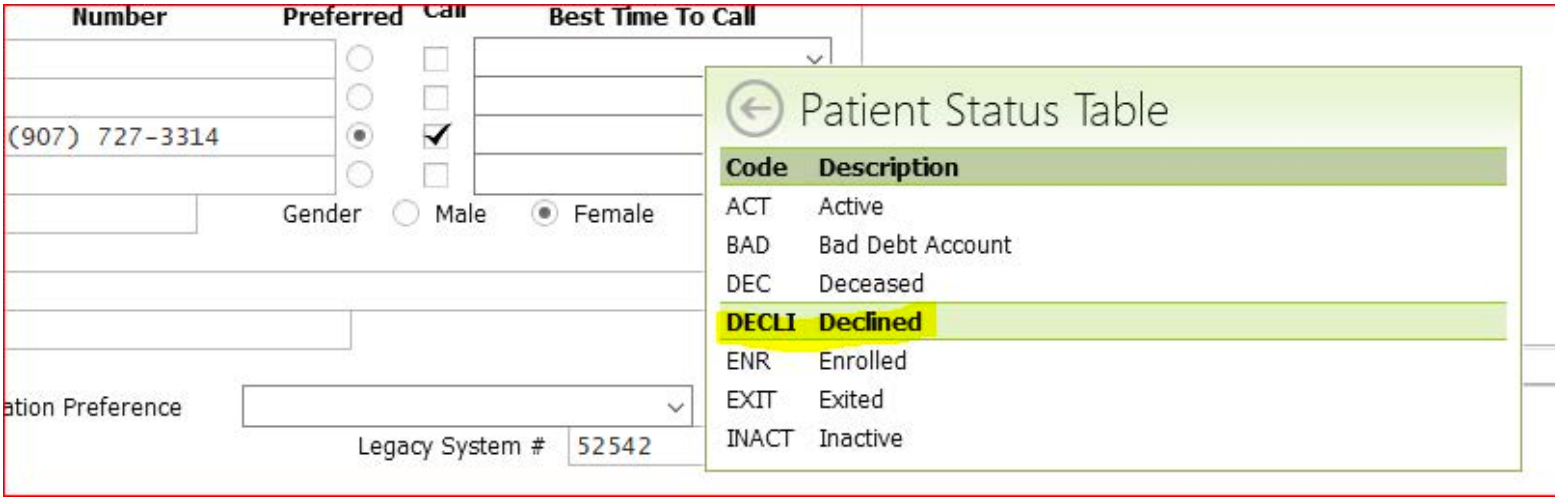
Returned mail: In the case of a 10-day letter being returned in the mail do the following:

1. Send an email to the provider/referral specialist who generated the letter letting them know it was returned.
2. Add a comm log note with the date and reason the mail was returned.
3. Shred the returned mailed

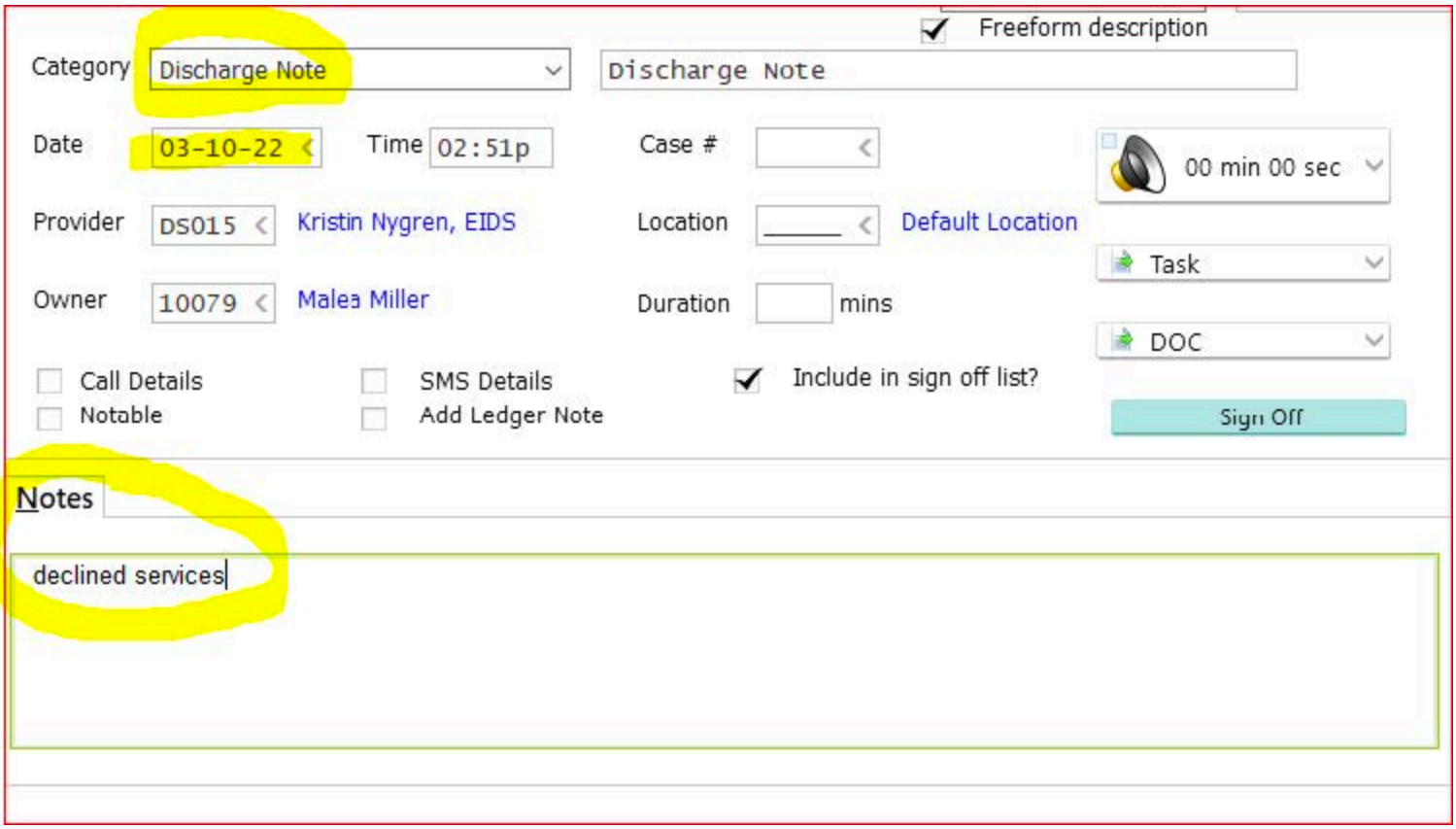
Declined Services Before Enrollment

If a family does not want services with PIC at any time BEFORE an initial IFSP happens then the child is exited with the status of "DECLINED" in Raintree.

1. CHANGE STATUS TO "DECLINED" IN PATIENT DEMOGRAPHICS TAB



2. IN PATIENT DEMOGRAPHICS TAB CHANGE CHILD'S STATUS DATE TO MATCH EXIT DATE FROM WHEN FAMILY DECLINED SERVICES
3. IN MAKEA A CALL LOG NOTE WITH DATE OF EXIT, CATEGORY "DISCHARGE NOTE" AND THE REASON IN THE NOTES BOX



4. IN “VISIT HISTORY” TAB CLOSE ROLE RECORD IF APPLICABLE WITH EXIT DATE

5. IN “ADMIN” TAB CHECK THAT ALL PACKET SIGNATURES ARE COMPLETE OR CLOSED OUT WITH VERBAL CONSENT

6. MAKE A NOTE OF EXIT REASON/EXIT DATE IN THE STATE DATABASE TASK
7. IN “ADMIN” TAB SEND REFERRAL FEEDBACK FORM TO REFERRAL SOURCE TO LET THEM KNOW OF STATUS

Within Normal Limits

EXIT: WITHIN NORMAL LIMITS

Once a child has had an initial evaluation and scored “within normal limits”, he or she needs exited.

Providers complete a communication log note.

1. CHANGE STATUS TO “NORMAL” IN PATIENT DEMOGRAPHICS TAB

2. IN PATIENT DEMOGRAPHICS TAB ALSO CHANGE STATUS DATE TO LAST DAY OF SERVICE AS EXIT DATE
3. CLOSE ROLE RECORD and ANY OPEN CASES

Role Records

Type	Case	Start	Assigned To	Lead Provider	Case Name
PTEAM	ST001	05-20-19	Kila Gilcart	Kila Gilcart, CCC...	Speech Therapy
PTEAM	DS001	03-29-19	Yulia Chen	Yulia Chen, EIDS...	Developmental Services

4. CHECK THAT ALL PACKET SIGNATURES ARE COMPLETE:

- IF A CHILD IS FOUND “WITHIN NORMAL LIMITS” THE ONLY TWO FORMS NECESSARY FROM THE POST EVAL PACKET ARE: PWN & ELIGIBILITY DETERMINATION

5. MAKE A NOTE OF EXIT REASON/EXIT DATE IN THE STATE DATABASE TASK

Assessment & Evaluation

Initial/Individual Evaluation

Purpose

Determining Eligibility by Evaluation

- Evaluation is one method by which Part C eligibility is determined.
- Per Part C law, PIC determines eligibility by using an Anchor tool that offers age equivalents, if the child is not eligible by diagnosis. Providers are encouraged to supplement the IDA with additional tools as appropriate—these can also be done during subsequent home visits
- Evaluation helps determine if there is a 50% delay in one or more areas of the child’s development
- Identify the child’s skills that seem to be emerging

- Share information with the family and discharge from the eligibility process or enroll and ready for Individual Family Service Plan (IFSP) meeting.
- Provide written prior notice for the IFSP meeting

Practice
Eligibility is determined by developmental evaluation that results in a 50% delay, medical diagnosis, or by clinical opinion (see guidance on medical diagnosis/established condition and clinical opinion).

Family Engagement is ensured throughout the process when we:

- Use evaluation procedures that ensure collaboration among the family and providers, including supporting the family to participate in the way they choose
- Give equal weight to the family's observations and reports about their child's behaviors, learning and development
- Reflect with the family about observations of the child's behavior, summarize results, clarify and confirm that the family understands the process and results and record the findings.

PIC will complete an evaluation with the family and child. This may be completed when:

- Two providers attend an evaluation meeting using the IDA, if available, use the original IDA from first eligibility evaluation.
- Child is a transfer from another ILP and current evaluation information is available.

If the child is determined eligible for services:

i. After completing the evaluation visit, both the primary and the secondary provider will complete an Individual Evaluation report in RainTree (see step-by-step instructions below).
ii. The primary service provider will write the Functional Evaluation report.
iii. Complete the Functional Evaluation and share document indicating that their child is eligible.
iv. Provide Prior Written Notice.
v. Prepare for the Initial Individual Family Service Plan (IFSP) by
    - Asking the family whom they would like to invite to the IFSP meeting
    - Scheduling time convenient for the family
    - Describing the IFSP process (a dynamic plan, developed by the team that guides the provision of family-centered early intervention supports and services based upon the changing needs of the child and family)
    - Explain that the family is an equal member of the early intervention team. Providers offer recommendations for services, families can opt for or decline services

If the child is not eligible by Part C or is Within Normal Limits, or do not Qualify:

a. The primary service provider will:
    - Complete the Functional Evaluation
    - Complete the Eligibility Determination signature page with family.
    - Support the family with additional information if appropriate (information on normal developmental milestones, etc.)
    - Provide an e-copy or hard copy of the Functional Evaluation for the parents; admin can mail or at a follow-up visit, if scheduled, and to the physician or other information sharing that has been requested
b. The second discipline attending the evaluation will complete an Evaluation in Raintree (see step-by-step instructions below)
    i. The PSP will access this information to include and complete the Functional Evaluation

Procedure

Primary and Secondary Evaluation

What to do when the evaluation takes place over 2 days

Write Up Examples

Cognitive

Communication

Motor

Self Help

Social Emotional

Additional Considerations

Beyond the IDA-2

Social Emotional Milestones Beyond the IDA-2

Child Outcomes Summary Overview

Eligibility Criteria

Purpose

Part C Eligibility Categories and Definitions

Part C Eligibility: The DHSS EI/ILP assures that children, birth to three years shall be eligible for early intervention services under Part C of IDEA, if the multidisciplinary team finds any one or more of the following exist, the ILP will enroll the child for services: developmental delay, physical or medical condition as determinted by the state, or observed significant atypical development (determined using ICO).

Practice

A. Developmental Delay—A child experiencing a 50% delay based on age equivalent skills or equivalent standard deviations below the norm in one or more of the following areas: cognitive; physical (including vision and hearing, fine and gross motor skills); communication (language, speech and communication); social and emotional development and adaptive development.
(34CFR, 303.21 (a) (1)

B. Physical or Medical Condition: An infant or toddler may be eligible for Part C when she/he has a diagnosed physical or medical condition that has a high probability of resulting in a developmental delay including, but not limited to the listed in 34CFR 303.21 (a)(2)(ii)

C. Informed Clinical Opinion: (taken from Part C Credential)
Informed clinical opinion is used by professionals in the evaluation process to make a recommendation as to the initial and continuing eligibility. Informed clinical opinion 34CFR 303.321 (a)(3)(ii) may be used by an evaluation team to determine eligibility when the approved tool(s) or other domain-specific tool(s) are not able to establish a developmental level due to the age of the infant or the child's level of arousal and ability to participate at the time of the evaluation ; or when there are inconsistencies in the child's performance or inconsistencies in the results of the evaluation and the team determined that the child has **significant atypical development.**

i. Informed clinical opinion means the knowledgeable perceptions of the evaluation team who use qualitative and quantitative information regarding aspects of a child's development that are difficult to measure in order to make a decision about the child's eligibility.
ii. Informed clinical opinion in accordance with these policies may be used if a clear developmental level cannot be gained through the use of approved tool(s) or domain-specific tools; or when there are inconsistencies in the child's performance or inconsistencies in the results of the evaluation; and shall be documented as "**significant atypical-development**".
iii. In no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish Part C eligibility.

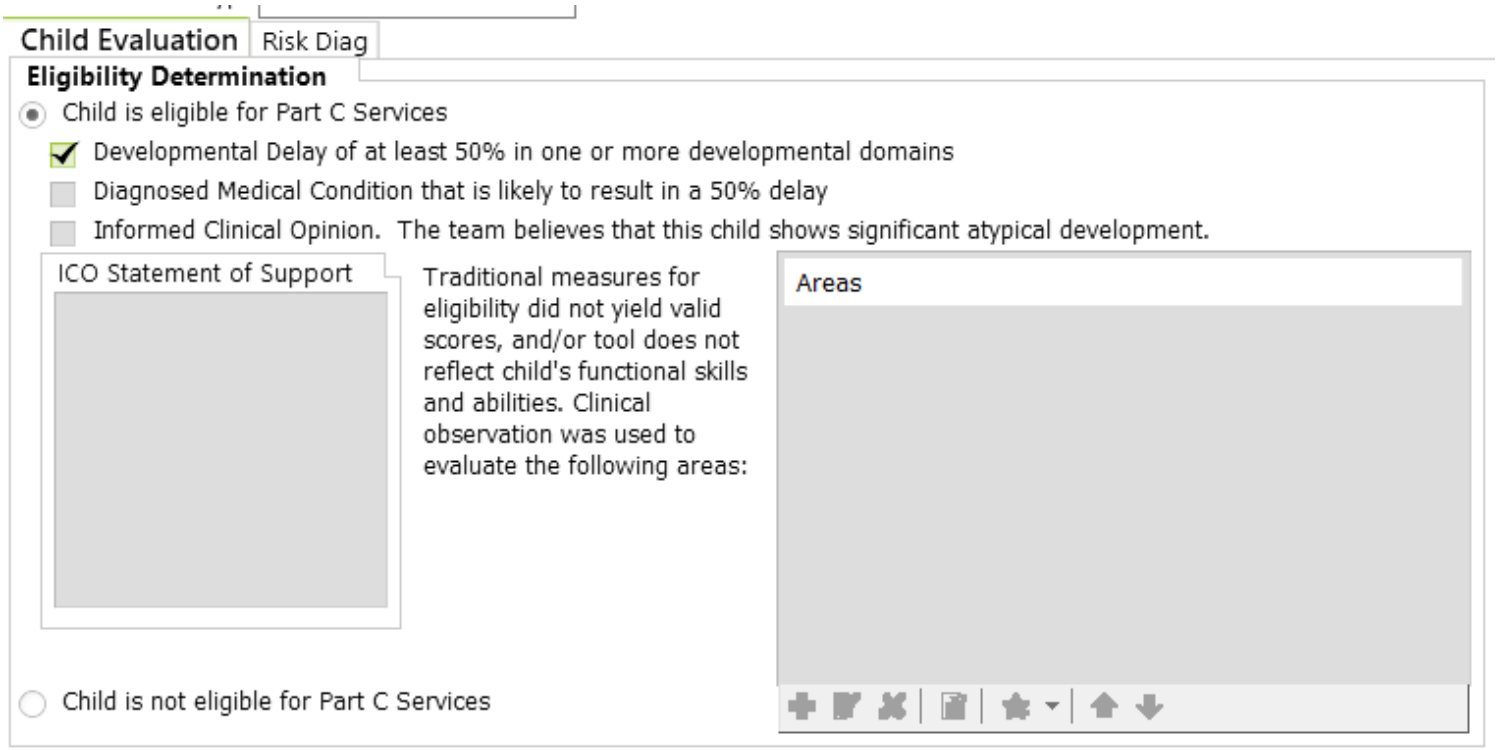
Procedure

A. Developmental Delay:

A child's developmental delay must be:

1. Measured and verified by appropriate approved diagnostic instruments and procedures that determines percent delay.

   On the primary evaluation, the primary service provider will complete this section

2. 

B. Physical or Medical Conditions (34CFR 303.21 (a)(2)(ii)):

1. Adjustment Disorder
2. AIDS or HIV Positive
3. Anxiety Disorder of Infancy and Early Childhood
4. Arthritis
5. Autism Spectrum Disorder
6. Blind or Visually Impaired, Significant/Progressive
7. Central Nervous System deficit or degenerative disorder
8. Cerebral Palsy
9. Chronic Lung Disease
10. Chronic Otitis Media longer than 6 months
11. Cleft Palate with or without Cleft Lip
12. Complex Seizure Disorder
13. Cornelia de Lange syndrome
14. Cystic Fibrosis
15. Cytomegalovirus (CMV), congenital
16. Deaf or Hard of Hearing, Significant/Progressive
17. Deafblind
18. Disorders of Affect
19. Disorders of Relating or Communicatin
20. Down Syndrome
21. Dwarfism
22. Epilepsy
23. Failure to Thrive
24. Fetal Alcohol Spectrum Disorder
25. Fragile X Syndrome
26. Hearing Impairment, Significant/Progressive
27. Heart Disease, Congenital
28. Hydrocephaly
29. Microcephaly

30. Muscular Dystrophy
31. Myelomeningocele
32. Neurological impairment
33. Orthopedic Impairment
34. Other (Diagnosis typically associated with substantial developmental delay)
35. Periventricular Leukomalacia, unresolved
36. Posttraumatic Stress Disorder
37. Prader-Willi Syndrome
38. Reactive Attachment Disorder
39. Renal agenesis with or without hypospadias
40. Rubella, congenital
41. Spina Bifida
42. Toxoplasmosis, congenital
43. Trisomy 13
44. Trisomy 18
45. Turner Syndrome
46. Uncontrolled maternal PKU

On the primary evaluation, the primary service provider will complete this section, and is required to complete and additional 'Risk Diag' tab circled below in red (will allow you to indicate medical diagnosis):

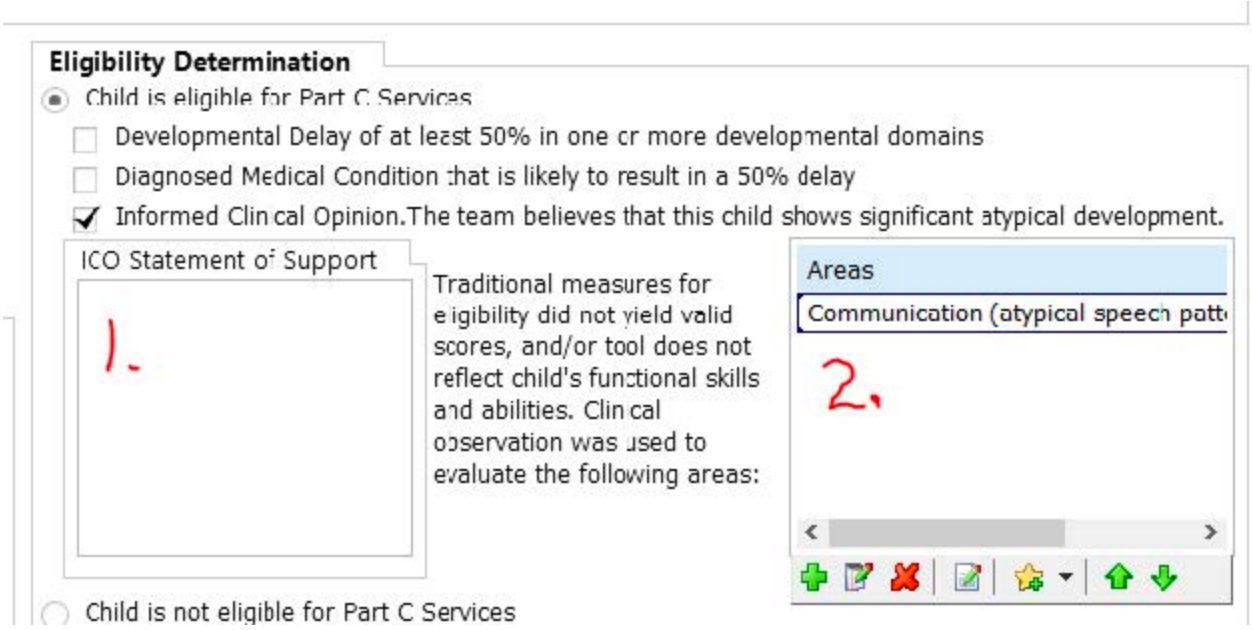
47. 

C. Informed Clinical Opinion:

ICO is an eligibility category to enroll children who experience significant atypical development in one or more areas, that is not captured by evaluation and may or may not be measurable with other assessment tools, but minimally is observed by provider and reported by family or record.

This is not for children who are at risk of developmental delays due to circumstances—but for children who experience delays that are difficult to measure. Do not use RISK to justify ICO. Focus on evidence of delay.

On the primary evaluation, the primary service provider will complete this section. Ask for support from the co-evaluator if eligibility falls into an area you did not evaluate:



Select the “Child is eligible for Part C services” and ICO, if they do not qualify by 50% or medical condition, and demonstrate significant atypical development.

For area #1, providers will write a statement of support. The state has encouraged the use of the following wording:

For a significant delay (Global Abbreviation icoalmst50): IDA-2 demonstrates substantial but not qualifying delay (ie, 45% delay in two areas):

- **Statement**: The IDA-2 results show a substantial delay, but the child does not qualify for Part C by evaluation scores. However, the child does demonstrate significant, qualitative delays including [enter observed delays examples from handout]. These delays interfere with the child's functioning in daily routines and activities and across environments.

Delay not captured: Child demonstrates a concerning difference (delay) that is not captured on the IDA-2 (may be captured on other tools such as the REEL, and is observed, or observed only):

- **Statement**: (Global Abbreviation iconotcapt):The IDA-2 results do not demonstrate the child’s observed delay, so the child does not qualify for Part C by evaluation scores. However, the child does demonstrate significant, qualitative delays including [enter observed delays examples from handout] and [if other test scores: name them here]. These delays interfere with the child's functioning in daily routines and activities and across environments.

After Annual evaluation (Global Abbreviation icoannual): the child continues to show a delay (substantial or not captured by IDA-2) but not 50% delay:

- **Statement**: While the child has made gains the child during enrollment in Part C services and IDA-2 results do not demonstrate the child’s observed delay, the child does not qualify for Part C by evaluation scores. However, the child does demonstrate significant, qualitative delays including [enter observed delays examples from handout] and [if other test scores: name them here]. These delays interfere with the child's functioning in daily routines and activities and across environments.

For area #2, providers click the predominant area(s) affected.

List of Statements of Observed Delay for ICO

During the intake or evaluation, a provider has observed that the child has skills that are not generalized, or, may demonstrate splintered skills in one or more developmental areas, and while difficult to measure can support qualifying a child for Part C by ICO.

Gross Motor

- Lacks general strength/muscle tone of all parts of body

- Posture concerns, alignment of joints
- Struggles with balance, static and dynamic
- Limited flexibility (muscles)
- Limited range of motion (joints)
- Does not like to move or fearful
- Frequency/amount is insufficient or much more than expected
- Substantial amount of support/assistance needed
- Compromised or very limited movement (quality)
- Needs equipment/devices to move through environments
- Limited or compromised rotation (ie, more linear movement patterns)
- Not progressing with “Mini milestones” (e.g. transitional positions between motor milestones)
- Limited endurance
- Limited awareness of safety – stairs/playground/equipment

Fine Motor

- Using a motor skill pattern that is immature (whole hand grasp, no pincer yet, etc)
- Limited or not engaged in utensil grasp
- Does not isolate index finger for poking/pointing
- Has had very limited opportunity/exposure (parent report)
- Heavy handedness/quality, or limited or absence of graded movement
- Visual motor – child does not maintain visual attention to grasp/release/play
- Not using both hands in coordination as expected for age, Limited bimanual skills (e.g. stabilizing toys with one hand while acting on with other)

Relationship to objects

- Demonstrates repetitive play
- Limited imaginative play
- Engaged in lining up toys
- Not vocalizing in play “talking to toys”
- Limited or not functional play vs not playing appropriately
- Hyper focused (close examination only of objects)
- Too much movement from toys to toys or place to place, wandering play, climbing
- Limited or not engaged in meaningful play
- Not inviting others to join play (ie, during kitchen pretend play, or referencing toys/interactions)
- Limited interactions with others (parallel vs interactive play, close exam only of objects)

Communication

- Very quiet/not engaged or never engaged in babble
- Limited or rigid communication patterns
- Not using or limited gestures (in addition to pointing)
- Not using or limited signs
- No or limited progress gaining vocabulary
- Do not attend to items pointed out by others
- Extremely difficult to understand by caregivers and others
- Limited use of words to label/request
- Limited response to labels/requests from others
- Consistently demonstrated a very limited understanding of others
- Does not make eye contact consistently
- Needs consistent support from caregivers to interact with others, needs additional cues to follow directions, get needs met

Self-help/Sensory

- Limited number of favorite activities in day
- Unable to or limited ability to engage in bath time
- Unable to successfully engage in transitions – quality of
- Unable to or limited ability to ride in car
- Strong reaction to sensory play/experience (messy, sticky, textures)
- Unable to feed self/disrupted or difficult feeding
- Does not tolerate clothes
- Vision/hearing sensitivities
- Sleep schedule is consistently disrupted, cannot fall asleep on own, struggles accepting support, wakes hourly, several hours needed to fall asleep

Relationships

- Hits, kicks, bites caregivers or other children
- Does not or limited ability to seek comfort and withdraws
- Does not interact with others
- Does not make eye contact, or very limited
- Limited or no engagement with caregiver as safe harbor or secure base
- Other delays significantly impede child's relationships
- Does not access parent using safe harbor or secure base behaviors

Coping/Social Emotional/Feelings
(consider absence, duration, frequency and intensity)

- Intense upset behaviors
- Does not or limited ability to engage with others
- Unable to play alone, consistently clinging across environments and caregivers
- Child consistently does not discriminate between caregivers, siblings or others
- Does not respond to or limited ability to calm
- Consistent limited participation or withdrawal from caregivers or others
- Consistent behaviors that interfere with engaging in environments
- Tantrum, physicality to cope
- Hyper focus
- Child not able to play with other children their age if age-appropriate
- Child is not responsive to or tuned to behaviors/emotions of others

OCS involvement
(consider what impedes development or functioning)

- Dysregulation (significant disruption in functioning, difficult behaviors, delay in some skills, loss of skills) as a result of changes in environment/ relationships (new relationships, loss of stabilizing relationships

Low Incidence Disorders: Hearing and Vision, State of Alaska Guidelines

Hearing Loss

If you have a child that has documented hearing loss in the file:

- Obtain medical records including an audiogram from an audiologist, and check to see if it meets the Part C Medical Diagnosis specifications.
- If they do not qualify with a Medical Diagnosis, check for delays at 50% or greater in combination with the documented hearing loss for Part C Developmental Delay.

- If they do not meet Medical Diagnosis or Developmental Delay, check for any delay or atypical factor related to hearing loss as determined by the team for a Part C Informed Clinical Opinion.
- If the child does not meet specifications for any category, they are NOT Eligible. (If the team agrees, suggest a follow up evaluation or check-in for 6 months later as many delays and atypical factors present or become more significant later for children with hearing loss.) Family may always re-refer at any time otherwise.

Age	Hearing Eligibility Criteria	Documentation
0-3 Years Old	Eligibility criteria for **Part C Medical Diagnosis** services for infants and toddlers with hearing loss • Note: Diagnosed Medical Condition that has a high probability of resulting in a developmental delay (see conditions listed in 34 CFR 303.21(a)(2)(ii))	Documented hearing loss a 40dB+ in two or more frequencies, bilaterally (pure tone), diagnosed by an audiologist. ---OR--- Chronic Otitis Media (ear infections for 6 or more months in duration) diagnosed by a medical provider, with documented fluctuating hearing loss diagnosed by an audiologist. (Also, check for specific syndromes if the Hearing Loss is the result of a syndrome.)
	Eligibility criteria for **Part C Developmental Delay** services for infants and toddlers with hearing loss • Note: A child has a 50% delay in at least one developmental domain. This is determined by the use of a standardized test.	A child with any type, degree, or configuration of hearing loss as documented by an audiologist (NOT Part C Medical Diagnosis eligible) and has a 50% delay in one or more developmental domains.
	Eligibility criteria for **Part C Informed Clinical Opinion** services for infants and toddlers with hearing loss • Note: Informed clinical opinion may be used to determine eligibility for Part C services. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. Clinical opinion of the multidisciplinary team could be used when a tool is not showing a 50% delay. The expertise of the team justifies the team decision.	A child with any type, degree, or configuration of hearing loss as documented by an audiologist (NOT Part C Medical Diagnosis eligible), some delays in the domains (NOT Part C Developmental delay eligible) or significant atypical development with one or more factors related to hearing loss (listed below) that is difficult to measure, and is determined by a team. Factors include but are not limited to: • Failed Newborn Screening • Failed OAE Screening • Any speech/language delay • Any cognitive/academic delay • Any perceptual/gross motor delay • Atypical tone/quality of voice • Atypical intelligibility • Atypical attention/focus • Atypical response or lack of response to sound • Atypical vestibular responses • Atypical balance/coordination • Use of assistive device (hearing aid, etc.) • Use of another language or communication mode
3-21 Years Old	Eligibility criteria for Part B services for preschool children with hearing loss	Deafness or hearing impairment that adversely affects educational performance and requires special facilities, equipment or methods to make his/her educational program effective and be diagnosed by a physician or audiologist and be certified as qualifying for and needing such services.

Blind or Visually Impaired, Significant/Progressive

If you have a child that has documented vision loss in the file:

- Obtain medical records including information from an opthalmologist, and check to see if it meets the Part C Medical Diagnosis specifications.

- If they do not qualify with a Medical Diagnosis, check for delays at 50% or greater in combination with the documented vision loss for Part C Developmental Delay.
- If they do not meet Medical Diagnosis or Developmental Delay, check for any delay or atypical factor related to vision loss as determined by the team for a Part C Informed Clinical Opinion.
- If the child does not meet specifications for any category, they are NOT Eligible. (If the team agrees, suggest a follow up evaluation or check-in for 6 months later as many delays and atypical factors present or become more significant later for children with vision loss.) Family may always re-refer at any time otherwise.

Age	Vision Eligibility Criteria	Documentation
0-3 Years Old	Eligibility criteria for **Part C Medical Diagnosis** services for infants and toddlers with vision loss • Note: Part C Diagnosed Medical Condition has a high probability of resulting in a developmental delay (see conditions listed in 34 CFR 303.21(a)(2)(ii))	The following diagnoses indicate “Significant/Progressive Vision Impairment” for Part C eligibility: • Cerebral Vision Impairment • Optic Nerve Glioma • Optic Nerve Hypoplasia iv. Bilateral Retinoblastoma • Retinopathy of Prematurity (Stage IV or V) • Bilateral Peter’s Anomaly • Retinal Dystrophy/Leber’s Congenital Amerousis • A designation of “Legal Blindness” as determined by an ophthalmologist • Also, check for specific syndromes if the Vision Loss is the result of a syndrome. Note: Even within one diagnosis there can be a wide range of visual functioning between individuals. Therefore, final Part C eligibility is determined by: ◦ An assessment of functional vision/developmental visual skills completed by a vision impairment educational specialist, ◦ Consideration of other medical/developmental concerns, and ◦ Findings of an ophthalmological exam
	Eligibility criteria for **Part C Developmental Delay** services for infants and toddlers with vision loss • Note: Part C Dev Delay is used when a child has a 50% delay in at least one developmental domain. This is determined by the use of a standardized test.	A child with any type, degree, or configuration of hearing loss as documented by an audiologist (NOT Part C Medical Diagnosis eligible) and has a 50% delay in one or more developmental domains. This is determined by the use of a standardized test.
	Eligibility criteria for **Part C Informed Clinical Opinion** services for infants and toddlers with hearing loss • Note: Part C Informed clinical opinion may be used to determine eligibility for Part C services. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. Informed clinical opinion of the multidisciplinary team could be used when a tool is not showing a 50% delay. The expertise of the team justifies the team decision.	There can be a qualification of “Significant/Progressive Vision Impairment” by Clinical Opinion when there is a high risk for a vision impairment diagnosis due to medical history (prematurity, birth injury, IVH, diagnosed syndrome, etc.) and visual skills less than expected for developmental age as assessed by a vision impairment educational specialist. The following diagnoses may qualify as “Significant/ Progressive Vision Impairment” by Clinical Opinion and should be considered for Part C eligibility with additional evaluation and information: • Albinism • Bilateral Congenital Cataracts • Delayed Visual Maturation • Glaucoma • Homonymous Field Defect • Microphthalmia • Nystagmus, Congenital • Optic Atrophy • Prader Willi Syndrome • Retinal Detachment

Age	Vision Eligibility Criteria	Documentation
		• Visual Field Defect
3-21 Years Old	Eligibility criteria for Part B services for preschool children with hearing loss	Vision loss that adversely affects educational performance and requires special facilities, equipment or methods to make the child's educational program effective and be diagnosed by a physician or audiologist and be certified as qualifying for and needing such services.

Documents

Practice - Part C Decision Tree

Functional Evaluation

Purpose

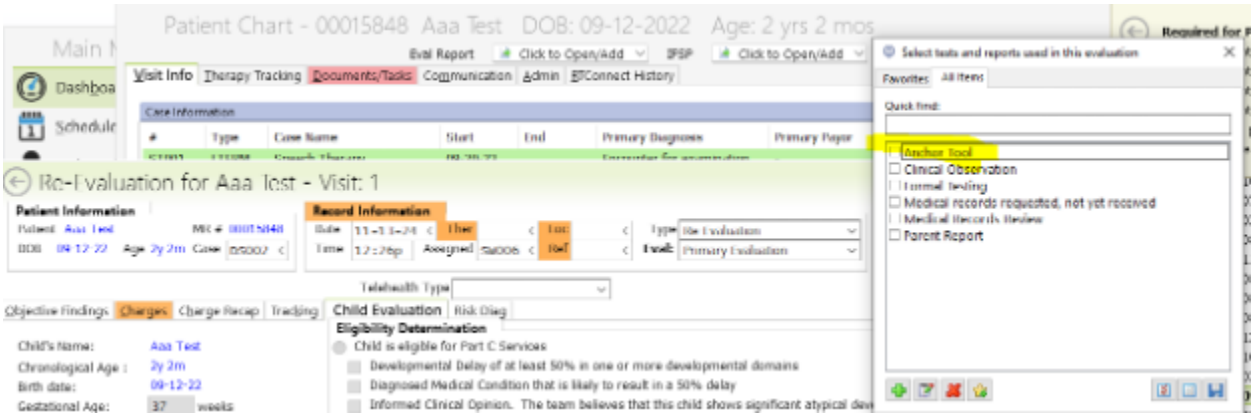
The *functional evaluation* is the combined documentation from both primary and secondary providers. It includes a detailed narrative of the child's current strengths and challenges, along with evaluation background, test scores, child outcome ratings, and eligibility determination. In some cases, the secondary provider may be substituted with relevant medical records from the child's healthcare history.

Practice

Evaluations are conducted with two providers who must be from different disciplines (e.g., OT, PT, SLP, SW, DS). One provider acts as the *primary service provider*, and the other as the *secondary provider*. Each completes their section of the initial or annual evaluation in the electronic health record (EHR), which supports service billing.

In some cases, a provider may use medical records in place of a second provider's input. Instructions for this process are provided below, scroll to 'Provider: How to complete Function Evaluation using Medical Records'.

Note: The IDA-2 is the state approved anchor tool that meets Part C eligibility criteria. While standardized, it is administered in the home, which is not a controlled or standardized testing environment. The State ILP maintains the list of approved anchor tools.



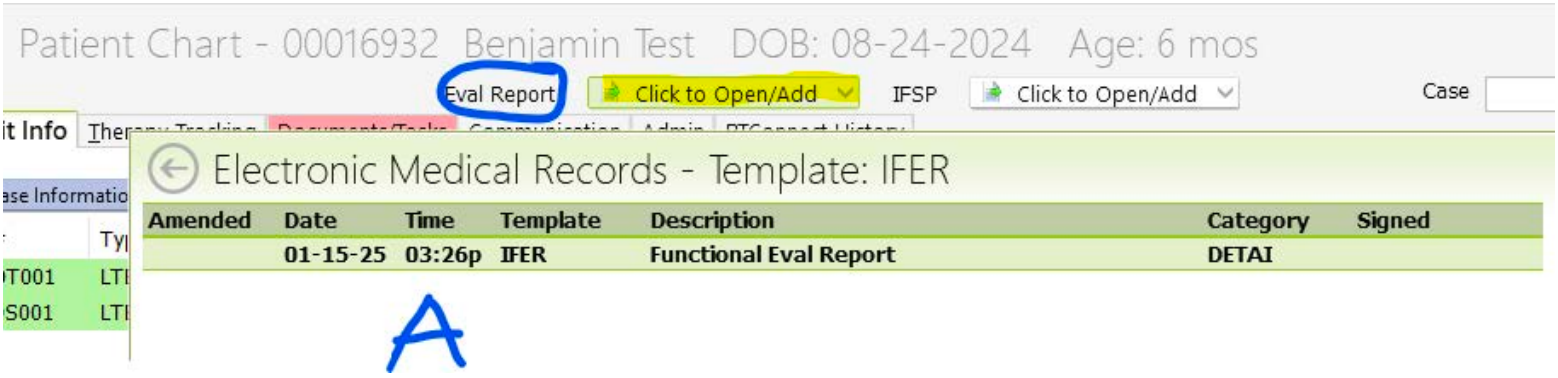
Procedure

Provider: Completing Functional Evaluation

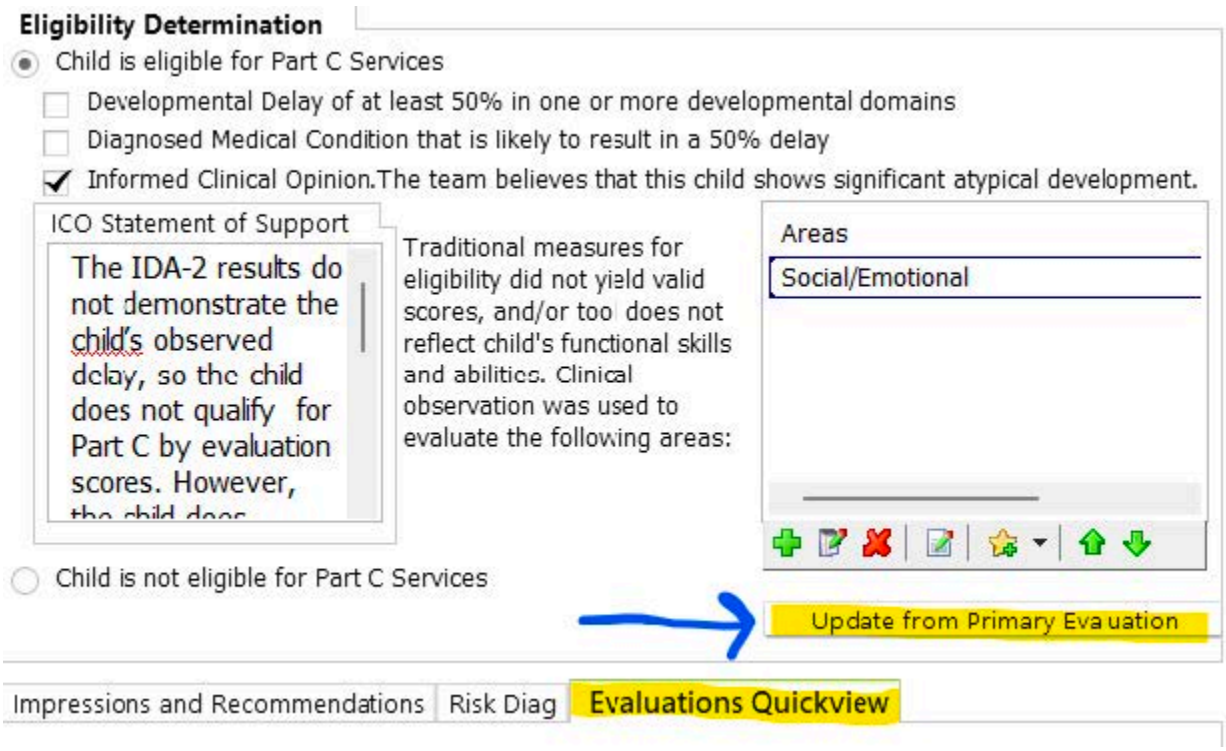
The Primary Evaluator generates the Functional Evaluation document through the Patient's Chart, after the Primary and Secondary evaluations have been completed.

In Patient Chart, in the upper center/left corner is the 'Eval Report', click on the bar 'Click to Open/Add' , it will take you to the Functional Evaluation medical records, enter 'A' to Add.

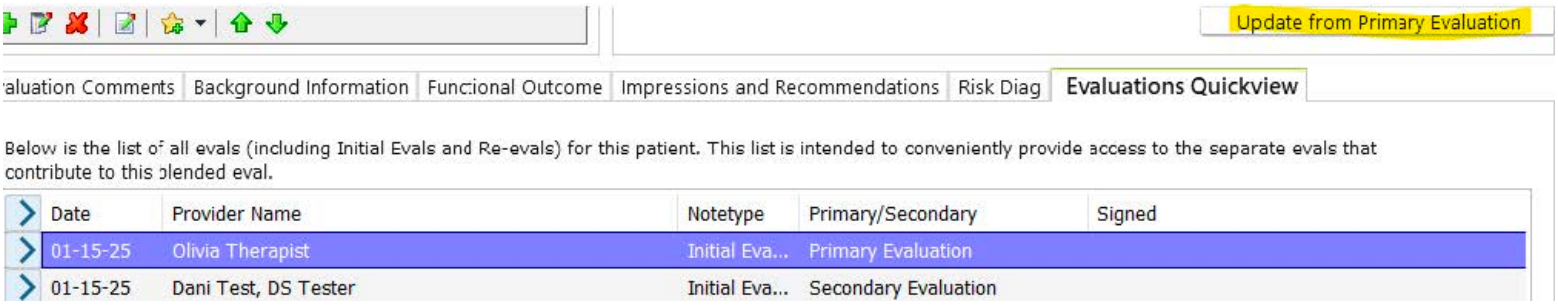
Note: Do Not Roll Forward (unless you would like the previous Functional Evaluation to be pulled into the Functional Evaluation). Just type "A" to add.



Under the Eligibility Determination tab, Begin by clicking on the 'Evaluations Quickview' tab:



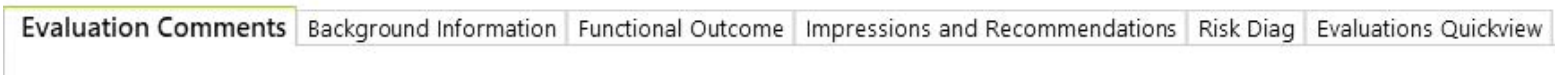
In the 'Evaluations Quickview' tab: there's a list of all the evaluations, use the scroll bar on the right to view the list (listed in chronological order) and under the 'Date' heading is a checkbox for each evaluation. Select the evaluations you would like to merge to this document by clicking on the checkbox on the left side, a right arrow will display to show you which evaluations you've clicked on:



Beginning with the Eligibility Determination, click 'Update from Primary Evaluation' to pull in the child and family demographics and the Eligibility Determination information.

Now work through the following buttons on this page to populate from the evaluations and make any edits that are appropriate.

To complete the following tabs, you may open each tab and click the bottom right corner button to **Update From Evaluation(s)**

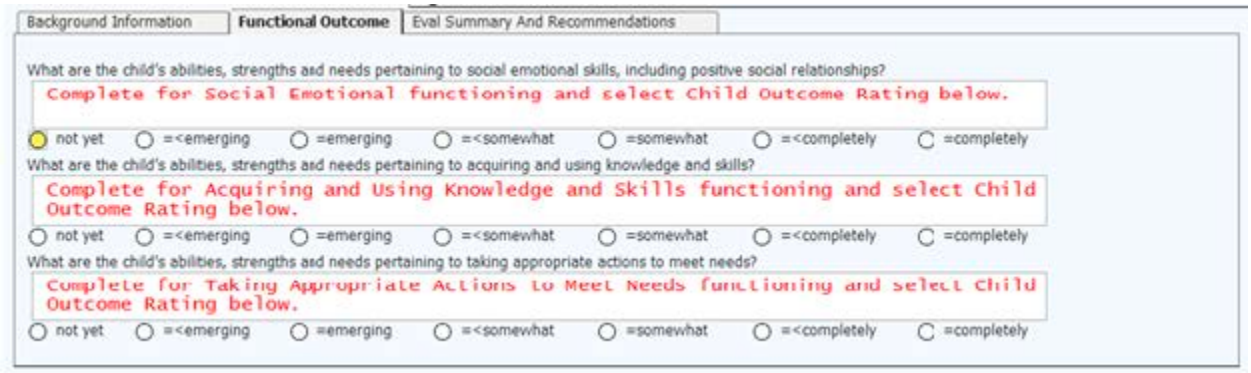


Evaluation comments tab: who was present? How long were you there? Who completed which section and was the child reported to be presenting typically or no?

Background Information: roll from the Initial Eval to this document and remember to remove duplicated information because generally the same information pulls from both providers individual evaluations.

Note: For Functional Outcomes, after rolling be sure that each outcome (radio) button is checked appropriately for each area (1. social emotional, 2. acquiring and using knowledge and skills, and 3. taking actions to meet needs).

Pro tip: The outcome ratings do not pull from the primary evaluation and need to be entered manually on the functional evaluation for those sections completed by the primary evaluator. Radion buttons seen here **(in yellow):**



Select **Save**, if you are not ready to signoff simply **Save and Exit** when the document opens.

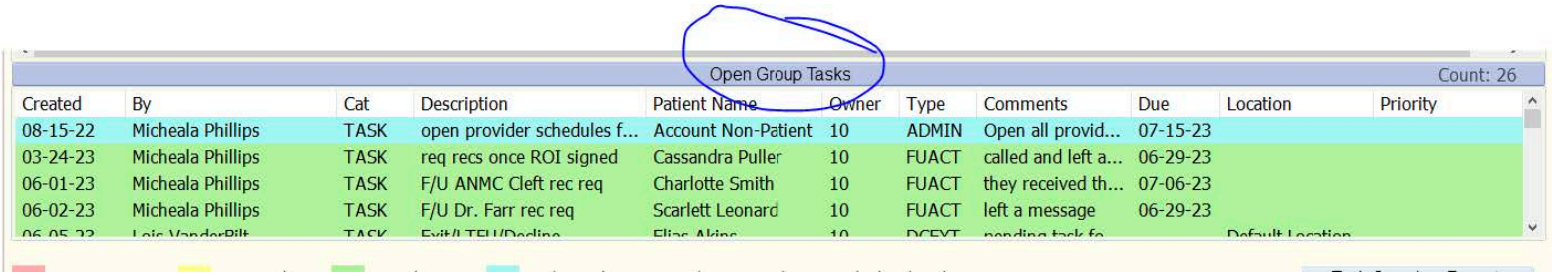
Or, if completed **Signoff and Close**. The Functional Evaluation report will appear in print preview, complete the sign off.

You may print the document by selecting this button **Print Document** at the top right of the page.

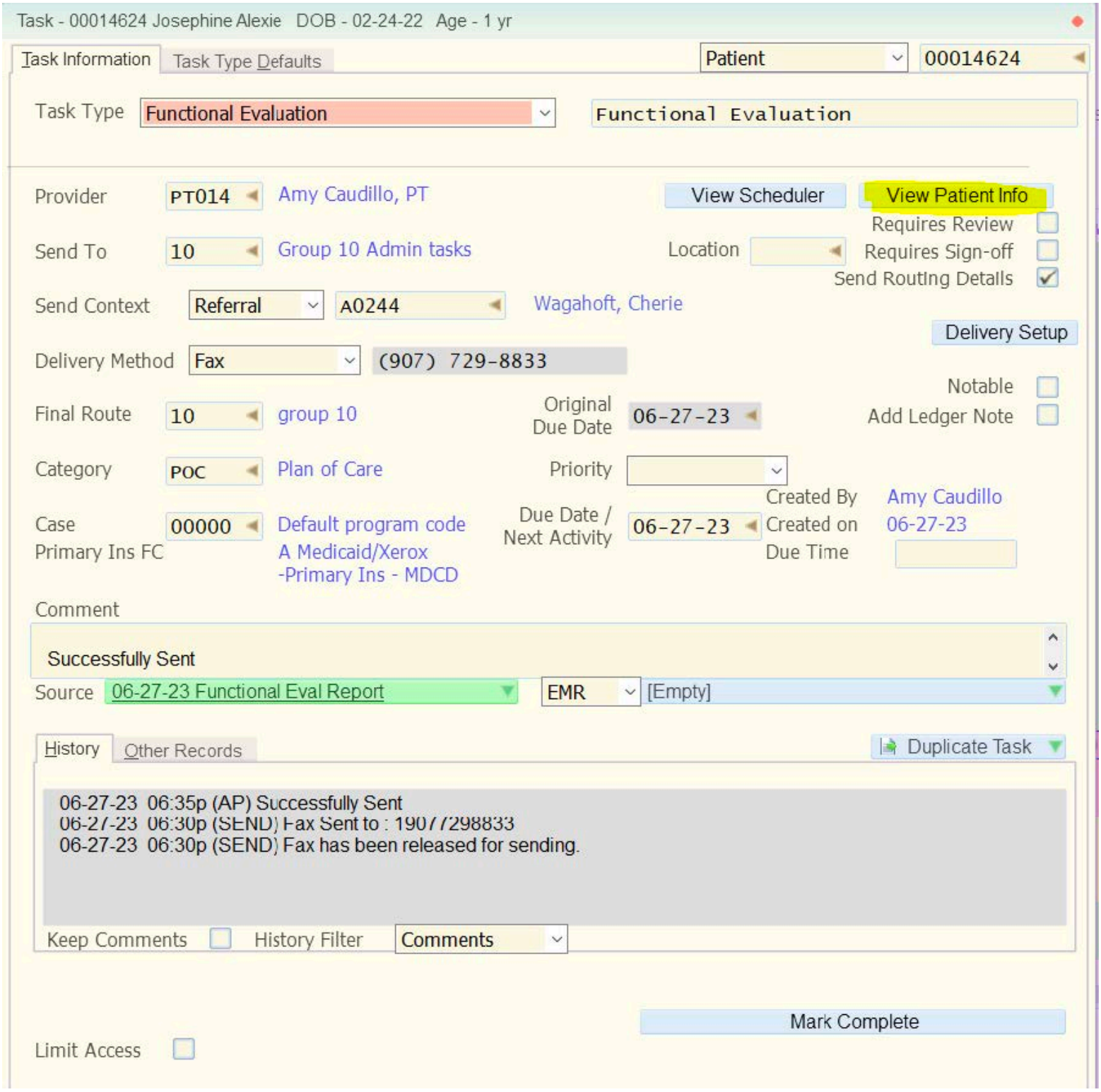
Note regarding Amendments: If edits are needed in the primary/secondary evaluation or re-evaluation, save your Functional Evaluation and go to the 'Visit History' section of the chart. All edits to the evaluation must be completed prior to signing off the Functional Evaluation. To amend an existing document see "Amendments and Corrections" section of this booklet.Admin: How to- Review Functional Evaluations

Admin: Functional Evaluation Entry

1. Admin gets an automated task sent to Group 10 every time a functional evaluation is signed off on by the primary PIC provider. You can find Group 10 tasks from the Main Menu → Dashboard → Open Tasks tab → Open Group Tasks (3rd grouping, on the very bottom. Then double click the Open Group Tasks to enlarge and see all the tasks

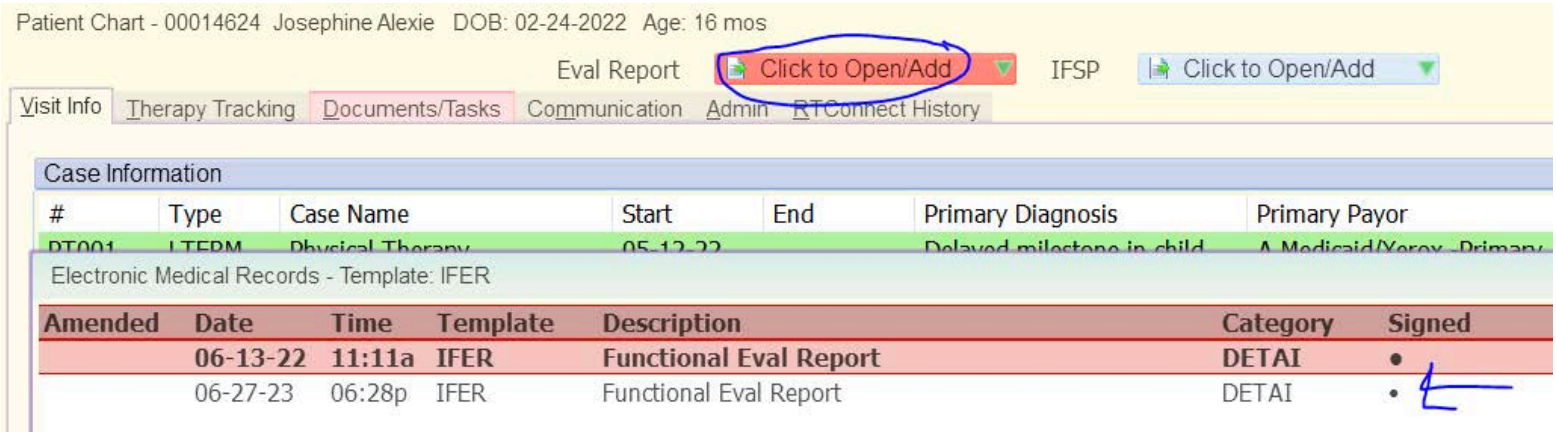


2. The category for functional evals is "FUNEV" and you can sort group 10 tasks by type to get all the same task type together. The task will look like this and you can tell who the primary provider is (Amy Caudillo), where the eval was sent (the PCP per the consent to eval sig form, Cherie Wagahoft) and the child (Josephine Alexie). Click on View Patient Info or you can also type "C" when the task is highlighted to take you directly to the chart without looking at the task.



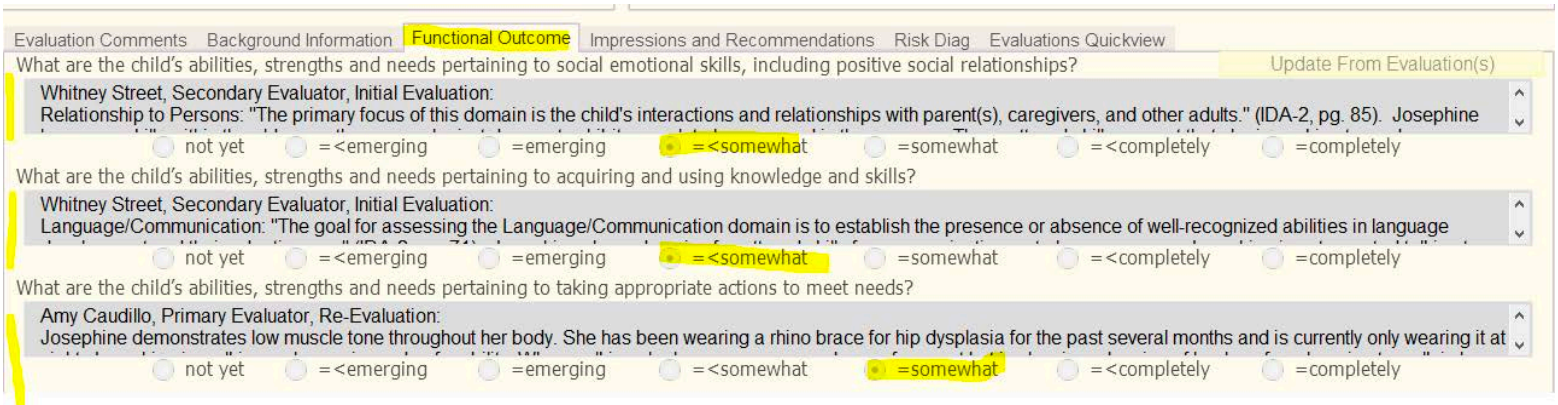
3. This will bring you to the Visit Info tab of the patient's chart, which shows the visit history. Make a note of the date the eval is scheduled for by both providers. Each provider does their own evaluation, then the primary provider combines both reports into the functional evaluation.

4. The functional eval is up at the top next to Eval Report, click where indicated and choose the most recent evaluation. Note: the date listed is NOT the evaluation date, it's the date it was combined, so it should be roughly correct but won't match the schedule date (and that's okay here)



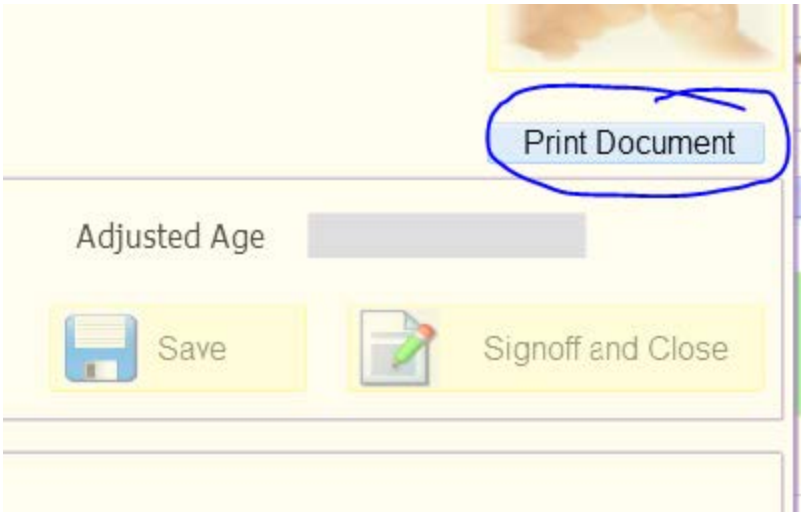
5. Once opened the main page shows the following information to check:
   a. Date of referral: previously pulled automatically, no longer does, is not required.
   b. Date of evaluation: should match the individual evals scheduled (that you just made note of)
   c. Evaluators names: should also match the individual evals you just made a note of
   d. Evaluation/Assessment tools and methods used: the usual 3 are Clinical Observation, Formal Testing/Standardized Assessment (both count as the IDA Anchor Tool in the state database), and Parent Report. There can be more if medical records were used or even requested but not received.
   e. Eligibility Determination: If the child is eligible, then one of the three boxes needs to be checked. If Informed Clinical Opinion, then the State of Support and Areas also need to be completed. If the child is not eligible the option "Child is not eligible for Part C services" should be marked.

6. After you've checked the main page, go the Functional Outcome tab (on the bottom third of the page) and scroll down to check that all three text boxes have both text and a radio button selected



7. Two tabs to the right is the "Risk Diag" tab with the State Diagnosis and Risk Factors. These can both be "none" but must be filled out (no assuming none if left blank).

8. Finally, up in the top right corner is a “Print Document” button, click that to review the IDA-2 scores are all there and none are duplicated. The 8 domains are:
    i. Self Help
    ii. Relationship to Inanimate Objects
    iii. Fine Motor
    iv. Gross Motor
    v. Language/Communication
    vi. Relationship to Persons
    vii. Emotions and Feeling States
    viii. Coping Behavior



The Infant-Toddler Developmental Assessment–Second Edition (IDA-2) is a com
gross motor, fine motor, relationship to inanimate objects, language/communication, self
and a quality rating.

Amy Caudillo, PT tested:

Domain	Performance Age Range in Months
Gross Motor	13-15.5
Fine Motor	11.5-13
Relationship to Inanimate Objects	13-15.5
Self Help	15.5-18

The Infant-Toddler Developmental Assessment–Second Edition (IDA-2) is a com
gross motor, fine motor, relationship to inanimate objects, language/communication, self
and a quality rating.

Whitney Street, EI Developmental Specialist tested:

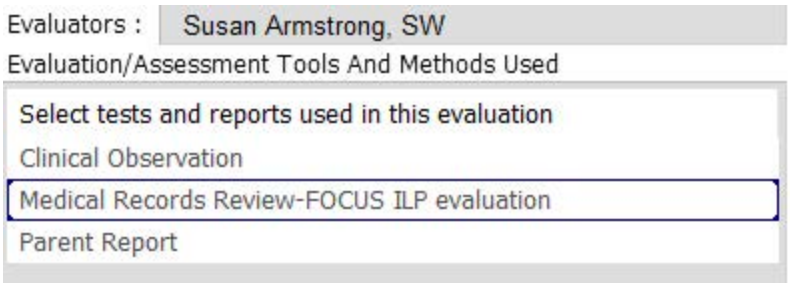
Domain	Performance Age Range in Months
Language/Communication	7-8.5
Relationship to Persons	4-5.5
Emotions and Feeling States	5.5-7
Coping Behavior	7-8.5

9. If everything is complete, add a note to the state database task “mm/dd eval comp” and set the due date to the next state database entry day (usually Monday or Tuesday of the next week). Otherwise, task the primary provider for any missing or incorrect information.

Provider: How to complete Function Evaluation using Medical Records

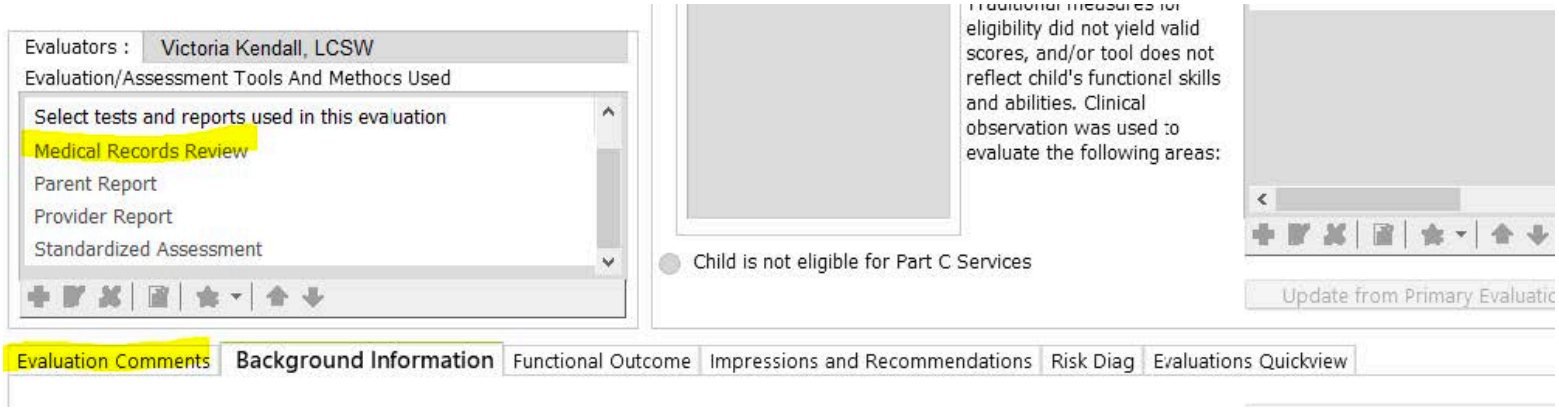
If there is not a secondary evaluator, or the provider determines that medical records are present and can be used to determine eligibility-- the provider must use recent medical records to evaluate the child.

- If the child is qualified by medical diagnosis, Part C determination regulations require that the diagnosis appear in the medical records.
- Records must be less than 6 months old at the time of primary evaluation



Provider will indicate that Medical records were reviewed as indicated above ^^^

As well, provider will indicate in the Evaluation Comment tab (see illustration below) that medical records were used this day to support determining eligibility:



The primary evaluator will complete the entire IDA-2, and report scores on the Objective Tab in their Initial Eval. The medical record's provider narrative/descriptions will be added to the Functional Eval when the primary rolls the Initial Eval to the Functional. A Snip It, or screenshot, is the easiest way to add these narratives to the Functional Eval, however sometimes you might have to re-type the information and reference the source.The primary will indicate that the sections that are screen shots are redacted, and indicate the provider and the date of the original record at the head of each screenshot:

ANMC therapist Scott Mitchell, PT, DPT 09/26/2022 Redacted from note on gross motor observations and progress:

Gait training:
1)Walking with one or two hands held by PT
2)Standing with one or two hands held by PT
3)Cruising practice - patient pulled self to standing and cruised while touching various support surfaces today.
4)Use of walker toy for walking practice
5)Patient stood without support and no hands held for 1-2 seconds several times today and also took 1-2 steps before lowering self back down to the floor.

Therapeutic Activity x 60 min.:
1)Transitional movements on the floor - moving in and out of sitting and standing.
2)Crawling/creeping: The patient was guided to perform this movement in order to smoothly creep and not flex the right hip to push through with that leg instead.
3)Playing with toys - attempted teaching use of cups that stack, a small ball filled with air, and a small toy car. In general, the patient tossed/threw the toys rather than play with them, but he did keep the cups stacked at times.
4)The patient slowed his movements/activities long enough to look outside at trees and engage with kidsongs for about 10-15 minutes today.

ASSESSMENT:
2 y/o male referred to Inpatient Pediatric PT for Evaluation and Treatment. The patient has global developmental delay but

Admin: How to enter Function Evaluation using Medical Records

When you see this on a functional evaluation report, if the provider states that they used medical records, then they should have rolled in those previous evaluation to get the scores to this functional evaluation.

In the case of an evaluation from another ILP/non-provider specific report, go into medical records and get the evaluators from that report for the roles drop down in SDB.

	Roles of people involved in summa
X	Developmental Specialist
X	SLP
X	Foster Parent
X	Social Worker

Annual Evaluation

Purpose

Annual eligibility is determined by two providers who conduct a developmental evaluation that results in a 50% delay, medical diagnosis, or by clinical opinion, and is completed with two providers from different disciplines. The eligibility meeting will occur as a result of this evaluation, and result in a renewal of the IFSP or exit from services.

Practice

Determining Eligibility at Annual Eval/Re-enrolling Children Practice

An eligibility meeting must be conducted on at least an annual basis to evaluate and revise, as appropriate, the IFSP for a child and the child's family. An eligibility evaluation must be conducted as part of that process, and must include two providers of different disciplines and/or the results of any current evaluations. Other information available from the assessments of the child that have been conducted, according to §303.321, can be used in determining the early intervention services that are needed and will be provided.

Eligibility should be determined based on multiple sources of information [34 CFR 303.323(c)], including the parent(s) and the professional evaluator's/assessor's concerns about a child's development, and the need for EI services.

When a child doesn't have a 50% delay, and the team is looking to re-enrollment it will be based on clinical opinion, if appropriate. The guidance is to then review the frequency of services and use the IFSP team (parents, PSP, other providers) to make the decision and recommendations.

Considerations: Every child & family could benefit from Part C/EI services. However, the federal law is meant to address a child's need for services, not whether or not he/she/or the family would benefit from services [34 CFR 303.12].

At the time of evaluation, please consider if the child has a medical diagnosis on Alaska's established conditions list. Eligibility is neither automatic, nor required. The guidance here is in direct response to the tradition of re-enrolling children because they have been previously enrolled without consideration for the current condition of the child (the "Once Part C, Always Part C" approach to eligibility).

When the IFSP team (parents, service coordinator, and service providers) decides that IFSP goals are met, services are no longer needed, and the family is in agreement then they are ready to transition out of Part C/EI.

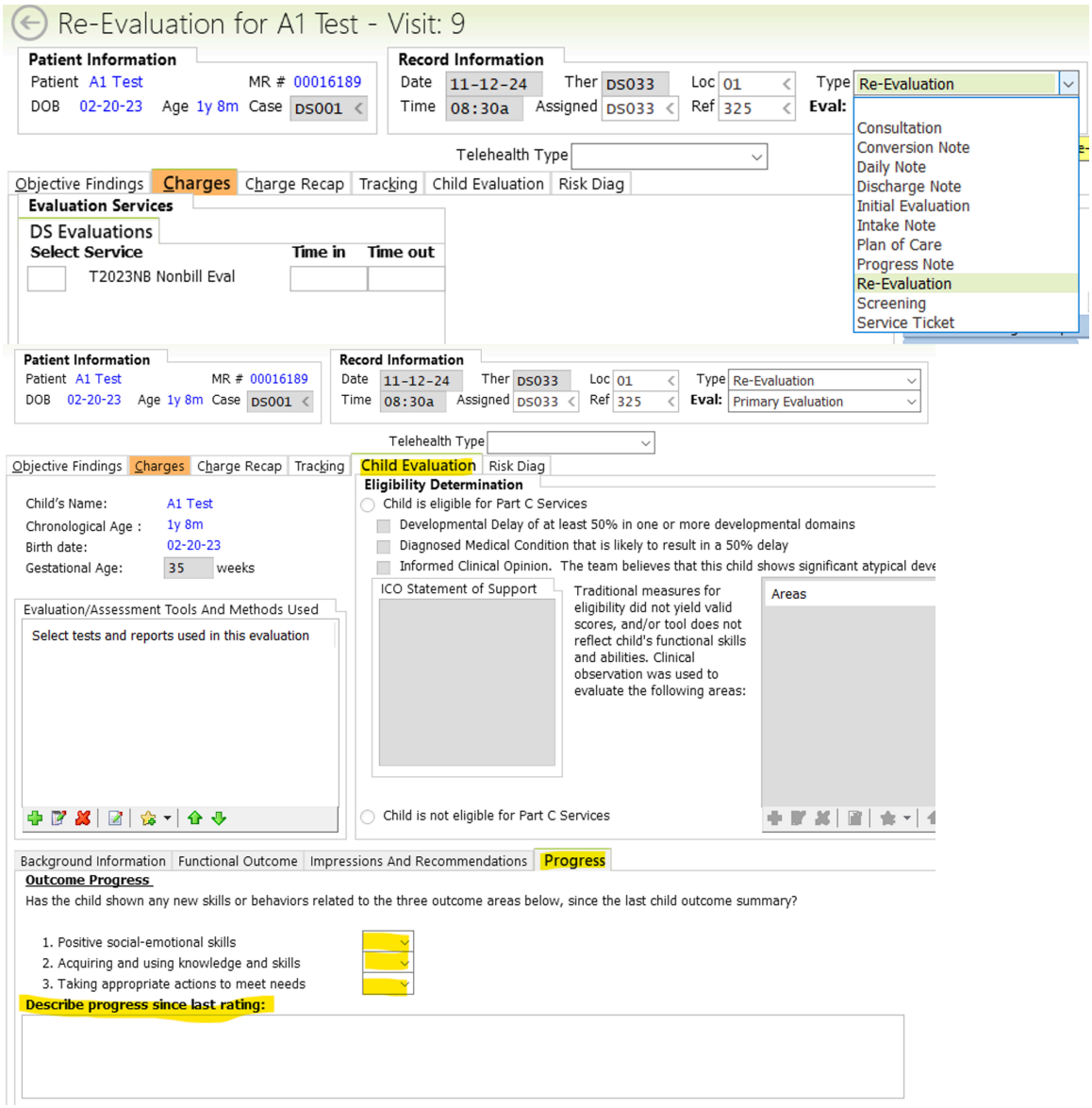
*Keeping a child/family enrolled until age 3 is not a Federal requirement.
*OSEP defines a child with a "complete IFSP" as "no longer eligible."

PIC will complete an evaluation with the family and child and schedule to be completed at the annual due date and no more than two months in advance of the child's annual due date. Two providers are required and use an IDA-2. If feasable, use the original IDA-2 from first eligibility evaluation.

See considerations: Guidance on Determining Eligibility at Annual Eval.docx

Procedure
When completing the individual documentation for the re-evaluation, the PSP needs to select "Re-Evaluation" as the type in order for the COS/ progress tab to appear.

Consent PWN, CTB, and request Med Records



If the PSP does not select Re-Evaluation as the type, then they will be required to report exit outcomes and progress even if the evaluation was within 3 months of exiting the child.

If the child is determined eligible for services:

The primary service provider (PSP) will:

- Prepare for the Individual Family Service Plan (IFSP) by
  - Asking the family who they would like to invite to the IFSP meeting
  - Scheduling times and locations convenient for the family
  - Remind the family of the IFSP process, if necessary (a dynamic plan, developed by the team that guides the provision of family- centered early intervention supports and services based upon the changing needs of the child and family)
- Provide Prior Written Notice
  - After completing the evaluation visit, the primary service provider will combine the Functional Evaluation report
  - The second provider will complete an Evaluation report in RainTree

If the child is not eligible:

a. The primary service provider will:
   - Give parent a Prior Written Notice that the child is not eligible for ILP services and request parent signature
   - Have the family complete signature pages
   - Support the family with additional information if appropriate (information on normal developmental milestones, etc.)
   - Complete the Functional Evaluation
   - Provide a copy of the Functional Evaluation for the parents, either via mail or at a follow-up visit, if scheduled, and to the physician or other information sharing that has been requested

b. The second discipline attending the evaluation will complete an Evaluation in Raintree.

Hearing & Vision Screening

Hearing

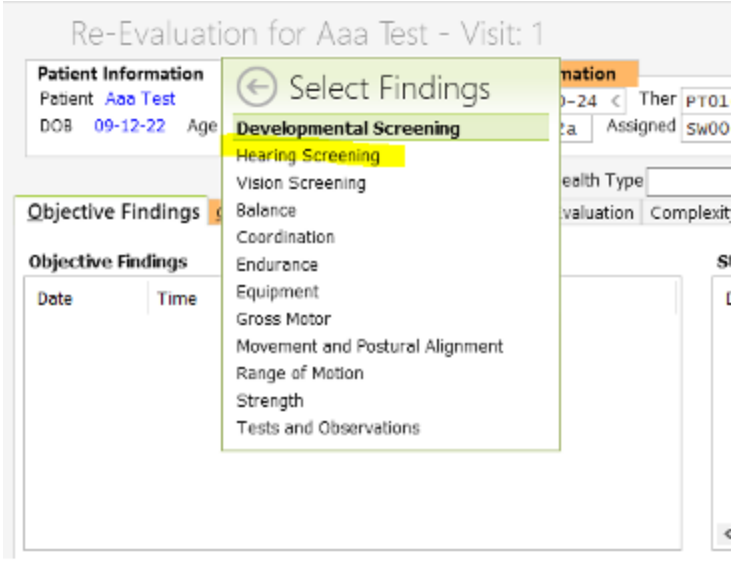
Hearing Screening

Purpose
The primary purpose of hearing screening in birth to three-year-olds is to identify children with hearing loss as early as possible so they can receive timely/early intervention and support, maximizing their potential for speech, language, and overall development. Early identification is crucial because hearing loss can significantly impact speech and language development impacting communication skills, and lead to delays in language acquisition, impacting and overall development. Speech delay can be an indicator of hearing loss.

Procedure
RT hearing screen forms are meant to be conducted online at intake, or as needed. OAE devices are used during an in-person home visit.

If hearing screening is completed within two months of the intake or after obtaining consent for annual evaluation, the consent to evaluate will serve as consent for this screening. If this screening is independent of the intake/annual and outside the two months, the provider will deliver PWN and obtain a Consent to Evaluate.

Documentation Guideline:
Under **Objective Findings – Hearing Screening**, document the recommendation from the Hearing Screen Questionnaire. Indicate whether the result suggests a **referral** or a **pass**.



Billing Documentation: No screenings (NICU prior to enrollment, developmental, hearing, or vision) are billed out, so the only necessary billing documentation is to list the screening clock times under the Long-Term Therapy Note type “Screening”.

Documents

Programs for Infants and Children Hearing Screen - Practice

Early Detection Hearing and Intervention (EDHI) Release

Purpose

Early Hearing Detection & Intervention (EDHI) is a program that is tasked with following families whose child experiences hearing loss or has had a failed hearing screen. Their responsibility is to refer a family to a second screening or to ILP where hearing concerns identified. EDHI will assure that the family is reminded, and the child is referred to annual assessment for language concerns, and referred for assessment or followed to access appropriate services during and after their enrollment in ILP.

EHDI website: https://www.infanthearing.org/resources_home/

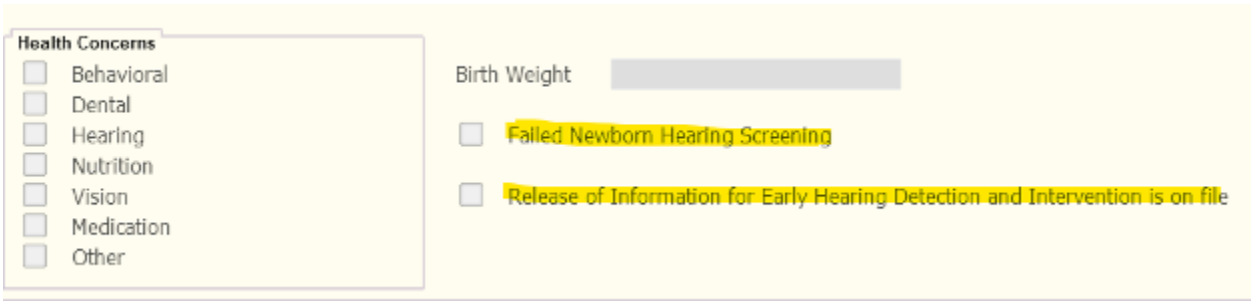
Practice

At Intake, the provider will ask the family if the child failed their newborn hearing screen. If yes, that box on the intake is checked and a reminder box of “EDHI Release” is also discussed with the family. The provider will explain EDHI and their role in tracking children with hearing loss, while ensuring that appropriate referral and services are offered.

Procedure

Provider

In the Intake Note provider will check the boxes highlighted below when appropriate:



The provider then includes the EDHI ROI in the signature forms (under All Signature forms), if the family agrees. Email admin@picak.org to let them know it’s been sent to family and admin will follow up as needed.

Admin

When an ROI for EDHI is signed, send the EDHI ROI and complete the EDHI Referral Information (this is a Pandadoc that is complete using information available in the chart) and fax both ROI and Referral Information in RT to the Referral Source NP039 in RT or:

Early Hearing Detection & Intervention Contacts:

Annette L. Callies
Program Manager
Early Hearing Detection & Intervention (EHDI)
Women's Children's and Family Health (WCFH)
Department of Health and Social Services
3601 C Street, Suite 322
Anchorage, Alaska 99503-7123
Phone: 907-334-2273
Fax: 907-269-3465
annette.callies@alaska.gov

Vision

Vision Screening

Purpose

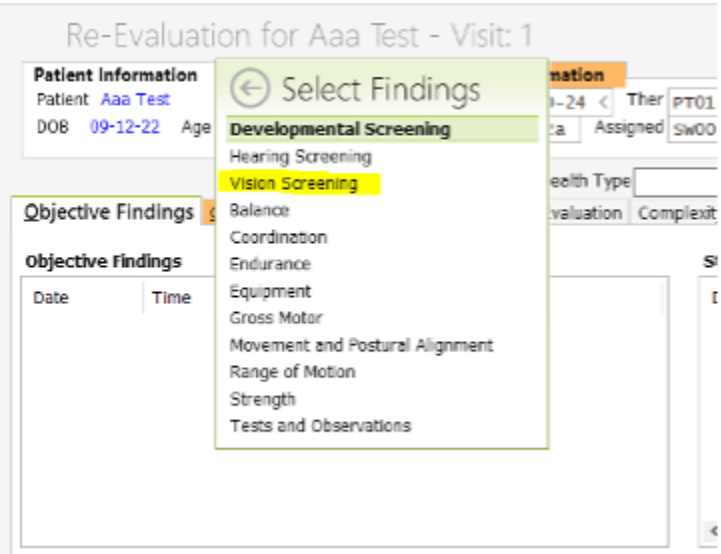
The purpose of a vision screening is to identify vision problems in a treatable stage, provide education, and provide a referral to an eye care provider for a comprehensive eye exam (if needed) and can help prevent permanent vision loss.

Procedure

RT vision screen forms are meant to be conducted online at intake using A Shared Vision online screener. It can also be used as needed. Photoscreeners are used during an in-person home visit.

Documentation:

- If screening is completed within the two months of the intake or consent for annual evaluation, the consent to evaluate will serve as consent for this screening. If this screening is independent of the intake/annual and outside the two months, the provider will deliver PWN and obtain a Consent to Evaluate.
- Take the recommendation to either refer or pass from the Vision Screen Questionnaire and add under Objective Findings Vision Screening:



Documents

Vision Practice

Consultant Process

Last Updated	**7/18/24**

Procedure

A Shared Vision Services: Requests for Service, Tracking, Documents and Billing

In addition to the contract, PIC and A Shared Vision have agreed upon the following processes.

PIC has assured that providers request services using the PIC Sharepoint form "Vision Services Request Form" at this link Vision Request Form for Providers

PIC assumes responsibility for securing an ROI for each family with whom they are involved -- there is a statement for providers to remind them of this responsibility while completing the request for service form.

PIC assures that A Shared Vision (Paula and Steve) will have access to the Excel spreadsheet that collates the information from the Request for Vision Services form, as it is received, and is located at: Vision Services Requests Made (Excel)

Providers will upload and store documents to client files.

Admin DE will then ensure that the Vision visits are manually input in the State Database as part of data entry when documentation is received.

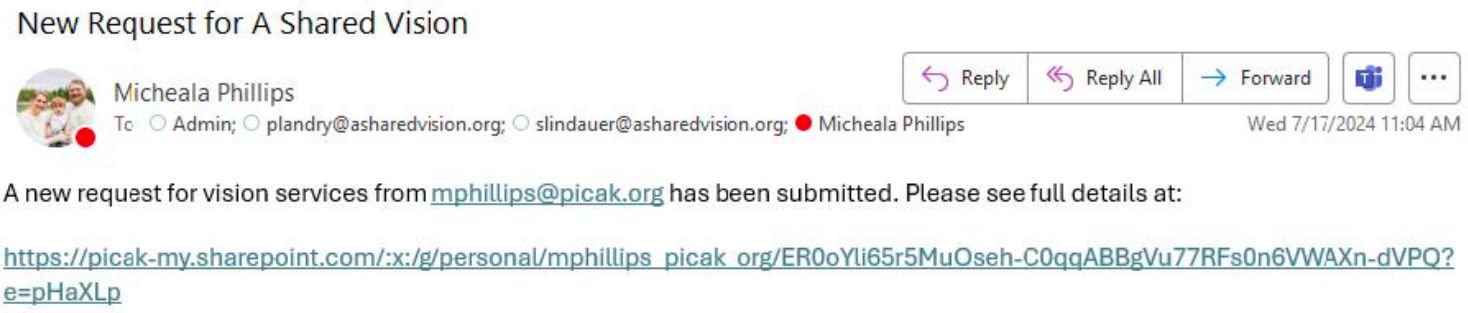
A Shared Vision will:

- Respond to requests for services with the provider who initiates the request within 3 business days of date of request
- Document eval/visit notes and send via encrypted email to the PIC provider and admin@picak.org within 3 business days of date of service
- Email invoices to swinslow@picak.org, Stacy Winslow Finance Manager
- **Background Check for contractors: none needed as the providers are online and engaged at PIC's request with PIC present.

Link to Vision Services Request Form

Admin How to-Vision Services

1. Admin will receive an email when a new request for vision services is submitted with a link to the spreadsheet, so you know what child the request is for. The provider making the request is also included on the email.



Link here: https://picak-my.sharepoint.com/:x:/g/personal/mphillips_picak_org/ER0oYli65r5MuOseh-C0qqABBgVu77RFs0n6VWAXn-dVPQ?e=pHaXLp

- The records to be sent to A Shared Vision are based on what's available, but look for the following available records:
  1. Eye reports from Ophthalmology and/or Optometrist
  2. Neuro reports
  3. IFSP

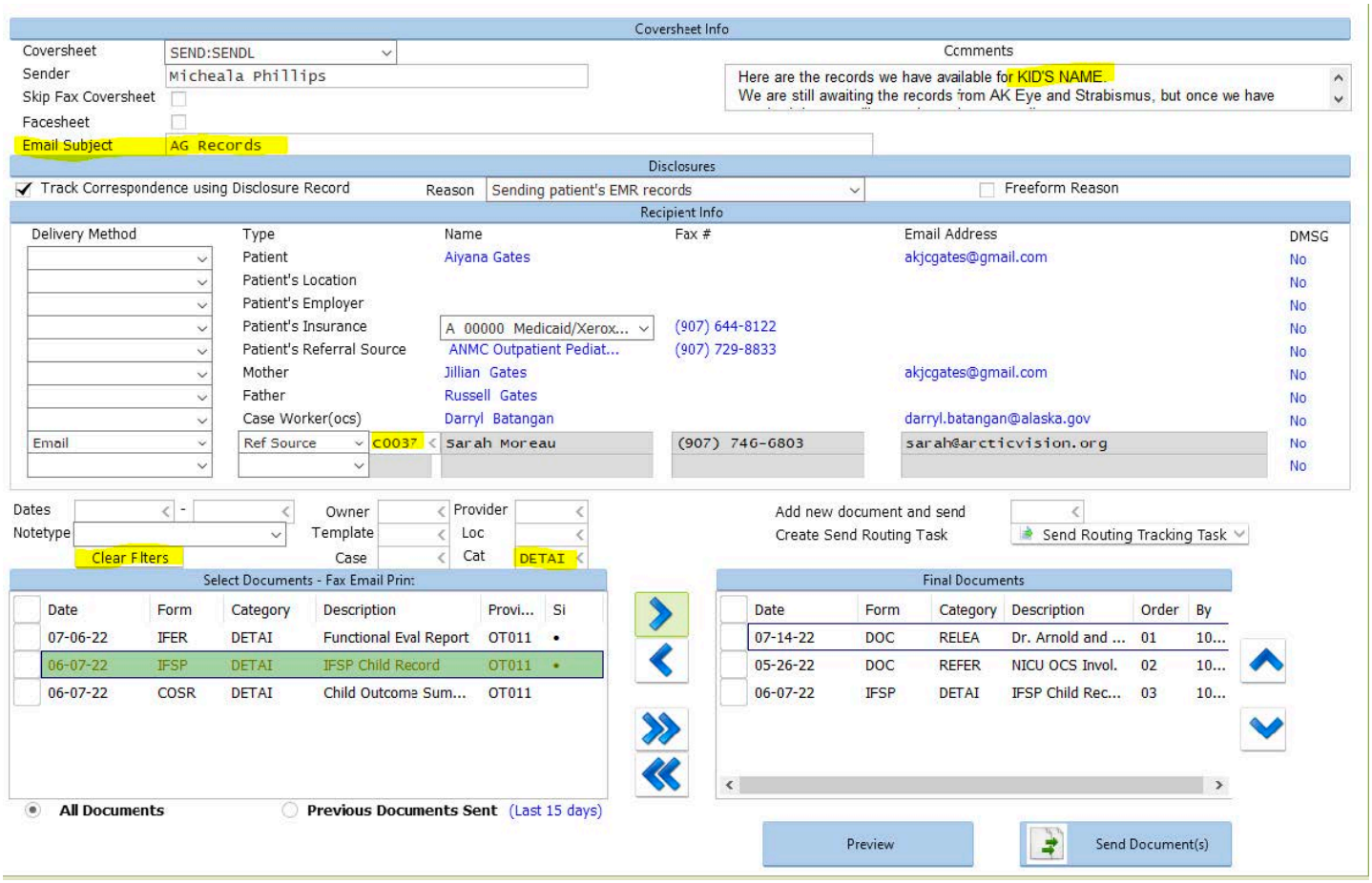
    4. Functional Vision Evaluation
    5. session notes from any previous TVI
2. Review the child's chart in RT. Start by confirming we have a signed ROI for A Shared Vision and any outside eye records needed (usually AK Children's Eye and Strabismus) by the family.
    1. If ROI is unsigned, follow up with parent to ensure we can request records/ they are onboard with TVI services.
    2. If ROIs additional vision records are signed by the family, but:
        i. unsent to outside provider, send ROI via fax and create task to follow up on status of records after 1 week.
        ii. Sent but no records have been received after 1 week, call to follow up on requested records. *Don't forget to make a comm log note/comment in existing task.
3. Check referral/medical records for any information pertaining to retinal screenings, vision, eye, etc.
4. Send records via RT email to Referral source NP037 for Paula or NP038 for Steven password to be set by each of them but will stay the same for every child with the ROI and including all available records. Remember to clear filter first to find ROI and other records, but IFSP is under VISITS Remember you have to click "Send Document(s)" rather than just F10.
    1. Be sure to include the email subject line: [kid's initials] records and the following comment (save as a sticky, but adjust as appropriate):

        Hi Paula,

        Here are the records we have available for **KID'S NAME**.

        +/- We are still awaiting the records from [AK Childrens Eye and Strabismus], but once we have received those, we'll pass them along as well.

        Please call with any questions.



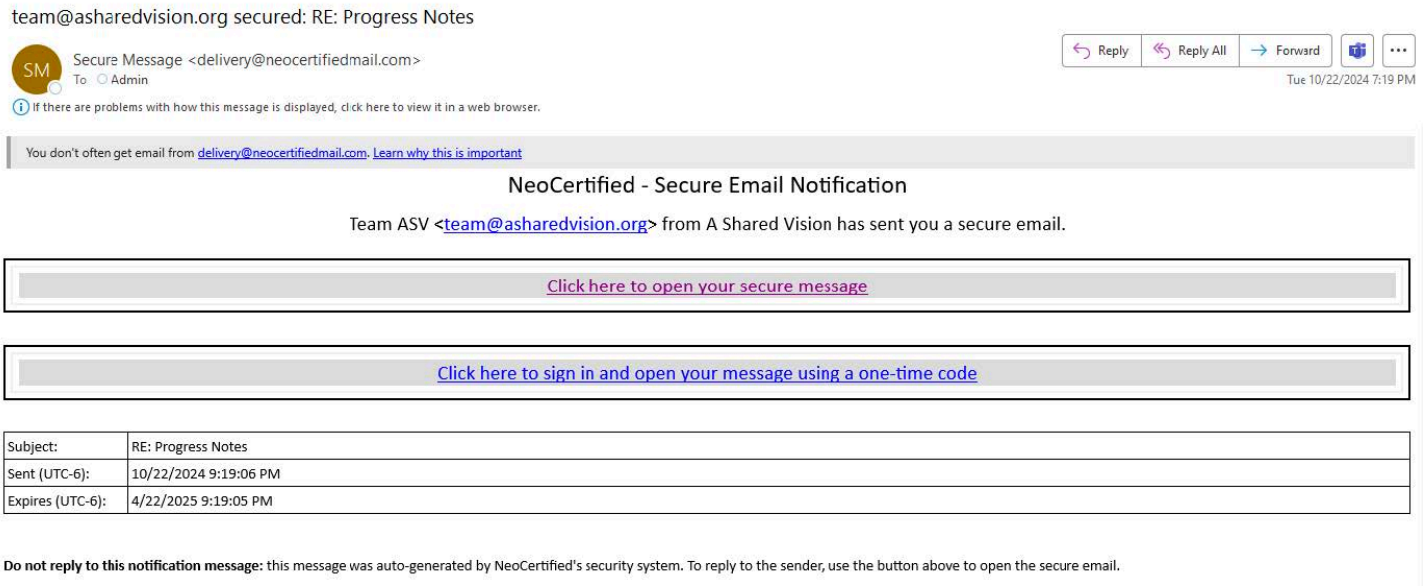
5. **Reply all to the admin email, to let them know records have been sent via RT or if we're still waiting on the ROI to send any/additional records**

If we get an IFSP with Vision Services Initiated on it (or continued) we need to send a copy to A Shared Vision every time.

This is to keep them updated on start dates and frequency.

Receiving Vision Documentation

1. Documentation is sent from team@asharedvision.org via a secured email system called “NeoCertified” that looks like this:



team@asharedvision.org secured: RE: Progress Notes

Secure Message <delivery@neocertifiedmail.com>
To Admin

Reply | Reply All | Forward

Tue 10/22/2024 7:19 PM

If there are problems with how this message is displayed, click here to view it in a web browser.

You don't often get email from delivery@neocertifiedmail.com. Learn why this is important

NeoCertified - Secure Email Notification

Team ASV <team@asharedvision.org> from A Shared Vision has sent you a secure email.

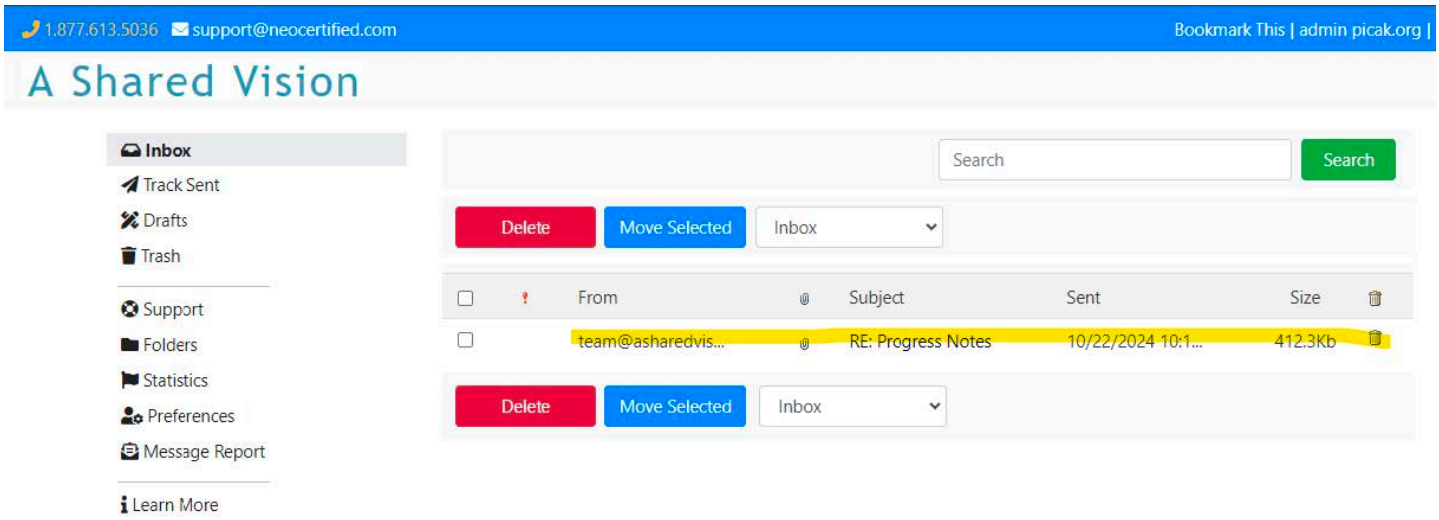
Click here to open your secure message

Click here to sign in and open your message using a one-time code

Subject:	RE: Progress Notes
Sent (UTC-6):	10/22/2024 9:19:06 PM
Expires (UTC-6):	4/22/2025 9:19:05 PM

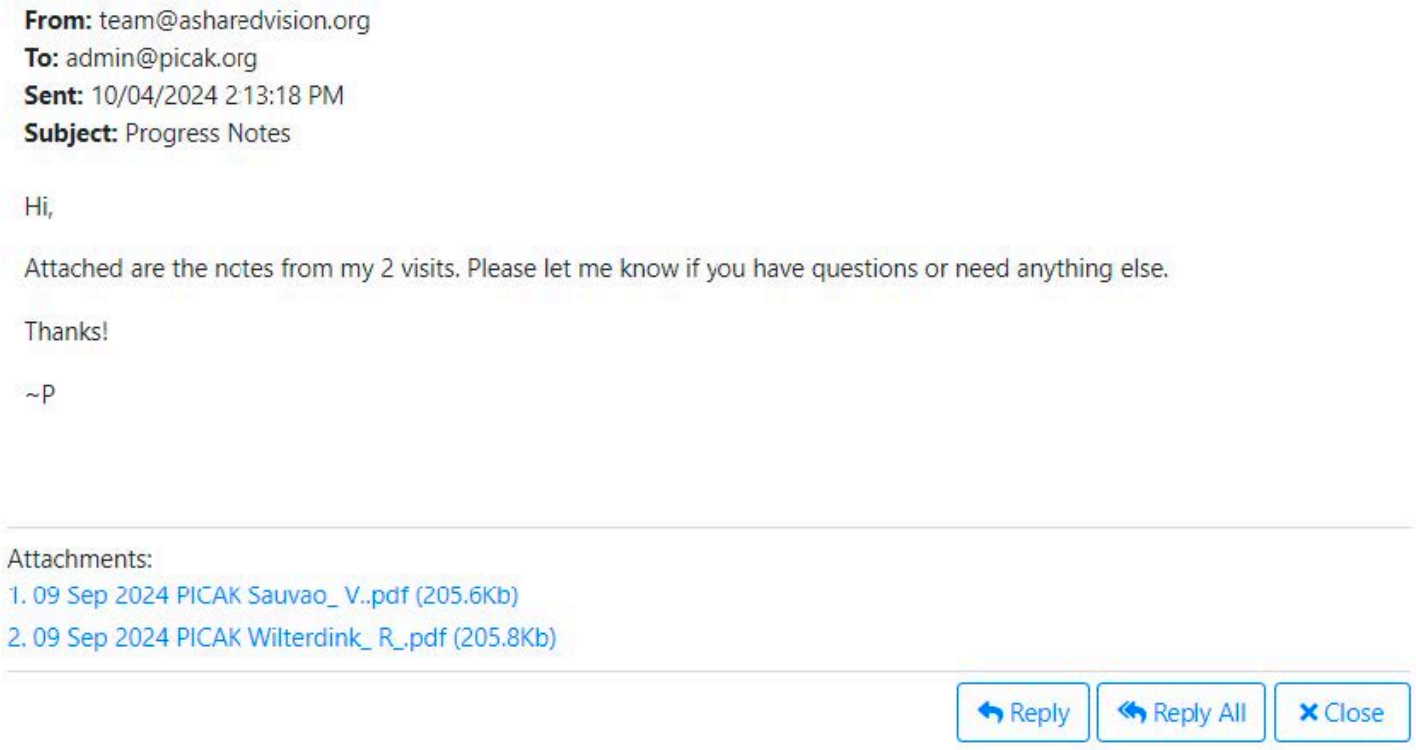
Do not reply to this notification message: this message was auto-generated by NeoCertified's security system. To reply to the sender, use the button above to open the secure email.

2. Website: https://med1.neocertifiedmail.com The username is: admin@picak.org password: r3EfOH*jluDo75qt Once logged in the inbox looks like this:



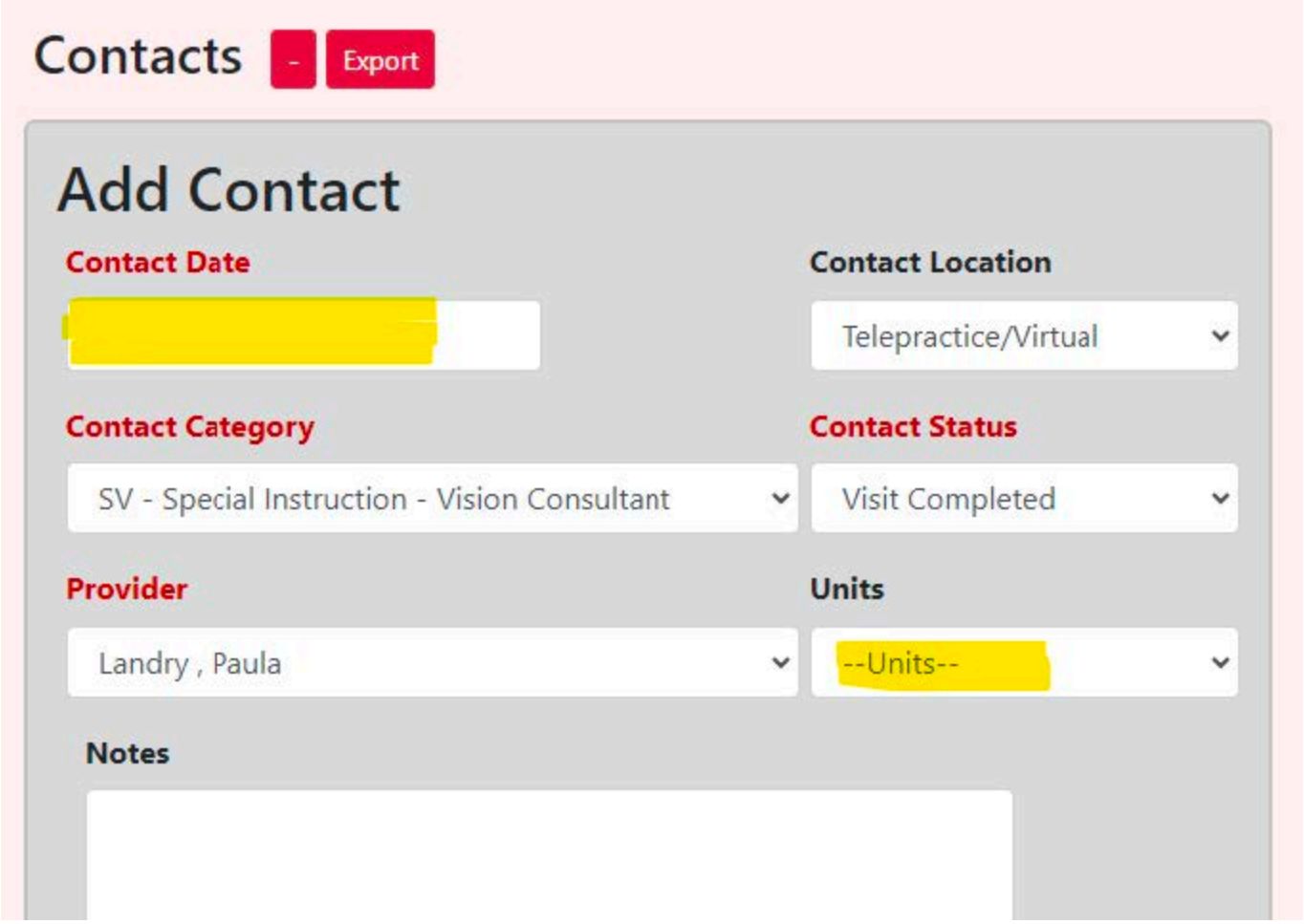
Click on the most recent email

3. Download the visit notes by clicking on the attachments at the bottom of the email



4. Upload documentation to the child's chart for the date of service, as "Outside Consultation" with freeform description "mm/dd/yy A Shared Vision Visit"
5. Send a "Medical History" task to the PIC provider, letting them know documentation has been received from A Shared Vision

6. In the State Database, go to the child's Contact tab and add a new contact as shown below with the correct Date of service as the contact date and Units (15 mins = 1 unit):



Individualized Family Service Plan (IFSP)

The Individualized Family Service Plan (IFSP) is the foundation of early intervention services. It is developed following the intake interview and the initial evaluation that determined eligibility. The IFSP outlines the child's developmental needs, the family's priorities, and the specific services and supports to be provided. It is created in collaboration with the family and guided by their goals, which are shaped by their daily routines and values. The purpose of the IFSP is to ensure that services are meaningful, coordinated, and tailored to support the child's development within the context of everyday life.

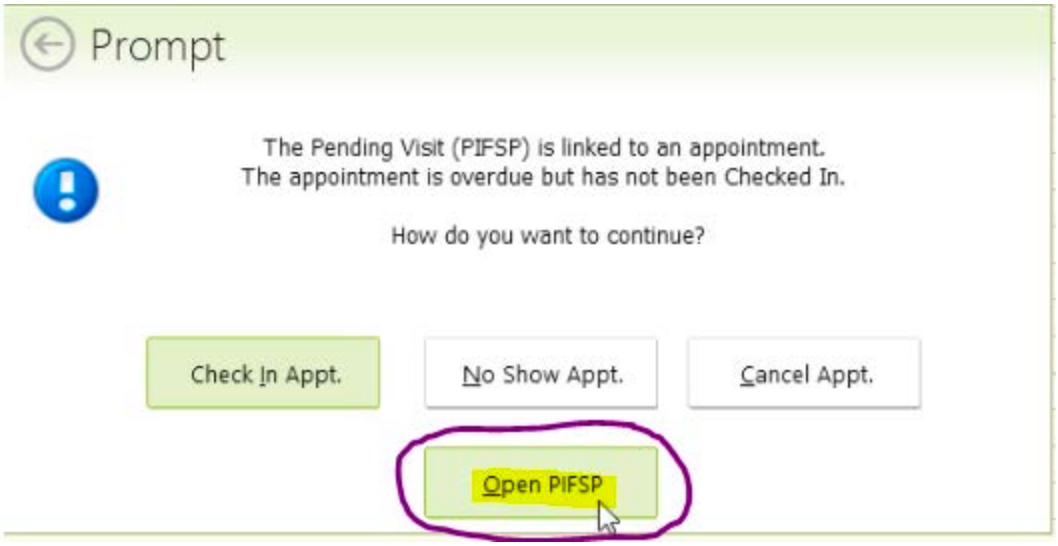
Initial IFSP - Program Procedure

Last Updated	**7/22/25**

Procedure

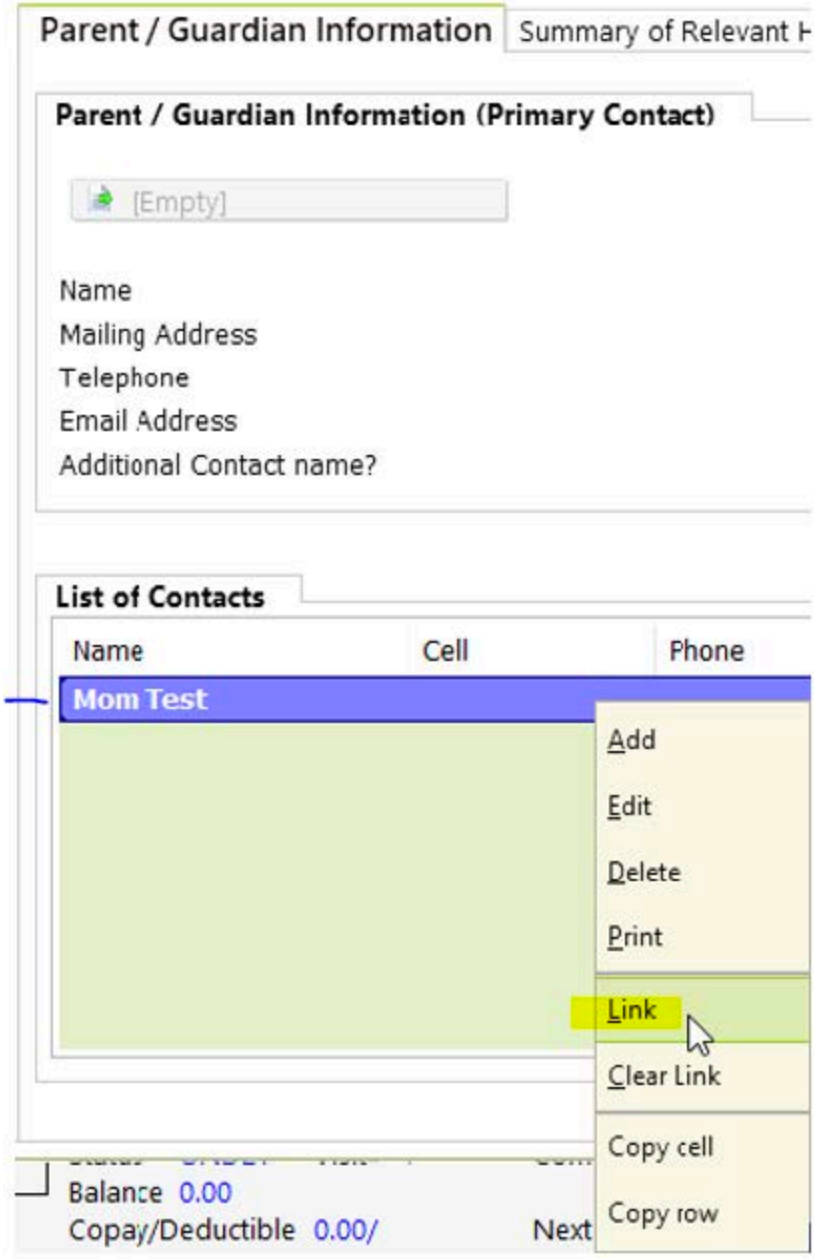
1. In the RainTree Scheduler, select "IFSP" Appointment Type and enter in the appt details.

a. If preferred, providers may start entering in IFSP information before the IFSP meeting appt, double click on the appt and select “Open PIFSP”:

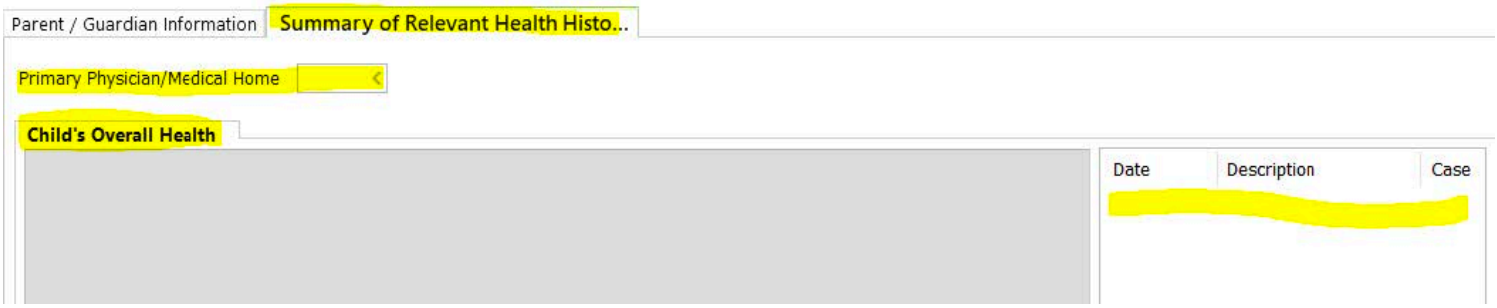


2. Select Roll Forward:

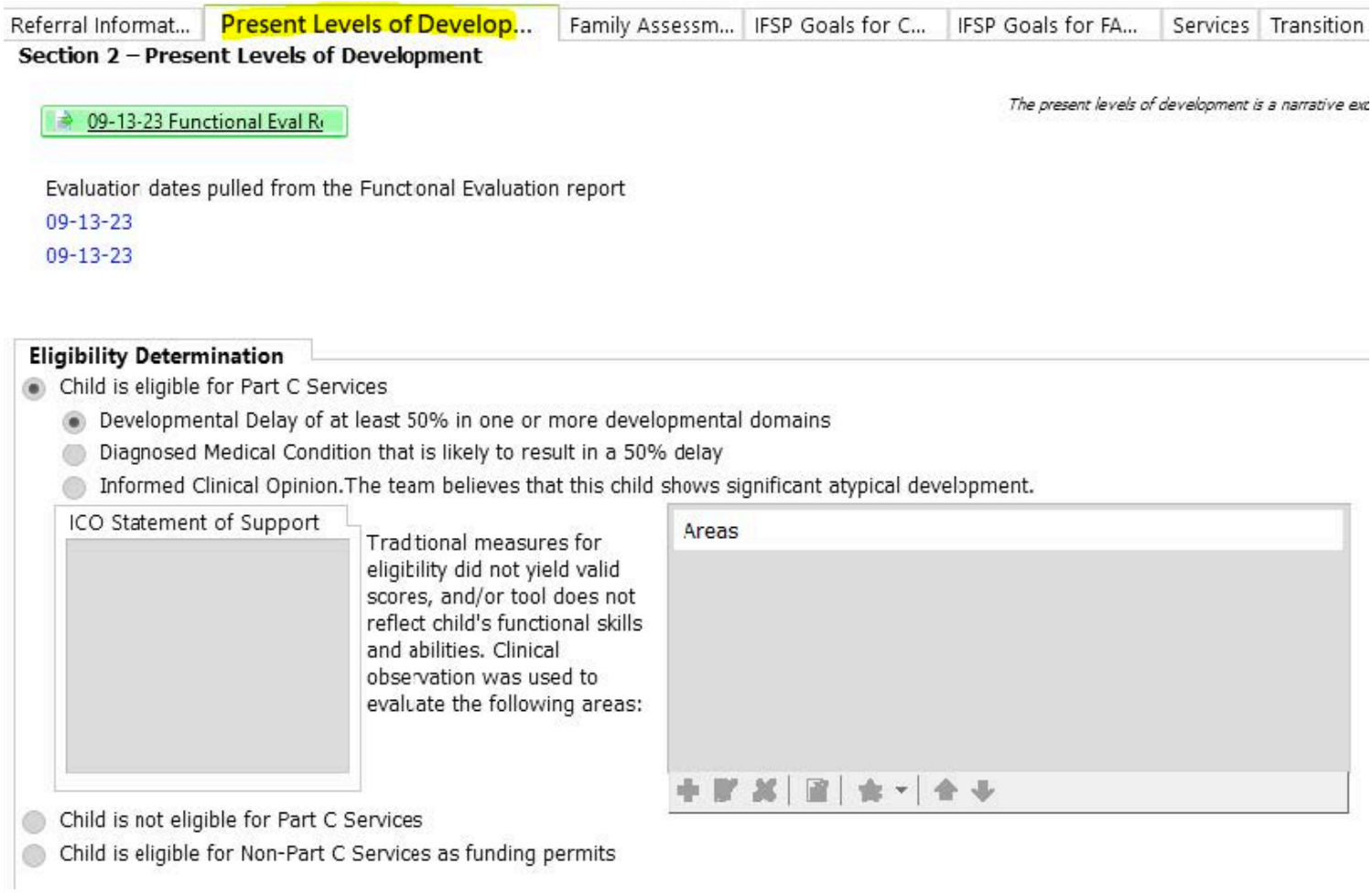
3. Start by entering information in the Referral Information tab. You will see all the Contacts for the child. To link the primary participating parent or caregiver to this IFSP, Right click on the parent and then select 'Link':



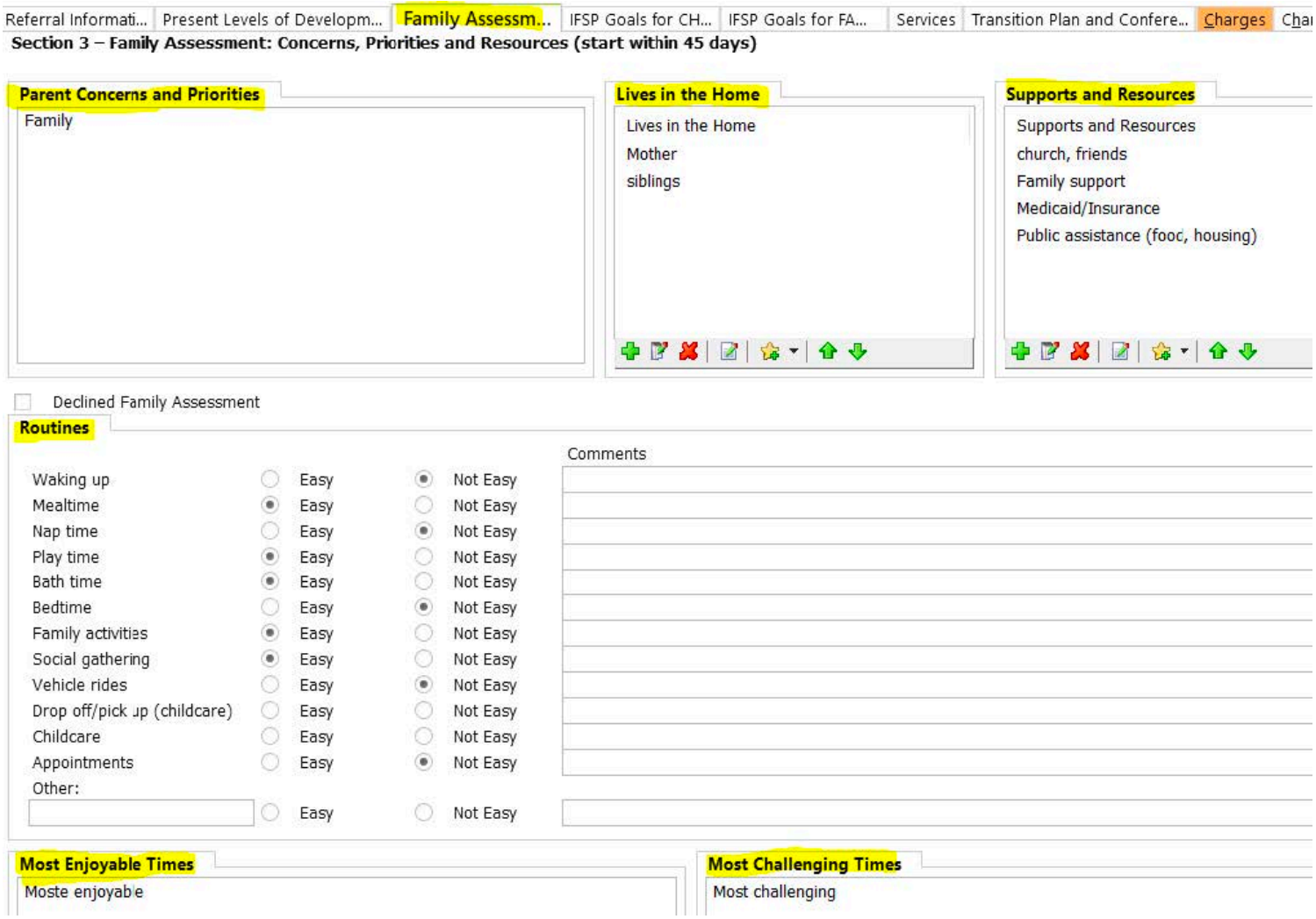
4. In the Referral tab, complete the Summary of Relevant Health History tab. Two sections need to be complete-- Child's Overall Health and Pediatric Medical Health:



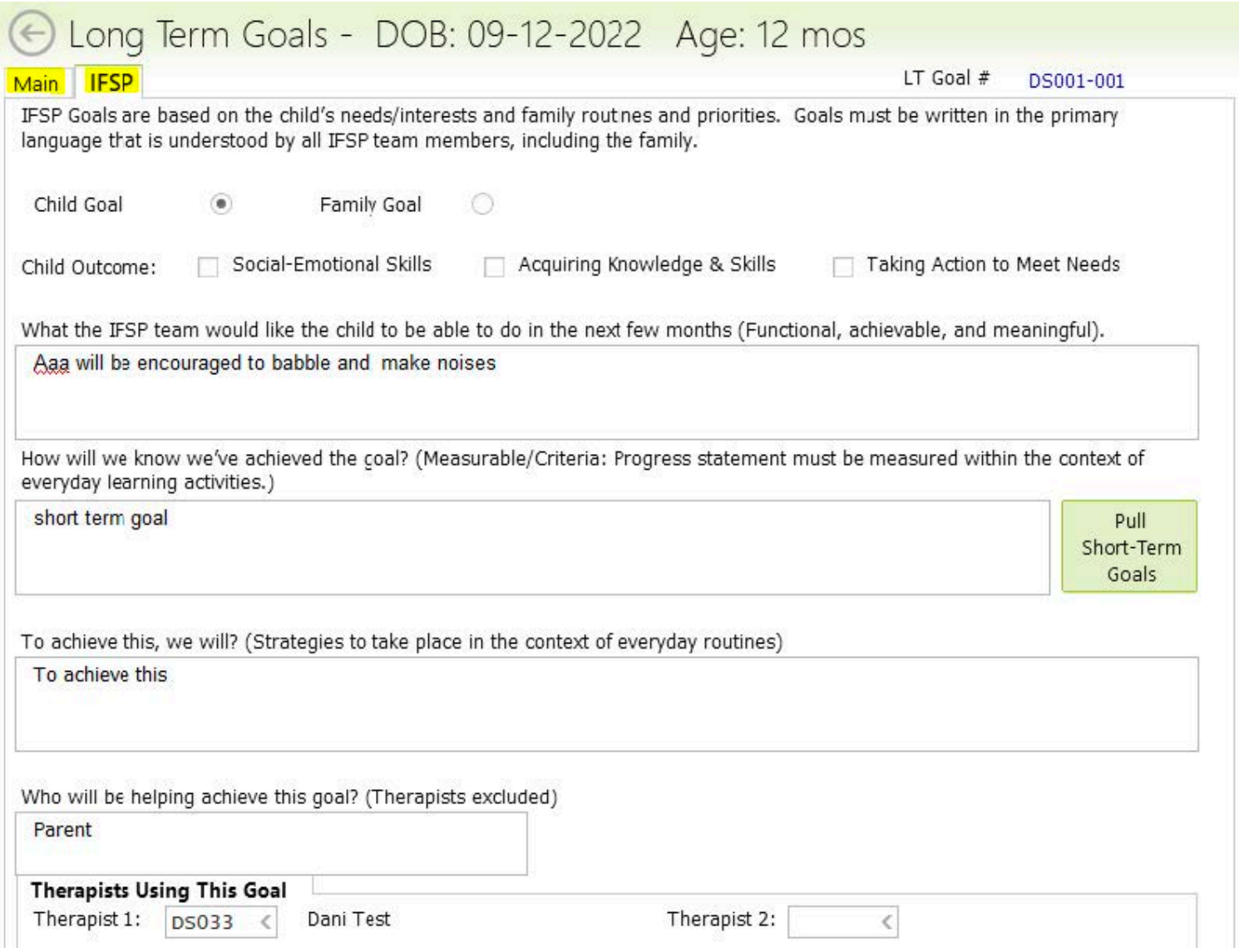
5. Review ‘Present Levels of Development’ tab, this should show all information from the most recently signed Functional Evaluation, including Eligibility Determination:



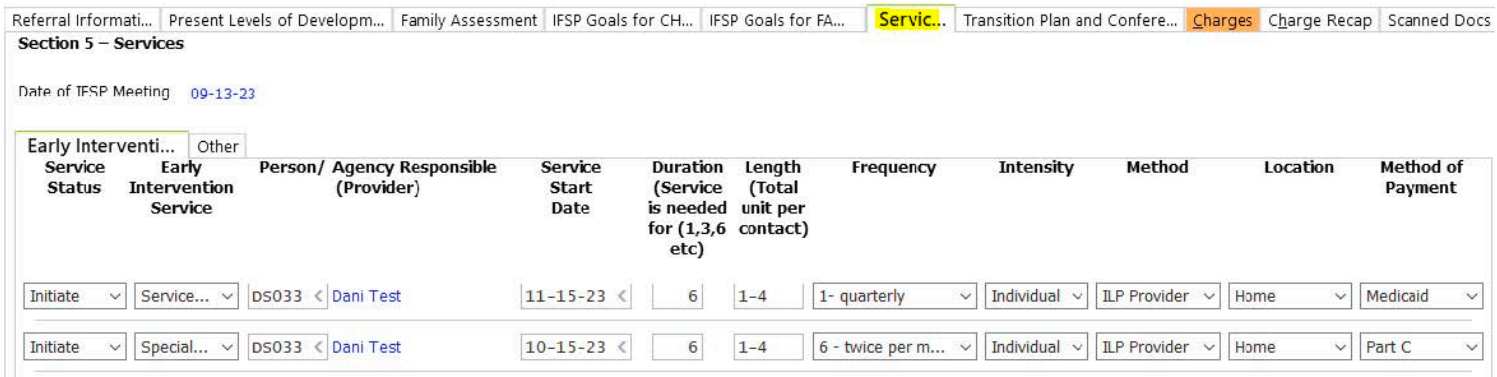
6. Review and complete the 'Family Assessment' section, information will be pulled from the most recent Intake note.



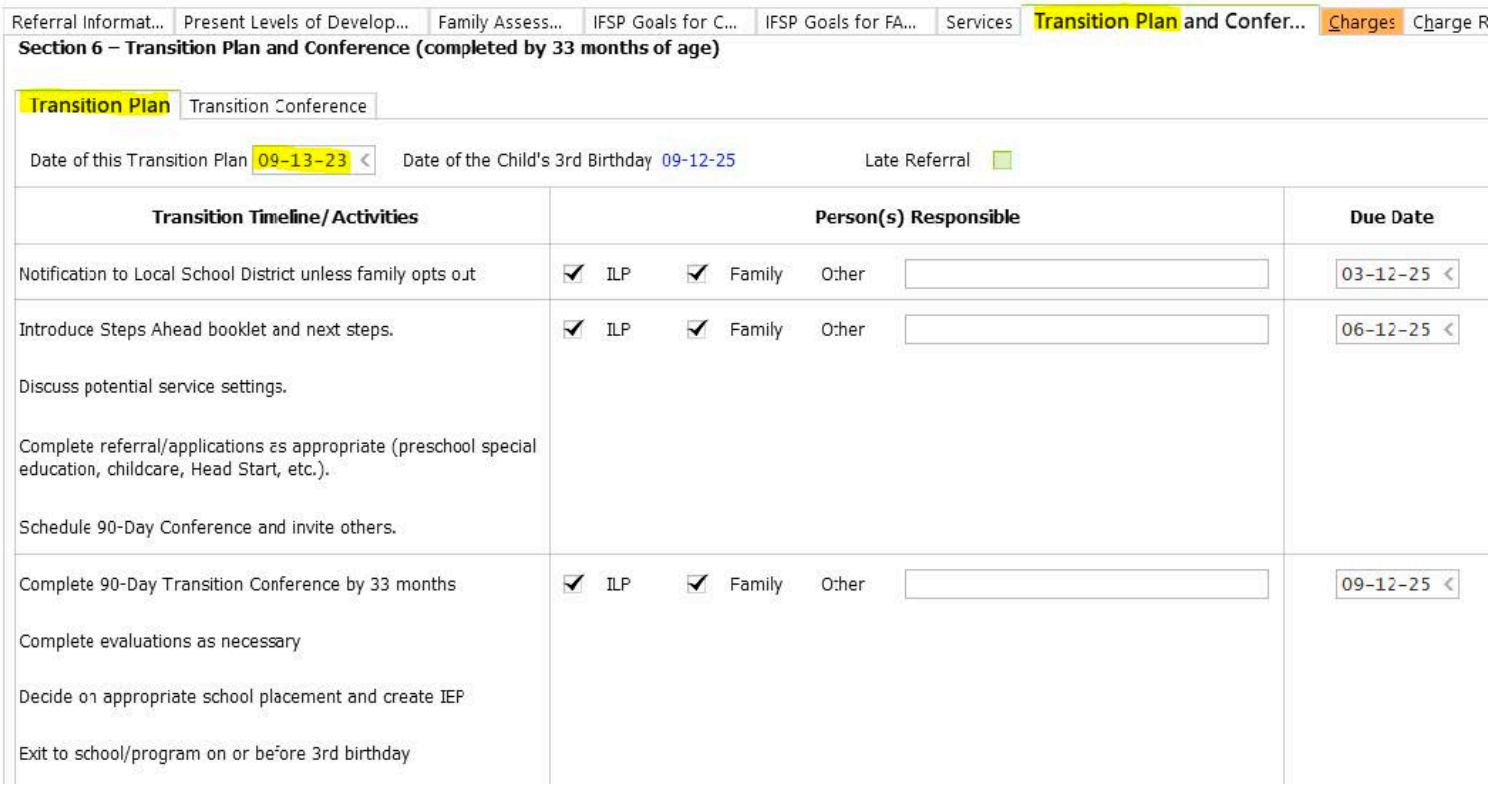
7. Start adding goals in the 'IFSP Goals for Child' tab, please note that all Long Term Goals should be added through the IFSP.



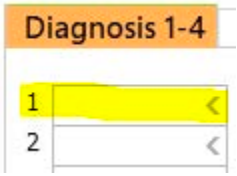
8. Enter the Services that the family will receive from PIC in the 'Services' tab.



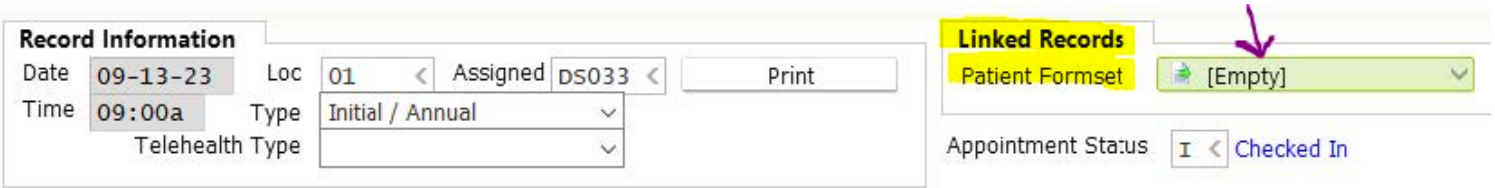
9. If the child is 30 months or older, the Transition Plan needs to be completed. Enter the Transition Plan Date in 'Transition Plan and Conference' tab. When the date of the plan is entered, all additional due dates on this page will auto populate.
   There is a separate tab for the Transition Conference, and if appropriate timing: click on the Conference tab if this also was completed.



10. **Charges tab:** enter in the IFSP begin/Time in and end/Time out clock times for IFSP Development and/or Transition Conference if completed. Diagnosis will automatically pull from the RainTree case, be sure to add to the case if you don't see a Diagnosis in the box.



11. **Linked Records – Patient Formset:** If the Signature Packet was already created and sent to the parent, click on the [Empty] bar and add the set to this IFSP. If it hasn't been sent, use the [Empty] bar to add an IFSP Packet, then f10 to save it so that it links to this IFPS:



12. When all information is entered, the family's long term goals have been written and the IFSP Packet has been linked, F10 to save and sign off the IFSP.
13. The last step that is separate from the IFPS, is to create a Plan of Care for the primary physician – all goals created in the IFSP will appear in the POC. Create and sign off the POC.

Note: Selecting a non-natural environment is rare, however, there's a section in the IFSP that is required when 'Other' is selected as the Location for services. **Non-Natural Environment Location Justification:** Note why the child is receiving services in a non-natural environment.

Date of IFSP Meeting 08-21-23

Early Interventi... | Other

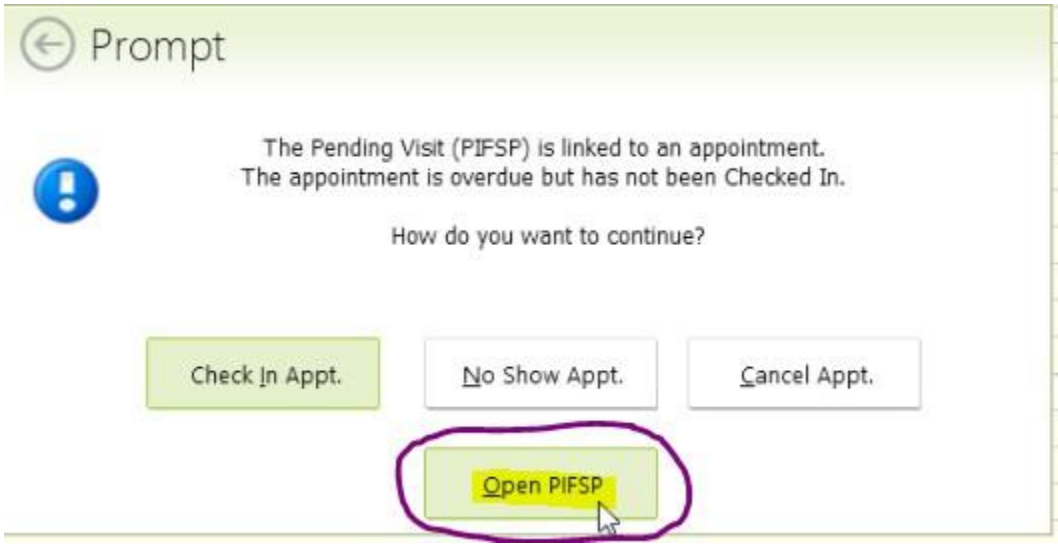
Service Status	Early Intervention Service	Person/	Agency Responsible (Provider)	Service Start Date	Duration (Service is needed for (1,3,6 etc)	Length (Total unit per contact)	Frequency	Intensity	Method	Location	Method of Payment
Initiate	Service...	10004	Julia Ramirez	10-01-23	6	1-4	3 - monthly	Individual	ILP Provider	Home	Private In...
Initiate	Special...	DS033	Dani Test	10-01-23	6	1-4	3 - monthly	Individual	ILP Provider	Home	Part C
											Other

Non-Natural Environment Justification

Updated IFSP - Program Procedure

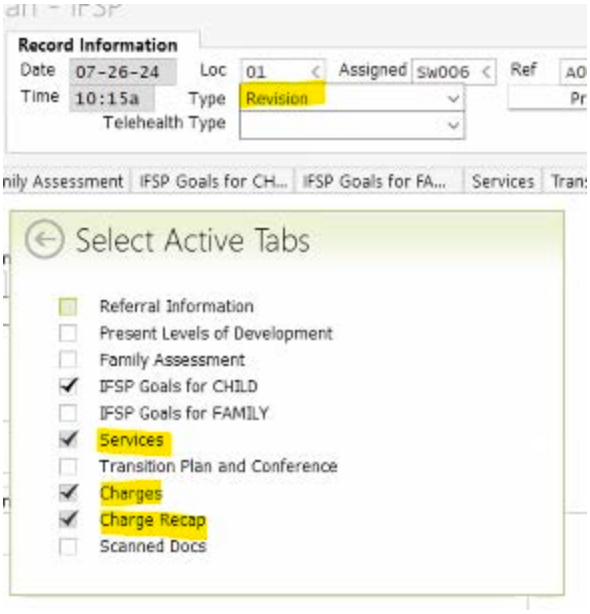
Procedure

1. In the RainTree Scheduler, select “IFSP” Appointment Type and enter in the appointment details.
   a. If entering in IFSP information before the IFSP meeting appointment, double click on the appointment and select “Open PIFSP”:

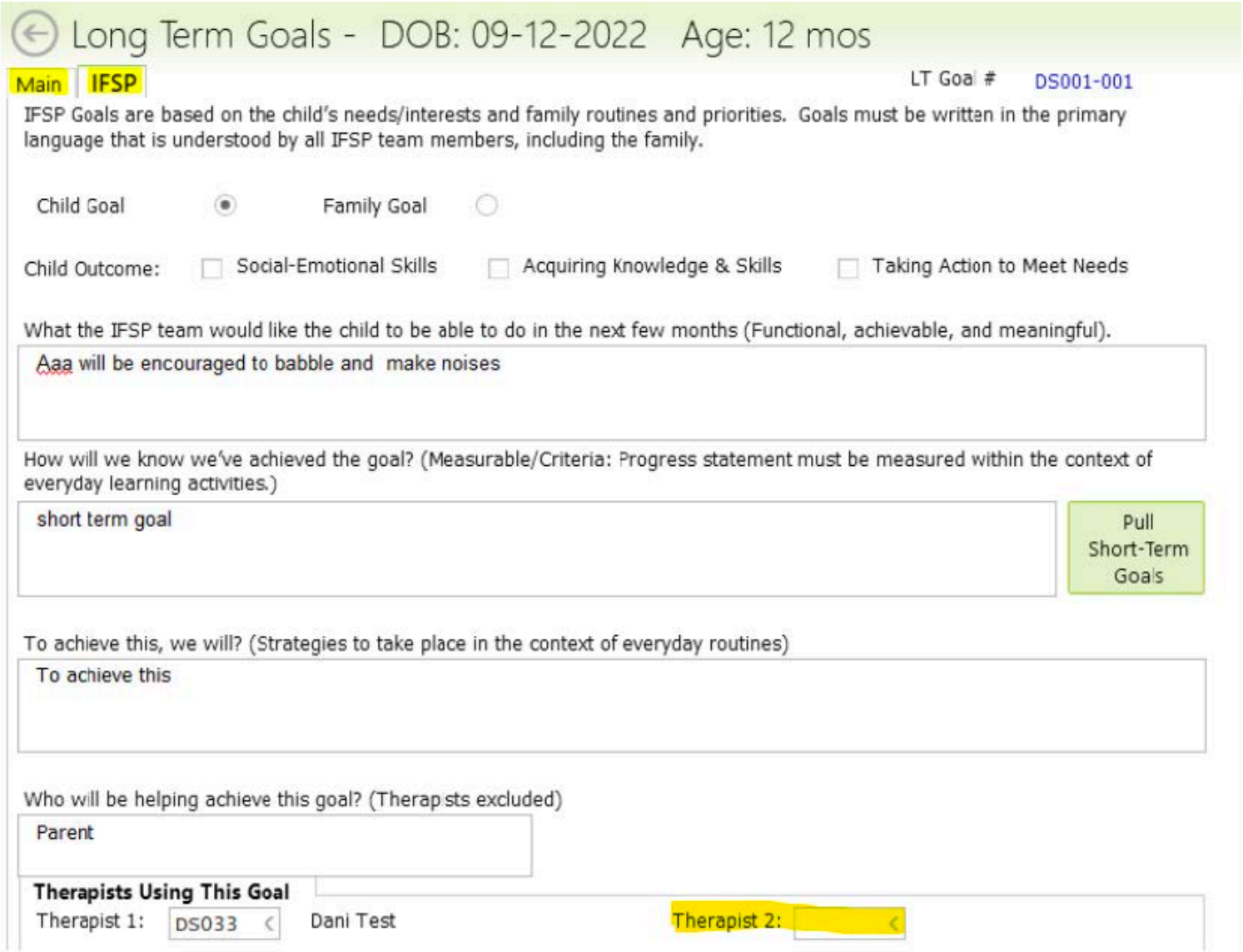


2. Select Roll Forward (keep up the habit):

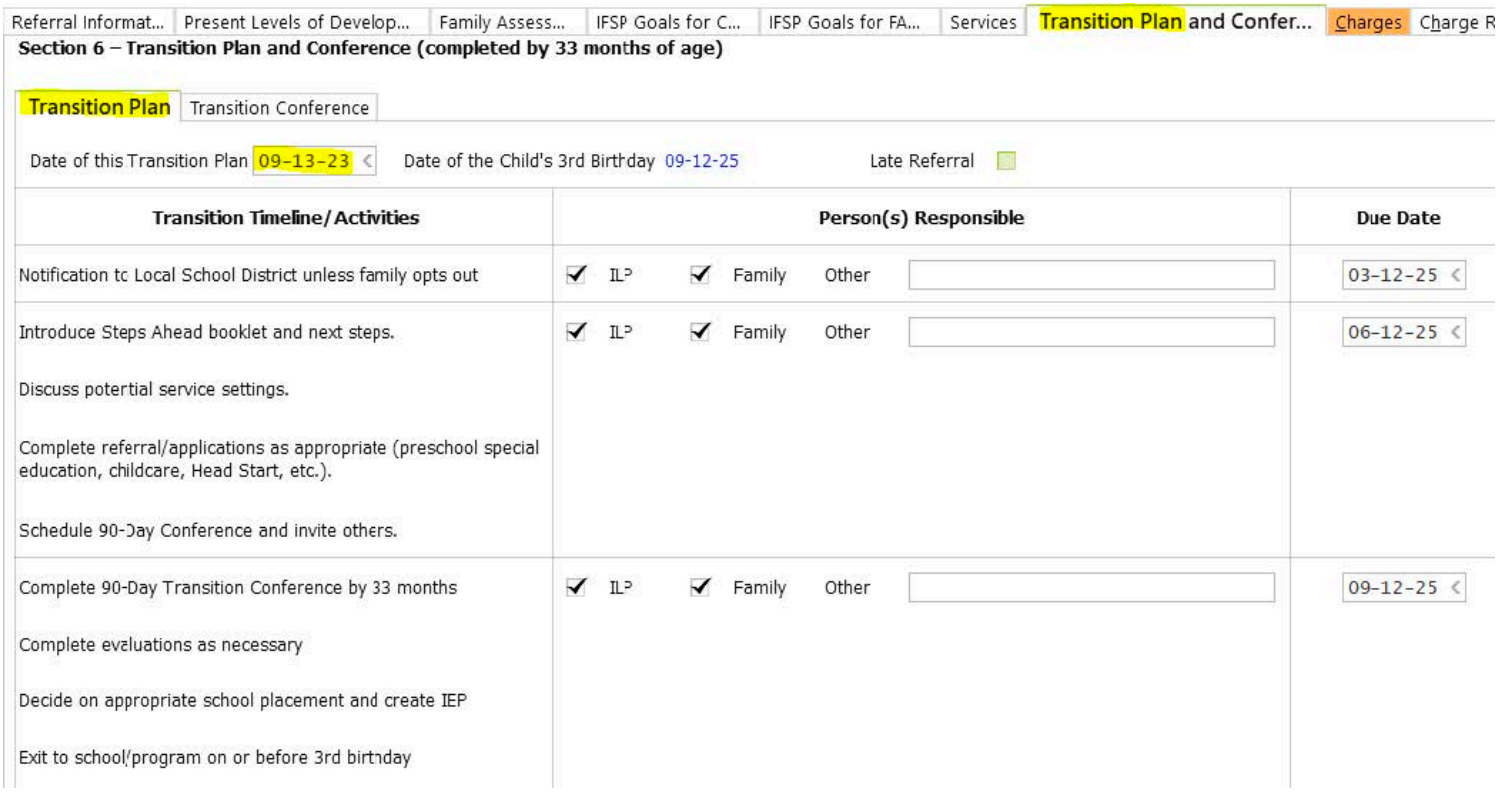
3. Select Revision and then select the appropriate tabs (required tabs are Services, Charges, and Charge Recap)



Updating Goals: select this box, when there is a need to change or update goals in the 'IFSP Goals for Child' tab. Note that all Long Term Goals are added through the IFSP. This is how providers get access to goals for their discipline specific POC. Additional therapists are added to appropriate goals as "Therapist Using This Goal" as Therapist 2

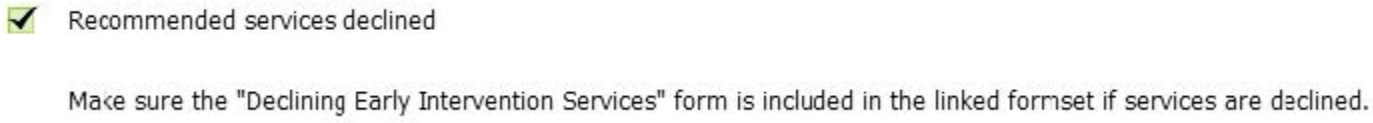


Transition Plan: select this box when this needs to be completed. Start by entering the Transition Plan Date in 'Transition Plan and Conference' tab. When the date of the plan is entered, all Due Dates will auto populate on this page. There is a separate tab for the Transition Conference: click on the Conference tab if this also was completed with the family.



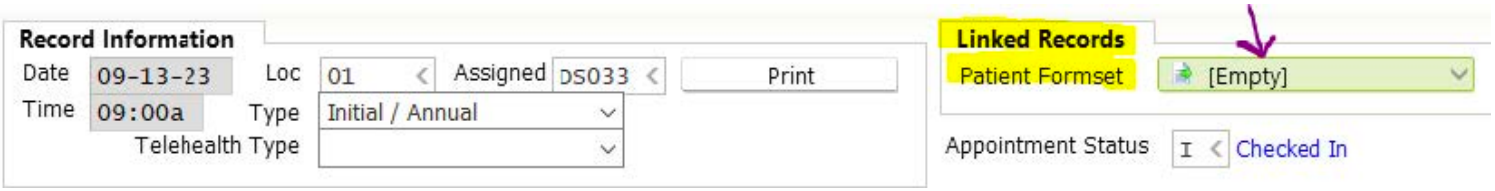
Update the frequency of service: In the 'Services' tab, if a service has already been added to the IFSP remember to update the status to "Continued." This is also where you would "Discontinue" a service.

4. **Discontinuation of Services**: Services should be discontinued when a child has met their goals or when the service is no longer deemed relevant to their needs, or the parent declines the specific service. The provider should formally indicate that the service has been discontinued in the service summary tab.
   - **Parental Request to Discontinue Services**: If a parent wishes to discontinue a service, the provider should acknowledge this request and mark the service as discontinued on the service summary.
   - **Continuation Recommendation**: If the service is still recommended by the provider AND the child is enrolled in services, AND the parent's request is to discontinue it, the provider should complete a "Decline Services Form" to document the recommendation and the parent's decision.



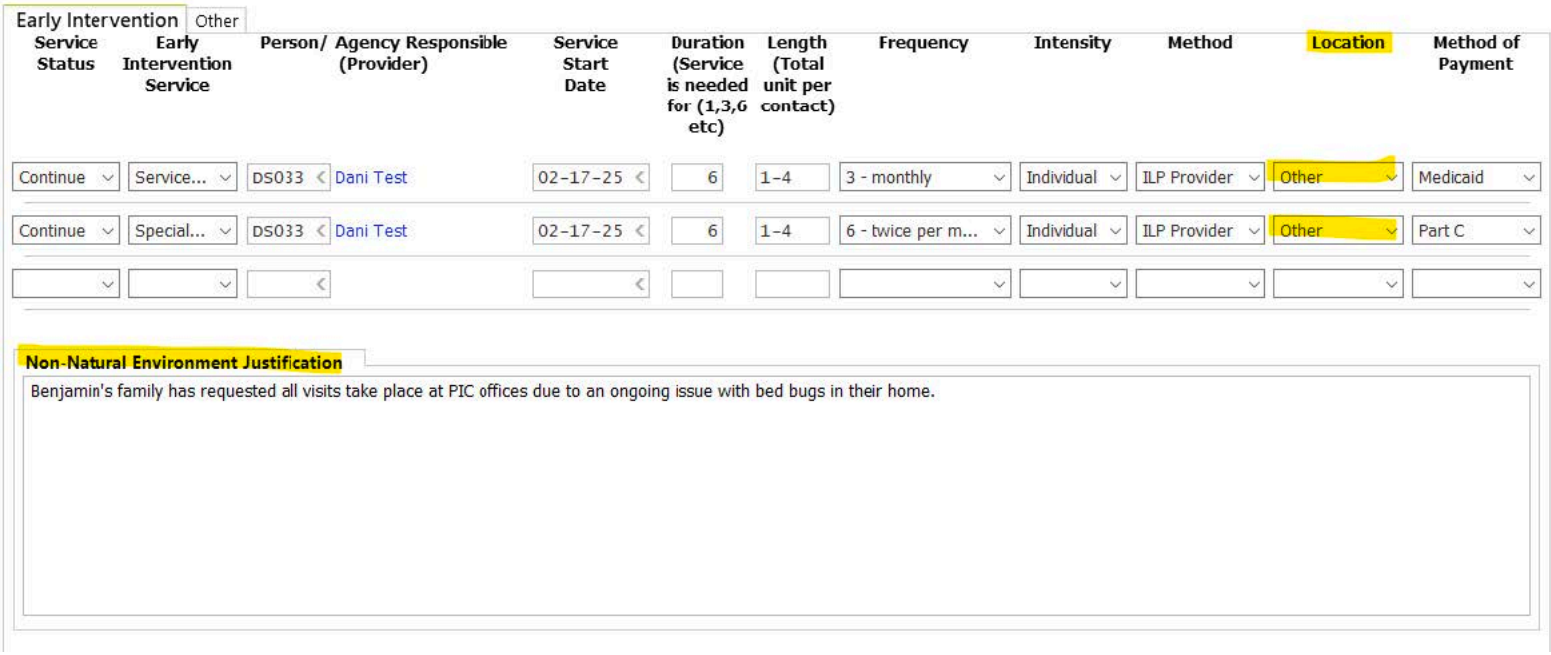
5. **Charges tab:** enter in the IFSP begin/Time in and end/Time out clock times for IFSP Development and/or Transition Conference if completed. Diagnosis will automatically pull from your RainTree Case, be sure to add to your case if you don't see a Diagnosis.

6. **Linked Records – Patient Form set:** If you already created and sent the IFSP Packet to the parent, click on the (Empty) bar and add them to this IFSP. If you haven't sent this, use the Empty bar to add a IFSP Packet, then save it so that it Links to this IFPS:



7. When all information is entered in, link the IFSP Packet and F10 to save and sign off the IFSP.
8. The last step that is separate from the IFSP, is to create a Plan of Care for the primary physician – all goals you create in the IFSP will appear in your POC. Create and sign off the POC.

Note: Selecting a non-natural environment is usually rare, however there is a section in the IFSP that is required when 'Other' is selected as the Location for services. **Non-Natural Environment Location Justification:** Note why the child is receiving services in a non-natural environment.

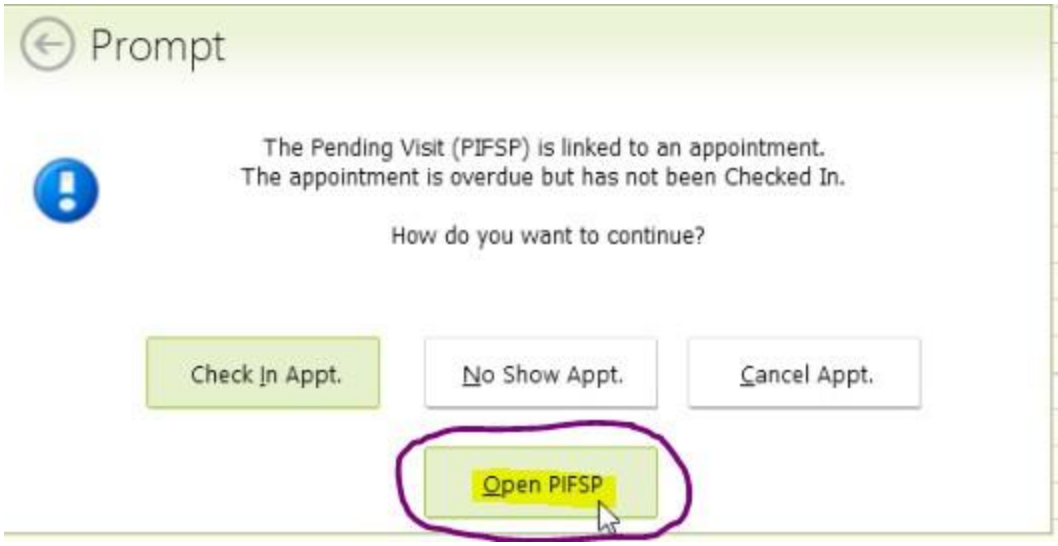


Annual IFSP - Program Procedure

Procedure

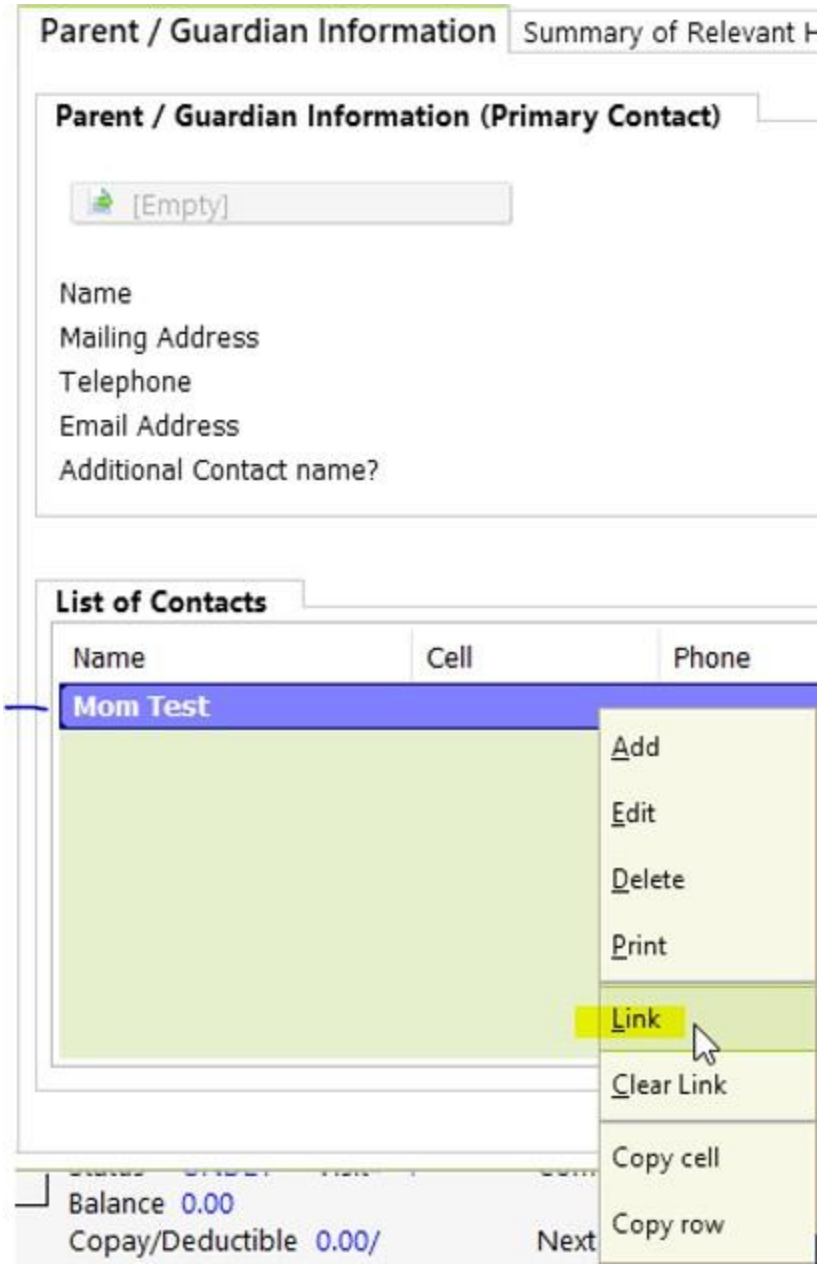
1. In the RainTree Scheduler, select "IFSP" Appointment Type and enter in the appointment details.

a. If entering in IFSP information before the IFSP meeting appointment, double click on the appointment and select “Open PIFSP”:

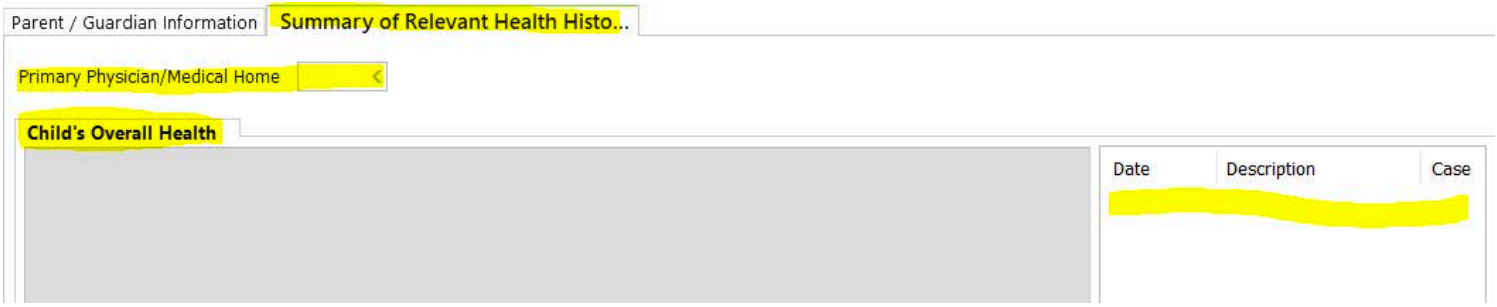


2. Select Roll Forward (keep up the habit):

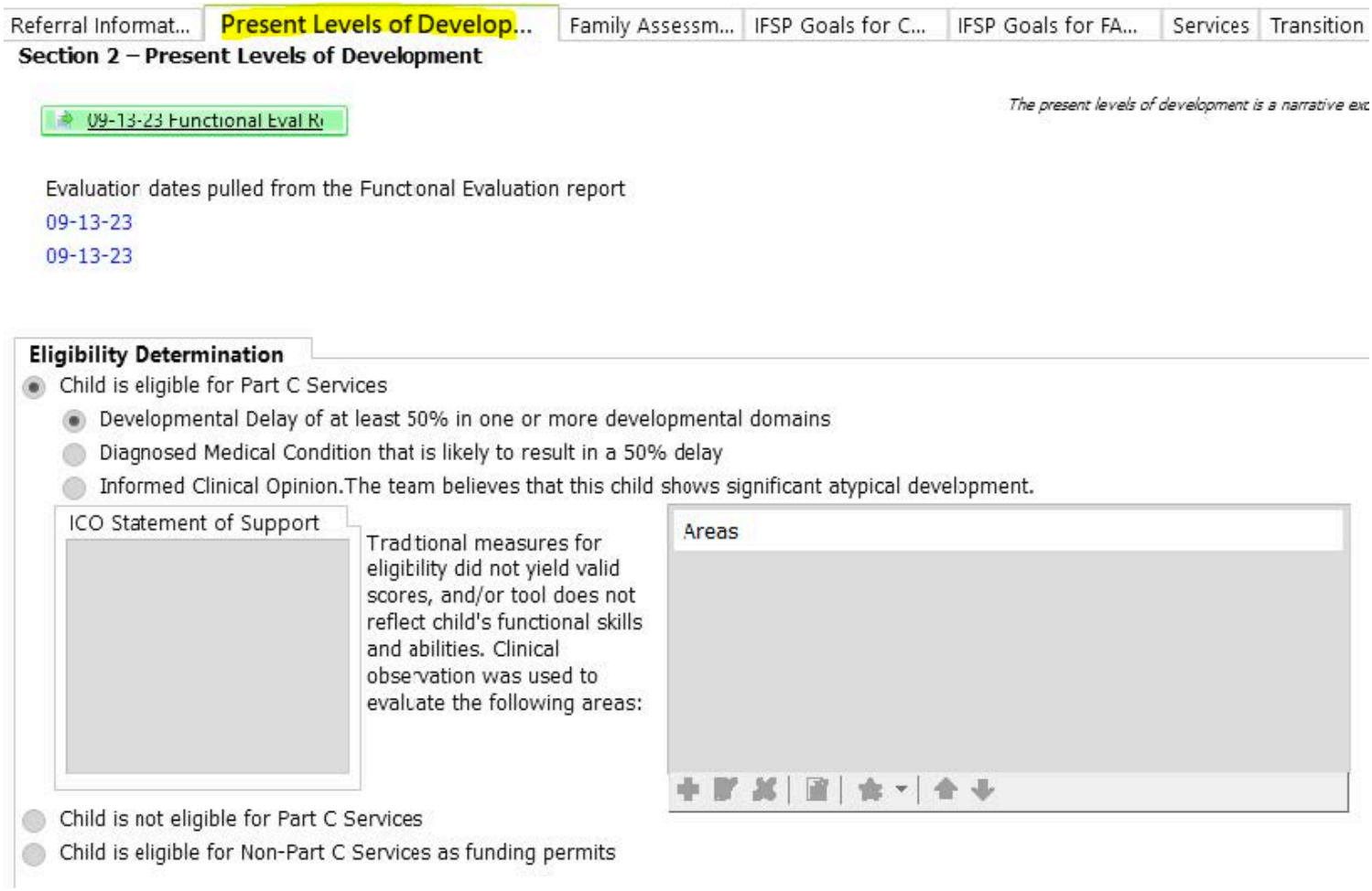
3. Start by entering information in the Referral Information tab. Look to the Contacts for the child. To link the primary participating parent or caregiver to this IFSP, Right click on the parent and then select 'Link':



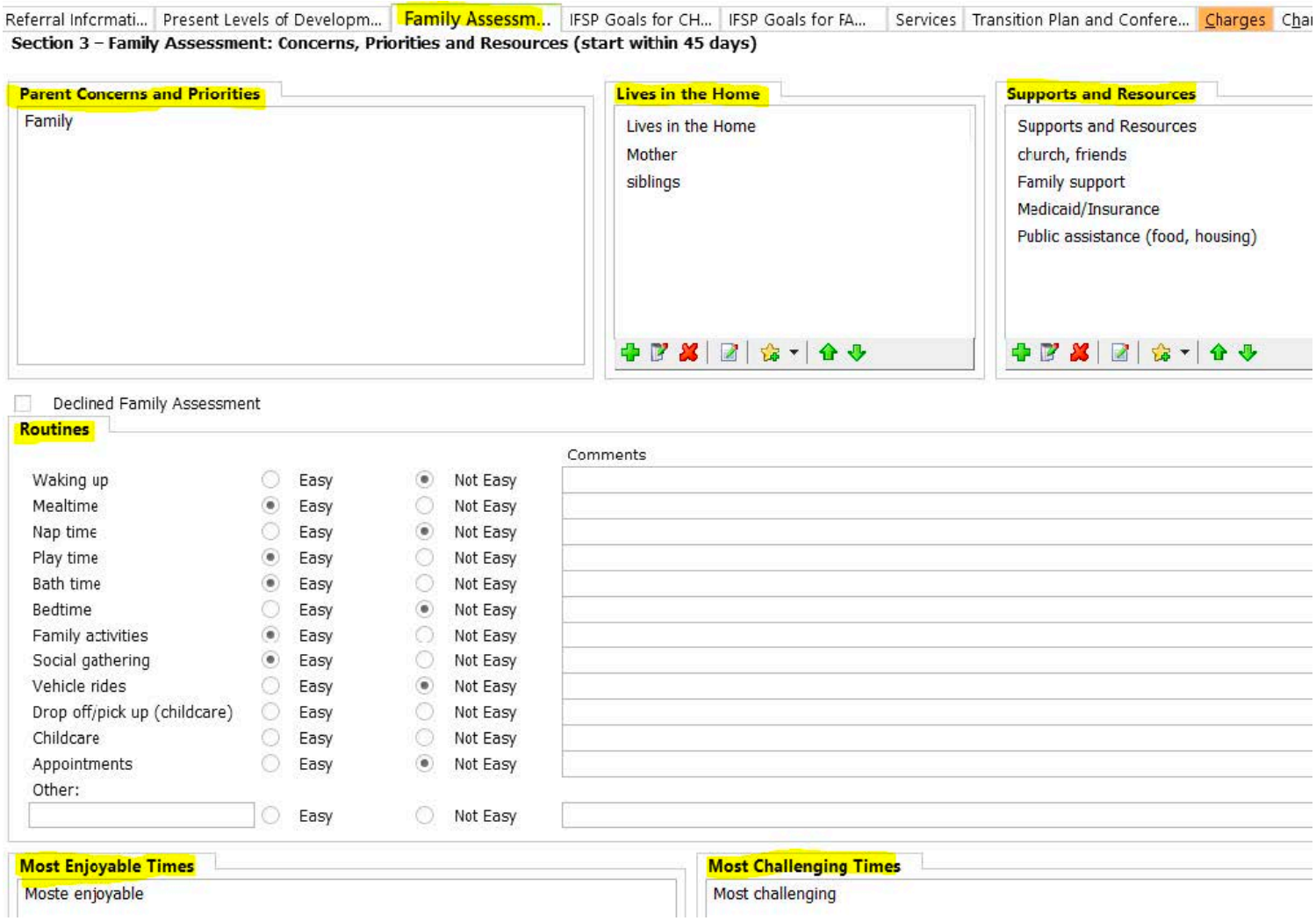
4. In the Referral tab, complete the Summary of Relevant Health History tab. Two sections need to be complete-- Child's Overall Health and Pediatric Medical Health:



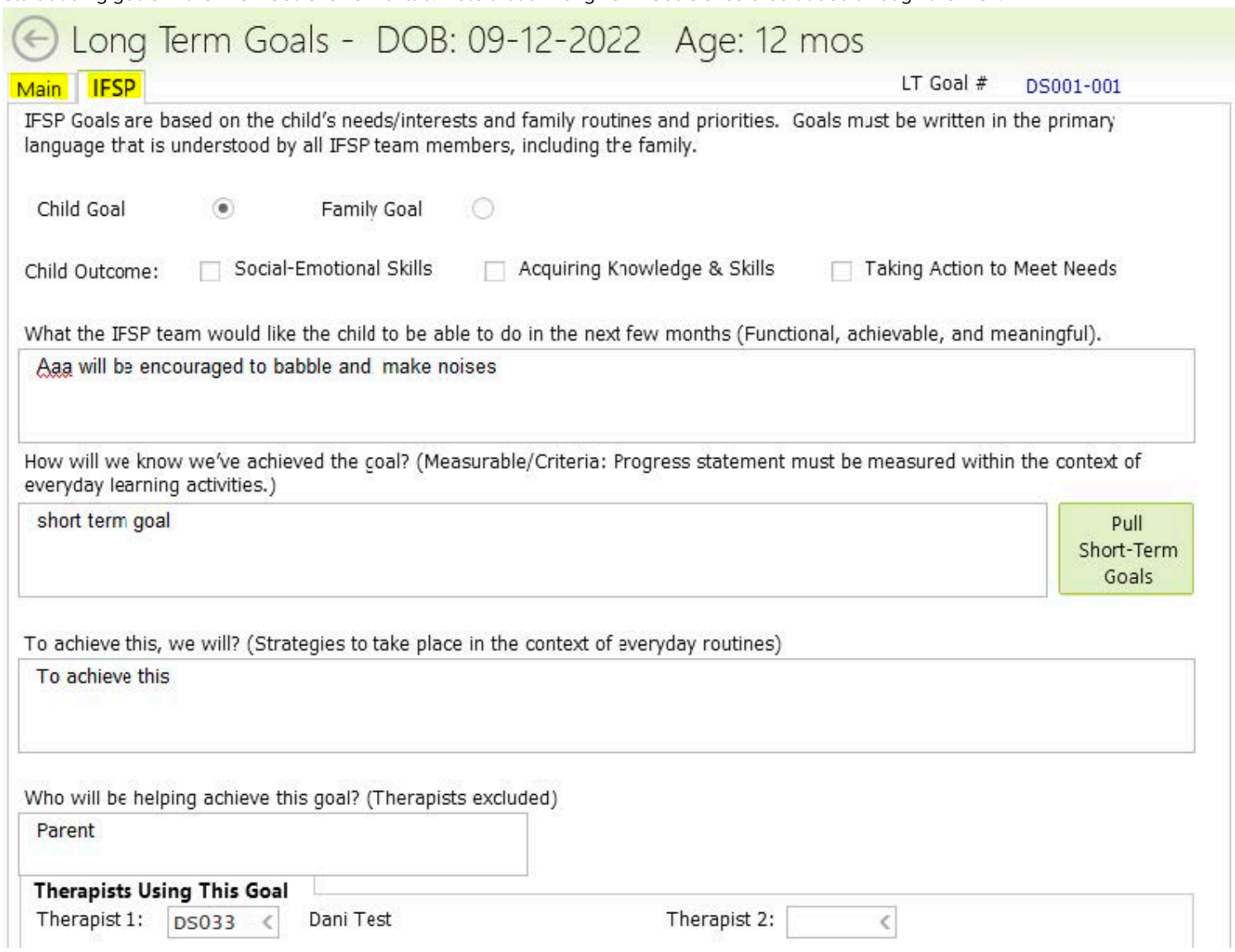
5. Review ‘Present Levels of Development’ tab, this should show all information from the most recently signed Functional Evaluation, including Eligibility Determination:



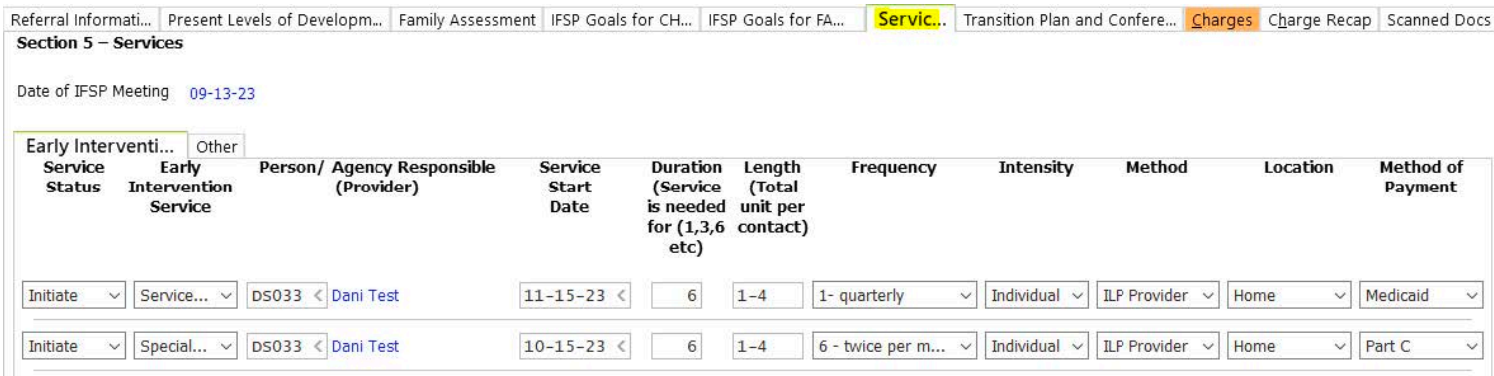
6. Review and complete the 'Family Assessment' section, information will be pulled from the most recently signed Intake note.



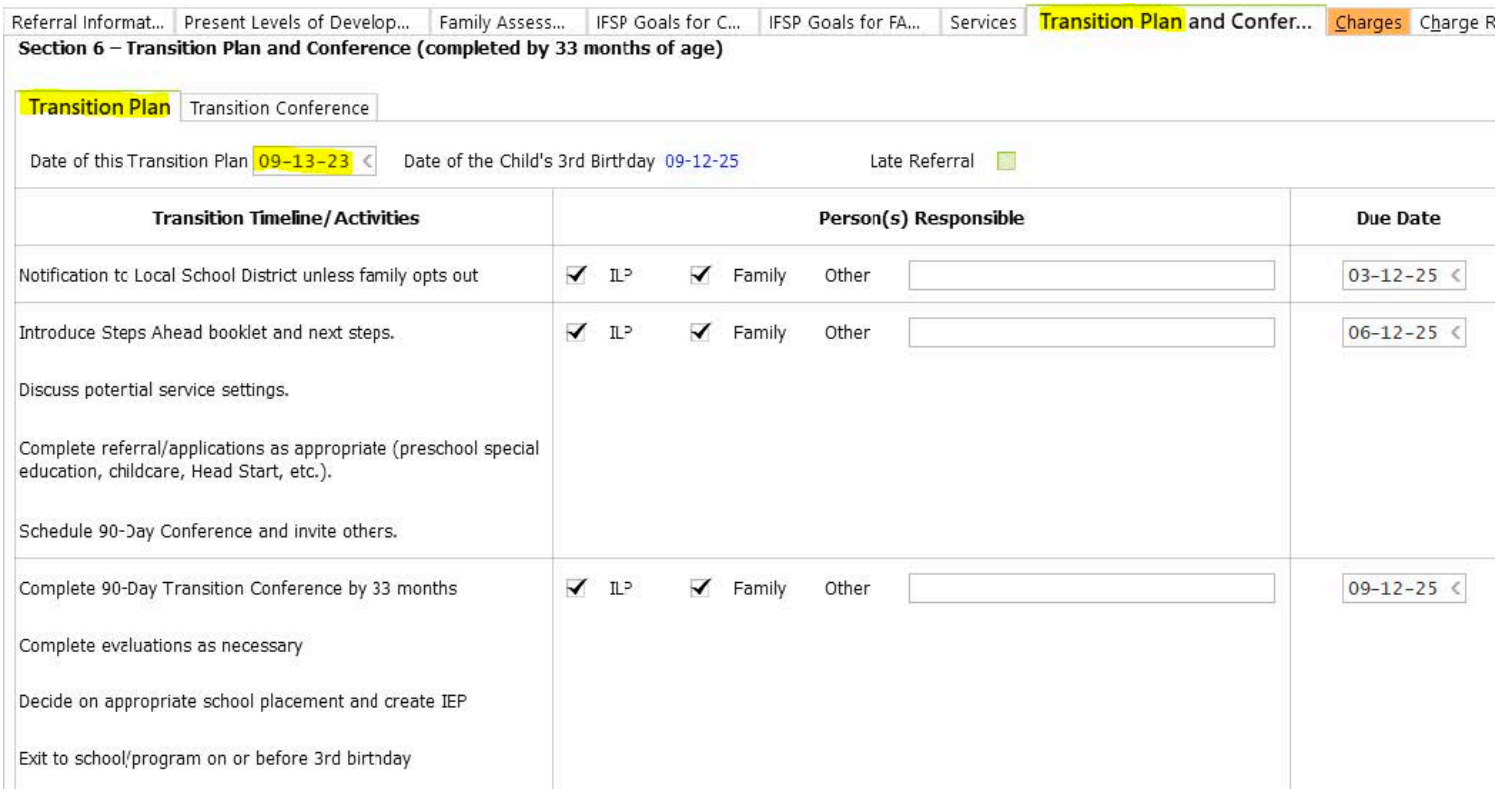
7. Start adding goals in the 'IFSP Goals for Child' tab. Note that all Long Term Goals should be added through the IFSP.



8. Enter the Services that the family will receive from PIC in the 'Services' tab.

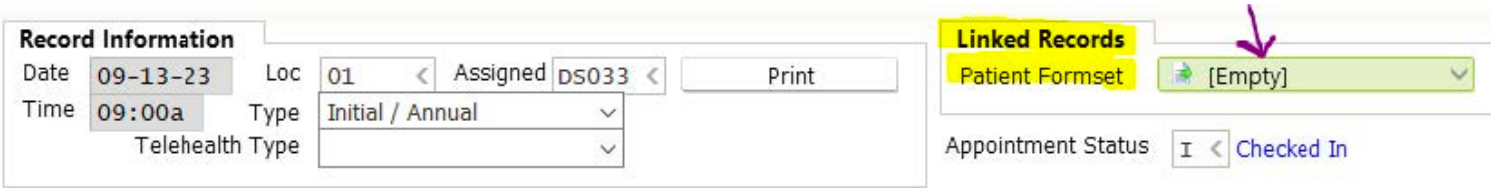


9. If the child is 30 months or older, the Transition Plan needs to be completed. Enter the Transition Plan Date in 'Transition Plan and Conference' tab. When the date of the plan is entered, all additional due dates on this page will auto populate.
   There is a separate tab for the Transition Conference, and if appropriate timing: click on the Conference tab if this also was completed.



10. **Charges tab:** enter in the IFSP begin/Time in and end/Time out clock times for IFSP Development and/or Transition Conference if completed. Diagnosis will automatically pull from your RainTree case, be sure to add to the case if you don't see a Diagnosis in the box.

11. **Linked Records – Patient Formset:** If the Signature Packet was already created and sent to the parent, click on the [Empty] bar and add the set to this IFSP. If it hasn't been sent, use the [Empty] bar to add an IFSP Packet, then f10 to save it so that it links to this IFPS:



12. When all information is entered, the family's long term goals have been written and the IFSP Packet has been linked, F10 to save and sign off the IFSP.
13. The last step that is separate from the IFPS, is to create a Plan of Care for the primary physician – all goals created in the IFSP will appear in the POC. Create and sign off the POC.

Note: Selecting a non-natural environment is rare, however, there's a section in the IFSP that is required when 'Other' is selected as the Location for services. **Non-Natural Environment Location Justification:** Note why the child is receiving services in a non-natural environment.

Early Interventi... Service Status	Other Early Intervention Service	Person/ Agency Responsible (Provider)	Service Start Date	Duration (Service is needed for (1,3,6 etc)	Length (Total unit per contact)	Frequency	Intensity	Method	location	Method of Payment
Initiate	Service...	DDD4	Julia Ramirez	1D-DI-23		1-4	3 - monthly	Individual	ILP Provider	Home	Private In,..	
Initiate	Special...	osD33	Dani Test	1D-DI-23		1-4	3 - monthly	Individual	ILP Provider	Home	Part C	
					D		1				other	
					D		1					

Non-Natura 1Environment	Justification

Transition to ASD

Part B & Part C Services

Purpose

ASD and ILP Service: How can they overlap?

Our goal is to support parents in transition and maintain compliance with Part C regulations

Scenario #1: eligibility determined but we are still going to serve prior to enrollment in school

Scenario #2: eligibility has NOT been determined prior to age 3, but is scheduled to take place

Practice

Scenario #1: For parents who would like to continue services up until child is three and have qualified for Part B services, we inform the parent that the child cannot be dually enrolled, or simultaneously enrolled in Part C and Part B services.

Scenario #2: Providers may attend an Evaluation and Eligibility Meeting/IEP Meeting after discharge. Providers may not deliver further services. If a child receives services after his/her 3rd birthday from PIC, the agency becomes responsible for their education. Child cannot be enrolled in Part B and Part C services simultaneously.

Procedure

Scenario #1: Provider will document in a daily note that “the child has qualified for Part B services, is not enrolled in ASD, and parent has requested to continue Part C services until child turns age 3.”

Scenario #2: For children with services after age three: Complete a discharge note prior to their 3rd birthday. For documentation of helping families through the ASD process there are 2 options:

1) Complete a daily note, do not bill for services after age three by indicating No Service Ticket on the RT Charges tab

OR

2) If the child’s file has already been closed out, complete a communication log note thoroughly documenting the time, location, people present, and your role/actions.

Summer Transitions

For children who have a birthday prior to May 15:
Proceed with transition as indicated. Complete all transition activities and discharge.

For children who have a birthday between May 15 and August 15:
Complete transition briefing, 90-day meeting, eval and eligibility meeting, keeping in mind that ASD is closed between
For children who are eligible for ASD services complete all transition activities up to 3rd birthday, and discharge the child on 3rd birthday. All children must be discharged by age 3.
You may attend an Evaluation and Eligibility Meeting/IEP Meeting after discharge. You may not deliver further services. If a child receives services after his/her 3rd birthday from PIC, the agency becomes responsible for their education. Child cannot be enrolled in Part B and Part C services simultaneously.

For children who are ineligible for ASD services. Complete all transition activities as planned

ASD Opt Out

Purpose
LEA Notification at 30 months AND after 30 months

Parents of children who are potentially eligible for Part B services are informed that IDEA allows disclosure minimal personally identifiable information at child's age 30 months to the Local Education Agency (LEA) (Anchorage School District, Chugach School District, Lake and Penn School District) and State Education Agency (SEA). Parents may opt out of ILP notifying the LEA at any time, however, after 30 months if the family has not opted out, an automated notification will have occurred. The purpose of the disclosure is to notify the LEA and SEA of the child's potential eligibility for special education and/or related services. Minimally personally identifiable information is defined as the child's name and date of birth and parents' name, address, and telephone number. If a parent has not chosen to opt out, notification to the LEA must occur not fewer than 90 days before and up to 9 months before the child's third birthday. THE NOTIFCATION ONLY OCCURS AFTER ENROLLMENT

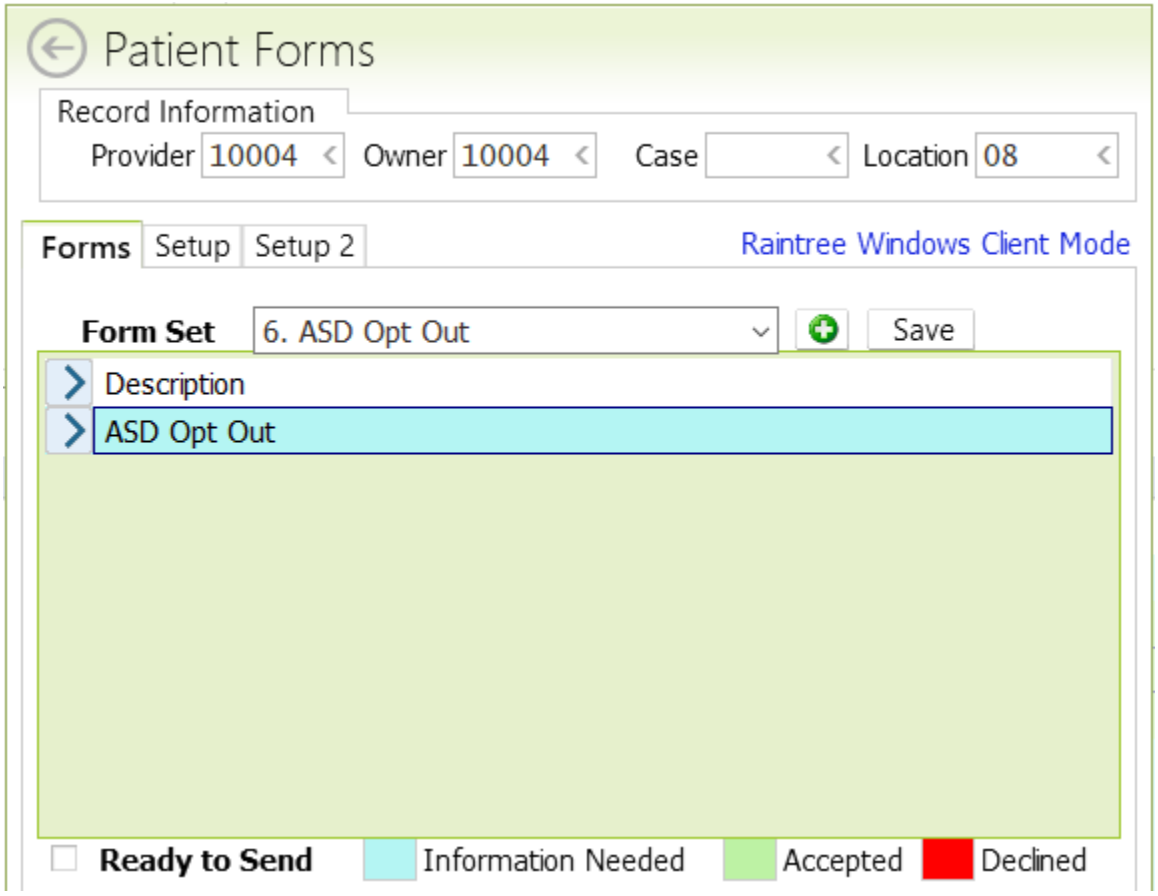
Practice
Prior to 30 months:
Every parent is informed of their right to opt out of the LEA and SEA notification.
Providers only take additional action if a family chooses not to refer their child for Part B services, the provider requests the parent complete the opt out form in RainTree.
Note: Parents may change their minds and choose to opt in to notification after 30 months. The provider will email admin@picak.org to let admin know that the family has changed their mind.

After 30 months:
When parents decline notification or further notification, the ILP will contact the LEA and notify that the parent has declined further LEA involvement.
Providers will document the date that the opt-out discussion occurred with the family in the child's RT record using the opt out form. Parents will be informed that since they did not opt out by 30 months, the ILP sent minimally personally identifiable information to the LEA.
Hot Tip: Children who are close to 33 months at the time of enrollment are at particular risk for being missing notification to the school district. A child who is referred after 33 months is in an exempt status, releasing the LEA from timeline obligations, and children are at risk of further l ate enrollment to Part B services.
Note: The date of notification of the child's potential eligibility for special education will serve as the referral date to the LEA

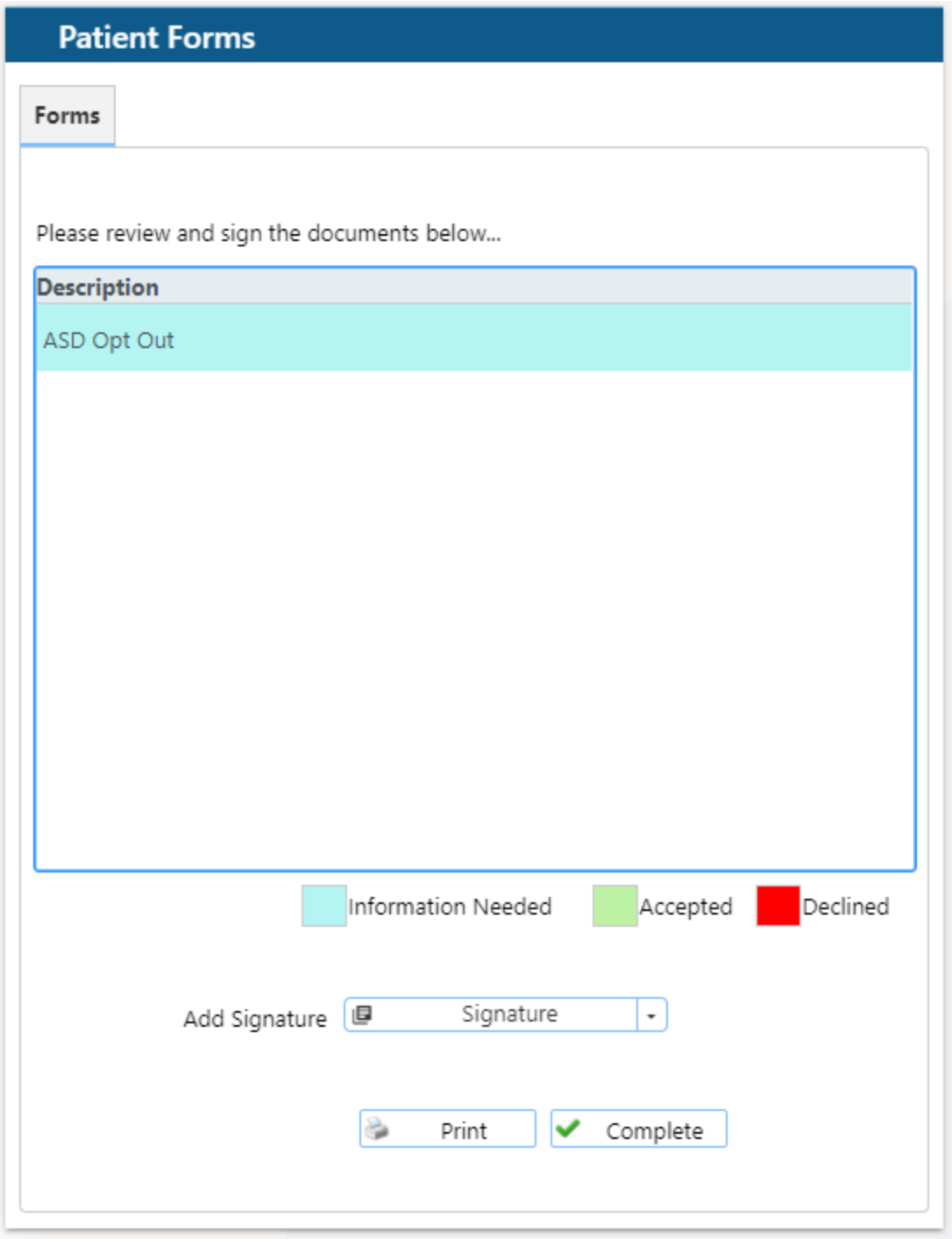
Procedure

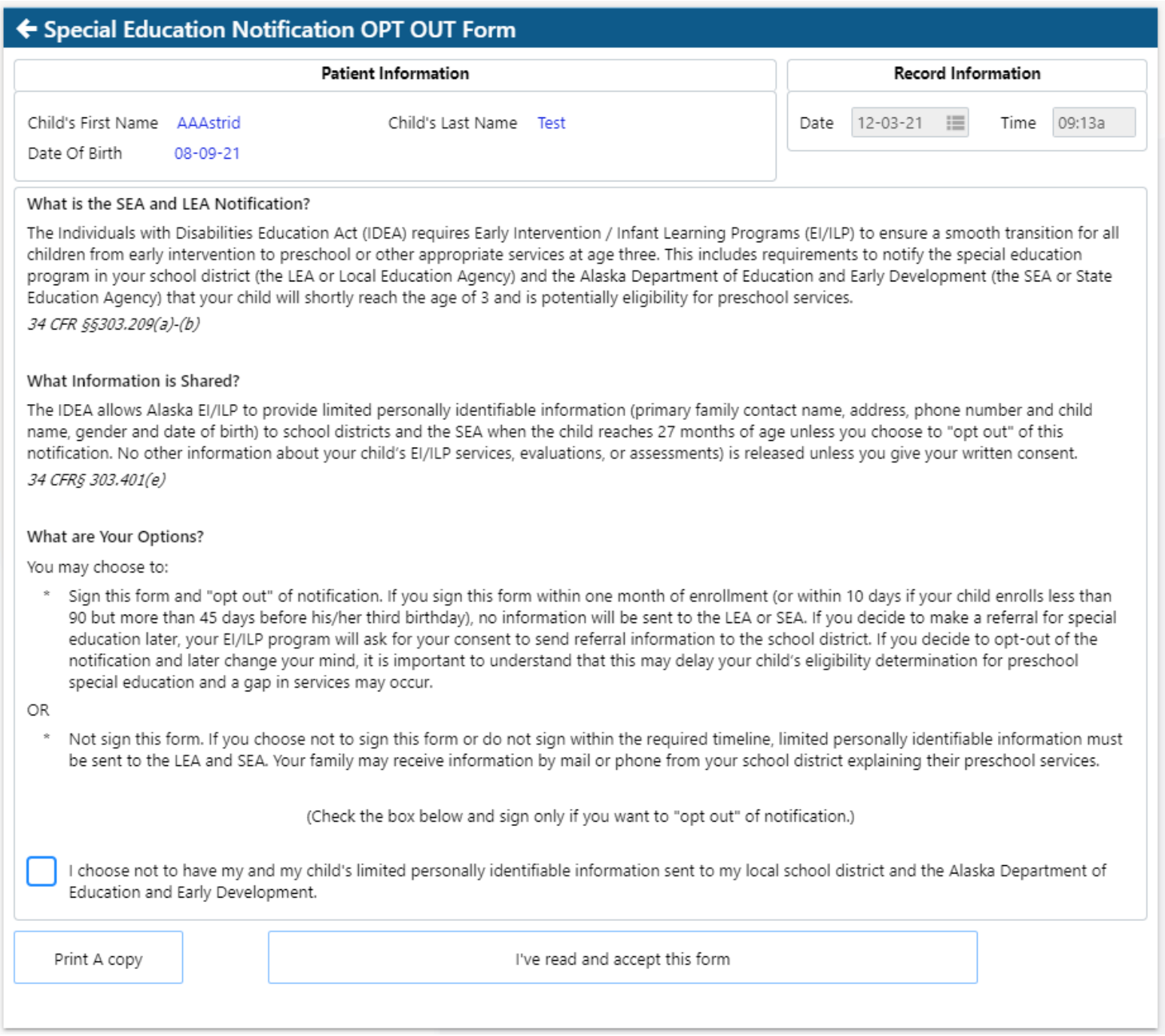
Provider

In RT Admin tab with all signature forms, choose the ASD Opt Out patient signature form/packet:

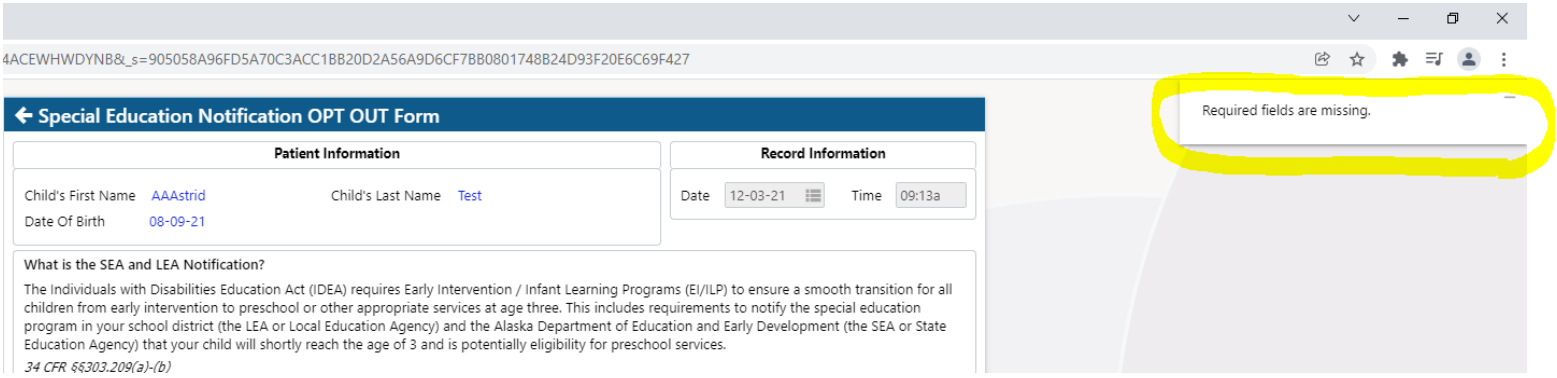


This is what it looks like to the parent:

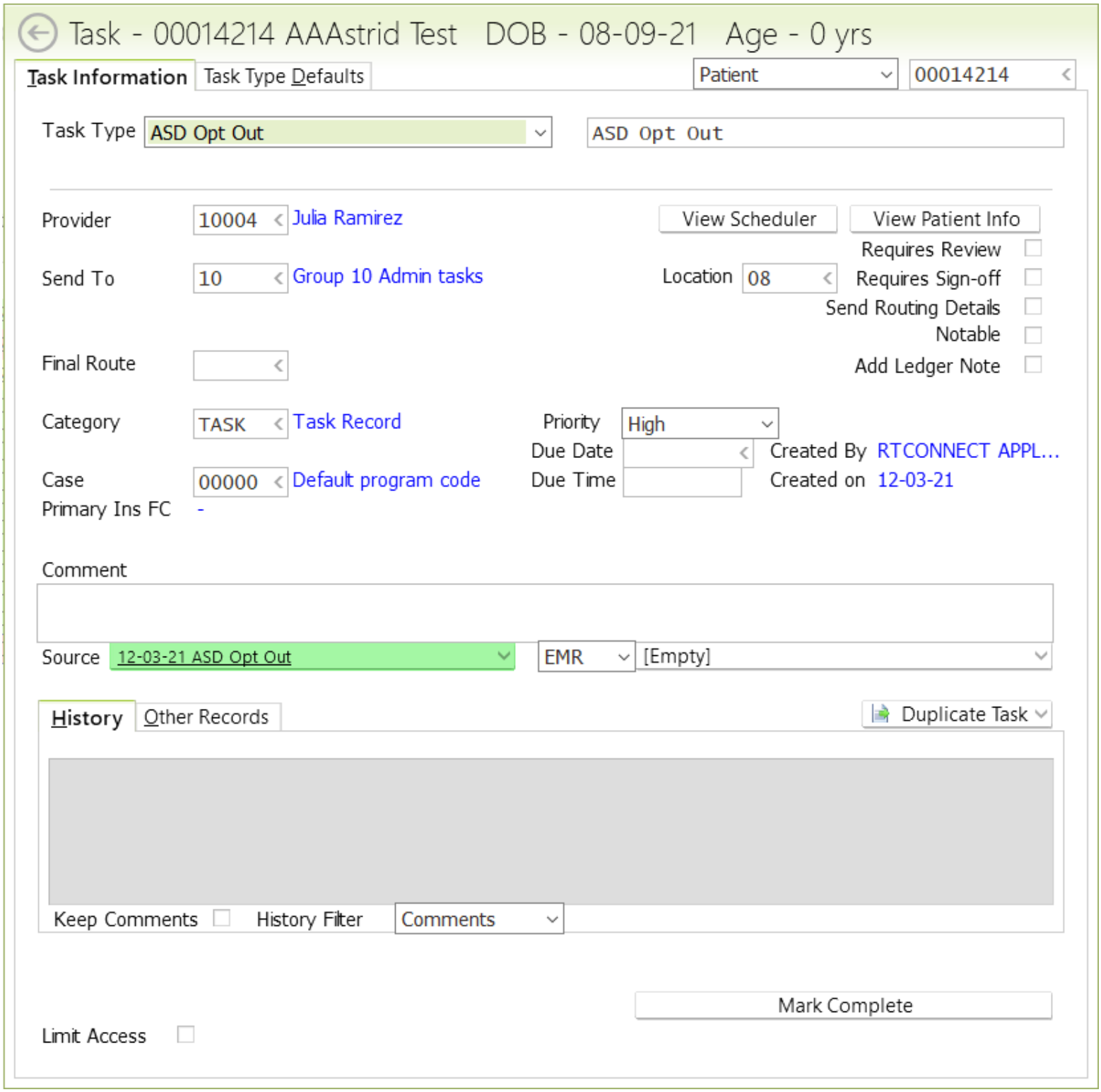

Patient Forms
Forms
Please review and sign the documents below...
Description
ASD Opt Out
Information Needed
Accepted
Declined
Add Signature
Signature
Print
Complete



If the parent doesn't check the box, a message will appear on the right corner of the screen 'Required fields are missing':

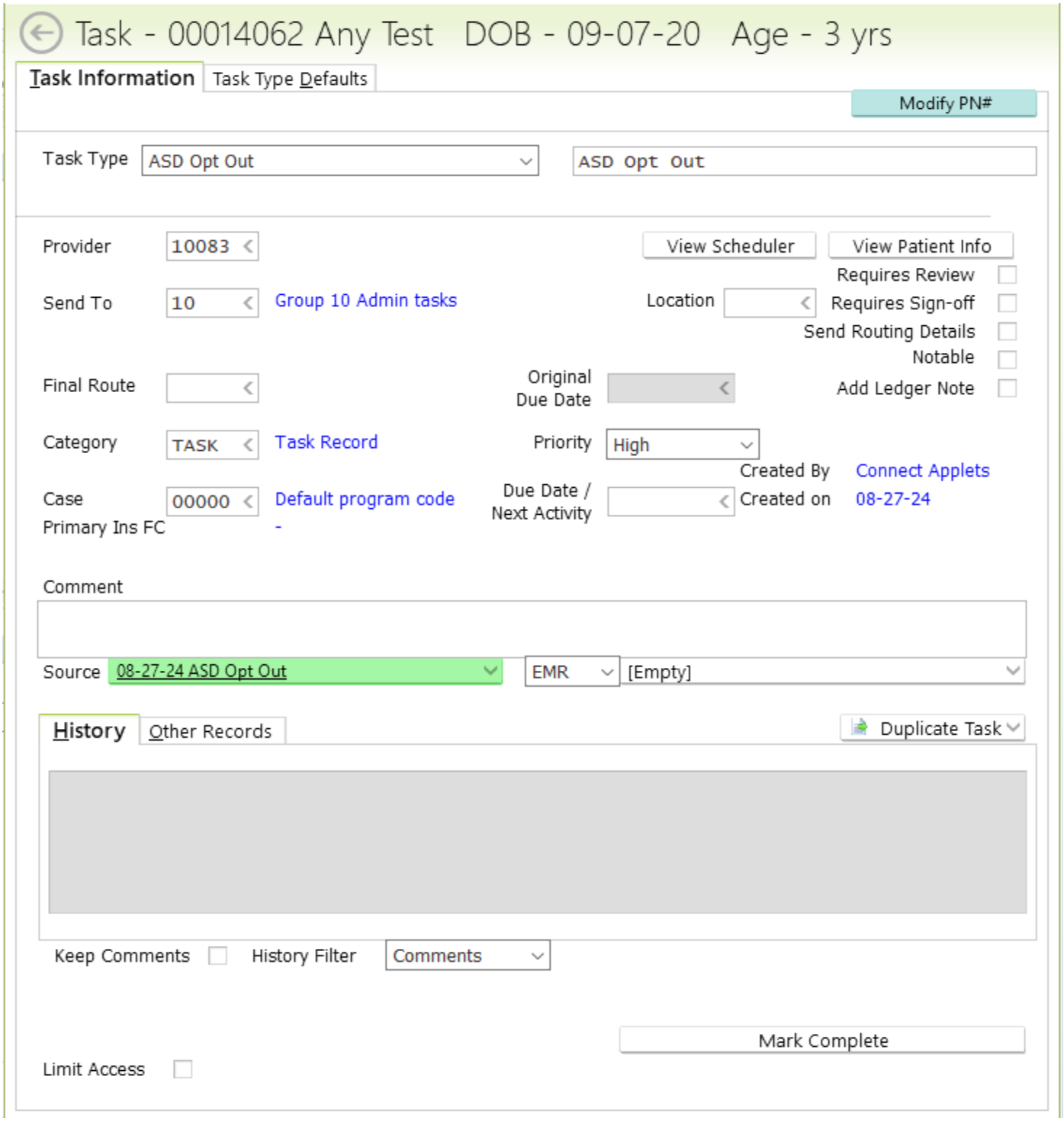


Then a Task is automatically created for the admin team and they will opt the child out in the state database:

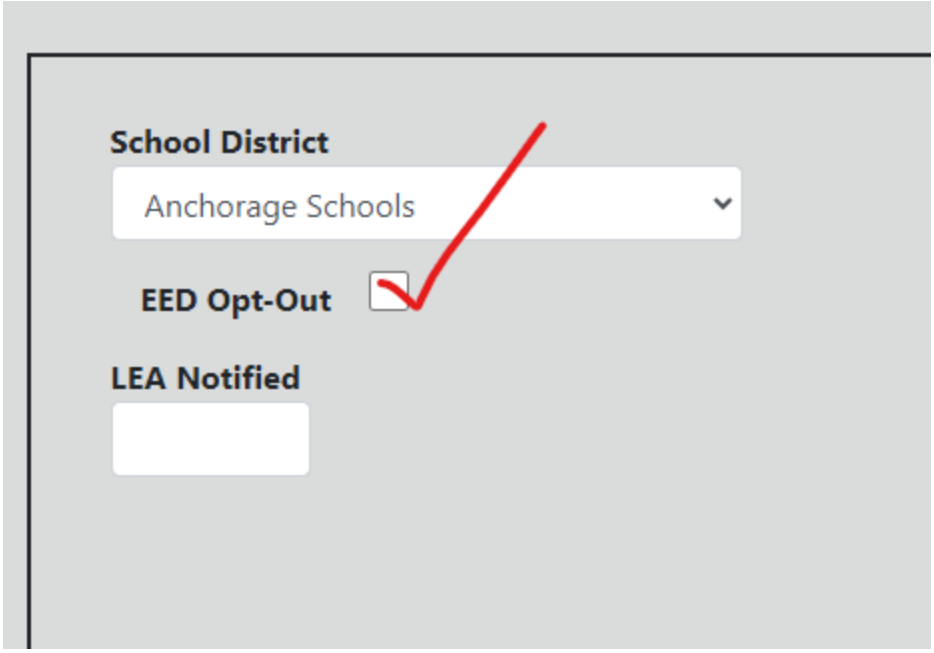


Admin

After a provider has discussed ASD Opt Out with a family, they will sign an ASD Opt Out form. Once that form is signed, a task will automatically be generated to Group 10



2. Go to that child's State Database chart and under the Child tab, click Edit and scroll down to the School District portion, then check the EED Opt Out box (shown below). DO NOT ENTER A DATE in the LEA Notification box.



3. Once box is checked in the State Database, mark that task complete and make a note of the opt out in our ongoing SDB task

ASD LEA Notification Report: /sites/default/files/program-guidelines/AdminProcedure-ASDLEANotificationReport.pdf

ASD Opt Out Automated Email Reminder: /sites/default/files/program-guidelines/AdminProcedure-AutomateASDOptOutEmailReminder.pdf

Transition

Transition and Late Referral

Purpose
When children are referred to Part C as they are approaching age 3, there are different program and Annual Performance Report (APR) reporting requirements for the IDEA Part C and Part B Programs depending on the child's age. The Part C requirements for these "late referrals" vary for three distinct date ranges before the child's third birthday.

- Referred and determined eligible between 135 and 90 days (child age 31.5-33 months)
- Referred and determined eligible between 89 and 45 days (child age 33-34.5 months)
- Referred less than 45 days (44 days or less, and child age 34.5 months or older)

These charts illustrate requirements, roles and responsibilities of Parts C and B programs within the three time periods. Most of the requirements for this first timeframe are identical to those for children referred to Part C at least 90 days before their third birthday; however, some reporting requirements and recommended practices are unique for this timeframe.

Coordination between the IDEA Part C and Part B program is critical to ensure that both programs can reach and maintain 100% compliance with SPP/APR Indicators C8 and B12 on early childhood transition. States must have transition agreements between the Part C and Part B preschool programs to address transition. It is also critical to ensure that families gain an understanding of the different service delivery systems and their options in a compassionate and meaningful way. And finally, it is important to ensure that children receive the services they need to promote their learning and development. Collaboration between the two programs helps families and children adjust to, and prepare for, this period of transition. The IDEA Part C and Part B programs are strongly encouraged to work together to develop collaborative State and local practices to ensure smooth transitions for children and families and that both programs meet the required timelines.

Procedure
Please reference the IFSP procedure sections for Transition Plan and Transition Conference.

Documents
Timeline Transition and Late Referral
Transition and Late Referral Practice

Transition Planning IFSP

Purpose
Prior to children turning 3, there are several transition activities that early intervention staff initiate or participate in. The goal of these activities is to ensure a smooth transition for the child and family, from Part C Early Intervention to their next setting. Children can discharge to community service providers, their home or to Anchorage School District (ASD) which is the Part B service provider for special education services, for children age 3 - 21. Children must be discharged from ILP by age 3.

Activity	Due Date
Notification Referral to ASD/Opt Out of Referral to School District Letter Official notification to ASD of a child with special educational needs occurs at in this time frame or upon enrollment if the child is 30 months or older. PIC administration sends demographic information to ASD of enrolled children age 30 months or older, unless parents have signed an 'Opt Out letter' at the time of enrollment. This discussion usually happens during a home visit; document discussion in the Daily Note- Subjective section. Record date in Transition Plan. The school district will send procedural safeguards to all families. ***IMPORTANT: children enrolled at 30 – 33 months are at risk of missing ASD notification. Be sure to let Data Entry know at the time IFSP is completed that the child is headed to school district, or not!	24-30 months
Transition Plan: This is an IFSP meeting Early Intervention program requirement. Begin talking to parents about transition process and options. Complete a 'Transition Packet' with ASD application forms (Link below), if parents choose. PandaDoc application forms are submitted automatically when all have completed the forms. Providers must send the most recent child evaluation. Discuss other options for preschool, Head Start services, and community therapies as appropriate. Panda Doc ASD Application Additional ROIs for ASD Packet PIC-ASD Transition Packet Instructions Set a Transition Conference appointment here, if family chooses to evaluate with ASD at this time: PIC-ASD Transition Conference Appointments	24-30 months
Transition Conference/90 day mtg: This is an IFSP meeting Early Intervention program requirement. Official transition conference with parents, to set final transition steps. Typically held at the family's home with ASD staff present. ASD staff meets child and family, gathers information, sets times for evaluation and IEP mtg., explains program options for qualifying children. Send an invitation to the school district to the transition meeting.	33 months
ASD calendar at this time: PIC-ASD Transition Conference Appointments	
ASD Evaluation, Eligibility and IEP meetings These are school district requirements. Child evaluation is typically held at ASD building by ASD staff. ASD evaluates for areas of concern. PIC evaluations are referenced by ASD in their evaluation report. Parents complete a health history; children complete hearing and vision screening at ASD as a part of this meeting. *Following evaluation, a meeting is held to review findings, determine qualification for special education services. Typically an IEP is completed and placement determined at the same meeting, with parent consent.	Prior to 3rd birthday
Transition Activities Activities to help the child and family become familiar with new settings, not required by IDEA. Can be done throughout the transition process. If a child is enrolling in ASD, a classroom visit will be scheduled prior to entry.	Prior to school entry

Practice
PIC begins explaining the transition process and next placement options to parents when the child is no later than 30 months old. If a child is enrolled after 30 months, this event will be completed at the time of enrollment or shortly after. The Transition Packet will guide PIC staff through the process, including the forms to complete.

Agenda for Transition Planning Meeting:

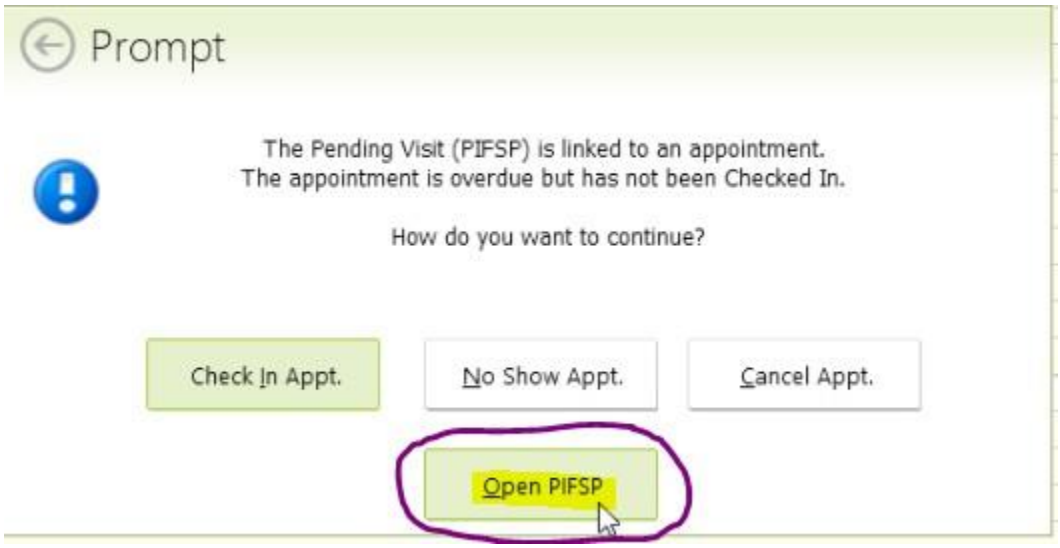
1. Explain that PIC services must end at child's 3rd birthday. Explain transition timelines
2. Explore options for placement services and families priorities
3. Complete a 'Transition Packet' with ASD application forms, if parents choose.

Logistics:

1. Schedule appointment as IFSP in the scheduler
2. Review Family Rights
3. Explain transition process using the Steps Ahead Transition booklet. This booklet is an important guide as it explains the transition process in detail
4. Obtain releases for programs or services parents are interested in pursuing
5. 5. Complete the ASD Panda Doc with the family if the family is interested and appropriate paperwork
   ASD-PIC PandaDoc Packet
   PIC ASD Transition Packet Instructions

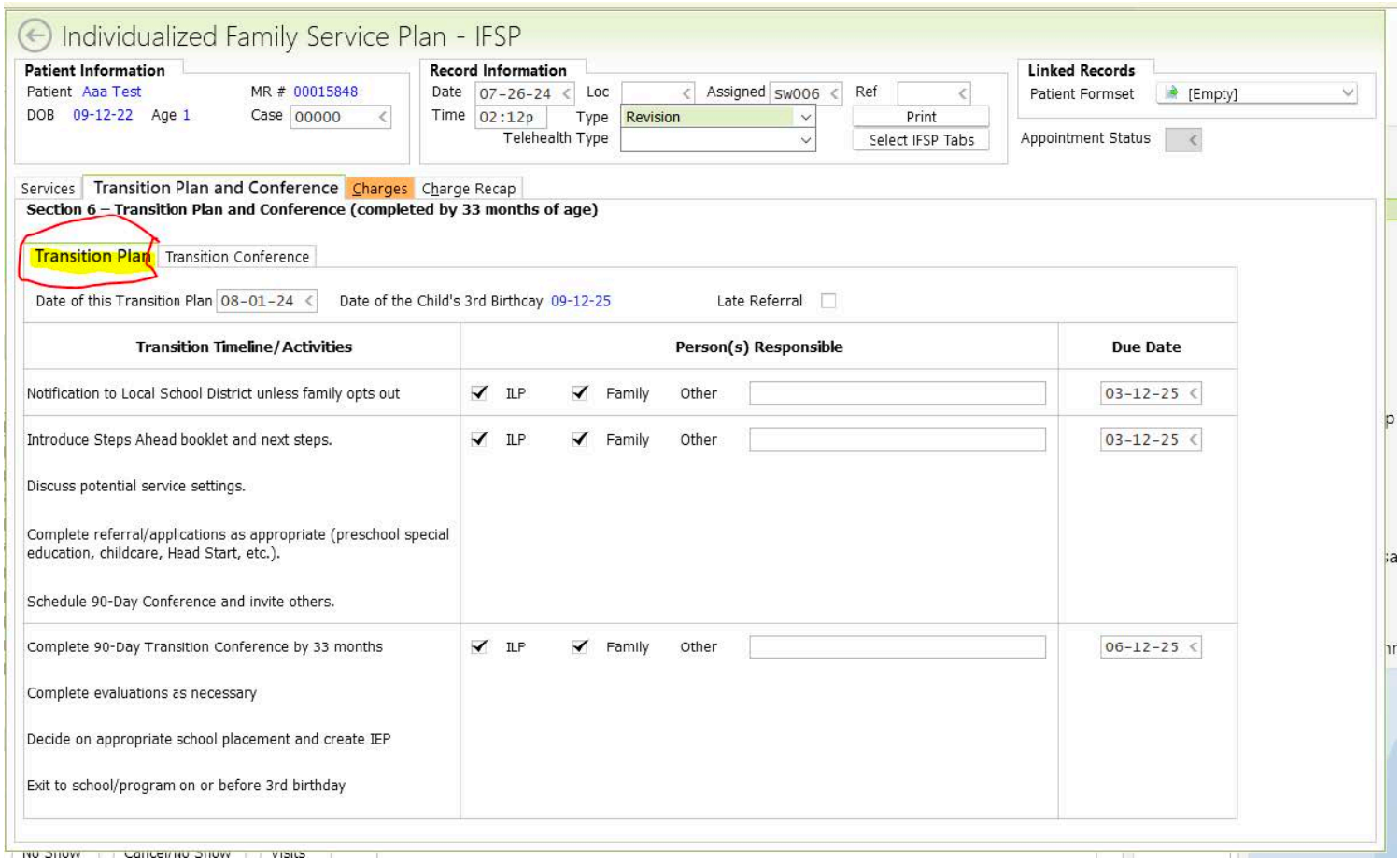
Procedure

1. In the RainTree Scheduler, select "IFSP" Appointment Type and enter in the appointment details.
   a. If preferred, providers may start entering in IFSP information before the IFSP meeting appt, double click on the appt and select "Open PIFSP":

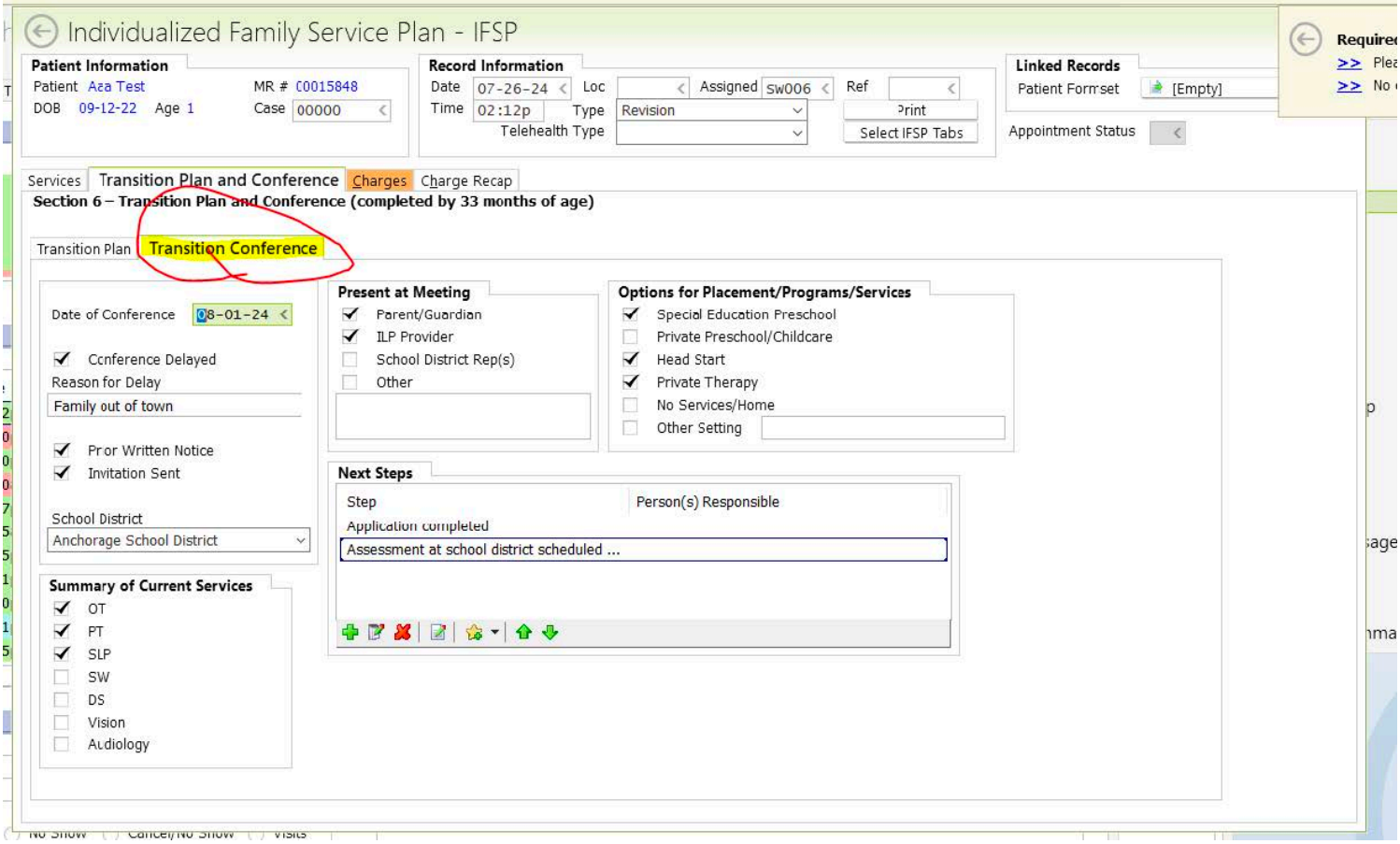


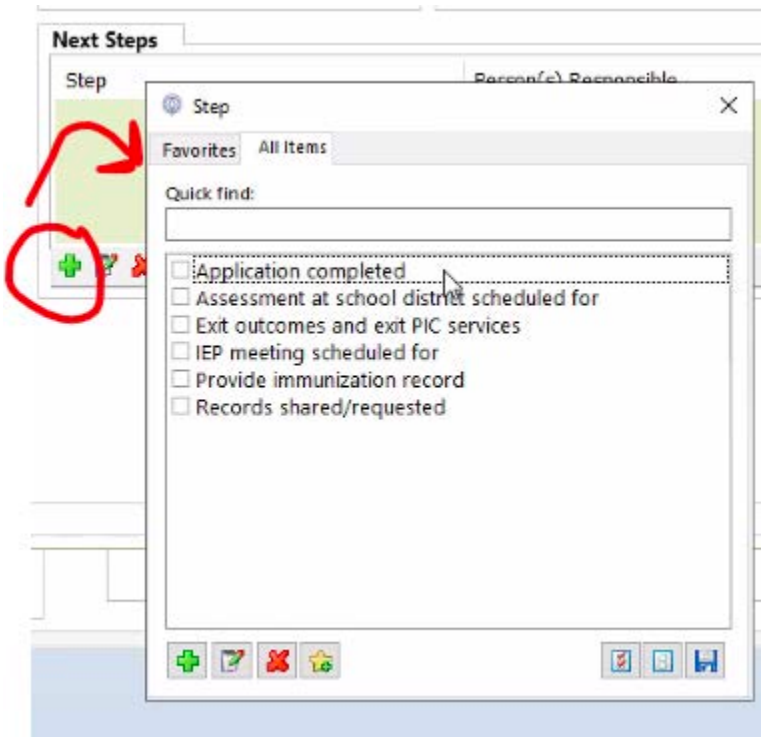
2. Select Roll Forward

3. When the Transition Plan needs to be completed, start by entering the Transition Plan Date in 'Transition Plan and Conference' tab. Once entered, all Due Dates will auto populate.
There is a separate tab for the Transition Conference, click on the Conference tab if this also was completed.

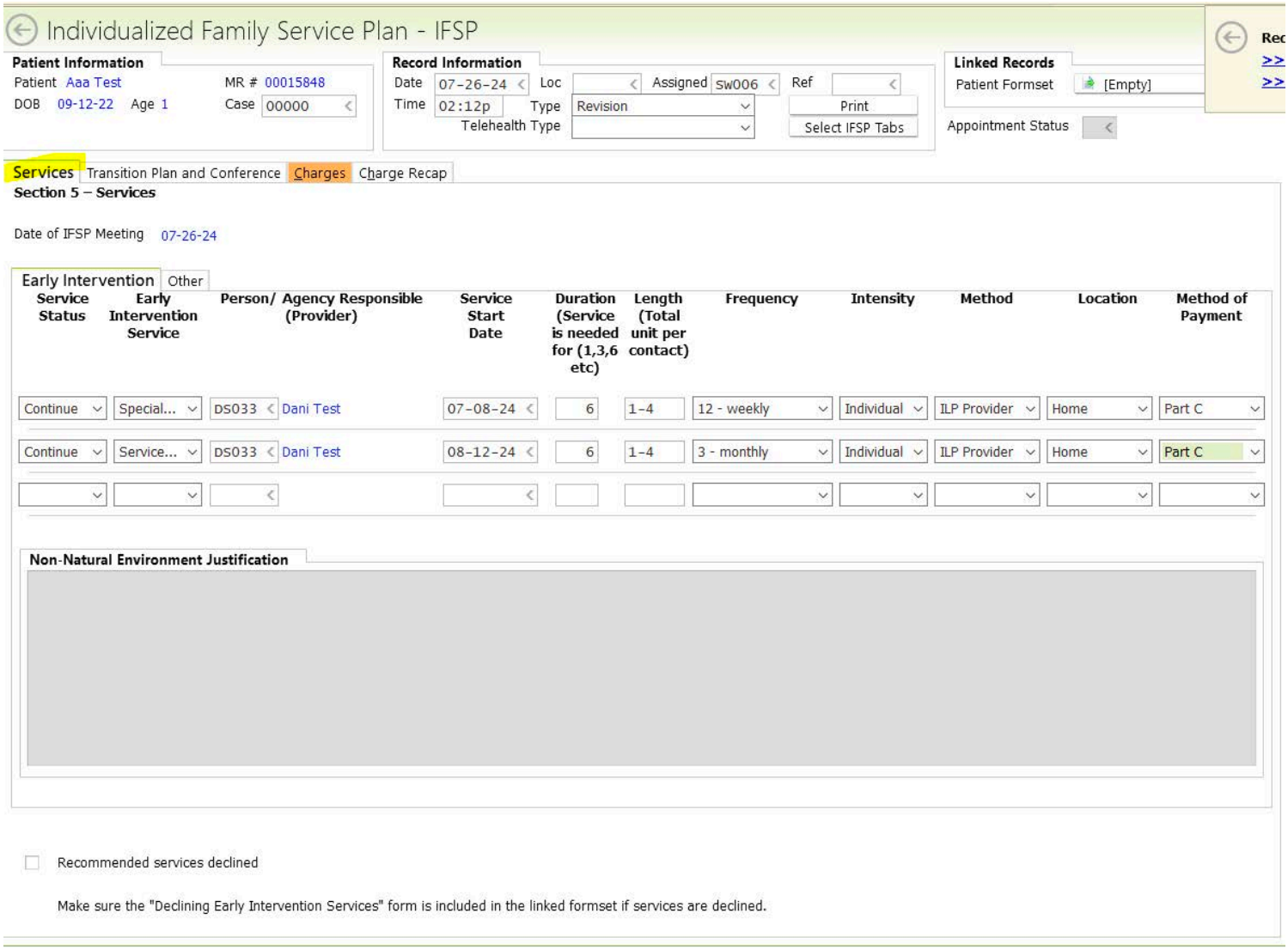


4. For the Transition Conference, click on the 2nd sub-tab and fill out the date, as well as all the other appropriate information, as shown below. If the Transition Conference was delayed, be sure to enter the reason for the delay. To add Next Steps, click on the green plus sign.

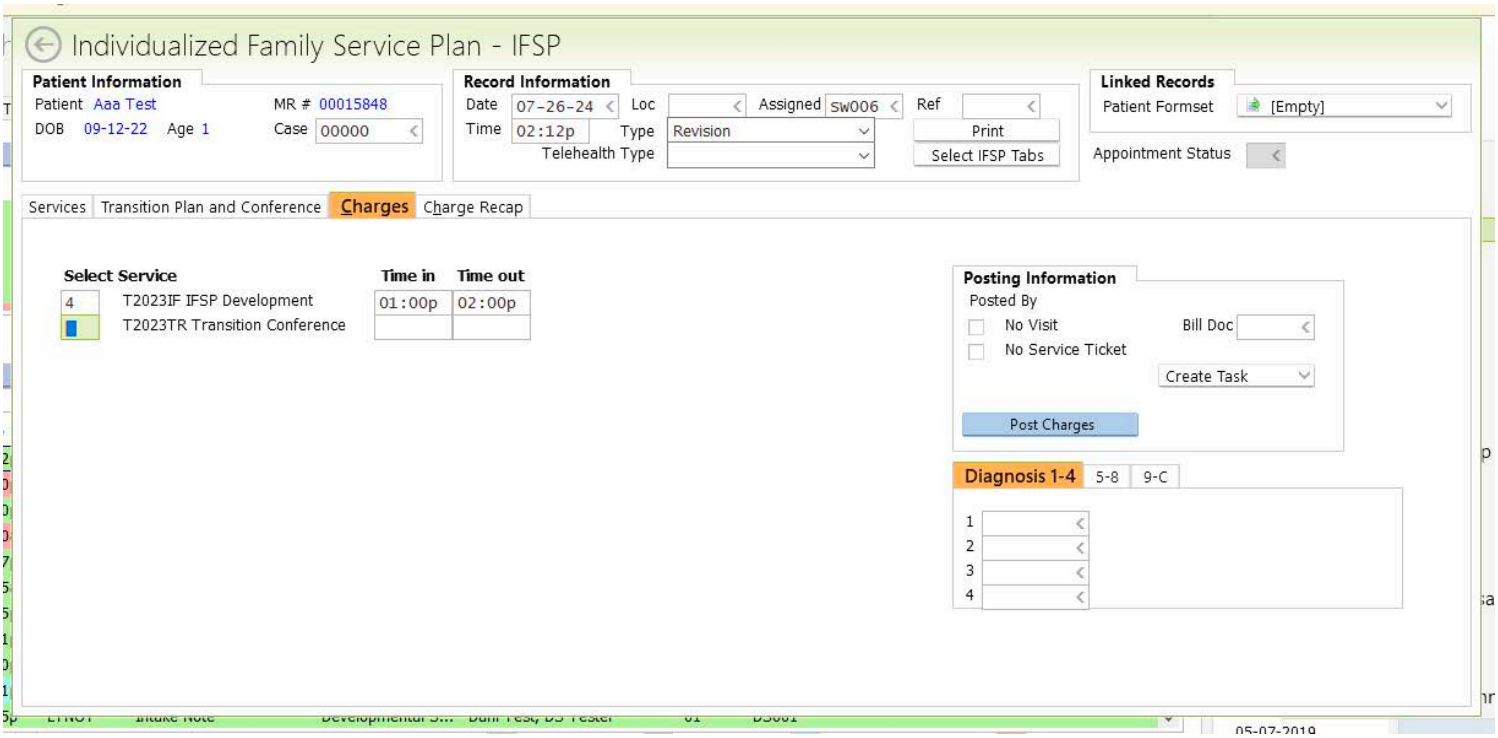




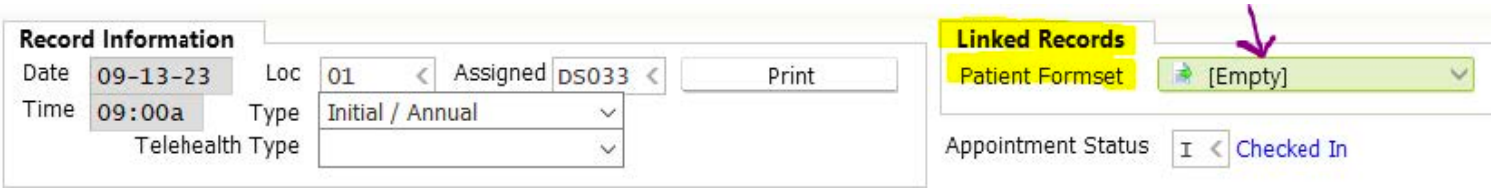
5. Enter the Services that the family will receive from PIC in the 'Services' tab. Since this is a revision, the services will be "Continued".



6. **Charges tab:** enter in the IFSP begin/Time in and end/Time out clock times for IFSP Development and/or Transition Conference if completed. Diagnosis will automatically pull from the RainTree case, be sure to add to the case if there is not one in the Diagnosis box.

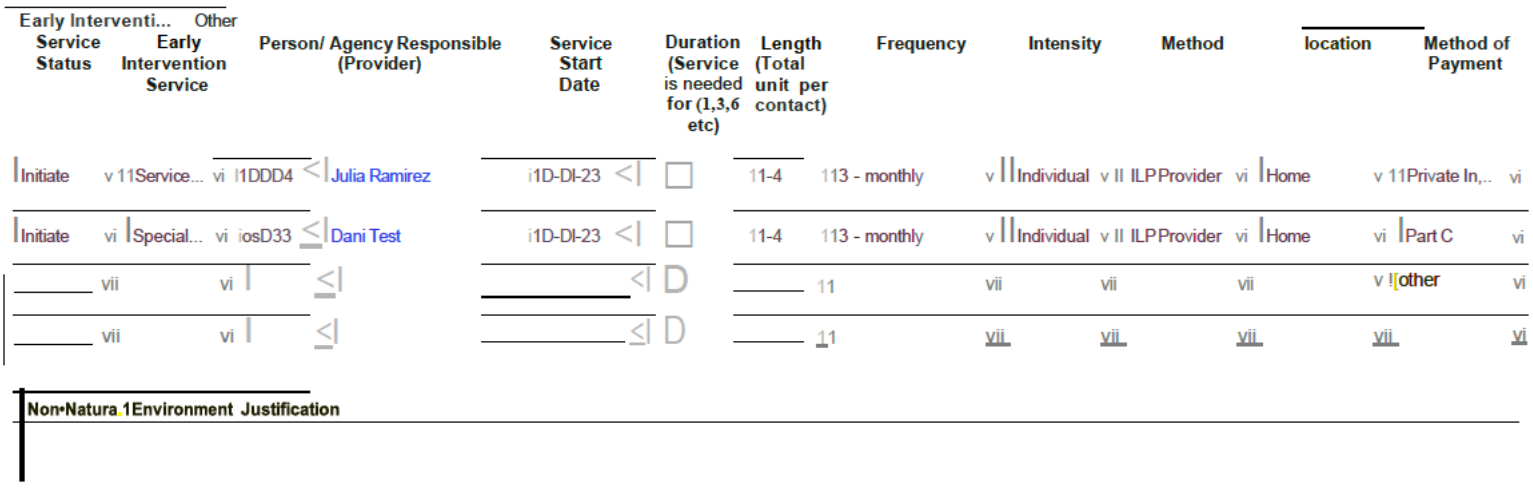


7. **Linked Records – Patient Formset:** If the Signature Packet was already created and sent to the parent, click on the [Empty] bar and add the set to this IFSP. If it hasn't been sent, use the [Empty] bar to add an IFSP Packet, then F10 to save it so that it links to this IFPS:



8. When all information is entered, the family's long term goals have been written and the IFSP Packet has been linked, F10 to save and sign off the IFSP.
9. The last step that is separate from the IFPS, is to create a Plan of Care for the primary physician – all goals created in the IFSP will appear in the POC. Create and sign off the POC.

Note: Selecting a non-natural environment is rare, however, there's a section in the IFSP that is required when 'Other' is selected as the Location for services. **Non-Natural Environment Location Justification:** Note why the child is receiving services in a non-natural environment.



Transition Conference IFSP

Practice

Transition Conference/90 Day Meeting

This meeting finalizes the plans for the last steps of transition. It is held by PIC staff with the family, and a representative of the program the family is interested in transitioning to. By this time, the family will likely have a decision about placement options they want to pursue. Possibilities include; preschool, ASD preschool, Head Start, private therapy. Any representatives for placement can be invited, with parent permission. If the family is interested in ASD services, they must invite ASD and complete the ASD packet. If the child is to be evaluated by ASD, it provides an opportunity for ASD staff to meet the family, begin building rapport, explain ASD processes and program options.

This is an IFSP meeting.

Agenda for Transition Conference:

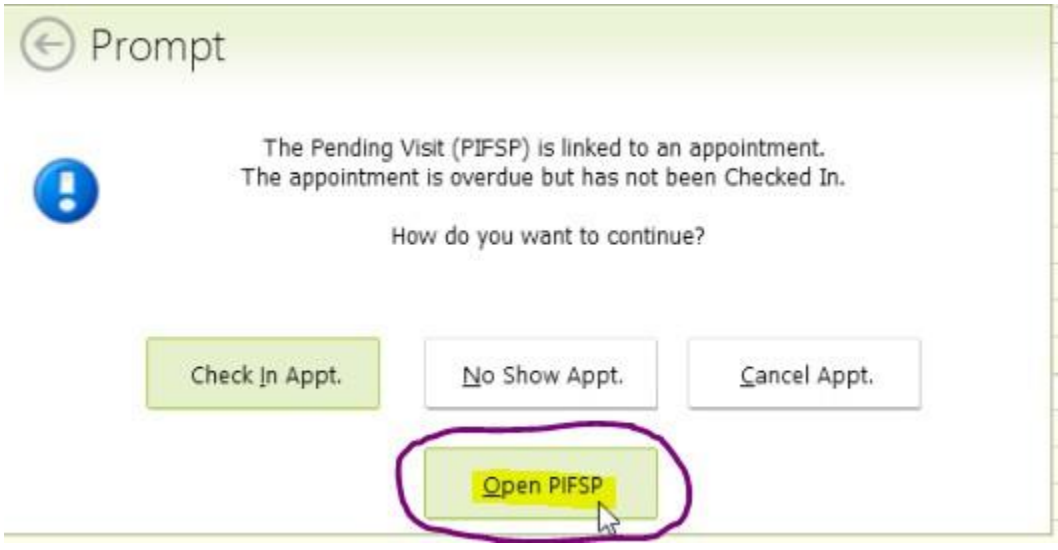
1. Staff introduces the family/child to participants.
2. Family shares strengths/concerns.
3. Team reviews information; determine what is still needed and plan for further evaluations, assessments, applications, releases of information, or updating contact information.
    - ASD may use PIC's evaluation information if completed less than 6 months from child's 3rd birthday.
4. Answer questions regarding what is next in the process and range of options
5. If the family chooses ASD, confirm the dates for the evaluation, and eligibility meetings. Discuss transportation if needed to evaluations and eligibility.

Logistics:

1. This meeting is PIC staff responsibility.
2. This can be held up to 9 months but no later than 90days prior to the child's 3rd birthday.
3. Meeting may be co-facilitated by PIC and ASD or other placement staff.
4. At this meeting, ASD schedules the dates for the evaluation, and eligibility meetings.

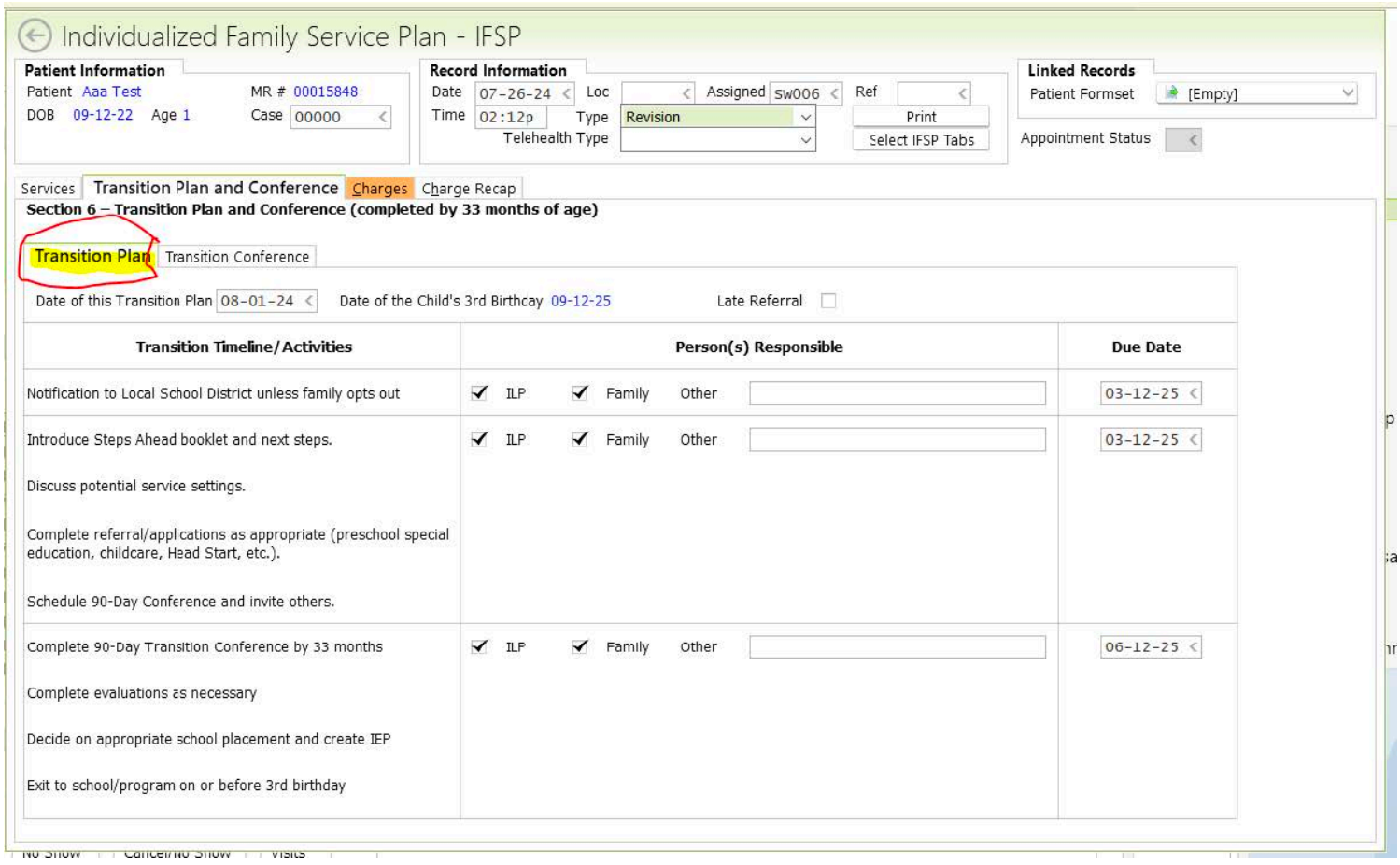
Procedure

1. In your RT Scheduler, select "IFSP" Appointment Type and enter in the appt details.
    a. If you would like to start entering in IFSP information before your IFSP meeting appt, double click on the appt and select "Open PIFSP":

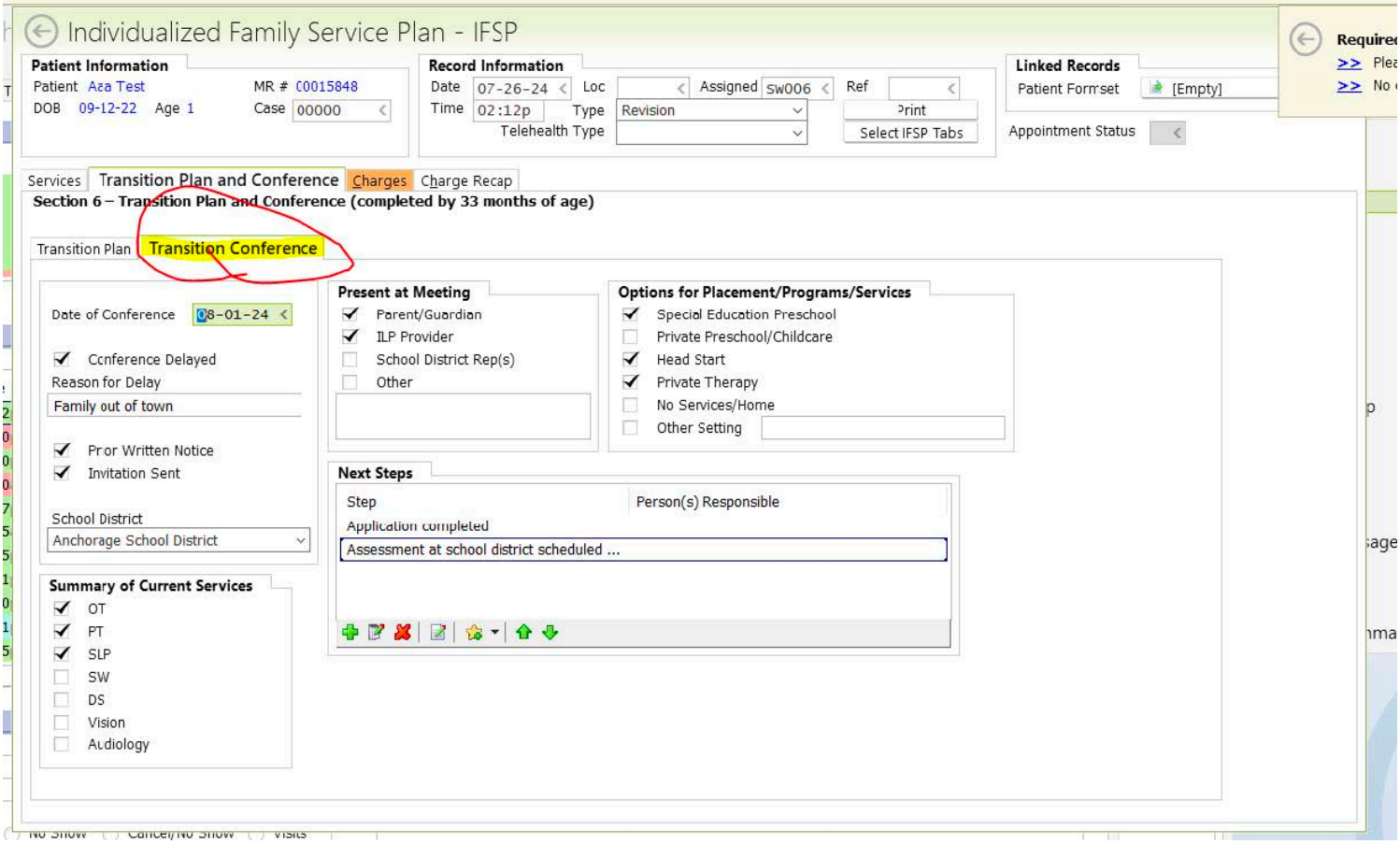


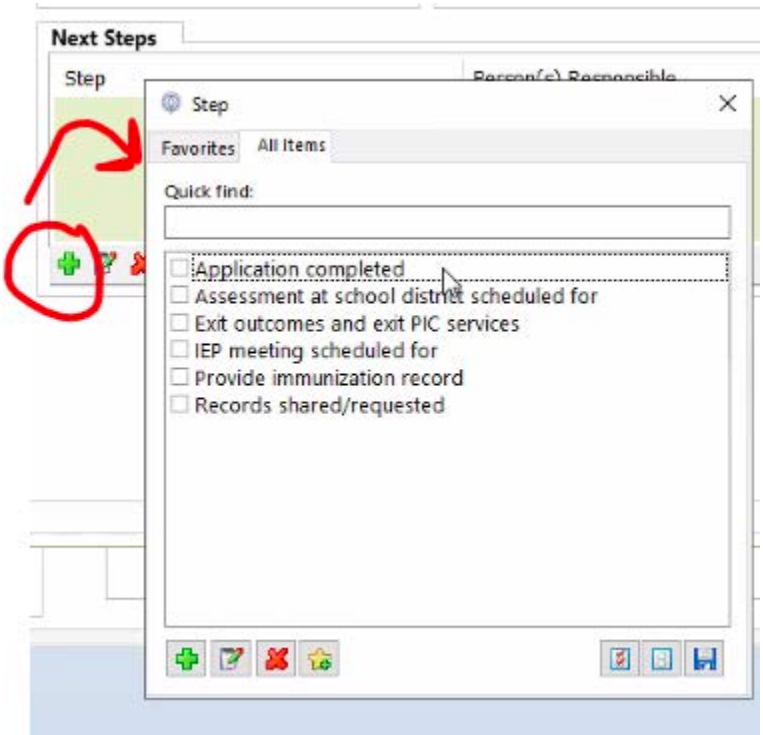
2. Select Roll Forward (keep up the habit)

3. When the Transition Plan needs to be completed, start by entering the Transition Plan Date in 'Transition Plan and Conference' tab. Once you enter in the date of the plan, all Due Dates will auto populate for you.
There is a separate tab for the Transition Conference, please click on the Conference tab if this also was completed.

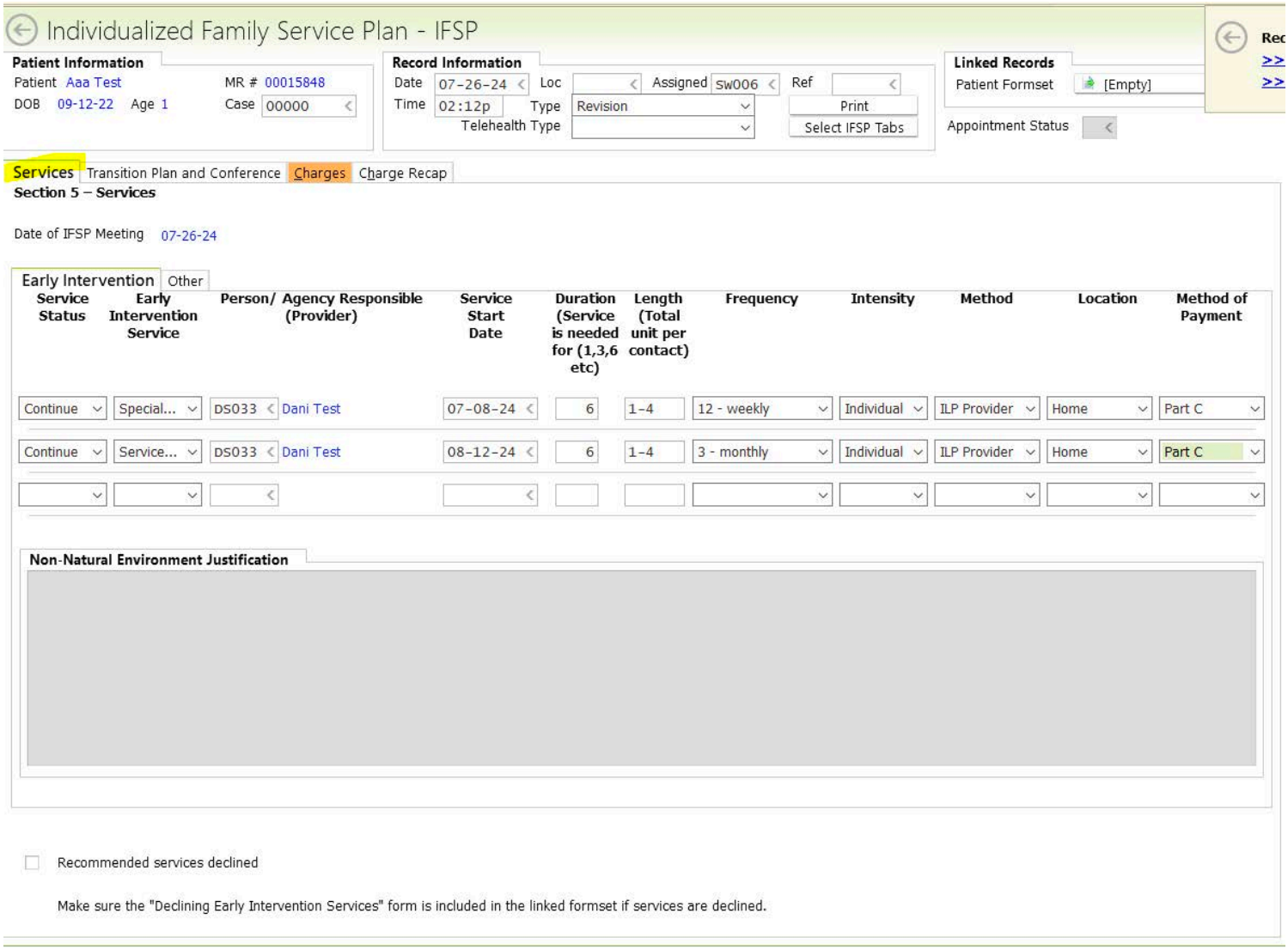


4. For the Transition Conference, go to the 2nd sub-tab and fill out the date, as well as all the other appropriate information, as shown below. If the Transition Conference was delayed, be sure to enter the reason for the delay. To add Next Steps, click on the green plus

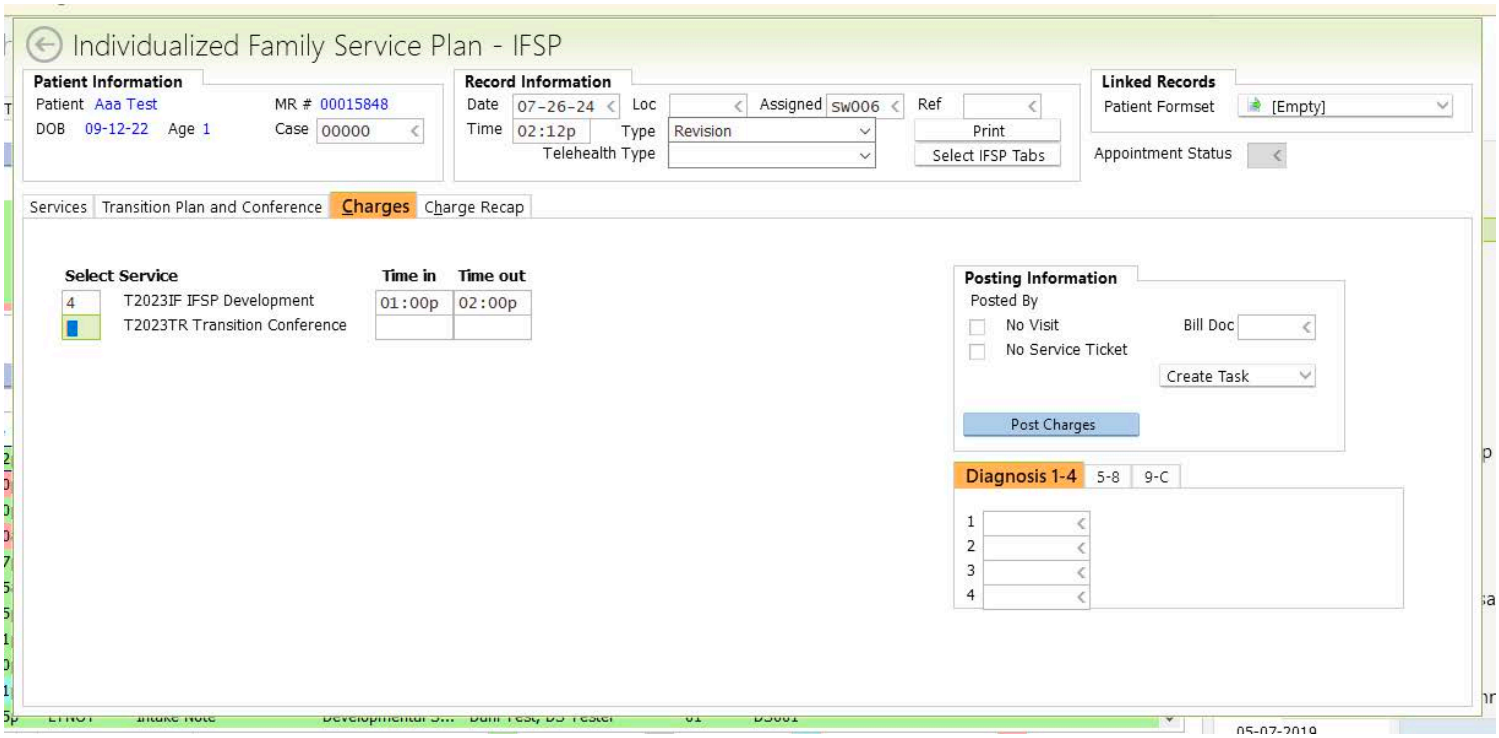




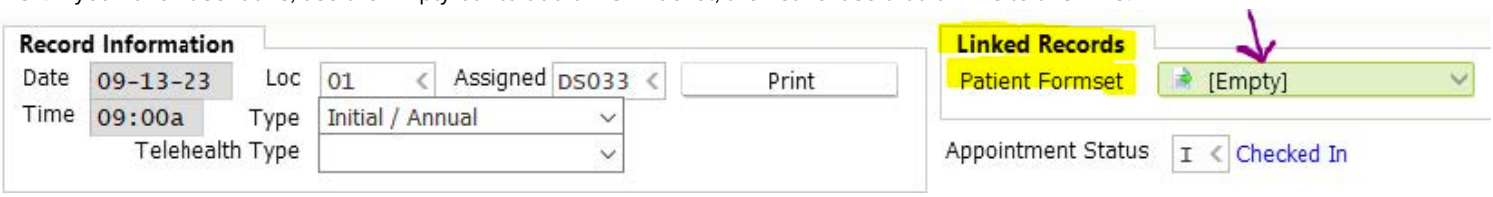
5. Enter the Services that the family will receive from PIC in the 'Services' tab. Since this is a revision, the services will be "Continued"



6. In the Charges tab enter in the IFSP begin/Time in and end/Time out clock times for IFSP Development and/or Transition Conference if completed.
   Diagnosis will automatically pull from your RT Case, be sure to add to your case if you don't see a Diagnosis.



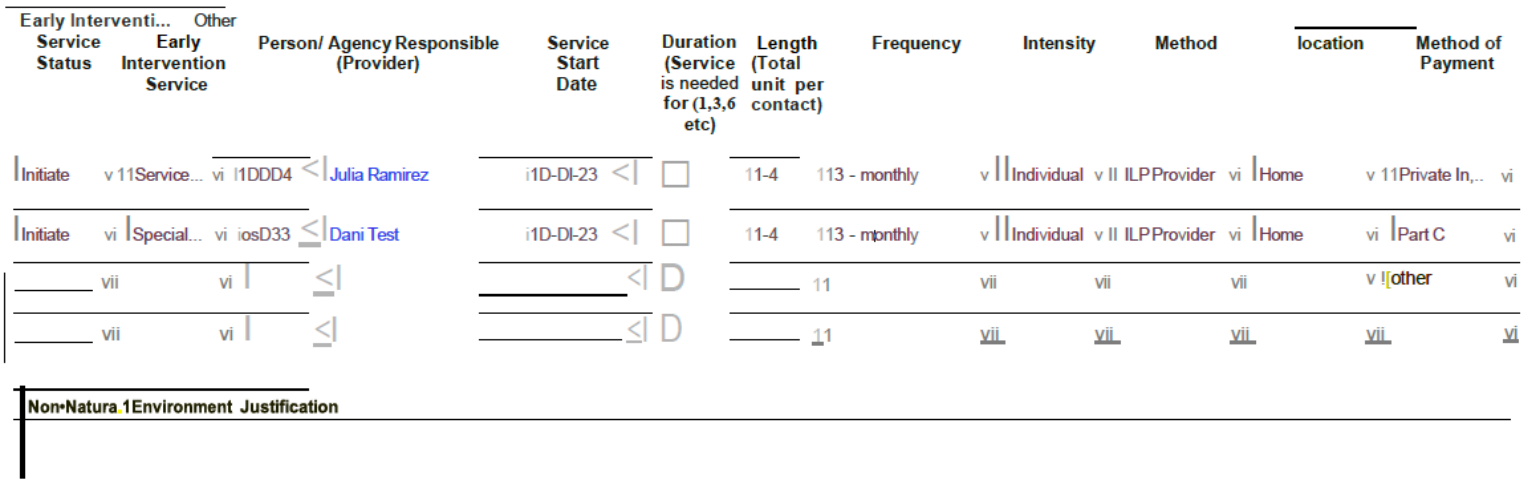
7. Linked Records – Patient Form set: If you already created and sent the IFSP Packet to the parent, click on the (Empty) bar and add them to this IFSP. If you haven't sent this, use the Empty bar to add a IFSP Packet, then save it so that it Links to this IFPS:



8. All long as all information is entered in and you have created all of the family's long term goal and linked the IFSP Packet, please save and sign off the IFSP!
9. The last step that is separate from the IFPS, is to create a Plan of Care for the Primary Physician – all goals you create in the IFSP will appear in your POC. Create and sign off your POC as you normally would.

Note: Selecting a non-natural environment is usually rare, however there's a section in the IFSP you must complete when 'Other' is selected as the Location for services.

Non-Natural Environment Location Justification: When you choose "Other" for the Location that services will be held, you must complete this section. Please note why the child is receiving services in a non-natural environment.



Exceptions to the Norm

Additional Considerations

What to do when an IFSP takes place over 2 days

If an IFSP takes place over two or more days, the provider will compile the results for all the days within the IFSP that is dated for the second or final date that all goals are determined.

Any earlier meeting(s) with the family, leading up to completing the IFSP are documented in a daily note as FSC with the appropriate charges attached.

FSC Only IFSP

Purpose

The situation is rare in which a provider and family generate an FSC only goal. It usually occurs when a child is a late referral (enrollment after 33 months) or has many services in the community. PIC responsibility is to still provide an evaluation for eligibility, coordination of care, and transition to ASD only. This fulfills guidance from the State to provide children who come in as a late referral with the family service coordination.

Practice

If needed, providers in consultation with the family will decide on a Family Service Coord goal, and set clear expectations for what will occur. Providers will need to take into consideration all the timeline variables depending on when the child is enrolled and what the needs are of the child. For children who are late referrals, providers will need to consider all the transition activities that need to take place within 45 days, or by discharge.

Procedure

Providers, Health Information and Data Entry will work together to assure appropriate information is shared in the RT provider dashboard, SDB data entry and billing are timely and accurate data.

Workflow for IFSP with FSC-only goal:

- Providers will consult with their manager that there is a single goal of FSC on this child's IFSP.
- Managers will support providers because although infrequent, if FSC-only goal occurs there is no need for a POC and to support staff with meeting transition timeline expectations.
- The goal will not be duplicated by the provider in a POC. Staff will not generate a POC (no need for a doctor to sign off on/prescribe this service).

- Data Entry Staff look at every IFSP and will be the first to see the FSC-only goals, and will inform HIT team to make a 'dummy POC'.
- HIT will create a Group 12 alert and a 'dummy POC' related to the PSP's case for the child with an end date that aligns with IFSP's six month review date.

Declining a Service After Already Initiated, Against PIC Team Advise

Purpose

Parent's Right to Decline Specific Services While Enrolled

Early Intervention services are voluntary. Parents may determine whether they, their child, or other family members will accept or decline any Early Intervention service. Parents may also decline such a service after first accepting it, without jeopardizing other Early Intervention services. If a parent accepts a service, it will be initiated, or at annual will continue a service. If a child no longer needs a service it will be discontinued. If a service is recommended however and the family declines, it will be documented as outline in the practice.

If a parent does not give consent, the program must make an effort to ensure:

1. that the parent is fully aware of the nature of the evaluation, assessment, or services that would be available, and
2. that the parent understands the child will not be able to receive an evaluation, assessment, or services without consent.

Early Intervention programs may not use a due process hearing to challenge a parent's right to refuse consent for evaluations and assessments to determine eligibility, or to refuse any aspect of the infant or toddler's Early Intervention services. A parent may withdraw his/her consent for Early Intervention services after initially providing it without jeopardizing other Early Intervention services.

Parent: As used in these standards, "parent" means:

1. a biological or adoptive parent of the infant/toddler,
2. a foster parent, however OCS will be contacted
3. a guardian generally authorized to act as the infant or toddler's parent or make Early

Intervention, educational, health, or developmental decisions for the infant/ toddler,

4. another person acting in the place of a biological or adoptive parent (including a grandparent, step-parent, or relative with whom the infant/ toddler lives) who is legally responsible for the infant or toddler's welfare, or
5. a surrogate parent, but does not include any parent whose authority to make educational decisions has been terminated under state law.

An Early Intervention service provider or a service provider from a public child welfare agency (DCF) may not act as a parent for the purposes of Part C services

Exceptions: An adoptive or biological parent may exercise his/her option to provide or refuse consent for Early Intervention services ("parent acting as a parent") if more than one of the above persons in Section 2, a–e meets the definition of parent, unless the biological or adoptive parent does not have the legal authority to make educational or Early Intervention decisions for

Practice

Parents may accept or decline any early intervention service for their child and may decline a service without jeopardizing other early intervention services. If a parent accepts a service, it will be initiated, or at annual will be continued. If a child no longer needs a service it will be discontinued. However, if a service is initiated and the family declines against provider recommendation, it will be documented:
• Provider completes IFPS Section 5 Parent/Guardian Decline Recommended Service checkbox and list the service(s) declined/or complete the signature form in RT child's file, All Forms.

• We do not complete this when the family seeks the service in community, or if the family does not want to address the concern prior to goal setting and enrollment. (See /sites/default/files/program-guidelines/IFSPPractice.pdf bullet #6 for details

Procedure
/sites/default/files/pdfupdates/EmployeeSelfEvaluation.pdf

POC (Plan of Care)

Plan of Care

Purpose
The Plan of Care (POC) is completed for each child after the provider and family have collaboratively developed goals on the IFSP. These IFSP goals form the foundation of the POC, and are automatically carried over to reflect those goals. The POC also serves as a communication tool with the child's Primary Care Provider (PCP) and supports PIC's ability to bill Medicaid and other insurance providers.

Most insurance payers, including Medicaid, require a POC signed by the child's PCP in order to authorize reimbursement for services. While PIC strongly encourages families to maintain a relationship with a PCP to support the child's overall health and care coordination, a signed POC is not required for a child to receive services through PIC.

Alaska is a Direct Access State, meaning that under state licensure regulations, therapy services can be provided without a physician's referral or a signed POC. However, reimbursement from Medicaid and most commercial insurances typically requires a PCP-signed POC.

Practice
PIC providers request an ROI for the PPCP from parents at intake. After the evaluation and IFSP, the provider can generate a POC and assigns themselves and if appropriate, secondary providers to the POC goals.

PIC providers must complete the POC upon completing the IFSP so that subsequent sessions are billable from their signature date, provided the PCP signs withing 14 days. The Health Information Team (HIT)nassures the signatures meet timelines and will inform the PIC providers of concerns.

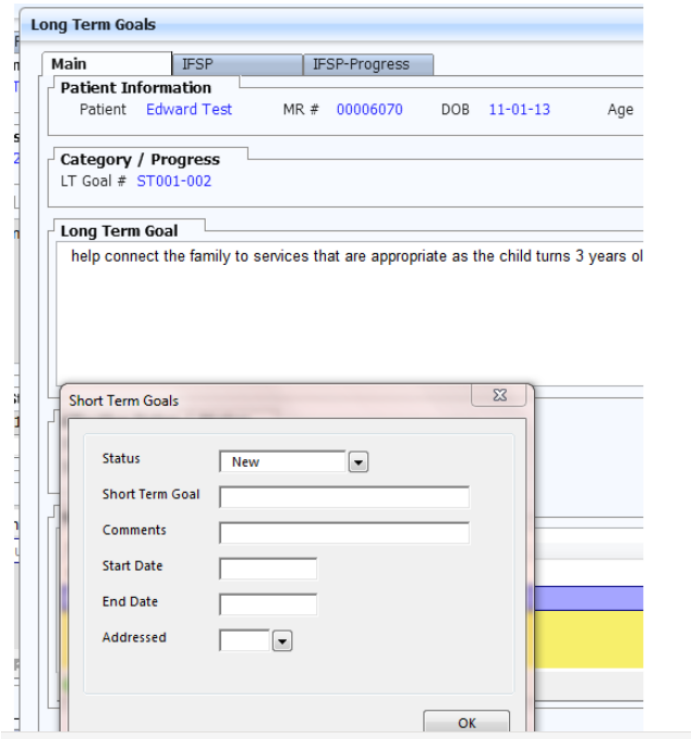
PIC provider's timely completion of the POC prevents gaps in PIC's ability to bill for services that children receive.

Procedure
Upon completion of the IFSP, providers open a POC from the child's chart.

Long-term goals are transferred from the IFSP completed with the family.

Each goal will need to identify provider or providers who will be working on each goal:

1. In RainTree, open a Plan of Care for the child.
2. Complete each tab including **Progress, Treatment Plan** and **Recommendations**. Where indicated, use the green cross at the bottom of the box to add set phrases.
3. Click on Treatment Plan Tab, and open each Long-term Goal and its Short-term Goals.



On the Treatment Tab, as required by Medicaid provide a prognosis, and a certification period. This should be about 6 months from the date of the POC but no more than.

4. In each goal, the **Main Tab** was completed with the IFSP process. Proceed to the IFSP tab and confirm that the previous entered information from the IFSP process is included in the IFSP:

F10 to return to the POC

Complete all tabs and their boxes, then:

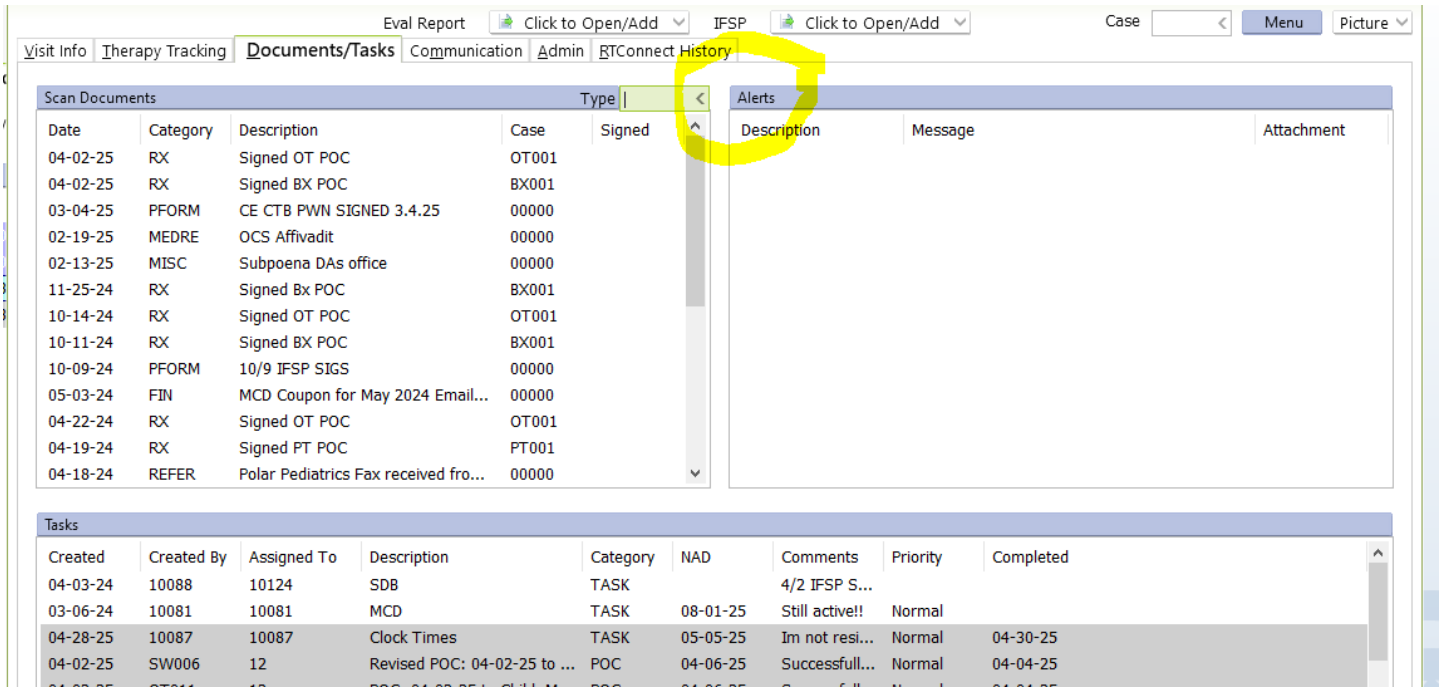
1. Save and Sign off
2. Notify any secondary providers that the IFSP goals are completed and they can complete their own plan of care.

Note: Once an IFSP is signed by the primary, no new long-term goals can be signed without the Primary Provider creating a revision to the IFSP. Revisions require a new IFSP be created and require parent's signatures that correspond to the date of the parent signature.

Short-term goals can be added to the POC without a signature from the family.

Secondary POC

All long-term goals need to be entered into the RainTree system through the IFSP process. The primary provider will assign any additional providers to goals. Secondaries, may not start a POC until the primary has added them to the IFSP goals.

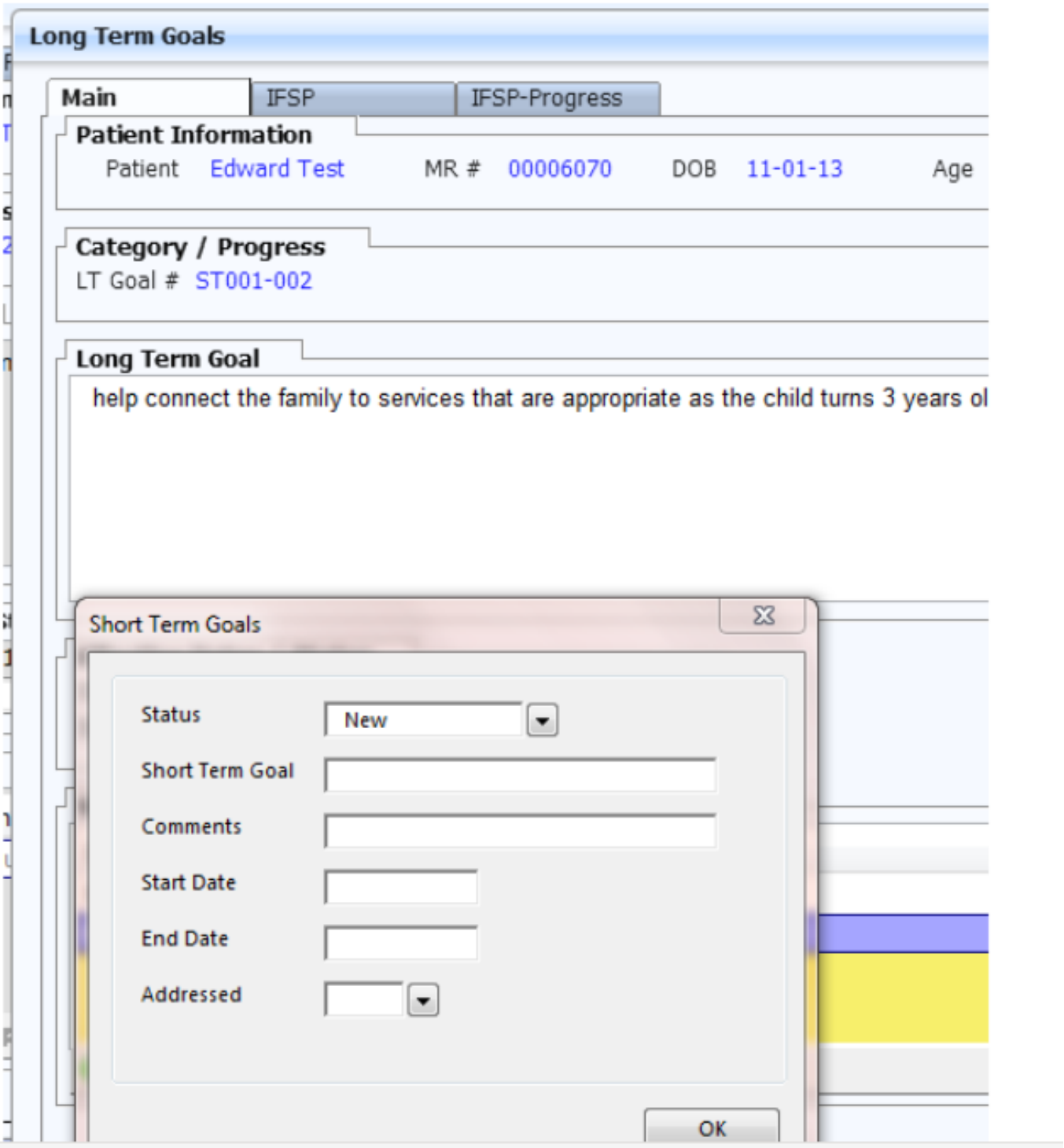


Upon opening a new POC, the secondary provider will find the assigned goals automatically appear. Secondary provider number will appear in the boxes indicated above--if not assure that they are the assigned provider number and match.

Then, the Secondary provider may proceed with entering Short-term Goals.

Adding Short-Term Goals

Switch to the Main tab and enter Short-term Goals at bottom of page:



At bottom of page, A to Add New in Short term goals

Click on New and then complete the Short-term Goal boxes (these boxes will accommodate about 250 characters)

F10 to save.

F10 to return to the POC

When you have added all the goals

1. Save and Sign off

No ROI for Primary Care Provider

Purpose

The Plan of Care (POC) is completed for each child after the provider and family have collaboratively developed goals on the IFSP. These IFSP goals form the foundation of the POC, and are automatically to reflect those goals. The POC also serves as a communication tool with the child's primary care provider (PCP) and allows PIC to bill Medicaid and other insurance providers. A signed POC is not required for a child to receive services through PIC. However, not having a POC is considered a rare exception.

Alaska is a Direct Access State, meaning that under state licensure regulations, therapy services can be provided without a physician's referral or a signed POC. However, reimbursement from Medicaid and most commercial insurances typically requires a PCP-signed POC.

In situations where a family does not have a PCP or declines to connect their child's PCP with PIC, services will still be offered without restriction. Families will be informed that:

- Having a PCP is strongly recommended to ensure comprehensive care and support care coordination;
- Billing for services allows PIC to sustainably serve more children and families;
- If they are open to it, the family service coordinator (FSC) can assist with finding or reconnecting the child to a PCP and include this effort as a documented FSC goal.

In these rare instances where the family declines to share information with a PCP or does not have one, and no Release of Information (ROI) is on file for the child's PCP, the following limitations apply:

- Evaluations and POCs are not be sent to the child's physician.
- If the physician originally referred the child, PIC may still confirm service engagement or provide referral feedback in alignment with what was shared at intake.

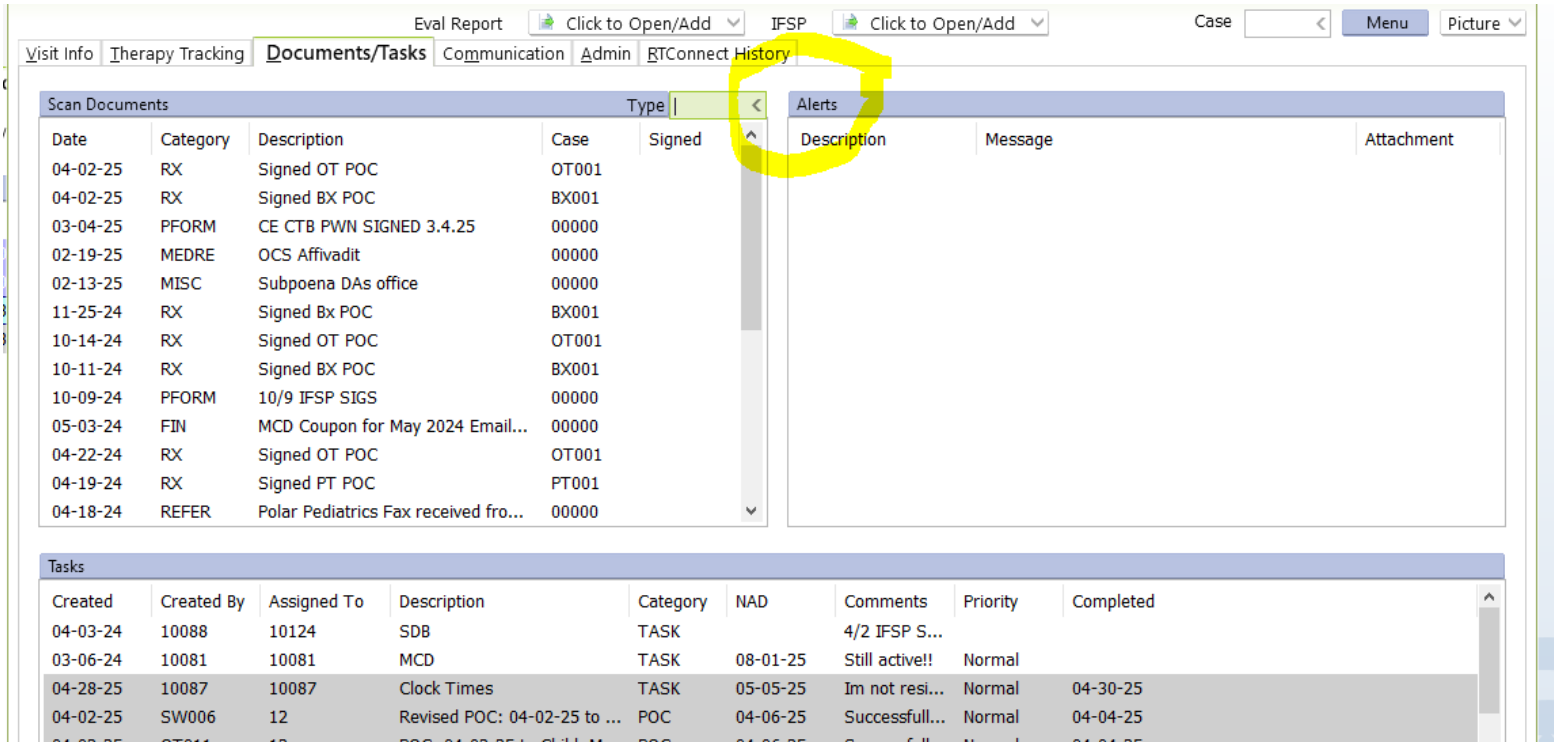
Practice

The same conditions that apply to families have a PCP apply to parents who don't have an established PCP:

- Providers request ROI for the child's PCP at intake. When parents indicate that they do not want to release information to the PCP, the provider will inform the family that OT/PT/SLP services cannot be provided without a POC in place which is signed by pediatrician. Providers may want to clarify which information parents do not want released (ie, the functional eval) and reflect specific documents to be released in the ROI.
- Parents can be given the option to release the POC only to the PCP, and attempt to secure provider's signature on the POC however, the parent will need to sign a limited ROI (ie, only POC to be released).
- Providers will inform parents that all services that are available to them even without a POC.

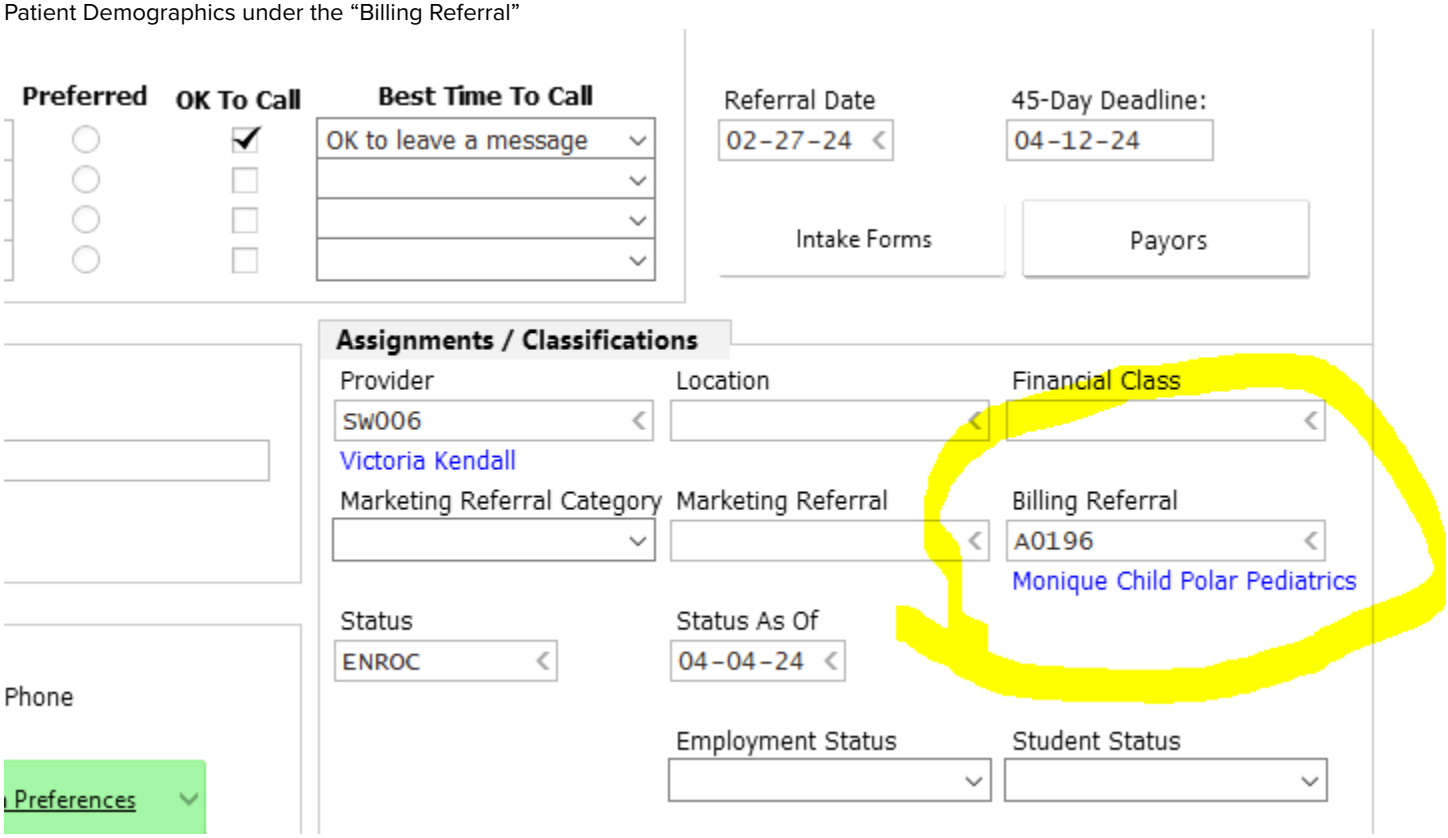
Procedure

- Add alert in Documents/Tasks --> Alerts section. You can even include unsigned forms for provider ease of access/information if ROI is waiting to be signed.

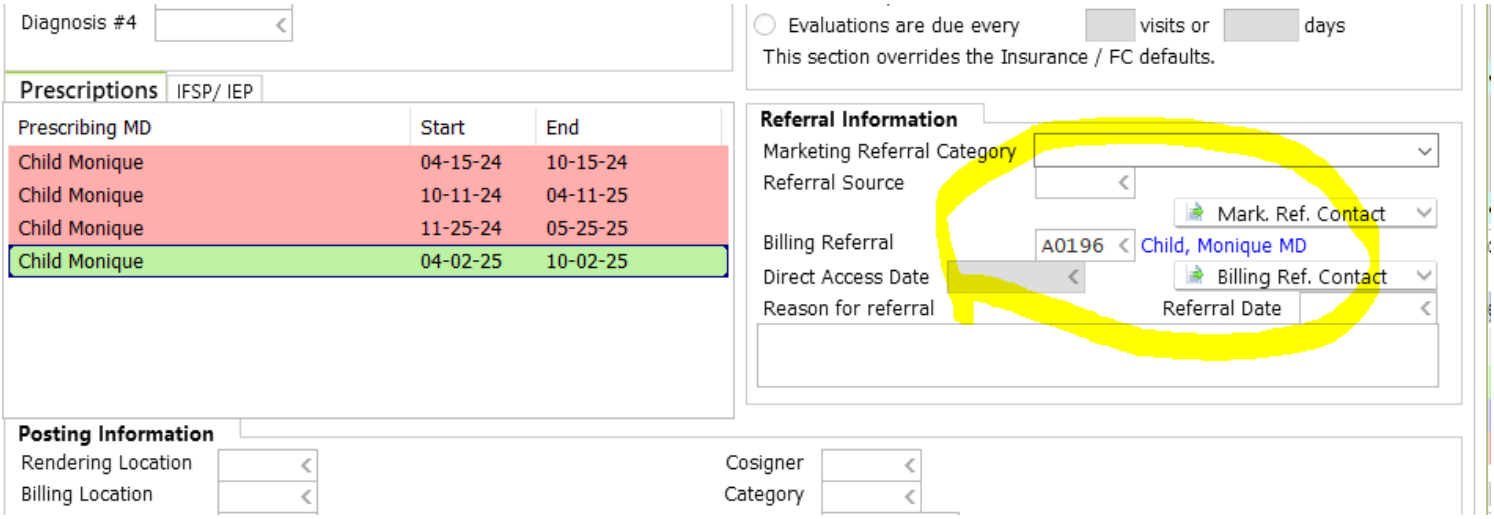


- Contact Admin or the HIT to remove/ensure no PCP is listed in the following places:

- Patient Demographics under the “Billing Referral”



- EACH case under the “Billing Referral”



Services During Enrollment

Family Service Coordination (FSC)

Purpose

Family Service Coordination (FSC) is a service that is specific to Early Intervention Part C services under IDEA. It includes activities carried out by the Primary Service Provider to assist the families they work with to recieve procedural safeguards, understand their rights under Part C and accessing services within EI/ILP and across agency lines. FSC is an active, and ongoing process.

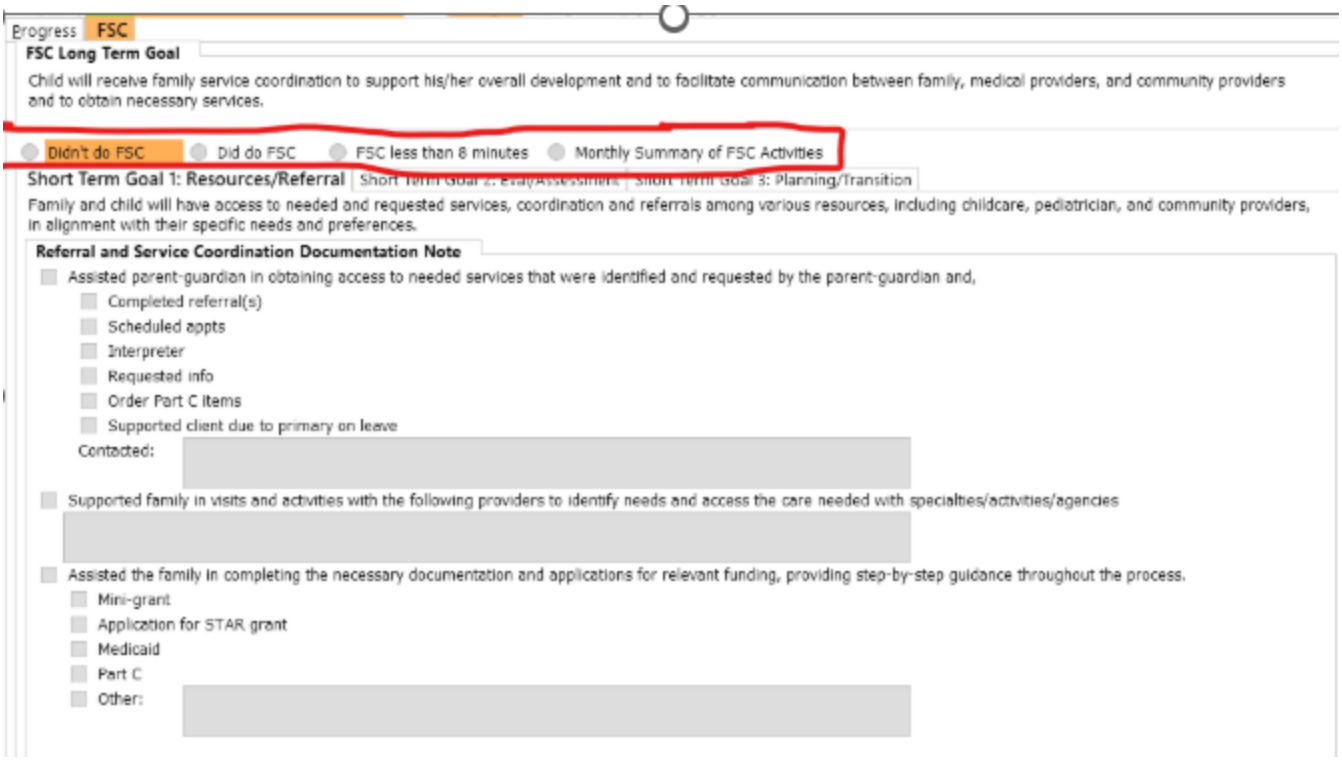
Practice

PIC providers are expected to complete FSC at least one time per month for every child regardless of insurance type. For each child who recieves FSC and has Medicaid insurance, PIC submits charges one time per month at a set reimbursement rate. PIC providers may complete FSC in many different contexts and settings with the purpose of advancing the child's developmental goals. See additional guidance /sites/default/files/program-guidelines/FamilyServiceCoordinationReferenceandTraining.pdf

Procedure

Noting and Documentation

There are three ways to document FSC, based on the time alloted and the setting of the services. Providers must indicate one of the sections:



1. **Standard FSC Daily Note (for event that is 8 minutes or more):**
   - **Documentation of FSC during a visit:** Providers will document Family Service Coordination (FSC) services provided during sessions in the FSC tab of the daily note for the date of service
   - **Documentation of FSC outside a visit:** add a note to scheduler and check-in. document Family Service Coordination (FSC) services provided under the FSC goal.
     - **Detail Required**: Provide comprehensive details to clearly describe the activity that occurred. Specific details are essential for accurate documentation.
     - **Billing**: FSC services are billed in units of 8-15 minutes.
     - **Reference**: For additional guidance, see the **Family Service Coordination Reference and Trainin**
2. **Provider did FSC during a visit but it was less than 8 minutes:**
   - **For brief FSC that occurred in a visit:** Providers will document services provided during sessions in their daily note for the date of service under the FSC tab. Complete with enough detail so that later in the month it can be reference for a monthly summary for billing.
   - **For brief FSC outside a visit:** Providers will add a note to the communication log with details of what occurred on the date including details as referenced above.
     - **Detail Required:** Provide details where required to clearly describe the activity that occurred. Specific details are essential for accurate billing.
     - **Charges:** At the end of the month, each of these short events will be referred to in a Monthly Summary Note (below) for the child if there are 2 or more events that occurred.
3. **Monthly Summary of FSC Note (a summary at month's end for events that are less than 8 minutes individually)**:
   - Providers use this to capture FSC that happened during the month that was either less than 8 minutes or didn't occur during a visit. (For instructions: see Monthly Summary FSC Notes)

FSC in IFSP and RainTree Goals and Examples

FSC Long term Goal:

Child and family will receive family service coordination to support his/her overall development and to facilitate communication between family, medical providers, and community providers and to obtain necessary services.

Short Term Goal #1:
Child and family will have access to needed and requested services, coordination and referrals among various resources, including childcare, pediatrician, and community providers, in alignment with their specific needs and preferences

Referral and Service Coord	Example of Activity	Documentation Note
Assisting in obtaining access to needed early intervention services and other services, or resources identified in the IFSP, including making referrals and scheduling appointments.	The provider connects a child/family to other agencies or providers for services that might benefit the child's development such as consulting PIC providers, community therapists and other medical subspecialities (ie, neuro, ENT, AuD, Vision services),	Assisted parent-guardian in obtaining access to needed services that were identified and requested by the parent-guardian and, Completed referral(s) to: Scheduled appts with: Interpreter Requested info from: Order Part C items for/from Supported client due to primary on leave Contacted:
Facilitating, attending and supporting during a visit with a PIC secondary, community provider, agency, subspecialty, or physician.	A provider arranges for PIC or community therapist or other and accompanies family in this visit provide support to family and provider to help meet the IFSP goals. Provider attends this visit.	Supported family in visits and activities with the following providers to identify needs and access the care needed: Specialties/activities/Agencies
Coordinating funding sources for services required under Part C of IDEA.	A provider helps a family navigate through funding options available for their child's needs: mini-grant application, Medicaid application, interpreter, Part C funding requests.	Assisted the family in completing the necessary documentation and applications for relevant funding, providing step-by-step guidance throughout the process for: Mini-grant Application for STAR grant Part C Request Medicaid

Short Term Goal #2: Child and family will have services coordinated for evaluations and assessments

Eval, Assess, Trans Coord	Example of Activity	Documentation Note
Coordinating evaluations and assessments	Primary service provider sets up assessments, evaluators for annual evaluation.	Coordinated the scheduling and arrangement of assessments with relevant evaluators to ensure a comprehensive evaluation covering all necessary developmental domains. PIC evaluators: ASD evaluators: Other:
Reviewed medical records	Reviewed and assessed all available medical records, including previous diagnoses, treatments, medications, and any relevant medical reports, to develop a comprehensive overview of the child's medical history.	Provider examined and assessed all available medical records, including previous diagnoses, treatments, medications, and any relevant medical reports, to identify of relevant developmental information and any specific medical considerations that may require special attention in screening and evaluation including:

Short-Term Goal #3: Child and family will have up-to-date information, IFSP goals, and experience a smooth transition to ASD or other community services at age 3.

Support and Planning	Example of Activity	Documentation Note
Assisted in the development, review, and evaluation of IFSPs.	A provider works with a secondary and the family to develop an Individualized Family Service Plan (IFSP) outlining the specific goals and services needed for a child's early intervention program.	Facilitated and supported discussion about specific and measurable goals that align with the child's developmental needs and the family's priorities.

Support and Planning	Example of Activity	Documentation Note
Provider initiated or family initiated a check-in regarding family and/or child progress, services, and concerns.	A provider or family initiates a check-in during a home visit to discuss the child's updates on progress, current treatments, address any concerns, and make adjustments to the intervention plan as needed. Family or provider initiate a check in that results in discussion regarding child progress.	Facilitated discussion and implementation of necessary adjustments to the intervention plan, incorporating insights and recommendations from the family and the service providers to ensure that the plan remains relevant and effective in meeting the child's evolving needs, and progress on goals. Facilitated discussion and check-in with the family about the family's priorities.
Conducted follow-up and activities to determine that appropriate services are being provided.	Check-in with family/providers to find out if services have been initiated. Set up appts to discuss which services are in place.	Followed up today to discuss which services are in place and being provided with: People contacted: [Comment] Services confirmed [Comment] Services recommended [Comment] Other [Comment]
TRANSITION: Facilitated the development of a transition plan to appropriate services, and completed associated activities.	Facilitating the development of a transition plan to preschool or other services as appropriate. Follow-up with activities related to transition.	Provider completed the following activity this day to support a smooth shift to preschool or other appropriate services: • Discussed opt out • Offered and reviewed Steps Ahead booklet • Discussed settings including: HS, ASD, Comm preschools, Community therapist • Completed and sent ASD packet • Scheduled briefing with ASD evaluators • Attended briefing with ASD evaluators • Coordinated 90 Day, calendared, sent tela invite, called my ASD • Attended Elig/IEP, supported discussion with ASD evaluators • Other

Daily Notes

Purpose

Notes are a concise summary of what intervention took place with the provider, parent and child, and briefly descriptive of parent and child response. Notes provide a record of events and allow PIC to bill for intervention services.

Practice

Providers notes interventions completed with parents, or service that is coordinated for the child. Daily notes are completed ideally on the day the service is provided, or by the end of the work week. Notes must be submitted within 7 days of services delivered.

Procedure

Each of the following RainTree tabs will be completed with information and each answers a question.

- **Subjective**: Who was there, for what activity and where the meeting took place?
  - Example: Met with child, parent and grandparent in family home for EI services. Etester Test, SLP was also present this day for consult.
- **Goal**: What occured; what did the provider do?
  - Select appropriate goal and describe the intervention that was applied.
  - Document strategies and, the child's response. Include role-modeling, coaching, feedback, reflection or joint planning that took place within daily activities and routines.
    - Use verbs such as modeled, coached, instructed, guided (see list below).
    - Only pair the words **encourage** and **suggest** with the description of the intervention that was applied. It is important to demonstrate that a treatment was delivered, demonstrated and practiced during the session
    - What did the parent do? Document what the parent did with the strategy modeled during the visit.
    - Make sure to **CELEBRATE** somewhere in your note.

        - **Example of note**: DS modeled the use of hand-over-hand instruction with child to sign ‘more’ during snack to request for more portions with caregiver. After demonstrating, instructed mom how to use signs, and offered additional instruction on how to use signs, introduce new signs, and which might work in their situation to start. Mom enthusiastically signed and child used sign for ‘more’ this day after only minimal prompting, and provider celebrated child progress.
        - **Example of how to note when most of the session is spent with parent in conversation rather than hands on intervention, role-modeling or demonstration**: Discussed with parent the stress of sleepless nights and difficulties resulting from those concerns. Problem-solved and parents agreed to use informal supports. Provider also offered additional resources and offered feedback that aligns with parent current strengths and preferences including: food bank, therapists in community and stated would reach out to team for additional resources and get back. Parent will follow-up on referrals as planned.
    - **Charges:** enter clock times in the appropriate box for the services delivered. Providers cannot have overlapping charges, except where using FSC. Aside from FSC, providers must divide the time based on what they did. Where there is a single provider, clock times may not overlap at all.
    - Plan: at minimum checkmark appropriate radio button, and if needed, any additional plans unless already listed in the goals section.

Documentation Verbs

Coaching/Intervention: Implemented, applied, instructed, guided, activated, coached, practiced, refined, prepared, used anticipatory guidance, informed, incorporated, pointed out, highlighted, referenced, reinforced, modeled, expanded upon, demonstrated, identified, built upon, reflected and showed, explained, adapted, educated, advised, formulated, equipped, constructed, directed

FSC: facilitated, coordinated, collaborated, supported, shared, provided, scheduled, partnered, discussed, introduced, arranged, navigated,

Childcare Visits

Purpose

While the preferred setting for Early Intervention services is the child’s home environment, PIC recognizes that flexibility is sometimes necessary. Services may be provided in child care settings when the child spends a significant portion of the day there and when family members are unavailable for visits during regular business hours.

However, providing services in child care is considered an **exception** rather than the norm. These settings often present challenges, including environmental distractions, inconsistent caregiver participation, and limited opportunities for carryover of intervention strategies from child care to the home environment.

Due to these concerns, PIC providers may deliver services in child care settings only under specific conditions and with clear parameters. For the purposes of this practice, "child care" refers to any group setting where the child is cared for by someone other than their parent or guardian.

Practice

Consider the concerns about serving in childcare prior to planning with families

The following observations have been made by PIC providers about delivering services in childcare:

- sometimes we are serving children in childcare for the convenience of the parent, rather than where the demonstrated need for the child is
- services are not consistently delivered with a coaching model approach in childcare, since they do not include the childcare provider who is busy caring for multiple children
- the childcare provider may not be the full-time carer/may be a substitute
- other primary caregivers/parents are not present, so they don’t they get the actual experience or practice of the interventions even though it is shared with them by PIC providers by email or phone, or through the caregiver.
- PIC providers may have very little time with the childcare provider, and, usually only connect after seeing the child and providing treatment
- many providers report that there is little carryover of treatment due to the circumstances above
- Some PIC providers have delivered services in larger childcare settings by “pulling children out of the class” so that the child and provider are not overwhelmed or interrupted by the other children who want to join in. It should be noted that this is not acceptable practice under child care licensing regulations and not consistent with coaching. Providers work with parents and caregivers to address how we can meet their child’s treatment needs. The most effective treatment for children under the age of three occurs with the people who know and live with them and, within daily activities and routines. If the parent needs to meet us at childcare, or there are no other options and there is a caregiver

available at childcare who can attend sessions there, PIC providers may decide to initiate session at childcare. PIC providers are encouraged to be creative and are aware that we must connect the adults who have the primary relationship with the child when delivering services. An exception to this practice is the circumstance where the childcare is run by the parent who is present and available for intervention.

Procedure
If childcare visits become a priority for meeting the child's needs, providers will consider the following with the family:

1. Since PIC requires a primary care giver (a parent/guardian or a consistent care giver) to be present to support the visit: can a parent/guardian attend the session in the childcare?
2. Will the childcare commit to having the teacher present for the entire session, or most of the session for coaching purposes in the childcare?
3. Is childcare a primary place where the child's intervention needs are best addressed?
4. What is the carryover plan for both settings?
5. How will effective communication occur between settings?

Then, if the only place and time a child can be seen is in childcare, PIC providers will consider the option and decide with their manager to provide services in this setting if there is:

1. a parent/guardian and/or a dedicated childcare provider is present for the visit,
2. a plan for intervention is in place
3. a communication plan with carers and parent/guardian.

Document in RT Communication log with templated note: **Chldcr**

PIC provider discussed with manager providing services in childcare because:

- child care is where the concern occurs,
- parent/guardian and/or a childcare provider is present for the visit,
- a plan for intervention is in place and includes: (ie, visit every other session in parent home, and emailed intervention),
- there is communication plan with carers and parent/guardian

Sample plans include:

- PIC provider will offer 50% services in the home and half at childcare because the care provider will be present for the session in the childcare, and there is a carryover plan to other providers. PIC provider will check in by phone, email or text with parent and home visit to support carryover, or at next visit with parent.
- Services will be provided at childcare and PIC provider will meet with the parent/child at childcare for a portion of each session.
- Care provider, Parent and PIC provider will meet once per month in the childcare for visits, and PIC provider will meet with the care provider and child an additional one time per month
- Parents can attend by Zoom for meetings 1 x per month and in-person at the childcare center in the early morning, and childcare provider will be present for 30 minutes of each session.

Referral: The preferred location is in the child's home with a parent present as an active participant. If visits have to be in childcare, it is under certain circumstances that are discussed with the manager first. If a parent is asking for childcare visits, the parent or guardian will be asked to be present for those visits, and with the consistent caregiver in the childcare. Evaluations will have to be in a dedicated space, if at childcare. If the problem is only happening in childcare, we will make sure to look at what is happening there.

Communication Log

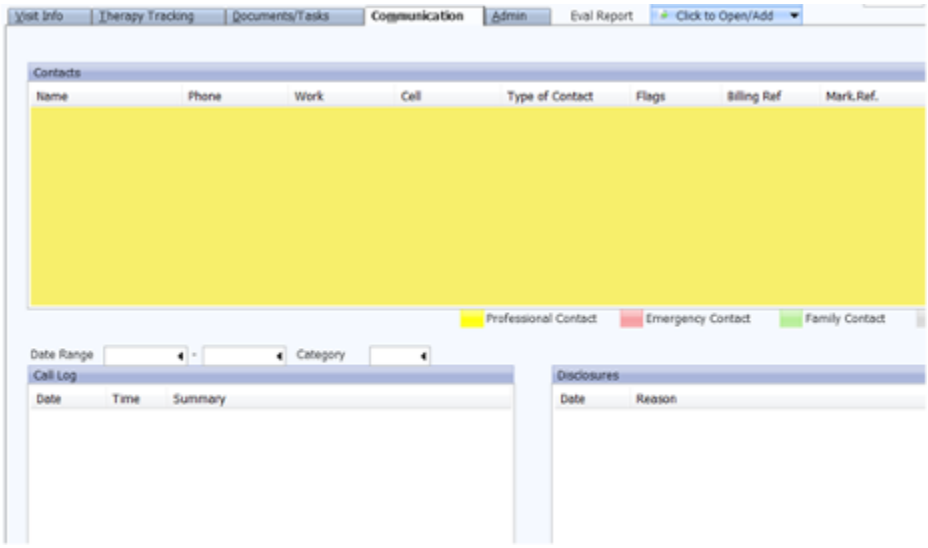
Purpose
Accurately documenting digital communication helps PIC meet the Privacy Rule's requirement to maintain comprehensive records of patient-related communication. Documentation also supports continuity of care, ensuring all members of the PIC care team have access to a complete patient history. Thoroughly documenting these communications creates a comprehensive, compliant record that supports continuity of care and legal accountability.

Practice

The RainTree communication portion of the chart is to log sending or receiving faxes, calls and texts made for service coordination with or for the family, requesting information, and to indicate the final step of exiting a child, 45-day pends and lost to follow up. Other communication that is not in a daily note will be logged here. Keep in mind that logs can be subpoenaed and while not typically released to the family, may be released.

Procedure
To find the communication tab select the client from the patient list and select Chart

The Communication Tab is the fourth tab:



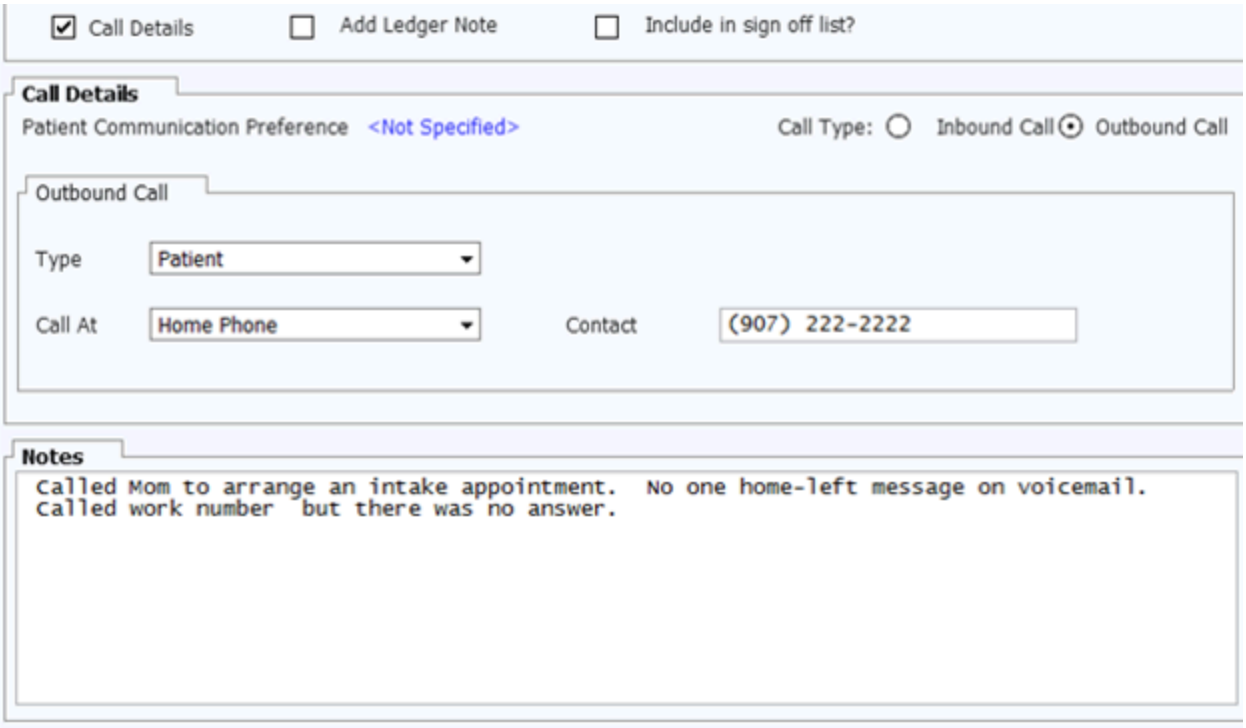
You will see three boxes:

Contacts Box-This is where a list of people involved with the care of the child are listed. Contacts can be added by selecting ADD and completing the information .The Drop Down box under “Contact Type” has a list of the most common relationships. This list can be expanded if there are others we use consistently.

Call Log-Is the location where we would document telephone calls or other communications regarding a child’s care or services.

To better identify the nature of the call, use the category “Freeform Description” box. Pick from the drop down menu.

Select Call Details and another box will appear to document the nature of the call. Please note that you will identify if you received the call or if you made the call.



When to add to the communication log

All communication log notes should include the following information:

- Date/time
- Name(s) of individuals involved
- Summary of information discussed

*All communication log notes need to be **signed off** to be included as part of the electronic medical record. Keep in mind that **logs can be subpoenaed** and while not typically released to the family or legal system, they may be released.*

- Communication with the family members/caregivers via phone call, texts, and/or email (if sent outside of RT) regarding:
  - appointment reminders
  - follow-ups
  - instruction
  - updates from the family,
  - ANY communication involving PHI*.
    *PHI includes the patient's name, dates related to patient's health or identity, phone number, email address, information regarding treatment or conditions, etc. This includes all methods
- Consultation with other health professionals once a Release of Information has been signed by the guardian.

Examples include (but are not limited to):

- Calling or texting the family to schedule, discuss updates, review insurance information, or follow up on signature forms.
- Verbal consent for signature forms
- Phone conversations with outside therapy clinics for coordination of care
- Updates from the family between visits.
- Coordination with OCS
- Referral information

Automated task categories- these will start an automatic process once the comm log note is signed off:

- **45Days Family Pend:** Pend requests, under category

- **Exit/LTFU/Decline/WNL:** Exit reason prior to enrollment under category
- **Screen to Evaluation:** If a child has had a developmental screening and the provider recommendation is for a full evaluation

Enrolled Extended Family Leave of Absence

Purpose
Children whose family contacts the provider with request to suspend services due to extended leave will be offered the choice to reduce their IFSP frequency. Families may also choose to exit services, depending on circumstances, and reenroll at a later date. This allows the provider to maintain compliance and the family to be served appropriately.

Practice
Providers contact the family and discuss options with them and their circumstances. If an enrolled child and family or caregiver goes on extended leave, their services can be pended until the next IFSP renewal or annual. You cannot extend services or continue them in an active status beyond the IFSP end date. When the IFSP has expired, it is invalid.

For less than 3 months' absence:

If the family has a return date and/or a plan to return to services in less than 3 months, the provider will conduct an IFSP meeting to reduce services with the family to an achievable frequency, but will set it no less than 1x per quarter.

For more than 3 months' absence:

If the family plans to be gone longer than a quarter, it's best to exit the child and then re-enroll when they return, if appropriate. This will help ensure that we complete the COS ratings if that child does not come back to PIC services. The family should be informed they will be exited and can restart services if needed and desired, and the child is under age three, and continues to qualify. If the child was evaluated less than 6 months prior, the provider may use that evaluation to continue eligibility upon their return.

Procedure
1. When informed that the family will be out of town for an extended period, conduct an IFSP meeting and provide a PWN to reduce the services to no less than quarterly
2. If the family has a return date, and an intention to return, discuss with the family options and set a date for the next appt or phone call.
3. The provider and family will agree upon contact means, and date for follow-up.
4. If the family is not sure when they will return within 90 days or the time is more than a quarter, let the family know that we will exit.
5. If exiting, conduct an IFSP meeting with a PWN to exit.
6. The family can re-refer with a call at any time up to age three.

Consultation and Secondary Provider

Consultation/Secondary Provider: One-time

Purpose:

This is a consultation that is completed with the primary service provider and the child/family by another PIC provider. The consultations may be for different reasons, such as a closer look at the child's functioning during a daily routine or activity.

Practice:

The consultant may be offering ideas about how to help facilitate success on a goal or outcome. This is a collaborative conversation and may or may not include an assessment tool beyond the provider's and family's observations and interview. The primary and the secondary will consult prior to visit so that the consulting provider knows what questions or concerns they are addressing. The primary service provider requests that a secondary provider attend the visit and may request that directly from a team member or in a team meeting.

Procedure:

- Signature forms: PWN, Consent to Evaluate, and optional ROI if consult results will need to be shared with outside agencies.
- Documentation: Consultation note in Raintree from the consulting provider about what occurred.
- Documentation from Primary service provider: Daily note that indicates FSC/service coordination with consulting provider and the outcome of the consultation-how the recommendation will be utilized.

- Billing for primary service provider: Family Service Coordination for the time spent in facilitating the interaction with the family.
- Billing for consulting provider (if appropriate): Billing codes used will be specific to your discipline, for example:
    - OT/PT: Physical Performance test with report
    - SLP: Speech/Language Evaluation
    - SLP/OT for Feeding: Feeding Evaluation
    - DS: Non Billable Evaluation
    - SW: Social Work

Note: if a consultant conducts a second visit and is not added to the IFSP:

Therapy/FSC-- The typical practice is for a consulting provider to schedule a return visit to share evaluation results. Activities (such as therapy services or FSC) delivered by the consulting therapist during the visit should be indicated on the billing tab with times/units, however, the consulting therapist's FSC activities are not billable since there is not a POC in place.

Evaluation--if evaluative activities take place during a second visit, the secondary provider activities are billable if evaluation occurs.

Consultation/Secondary Provider: On-going Services

Purpose:

When a provider, who is not the Primary Service Provider, is added to the IFSP with the permission of the family, to provide more support around a specific domain, such as motor development to the child, parent, and primary provider.

Practice:

After completing an evaluation, and/or interview and observation visit, the team subsequently recommends that the consultant provider be added to the IFSP for regular intervention/treatment due to child need for their intervention. They will support the development of the appropriate goals and then help facilitate success for goal or outcome. This all takes place within a collaborative conversation and may or may not include an assessment tool beyond the provider's and family's observations and interview. The primary and the secondary will consult prior to visit so that the consulting provider knows what questions or concerns they are addressing. The primary service provider requests that a secondary provider attend the visit and may request that directly from a team member or in a team meeting. The primary is responsible to adding the secondary to the appropriate goals on the IFSP.

Procedure:

- After the consult or evaluation, the primary service provider will add new service (if indicated) to the IFSP with appropriate start date and frequency for the quarter. Any new or revised goals need to be added to the IFSP/Plan of Care. All changes to IFSP services require a parent signature & initials, date and PWN.
- The consulting provider completes a Plan of Care and may use the following codes based on what occurs at the consultation visit
    - OT/PT: Physical Performance test with report
    - SLP: Speech/Language Evaluation
    - SLP/OT for Feeding: Feeding Evaluation
    - DS: Non Billable Evaluation
    - SW: Social Work
- Documentation needed by the Primary Service Provider: Document the visit that occurs with the consulting provider in a Daily Note. This is evidence of collaborative teaming and is a FSC event.
    - Documentation needed by the consultant/secondary: Prior to being added to the IFSP, document your consultation visit in a Consultation Note. After being added to the IFSP, complete Daily Notes. If there is a need to add objective findings, use a Consultation Note.
    - Billing for Primary Service Provideres: Family Service Coordination if the consulting provider is also coaching you how to facilitate a specific position or activity, or you facilitated or supported the visit.
- Caseload: An opportunity to add the child to the secondary's RT caseload, after signing off a Plan of Care note in child's chart, please mark 'Yes' to the popup question 'Do you want this child added to your caseload?'.

Noting and Billing In Raintree for Assessments that are completed by the Primary and Out of Normal Timeline Sequence

Purpose:

PSP therapists occasionally complete an assessment that is requested of them by the family, or they have recommended in the course of intervention/treatment. Documentation and billing will be completed by the primary and should note that this stands as a separate document from a daily note for that day. Another way a provider may think of this is that they have completed a consult to themselves.

Assessments are documented in a RainTree Consultation Note.

Complete the following tabs:

- Observation: enter a complete a description of the assessment activity completed, write-up of observations made during the assessment
- Summary of Findings: enter the interpretation and the recommendations
- Objective Findings: enter the test/assessment results

Billing Codes

OT, PT, SLP Therapists

Developmental Eval

Health and Beh Assessment

Developmental Therapists and Social Workers

Nonbill eval

Additional Resources: Mini Grant and Part C Requests

Mini-Grants

Purpose

PIC providers may apply to the Mental Health Trust Authorithy on behalf of enrolled children for additional fundin for items that will not be covered by Medicaid, Part C grant funding, or other funding sources. The MHTA receives $70,000-$90,000 dollars in requests from agencies per month and have about $30,000 to allocate. Therefore, MHTA will review requests in order of the following priority:

1. Medical equipment and services
2. Mental equipment and services
3. Vision equipment and services
4. Hearing equipment and services
5. Physical, occupational or speech therapy equipment and services
6. Home improvements or environmental modifications

Practice

PIC providers establish with the family their needs and concerns when applying for minigrant. If ordering man items, the provider will work with the family to prioritize the items requested in order from highest need to lowest need. $2500 is the maximum amount that that can be requested, and for items that are not included in thecategories above will be excluded from the award, and likely will be limited to $1250.

Providers should attempt all funding sources (Medicaid, insurance, parents) prior to applying for mini-grant funds.

The MHTA has requested that PIC consider carefully what items are requested in relationship to the categories list, prior to application. For example, specialty items such as a car seat that accommodates a disability, or a highchair that adjusts for a feeding need are likely to be awarded. Everyday items that do not fulfill a specific therapeutic need to increase child functioning. Additionally, they won't approve a trampoline, hoverboard, or everyday items such as a booster seat that any typical toddler might need or benefit from. Assure when requesting from this funding source that only specialty items for the child.

For OCS, please check in about funding that be available for a child through OCS—letter of denial from the OCS worker is helpful. This can be a copy of email that is included in the application.

PIC providers may withdraw the funding request after the award, if the amount awarded is insufficient.

Procedure
Providers:

1. **Add PIC provider** name and client name to MHTA Mini-Grant Tracking here in Sharepoint to reserve a mini-grant spot
2. **Complete the Mini-grant** Application at the MHTA website
    - Applications must be received by the close of business on the 15th of each month.
    - In the narrative state: the highest priority items, if the child will age out within a few months, consider items that go together as group (ie, iPad and apps), if time is limited equipment is needed to address developmental concerns immediately. Also in the narrative, add the following statement to allow for some flexibility with leftover funds: “With prices of goods changing daily, we also request that any funds left over due to a change in price be approved toward miscellaneous learning materials appropriate for this beneficiary (books, puzzles, etc.).”
3. **Complete this ordering and application worksheet** to include item, shipping, website, and totals, shipping address and indicate the following
    - Ship to PIC, or to provider home, if preferred. Do not ship smaller items to families as they often get stolen from residential areas.
    - Very large or heavy items ship directly to families
    - Check shipping by completing order up to payment but DO NOT pay for item
    - Subscriptions and memberships can be requested--**tell parents not to pay**, as they cannot be reimbursed
4. **When the award is received:**
    - Email award to Deputy Director or Executive director for signature.
    - Set an appointment with Julie when she is available Tu, We, Th. This is an FSC appointment for the provider—it will take an hour at least, and completing the worksheet is critical to expediting.
        - Prior to meeting with Julie--Provider confirms worksheet items, shipping, website and totals, or update items prior to meeting with Julie:
            - Reconfirm each item is available at the website.
            - For items that are not available: update with new items and check shipping through to payment page, but DO NOT PAY FOR ITEM.
            - Total must not be more than +/- $10 of the total of the award.
            - When confirmed, email list to Julie.
    - Attend appointment with Julie with worksheet, Julie will place order. If changes are needed, you update the worksheet as the order is placed.

Mini-grant Ordering--Julie will:

1. Communicate with provider to set appointment to order items, request copy of worksheet and confirm that it was checked and updated prior to appointment.
2. Order with providers: during order appointment any changes that are made to the order will be changed by the provider, including shipping and that order within +/- $10 of grant award.
3. Remind providers that iPads are set up with the parents—they are hard to set up and if not set up with the parents, the app receipts may get hung up in process for weeks
4. Handle payment for order.
5. Collect and file receipts, provider work sheet and the signed mini-grant in SharePoint.
6. Track order and shipment.
7. Inform provider that order has arrived.

8. Mark the file completed.

Finance Manager Process

1. Sign the mini-grant, send out to Julie, and the MH Trust, and provider.
2. Confirm that money arrives in the account and inform Julie so that she can set appt with the provider.
3. Send receipts from file in Sharepoint>Finance>Minigrants to Mental Health Trust.
4. Confirm amounts spent and reconcile finances.

Part C Requests

Purpose

Part C funds may be requested to by the provider on behalf of the family if certain conditions have been met, and if approved by PIC's Part C Coordinator and the Executive Director. Only ILP-enrolled children can be the recipients of Part C funding requests.

Practice

Providers may request funding using Part C grant funds with the following considerations:

- Part C is the **funder of last resort and is paying for intervention that is,**
  - Therapeutic or developmental in nature, and is
  - Provided by qualified therapists
  - Items or therapies that are necessary for the child to benefit from Early Intervention
  - Aligned with the IFSP outcomes

Prom the legistlation, payment may be made for:
(1) Early intervention services under Part C;
(2) Eligible health services, as defined in34 CFR §303.16;
(3) Other functions and services authorized under Part C including Child Find (34 CFR §§303.115 through 303.117 and 34 CFR §§303.301 through 303.320), evaluations and assessments (34 CFR §303.321).
iii. Payments do not apply to other medical-health services or well-baby care as defined in Part C.

Procedure

Providers will complete the Part C request using the form attached here. This PIC form will be approved by the Part C Coordinator, and the Executive Director. Orders for items will be placed by the Part C Coordinator who will maintain a record of the request and reciepts for audit, and submit reciepts for payment to PIC's Finance Manager. Request cannot be less than $30.

Part C Funding Request

Transfers To and From ILP

Transfers from Other ILP for Enrolled Child

Purpose

This process assures that there is continuity of care when children move from one agency to another in the State of Alaska ILP system.

Practice

When a child is transferred from another Infant Learning Program (ILP) and is already enrolled, PIC will assume the enrollment. The Referral Specialist will ensure that a copy of the child's evaluation and IFSP are located in the child's RainTree (RT) file.

PIC providers will then complete the standard intake process with the family.

If the child is enrolled in a **non–Part C** program, the **Referral Specialist** will consult with the sending program to determine appropriate next steps.

Review of Existing Evaluation

PIC reviews and may use the existing eligibility evaluation **if**:

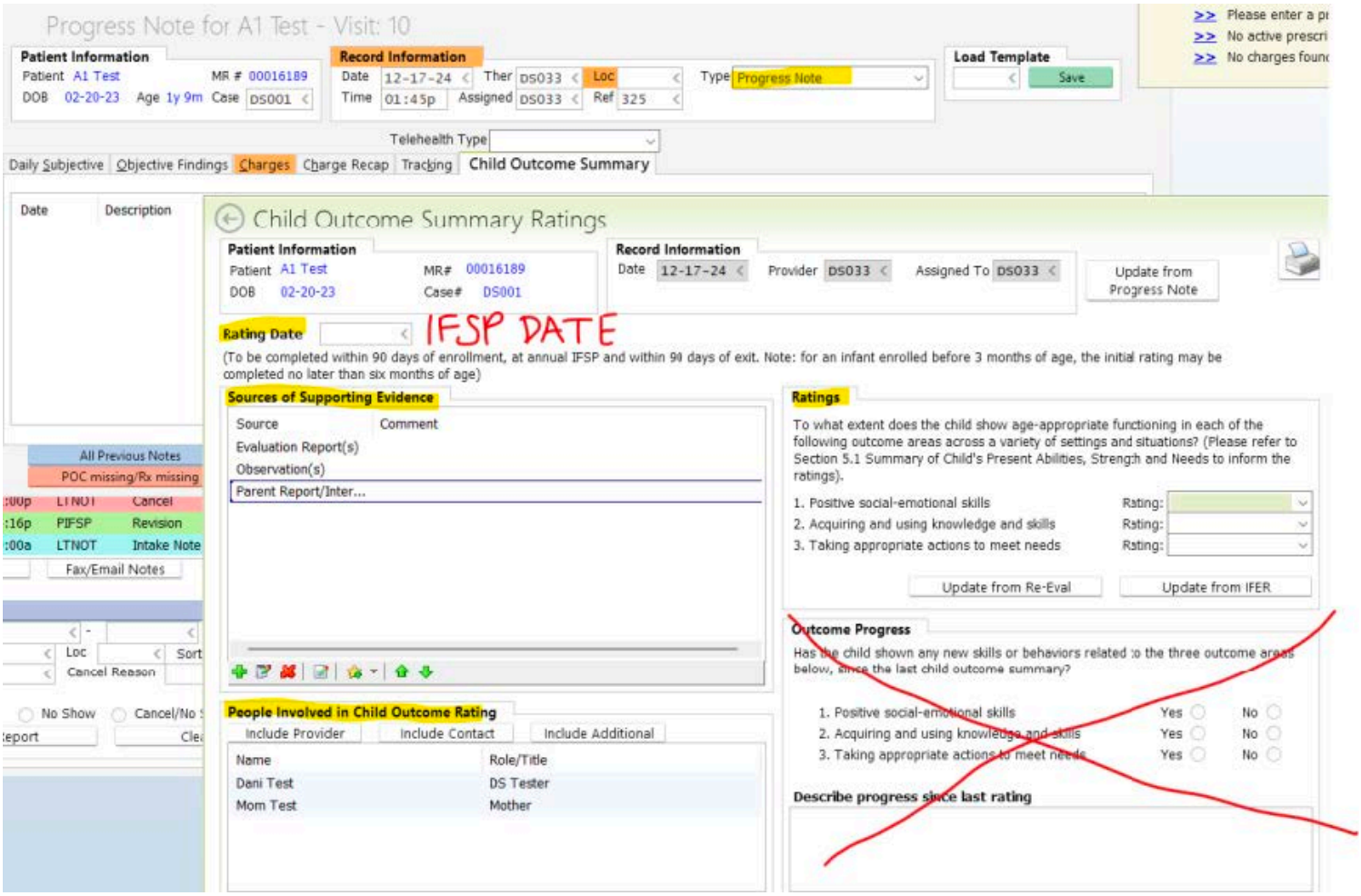
- It is **not past the annual due date**, and
- It provides **sufficient and accurate information** to update the IFSP.

If the evaluation **does not accurately reflect the child's current presentation** or lacks sufficient detail, the provider should recommend a **re-evaluation**.

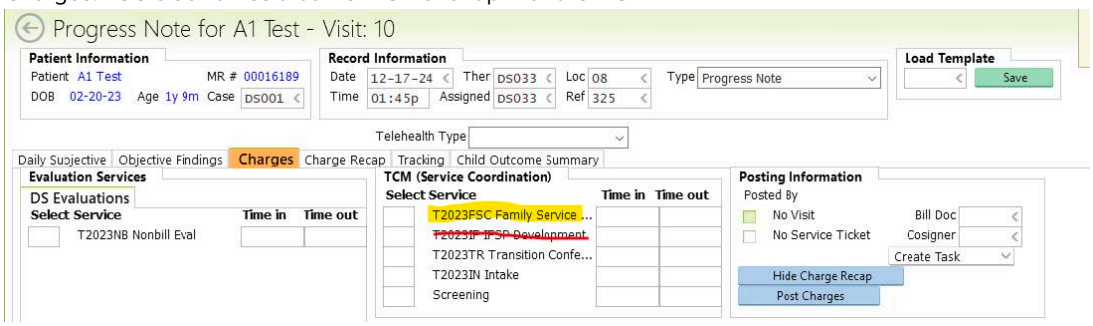
Procedure
Documentation:

- Intake
- Releases and consents, procedural safeguards
- **Record review for the evaluation**: The provider reviews the records and consider the following,
    - is the evaluation complete,
    - descriptive of the child's current level of development,
    - can the IFSP be updated to create appropriate goals that address the parent's concerns and child's current presentation.
- **Re-Evaluation:** If the provider finds the evaluation does not meet the above criteria and recommends re-evaluation and the parent agrees, then provider will complete the re-eval and update the IFSP and goals (see below).
- If the provider finds the Other ILP evaluation meets the criteria:

  Assure that the evaluation is complete with COSF scores. If COSF scores are not included with the evaluation, complete a Progress note with **ONLY** the COSF for the date of the enrollment IFSP, and completed based on the evaluation notes, provider observation, and parent input.



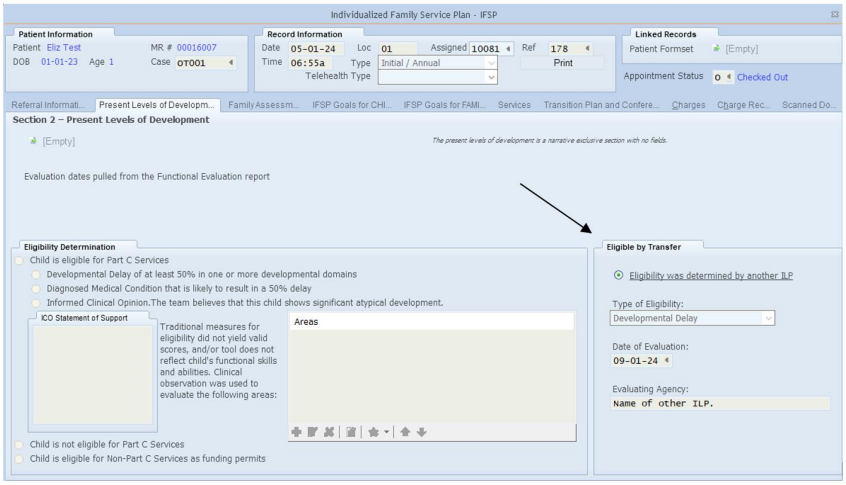
Charges: FSC clock times that **DO NOT** overlap with the IFSP



1. In the IFSP, go to Subtab (see below) Eligible by Transfer.
2. Select the radio button “Eligibility was determined by another ILP”

   Provider must complete the fields for EACH:
   - type of eligibility (50% delay, Part C dx, ICO)
   - date of eval

- evaluating agency



Note: The evaluation date from the previous ILP carries over. If PIC does not complete a new evaluation, PIC remains bound to the previous ILP's annual review timeline. If PIC completes a re-evaluation, new timelines begin from that date.

Out-of-State Transfers

PIC does not have an automated transfer process for out-of-state cases. Therefore, providers must complete all steps of the intake-to-enrollment process as if it were a new referral.

Transfer to Another ILP (Within Alaska)

Out Going Transfer Workflow

Non-OCS Children

Provider Responsibilities

- Obtain an ROI for new ILP, signed by parent or guardian.
- Confirm all contact information is correct.
- Complete all notes and documents including a discharge note in Raintree.

  Non-enrolled children: enter a note in the communication log and choose the Category Exit/LTFU/Decline.

- Email Admin and CC Referral Specialist Rose: use the following "please transfer (enter child name) to (enter new ILP). Family relocated to (enter City) on (enter date)" and include that the discharge note has been completed and a ROI is on file.

Admin Responsibilities

- Confirm in Raintree discharge note is completed, and then change the status to Exit or Decline.
- Enter data in the State Data Base: Evaluations, IFSP, Outcome etc. (Micheala can confirm this portion)
- Confirm the ROI is on file.
- Update contact information in both systems, if needed.
- Enter a note in both systems regarding the transfer and include important information such as additional contact info or special instructions. (Example: Transfer services to MSSCA per PIC provider request. ROI on file and PIC records faxed to MSSCA ILP. Contact information is updated, please contact parents to resume services.)
- Complete the Transfer in State DB
  a. Enrolled Children - Click on IFSP/Enroll tab, click green plus sign next to Enrollment, Record Type is transfer, choose ILP and save.

b. Non Enrolled – Click on Admin, then Transfer Unenrolled and complete the prompts.

- Fax records to new ILP which include Functional Eval, IFSP, Plan of Care and consults. In the comment section It will state To: MSU ILP, Incoming Transfer from PIC.

OCS Transfer

Under the **OCS–ILP MOA Guidance** (April 2025), children in OCS custody who are either currently enrolled in ILP or are in the referral process **do not require a Release of Information (ROI)** to be transferred to another ILP within the State of Alaska. Their records may be shared directly with the receiving ILP.

Additionally, **information and documents related to a child in state custody can be released to parents or foster parents without an ROI**.

Important considerations:

- If **parental rights have been terminated**, OCS must provide an ROI before any information can be released to that individual, as they no longer have legal access to the child's records.
- In most cases, **parents retain their rights** while their child is in state custody, and termination of rights is relatively rare.
- Providers must exercise **careful judgment when documenting services involving foster parents**, to ensure that if the record is later released to the biological parent, **confidential information about the foster family is not inadvertently disclosed**.

Provider Responsibilities:

- Confirm with the caseworker the child is changing placement and OCS would like services to be transferred. (Do not transfer until child relocates in order continue services as long as possible)
- Email Change of Placement form form to the caseworker or the Placement Search and Support Unit (PSSU) for updated placement information:
  - 1-855-603-8637, Option 2
  - fcs.ocs.pssu@alaska.gov
- Assure all data entry is completed and enter a discharge note in Raintree.
  - **For children not enrolled in ILP/still in referral:** enter a note in the communication log and choose the Category Exit/LTFU/Decline.
- Email Change of Placement form: "please transfer (enter child name) to (enter new ILP). Family or child relocated to (enter City) on (enter date)" and advise if the discharge note is completed.

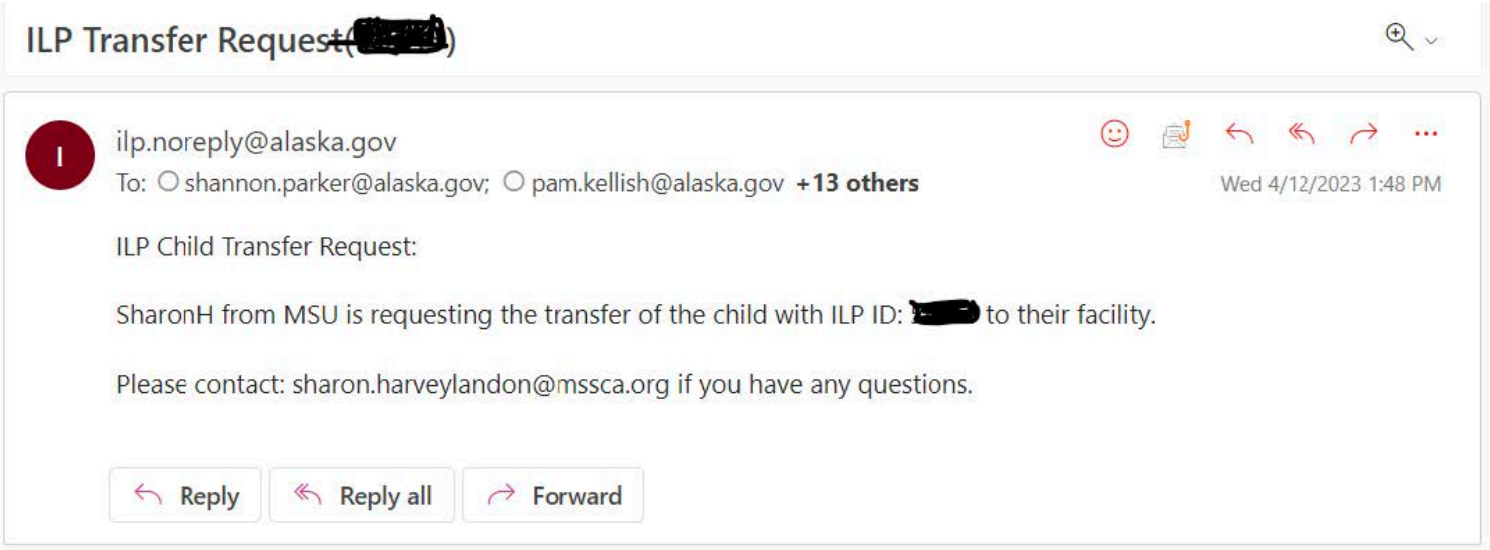
Admin Responsibilities

- Confirm in Raintree discharge note is completed, and then change the status to Exit or Decline which ever applies.
- Enter data in the State Data Base: Evaluations, IFSP, Outcome etc. (Micheala can confirm this portion)
- Update contact information in both systems if needed. (The contact information in the State DB should be updated to the new placement, so the new ILP knows who to contact).
- Enter a note in both systems regarding the transfer and include important information such as additional contact info, OCS info or special instructions. (Example: Transfer services to MSU per PIC provider request. PIC records faxed to MSU ILP. Contact information is updated, the assigned caseworker is _ and their information is _. Please contact parent/guardian to resume services.)
- Complete the Transfer in State DB
    a. Enrolled Children - Click on IFSP/Enroll tab, click green plus sign next to Enrollment, Record Type is transfer, choose ILP and save.
    b. Non Enrolled – Click on Amin, then Transfer Unenrolled and complete the prompts.
- Fax records to new ILP which include Functional Eval, IFSP, Plan of Care and consults. In the comment section It will state To: MSU ILP, Incoming Transfer from PIC.

ILP Transfer Request Workflow

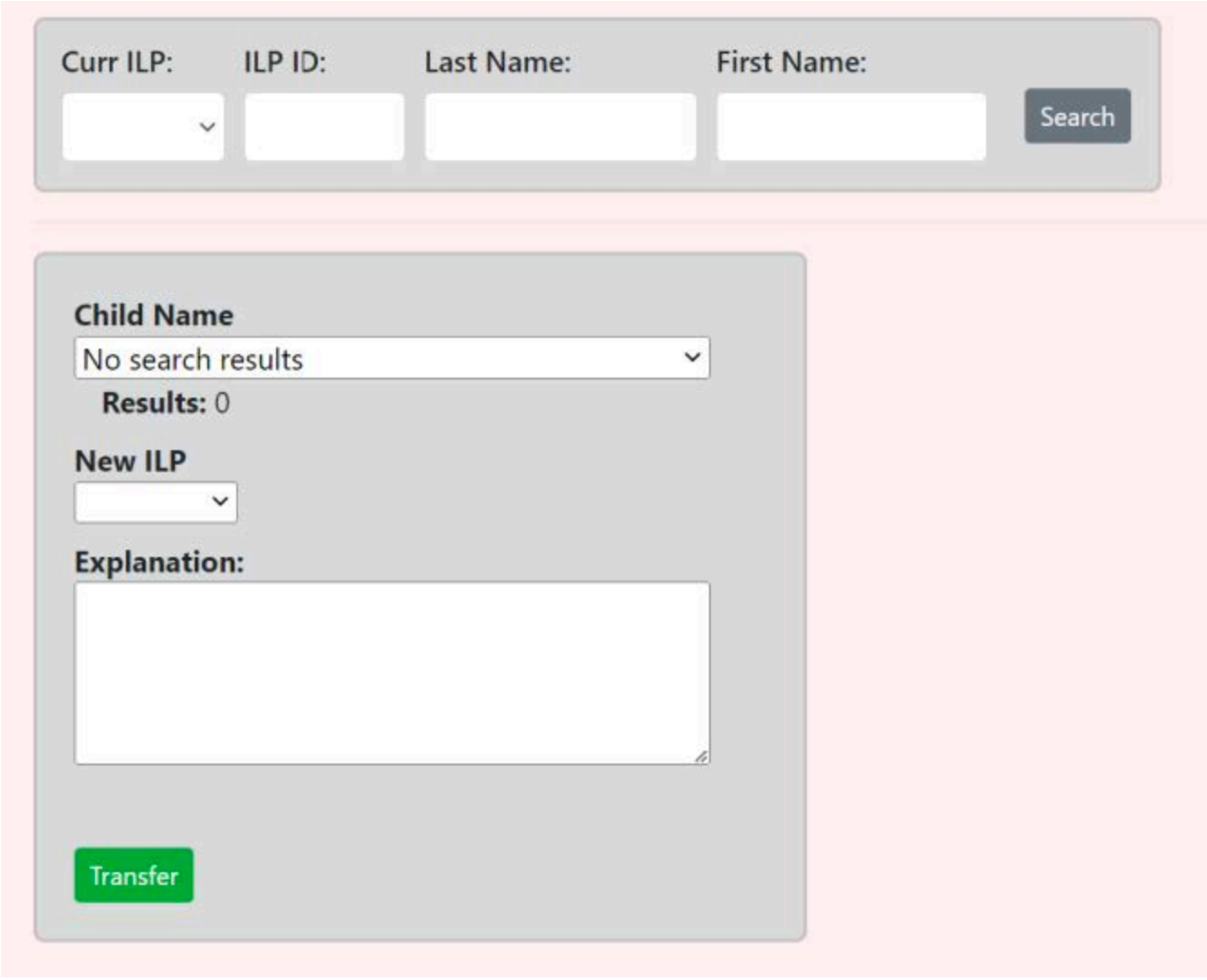
Early Intervention programs across Alaska often request transfers for children that may not be actively receiving services. When an agency receives a referral and a possible match is identified in the State DB, it will request if you would like to transfer this record to your agency. When an agency clicks 'yes' it will send a notification via email to the current assigned ILP requesting a transfer. At that time, the recieving agency has 24 hours to transfer those records.

- **Agency will receive a request from the State DB via email.**



- Look up the ILP ID number in the State DB and in Raintree. **(Make sure the ILP ID matches the information in Raintree)**
- **For in-process children (pending or undetermined): Send an email out to anyone associated with the child in RT (Referral Specialist, PSP, team manager) to update RT with any/all information so transfer can take place within 24 hours of request**
- Enter a note in Raintree stating the following: Transfer completed per MSU ILP request.
- Complete the Transfer in State DB
    a. Non Enrolled – Click on Amin, then Transfer Unenrolled and complete the prompts.

b. In the Explanation box enter: Transfer per MSU ILP request.



Incoming Transfer Workflow

- PIC will receive an incoming transfer by email and sometimes fax.

Rose's Responsibility

- Process the transfer by following referral guidelines.

Office of Children Services

In October 2024, a Memorandum of Agreement (MOA) between Senior and Disabilities Services' Infant Learning Program (ILP) and the Office of Children's Services (OCS) was completed at the state level. This document is meant to guide ILP programs to a better understanding of what this MOA means for your everyday work regarding the Child Abuse Prevention and Treatment Act (CAPTA).

Practice of OCS Legal Custody but Living with Family

Practice

Role & Responsibility	OCS assumes legal custody of a child; child remains placed with parents
Authorization rights	OCS signs initial PIC ROI with medical releases and Consent to Bill. Parents retain right to make educational decisions on behalf of child. Parents authorize: IFSP, Consent to Evaluation, non-medical or school-based ROIs. In order to obtain a copy of the full record, parent or caretaker must obtain written permission from OCS worker.
Medical Records	OCS can sign ROI for medical records. In order to obtain a copy of the full record, parent or caretaker must obtain written permission from OCS worker.
Transfers	OCS signs PIC ROI permitting the release of information to the new ILP. (Also see State Transfer Guidance)
Share eval. with OCS/GAL	Yes
Surrogate Parent form	No

Legal & Physical Custody/Living with Foster Family

Role & Responsibility	Assumes primary responsibility for safety/placement of a child, when removed from parents
Authorization rights	OCS signs initial PIC ROI with medical releases and Consent to Bill at referral (this is a single document effective 1/2025). The law allows foster parents to make educational decisions on behalf of the child, and they authorize: IFSP, Consent to Eval, non-medical or school-based ROIs. In order to obtain a copy of the full PIC record, parent or caretaker must provide written permission from OCS worker.
Medical Records	OCS signs ROI to obtain medical records, includes court order (for hospitals) documenting child in OCS custody. In order to obtain a copy of the full record, parent or caretaker must obtain written permission from OCS worker.
Transfers	OCS the ILP informs that the child is being transferred to a new foster home (Also see State Transfer Guidance)
Share eval. with OCS/ GAL	Yes
Surrogate Parent form	No

Contacting foster families and the caregivers of children in OCS custody

OCS will support PIC and provide updated family contact information or updated case worker information and provide current ROIs if needed. This is to reduce barriers to enrollment and shorten wait times for children in custody.

OCS Placement Search and Support Unit (PSSU)

1-855-603-8637

Press option 2

fcs.ocs.pssu@alaska.gov

Change in Placement

Purpose
Keeping with Alaska ILP's policy that "an agency may presume that the parent has authority to inspect and review records relating to his or her child unless the agency has been provided documentation that the parent does not have the authority under applicable State laws governing such matters as custody, foster care, guardianship, separation, and divorce."

Once PIC becomes aware that a child is no longer with the previously known placement, it is PIC's policy that we establish the correct placement in writing.

AK ILP Policies effective July 2023

Practice
Once PIC becomes aware of the change in placement of a child, PIC will no longer contact the previous placement's primary contact until written documentation has been received for who the primary contact/guardian is for the child.

PIC has an OCS Change in Placement with ROI as of 2.18.25.pdf

If there is a delay in services due to non-responsiveness of the caseworker, the provider should reach out directly to OCS Placement Search and Support Unit (PSSU):

Phone: 1-855-603-8637

Press option 2

Email: fcs.ocs.pssu@alaska.gov

Procedure

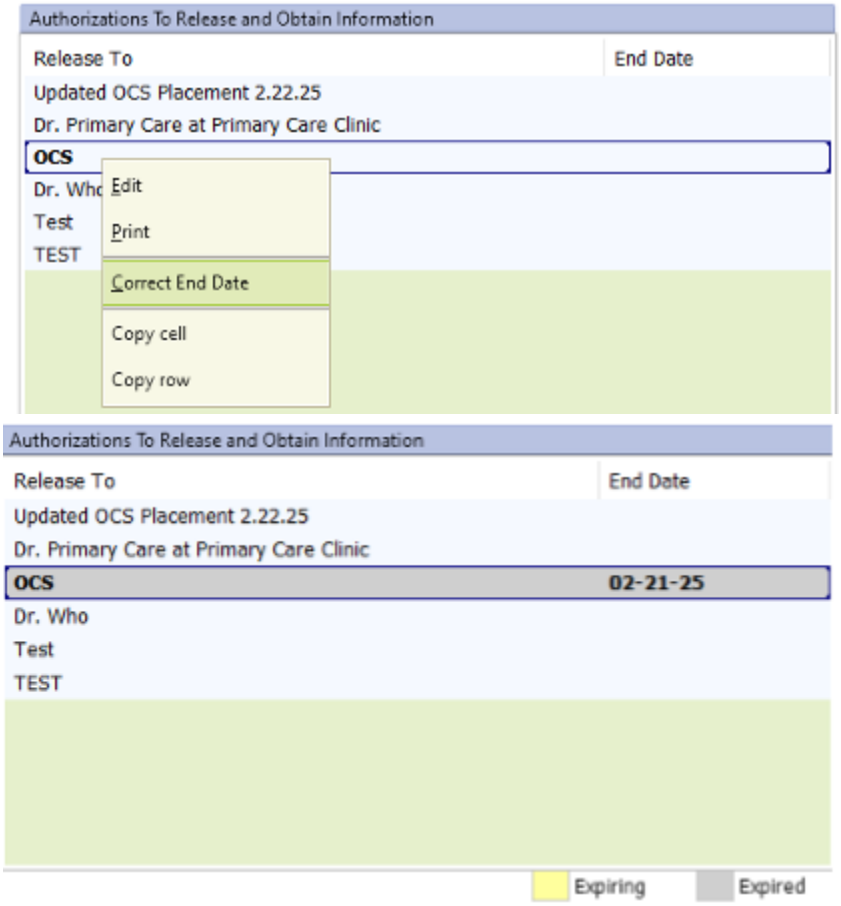
Providers

1. When the PSP becomes aware of the change in placement, they should reach out to the child's caseworker for the updated OCS Change in Placement with ROI as of 2.18.25.pdf form.
2. Once that has been signed, the PSP should email it to admin@picak.org

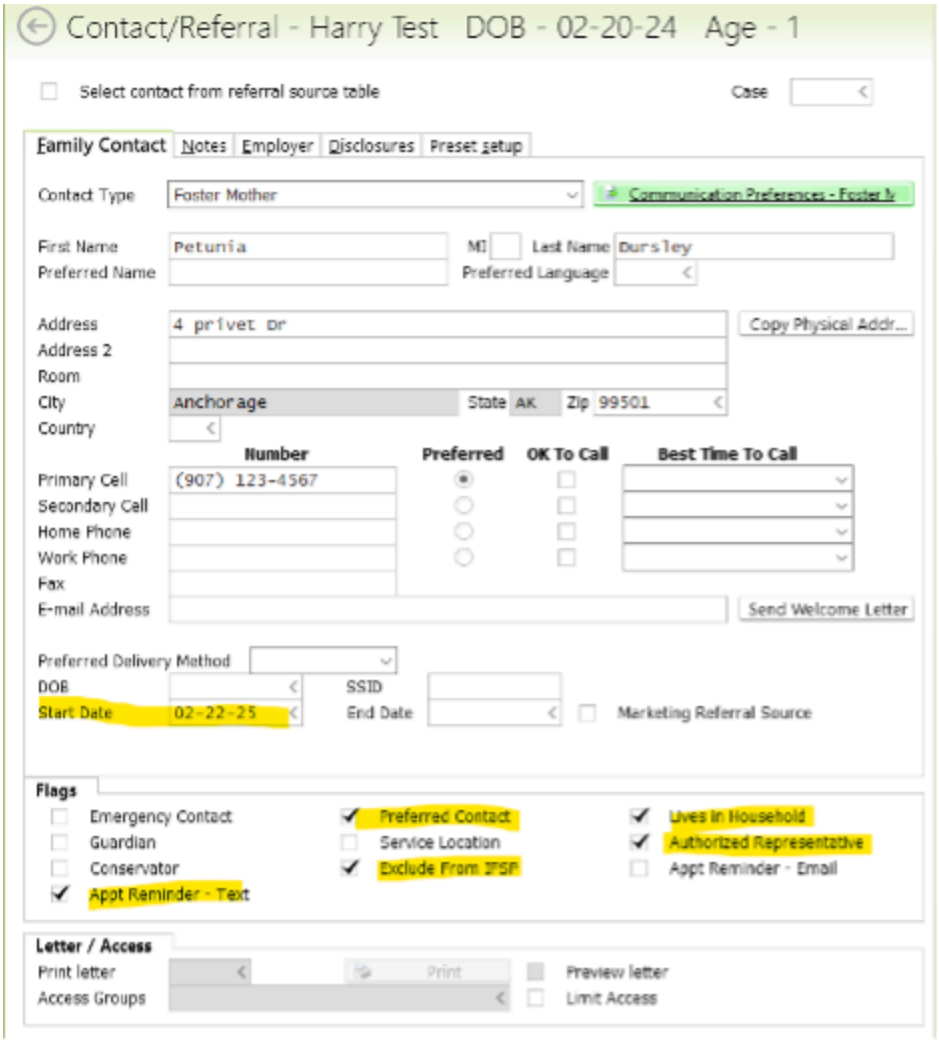
Admin

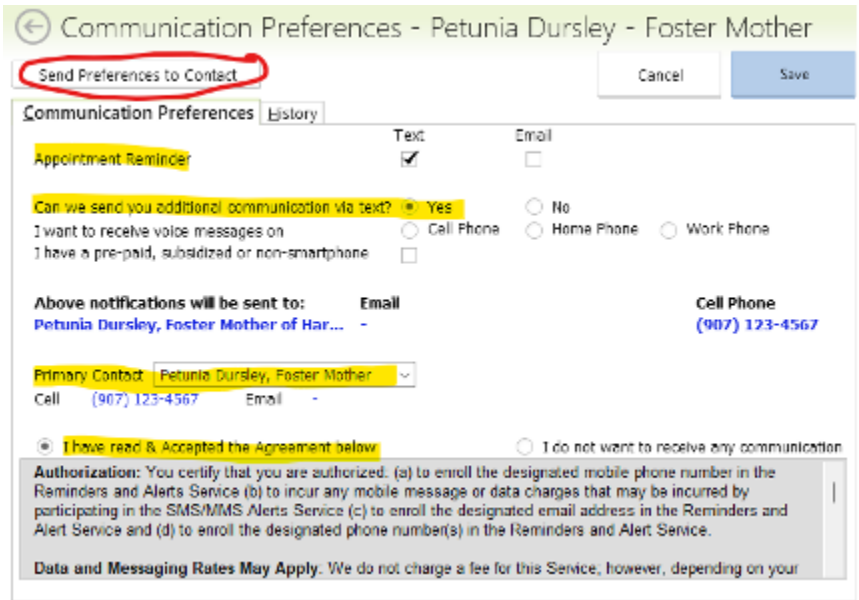
1. When a Change in Placement with updated ROI is received, upload to the child's chart Documents under the category "Release of Information" and freeform description "Updated OCS placement as of mm/dd/yyyy" The date should match that listed on the placement form, not necessarily the date the paperwork was received.

2. In the Admin tab, then go in and manually add the end date for the previous OCS ROI with the day prior to the placement date.



3. Then update the contacts per the form. This will include adding the new contacts with a Start Date, as well as the COMPR with the standard preferences pre-chosen and sending it to the primary contact.





4. The Patient Demographics tab also needs to be updated, so that the signature forms no longer go to the previous placement's email address/ phone numbers. **Don't forget to add in a gibberish password to prevent a password loop!**

5. For OCS children, PIC uses the OCS office address for their demographic address, only the contacts have their physical address, so there is usually no need to update the address outside of the specific contact, but always double check!

Documents

OCS Change in Placement with ROI Form

Safeguards

HIPAA

Purpose

PIC falls under the umbrella of a "health care provider that transmits health information in electronic form in connection with a transaction for which the Secretary of HHS has adopted standards under HIPAA" (see document Summary of the HIPAA Security Rule _ HHS.gov.pdf). PIC is held to HIPAA security standards. PIC's HIPAA FAQ form covers our HIPAA and Notice Privacy Practices, which must be reviewed and signed annually by families. Please also see the reference document Understanding Patients' Health Information Rights for PIC's responsibility for use and disclosure of PHI.

Practice

HIPAA Practice/Legal Name Policy

PIC does not collect birth certificates for children in its care. Instead, the child's legal name is confirmed by the parent or caregiver at the time of intake. The legal name is defined as the name that appears on the birth certificate, which may differ from the name commonly used by the parent or caregiver. PIC often receives referrals for infants whose legal name includes "Baby Boy" or "Baby Girl" as their designated first name. In all cases, the legal name provided will be entered into RainTree exactly as it appears on the birth certificate, and as reported by the caregiver.

Designating a Nickname or Given Name

Until the child has change of birth certificate, the child can have a nickname or given name in quotes in RainTree such as Baby Girl "Birdie" Smith

Establishing an Alias in RainTree

If a provider is informed that a child's name has been legally changed, the provider will inform the PIC Data Entry team, who can establish and Alias in the electronic Health record. PIC will request documentation of this change; however it is **not** required.

Guardianship

PIC does not require documentation of legal guardianship. In cases of OCS involvement, PIC will accept a change in placement form, paired with an ROI sent to OCS (Change of Placement with ROI- fillable). Due to "Unreasonable Measures" PIC does not require guardians to have a signed ROI in place to receive the minor's records themselves, only if being sent to a 3rd party.

Procedure

A summary of PIC's HIPAA procedures includes, but is not limited to:

1. Client Legal Name Change and Documentation.docx
2. Written Disclosures: Rain Tree automatically tracks written disclosures when records are faxed or emailed through Rain Tree. This is found in the Communication tab of the Chart under "Disclosures" including date/time, what records are sent, and reason for the disclosure.
3. Communication Log Procedure.docx
4. Release of Information Procedure.docx
5. Medical Records Requests Admin Procedure for Processing Record Requests.docx
6. Corrections may be made to the record Correction to the record per parent request

Correction to the Record Per Parent Request

Guardians can request a correction/amendment to the record for anything that they've identified as clerical error or not factually accurate. The most common examples of this include a misspelled name or correcting who was present during a home visit. It does not include a provider changing their clinical opinion. The guardian needs to do the following steps:

- Identify the Record: Clearly specify which record they are requesting a correction for.
- State the Correction: Clearly state the specific correction or amendment they are requesting.
- Justify the Request: Provide a detailed explanation of why they believe the record is inaccurate, irrelevant, untimely, or incomplete.
- Submit in Writing: Addressed to the responsible agency.

PIC will then have 60 days to respond the written request:

- If a parent/guardian indicates that the information in the record is incorrect, they can request a change, or amendment, to the record. If PIC created the information, we must amend inaccurate or incomplete information.
- If the PIC provider does not agree to the request, parents and guardians have the right to submit a statement of disagreement that the provider must add to the record.

See 45 C.F.R. §§ 164.508, 164.524 and 164.526, and OCR's Frequently Asked Questions.

HIPAA Forms & Documents

Documents
HIPAA Signature Form
Summary of the HIPAA Security Rule - HHS.gov
Understanding Patients' Health Information Rights

FERPA

Procedure
In addition to HIPAA, PIC is also governed by Family Educational Rights and Privacy Act (FERPA). As a result, PIC is held to a higher standard than if operating under HIPAA alone. In practice, this most often affects the handling of medical records and release of information (ROI). Unlike under HIPAA, FERPA does not allow us to share information with referring providers without a signed ROI on file.

Purpose and Practice

What is FERPA?

FERPA is a federal law that affords parents the right to have access to their children's education records, the right to seek to have the records amended, and the right to have some control over the disclosure of personally identifiable information from the education records.

Key points:

- FERPA is more restrictive than HIPAA, health records are considered education records, so we cannot release those records without an ROI, even to the referring doctor.

- We can't make a referral without an ROI, due to releasing Personally Identifiable Information (PII), covered under FERPA. PII is considered any identifying information that makes the child easily recognizable by itself or in combination, for example:
  - Child Name
  - Parent Name
  - DOB
  - Age
  - Address

See pages 3-5 on the following document for more details:

https://acrobat.adobe.com/id/urn:aaid:sc:US:9f7b8a5e-8a3c-4334-a8d1-7abdad763b03

Practical Application:

- Check patient file for ROI or Release of Information for the establishment or doctor in question, and if there is not an ROI state or email the following:

  "Due to FERPA I can only confirm/deny that we are in communication with this mutual patient until we have a completed ROI on file, would you like me to send over our Release of Information paperwork for the Parent or guardian to fill out?"

- If ROI is on file, provide information requested.

Secondary Release under FERPA

Secondary release of information, including all medical and educational records, is not allowed under FERPA.

IDEA and FERPA Privacy Provisions - Understanding the Basics

Documents

FERPA

10-Day Letter

Pre-enrolled Child/Notification of Potential Discharge

What is a 10-day letter?

This is a notice sent to families who are pre-enrolled and informs the family or case worker that:

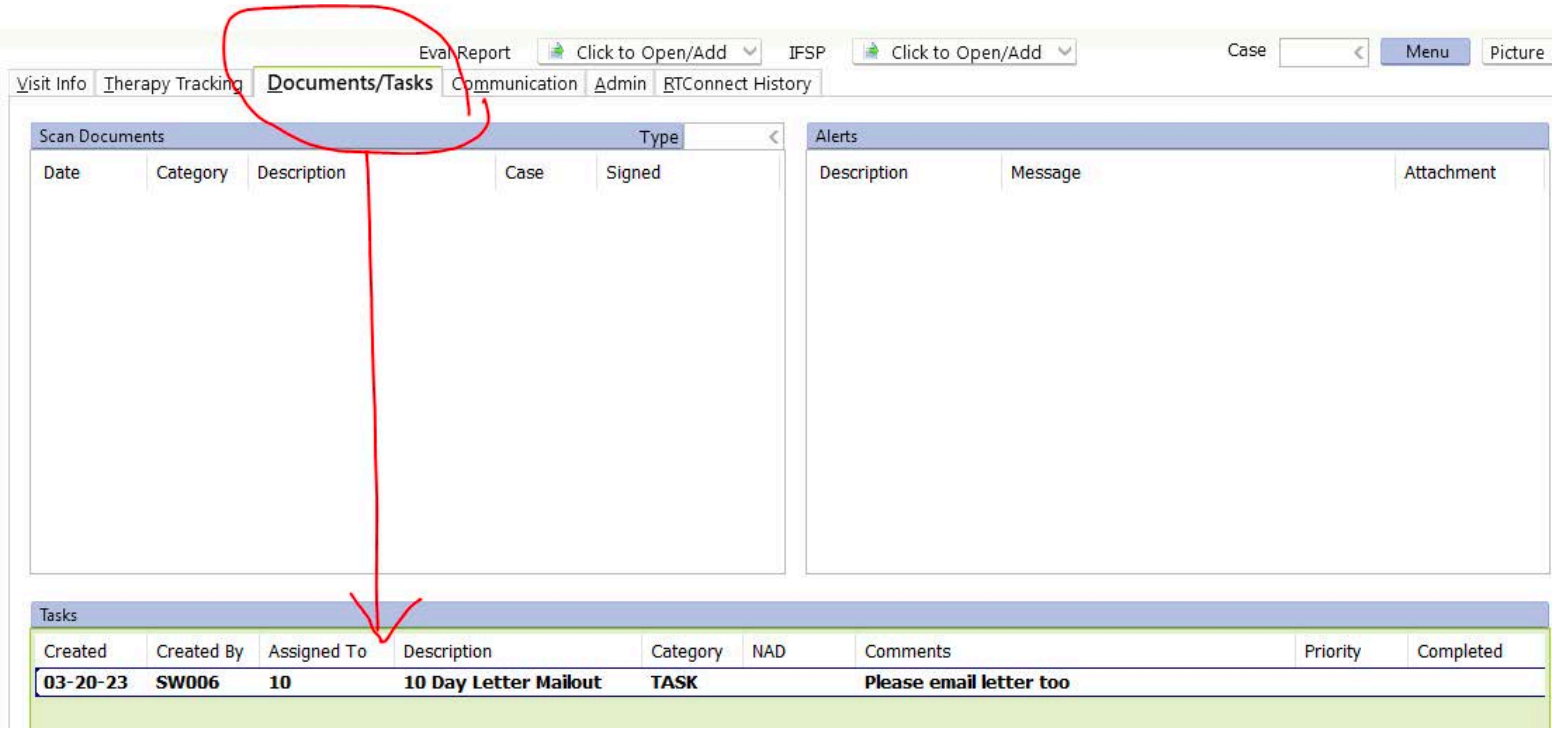
1. they were referred to PIC but we are unable to contact them to complete referral, intake, evaluation or enrollment.
2. they will be discharged from the process if they do not contact PIC within 10 days of the date of the letter.
3. they are encouraged to contact us in the future and before child's 3rd birthday.

Providers or Referral staff--How to initiate:

- Verify that attempts to contact the family or case worker are in the communication log. Make at least 3 attempts across about 2 weeks to contact the family, and document
- In RainTree admin tab, initiate and review 10-day letter for address(es), content (Provider can EDIT THIS LETTER)—addresses need to be verified by provider for accuracy
- F10/Save letter: a task is auto-generated for Data Entry to print and mail out
- If at 10 days there is no further contact, the provider completes the exit process/documentation (see below)

**Children who are in OCS custody: create a 10-day letter for the OCS caseworker as well.

Admin will automatically get a task and send out the 10-day letter to the address listed on the letter. No further action is needed from the provider.



Providers Exit at 10 days:

Go to the Communication tab and select the Exit note from the dropdown: in the text box, use the global abbreviation LTFU and the following will appear, edit the note

The family is being exited due to:

- declining services with this provider. They were encouraged to reengage if needed.
- being lost to follow up. This provider made several attempts to contact the family, see comm log. Family was encouraged to engage in early intervention services, and contact within 10 days of letter, and did not.

Sign off the note; it goes automatically to Admin. (Remember to edit!)

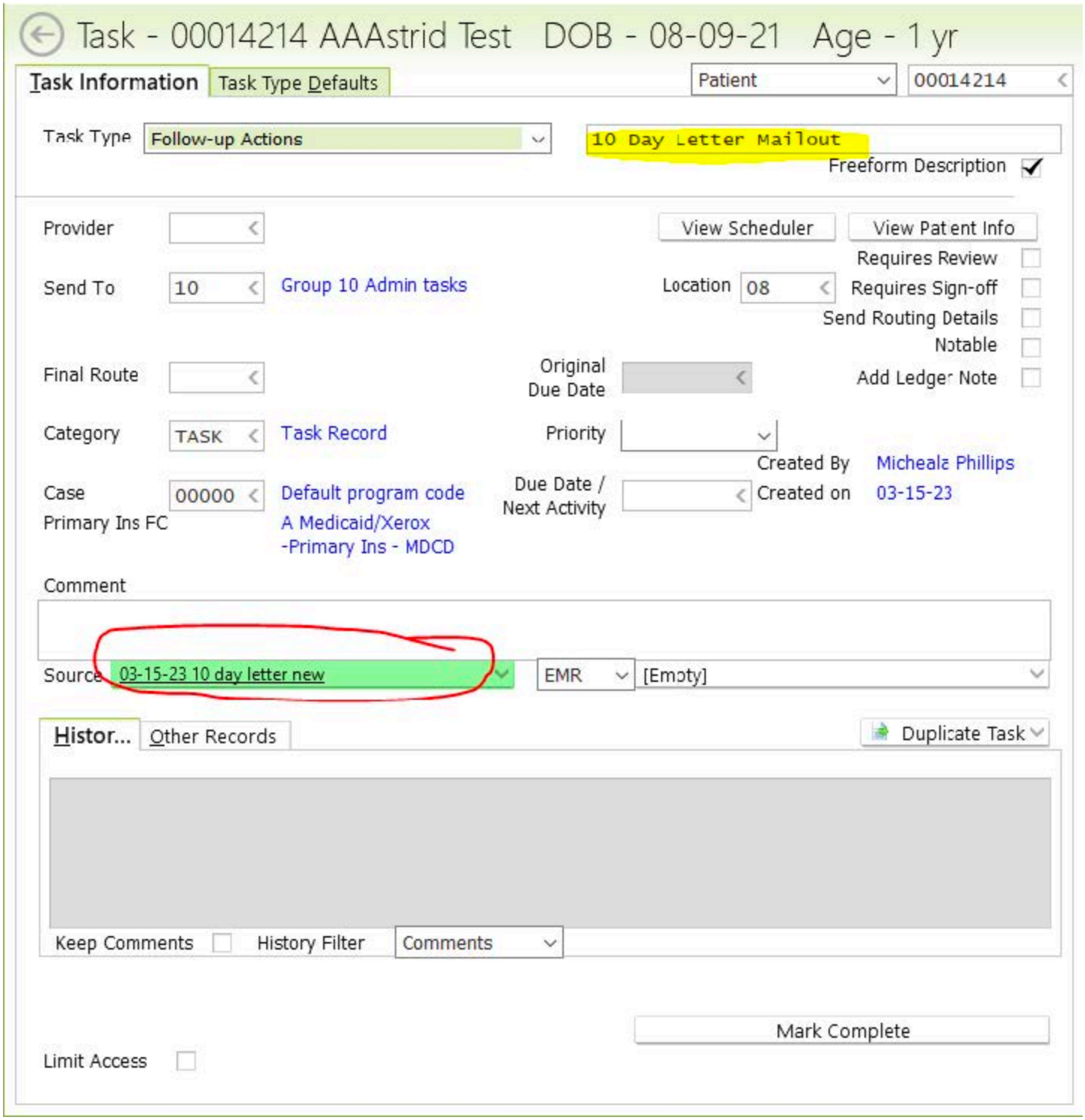
Providers will get a task/reminder sent to them to follow up on the 10-day. If the family exits, complete the exit process and mark complete and the task is filed in child chart. If the family reengages, put a quick note in saying so, and the task will be filed in child chart. The task will be scheduled 10 days out from the 10-day and 30 days from the 30-day letter.

- **How to know when admin has completed and what date it was sent?**
  - Admin sends the task back to the provider (final route to themselves so that they can complete the task) with the due date out 10 days and a comment, “This task is coming back to you as a reminder of 10 days. Please exit the child via the comm log if no response from the family.” There is a note in the comm log specifying where the letter was sent and when.

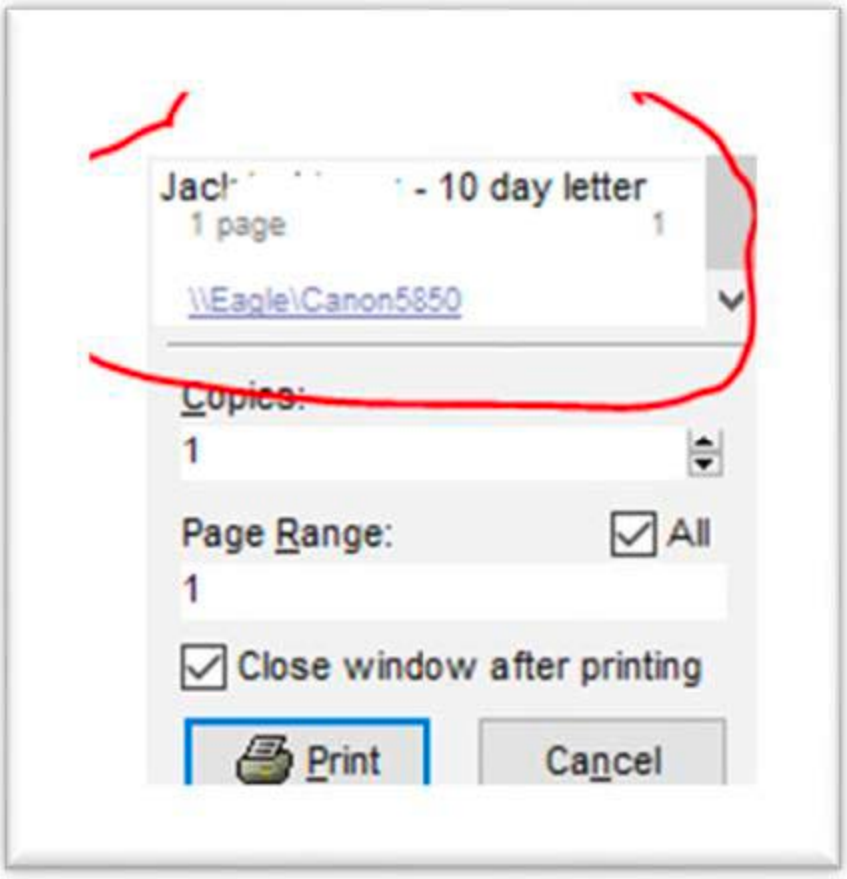
Administrative Staff–How to print and mail letter:

A task will be delivered to Group 10

1. Go to Group 10 tasks, open the automated task and print the 10-day letter

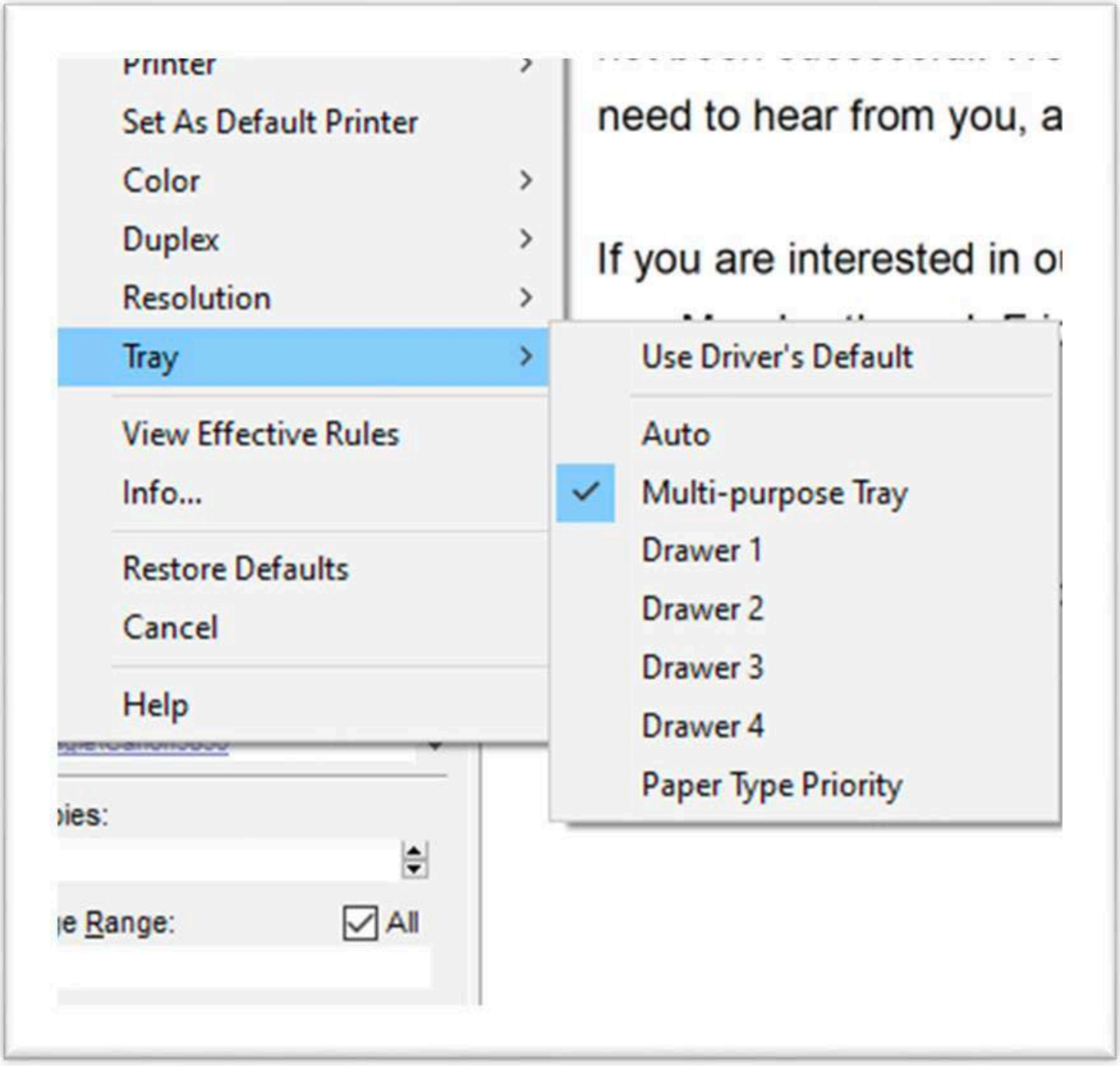


2. A RT editable word document will pop up with letter.



3. Control P to print or click printer icon

4. Left click on the //Eagle/Cannon 5850 to select the correct tray: Multi-purpose Tray



5. Then, click “Print”
6. Collect the printed letter, put in envelope and stamp with postage meter
7. The default setting is for a 1st class letter so you can place it on the weigh tray if sending additional papers and you think the envelope might be heavier than typical.
8. Enter Comm Log stating that letter has been mailed, and to whom at what address.
9. For Provider generated letters: send the task back to the provider (final route to themselves so that they can complete the task) with the due date out 10 days and a comment, “This task is coming back to you as a reminder of 10 days. Please exit the child via the comm log if no response from the family”
10. For Referral Specialist generated letters: close out the task.
11. Electronically send referral feedback letter to referral source at the time the ten-day letter is being mailed
12. Children in OCS custody: you need to send OCS caseworker the 10 day letter as well.

Returned mail: In the case of a 10-day letter being returned in the mail do the following:

1. Send an email to the provider/referral specialist who generated the letter letting them know it was returned.
2. Add a comm log note with the date and reason the mail was returned.
3. Shred the returned mailed

10-Day Letter in Spanish

Date

Address

RE:

Estimado padre/tutor de (Child's Name)

Esta carta trata sobre los servicios de intervención temprana para Yael Aquino Disla. Nuestros registros indican que:

___ Su familia fue remitida a Programs De Niños Y Infantes (PIC) para una evaluación del desarrollo.

___ Se completó una evaluación del desarrollo y se necesita una reunión para discutir los resultados.

___ Su hijo es elegible para recibir servicios según los resultados de la evaluación del desarrollo y es necesaria una reunión del IFSP.

Puede acceder a sus derechos de paternidad en nuestro sitio web www.picak.org

Hemos hecho varios intentos de contactarnos con usted pero no hemos podido. Si todavía está interesado en una evaluación o en discutir los servicios de intervención temprana, comuníquese con el número de teléfono (phone number) dentro de los 10 días a partir de la fecha de esta carta (date). Si no tenemos noticias suyas, su expediente se cerrará. En ese caso, esta carta servirá como notificación por escrito y confirmación del alta de la derivación a servicios de intervención temprana.

Brindamos servicios de desarrollo para niños hasta los 3 años y puede volver a recomendarnos en cualquier momento antes del tercer cumpleaños de (child's name).

Gracias y sinceramente,

personal de PIC

30-Day Letter

Purpose

PIC Guidance on Enrolled Families with No Contact

If an enrolled family is not returning calls after cancelling and/or no-show visits, PIC will attempt a variety of ways to contact the family and determine desire to continue:

Attempt to contact the family on at least a weekly basis by phone, text, email or a combination of all three methods. If there is a signed Plan of Care, attempt to contact the physician. Additionally, if the family is enrolled in OCS, attempts to contact the family will be made through the OCS caseworker. After 30 days send a 30 day letter. If the family re-engages, continue with services. If you do not hear from the family, exit the family from the program. If you contact the family, review the Working Together Agreement. If the pattern continues, request that the supervisor contact the family to discuss.

According to the CFR, agencies are not held accountable for not achieving child outcomes if agencies make a "good faith effort" at service delivery and contact:

§ 303.346 “Responsibility and accountability. Each public agency or EIS provider who has a direct role in the provision of early intervention services is responsible for making a good faith effort to assist each eligible child in achieving the outcomes in the child’s IFSP. However, part C of the Act does not require that any public agency or EIS provider be held accountable if an eligible child does not achieve the growth projected in the child’s IFSP.” (Authority: 20 U.S.C. 1436) Subpart E—Procedural Safeguards.

The National Part C Data Dictionary defines Lost to Follow-up: “Attempts to contact the parent and/or child were unsuccessful: This includes all children under the age of 3 who had an active IFSP and for whom Part C personnel have been unable to provide early intervention services either due to lack of response from the parent or family, or inability to contact or locate the family or child after repeated, documented attempts. Include in this category any child who was no longer receiving services under Part C before reaching age 3, and who has not been reported in the categories 7-9” (these are the other exit reasons).

Practice

Client Low Participation and Exit Guidelines

Families will be given ample information about PIC during intake with a review of the Partnership Agreement that is sent out with the Intake Packet.

Families who have the following will receive a phone call from their provider with a review of the practice, if the family is available, which will be documented in the Communication Log or Daily Note. A 30-day letter is mailed if there is a lack of contact or response from family to provider. The PIC provider might also want to consider the following when deciding to send a letter:

- three appointments in a row are cancelled, or
- fewer than 50% of scheduled visits are completed, or
- three appointments are missed in three months without notice

For families who reengage and the pattern persists, providers are advised talk to the team manager who will contact the family and review the agreement.

Families who cannot be contacted by phone or do not respond to our calls, within 30 days will a receive a 30-day letter (see template) from the provider.

Families who do not contact PIC will be discharged and can be re-refer, but must go through a basic intake process.

Provider will notify other providers, or referral source, OCS or medical home, depending on which is most appropriate and after assuring there is a Release of Information in place.

Providers who work with a family who have been sent a letter, re-engage in services, only to disengage again with a pattern of no-show/cancels should contact their supervisor to develop a plan in order to address this with the family.

Enrolled Child/Notification of Potential Discharge

What is a 30-day letter?

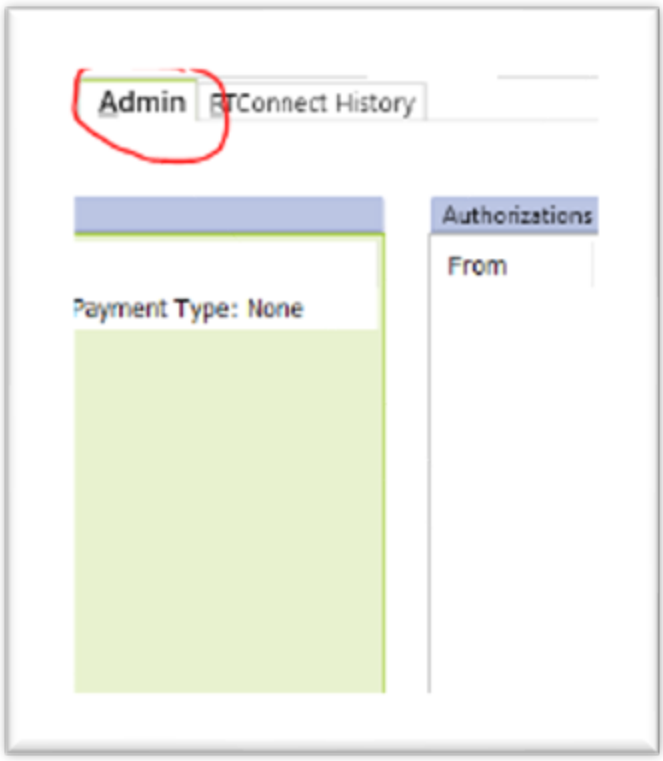
It is a notice sent to an enrolled family who have been out of contact for a month (or more) with the PIC provider and that we have attempted to contact several times (at least weekly), across a month, and not heard from.

A. addresses that they have not received services recently and we are unable to contact them, Make at least 1 attempt per week, across 4 weeks and document in communication log
B. At 4 weeks (or more) you do not hear from the family, initiate the 30-day letter (see below)
C. At 30 days from the date of the letter, if there is no further contact with the family, the provider completes the exit/discharge process.

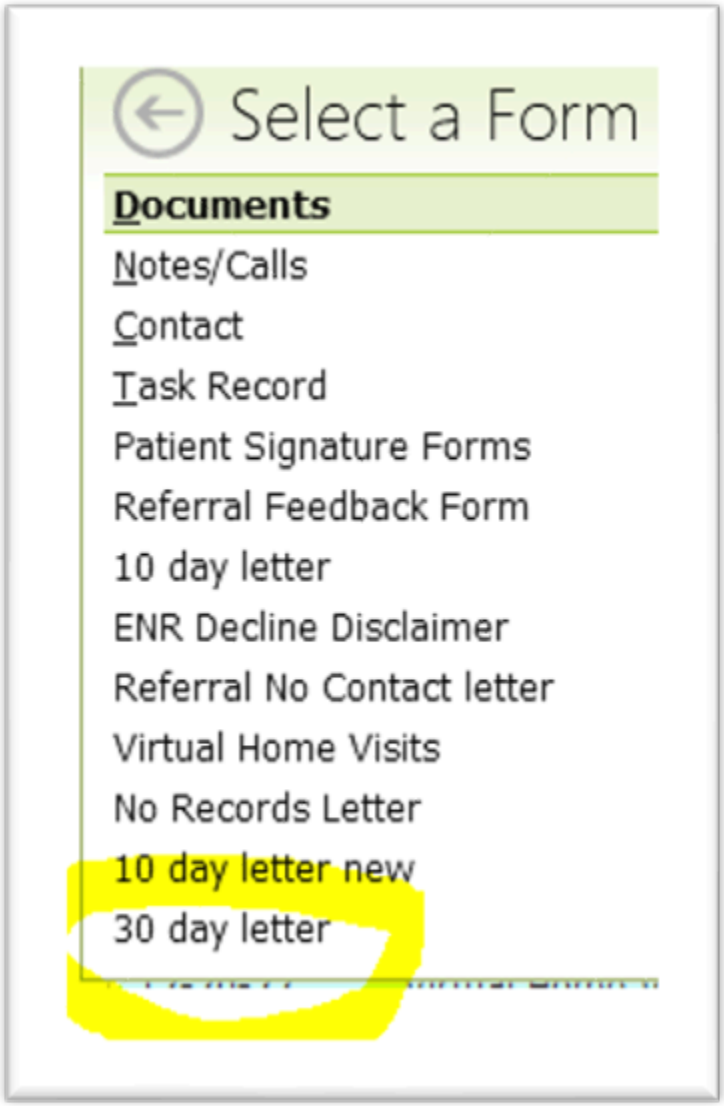
Children who are in OCS custody: send OCS caseworker the 30 day letter as well.

Therapy staff--How initiate a letter:

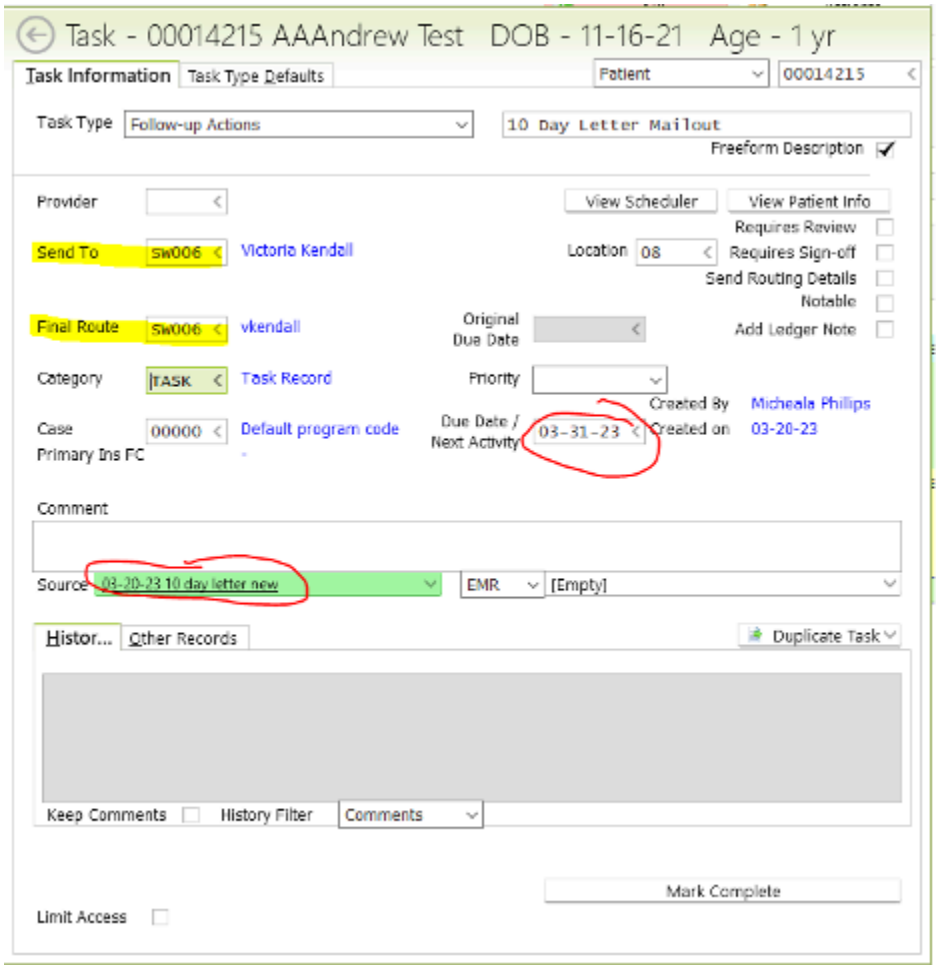
1. Go to the child's chart in RT, select the Admin tab



2. Select the 30 letter, review for accuracy, f10/Save, and an automated task with be sent to Data Entry. **If the child is in OCS custody: send OCS caseworker the 30 day letter as well.**



3. **Providers will get a task/reminder sent to them to follow up on the 30-day.** If the family exits, complete the exit process and mark complete and the task is filed in child chart. If the family reengages, put a quick note in saying so, and the task will be filed in child chart. The task will be scheduled 31 days from the 30day letter.

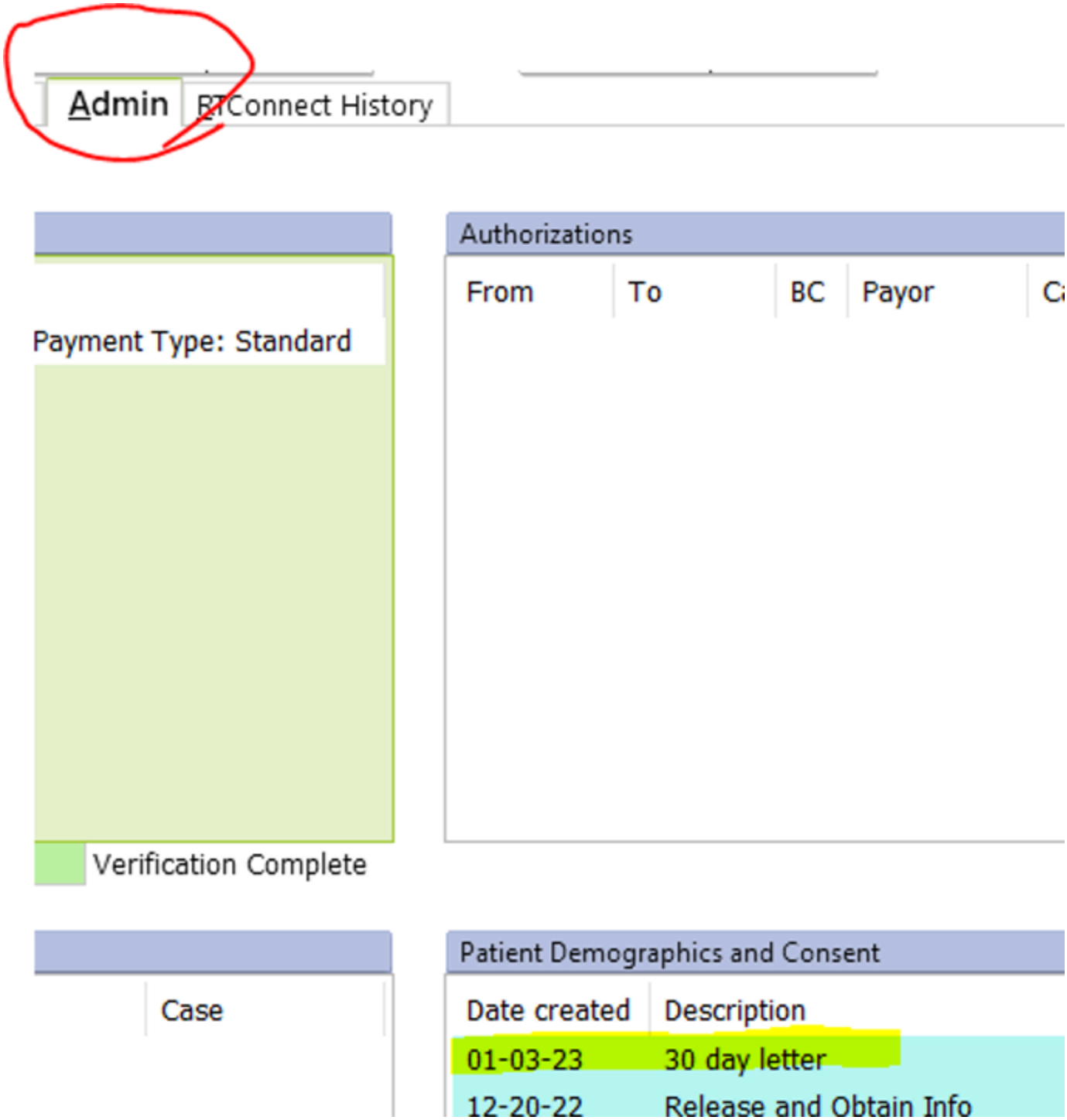


Providers Exit at 30 days:

If family has not made any further contact since the 30 day letter, complete the discharge process.

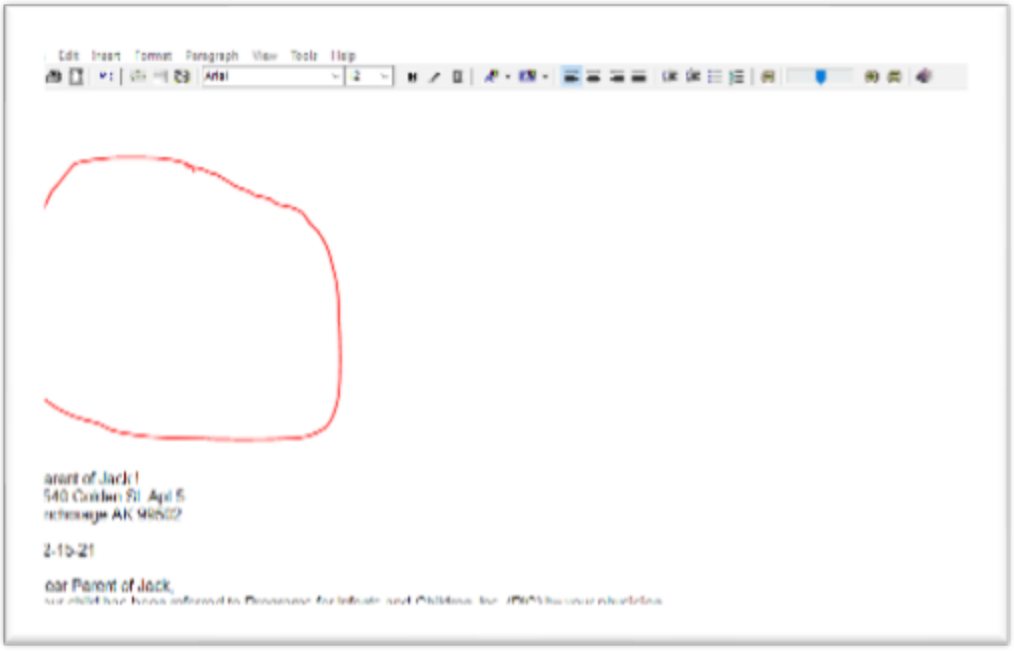
Data Entry-How to print for mailing out the letter:

1. Go to the child's "Chart" tab then the "Admin" tab and look at the bottom right hand corner under "Patient Demographics and Consent"- it will be labeled 30 day letter | double click

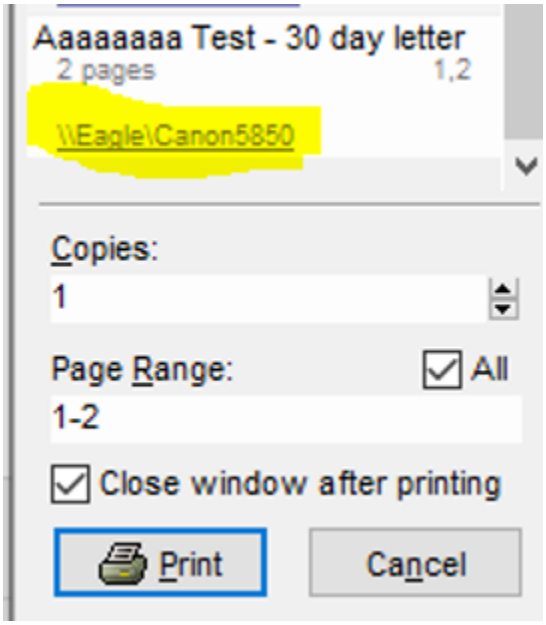


2. An RT editable word processor will pop up with letter.

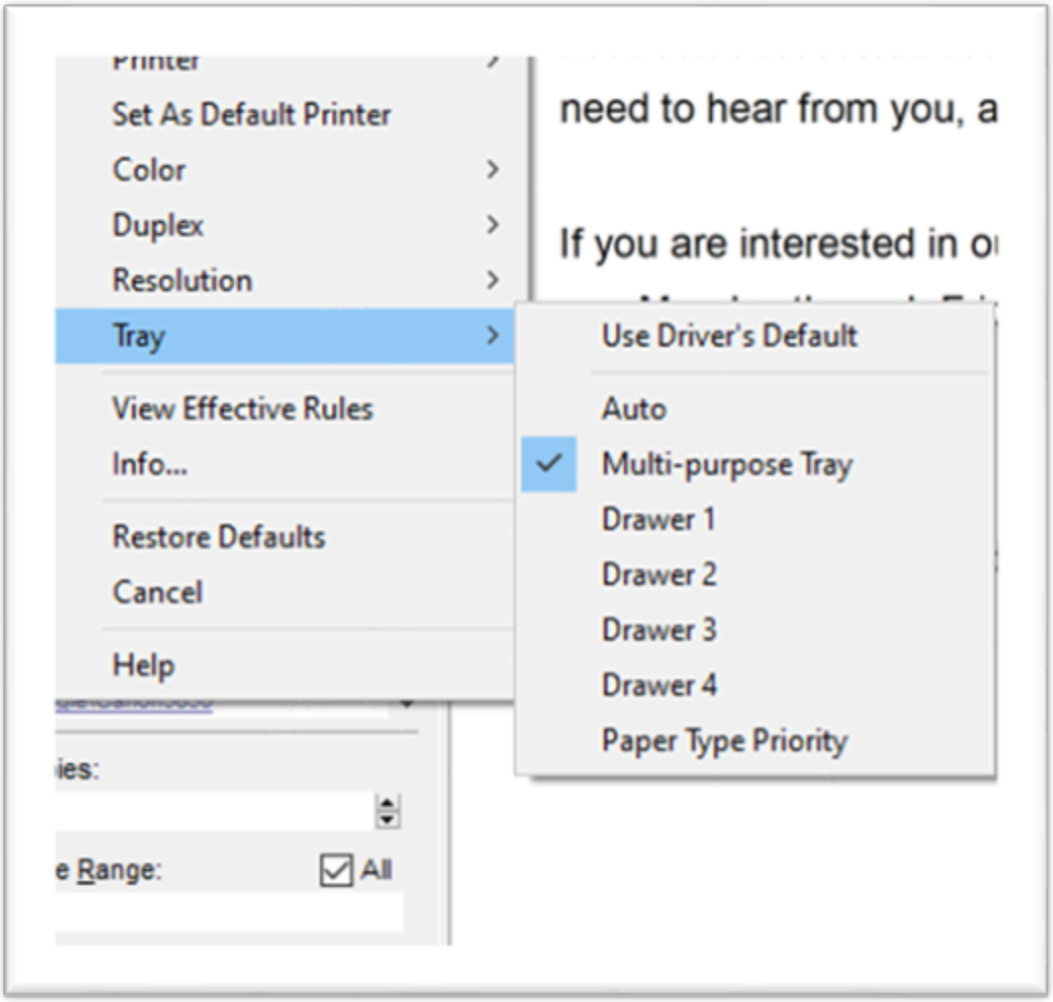
3. DON’T FORGET to space down to allow room for the letter head header



4. Control P to print or click printer icon



5. Left click on the //Eagle/Cannon 5850 to select the correct tray: Multi-purpose Tray

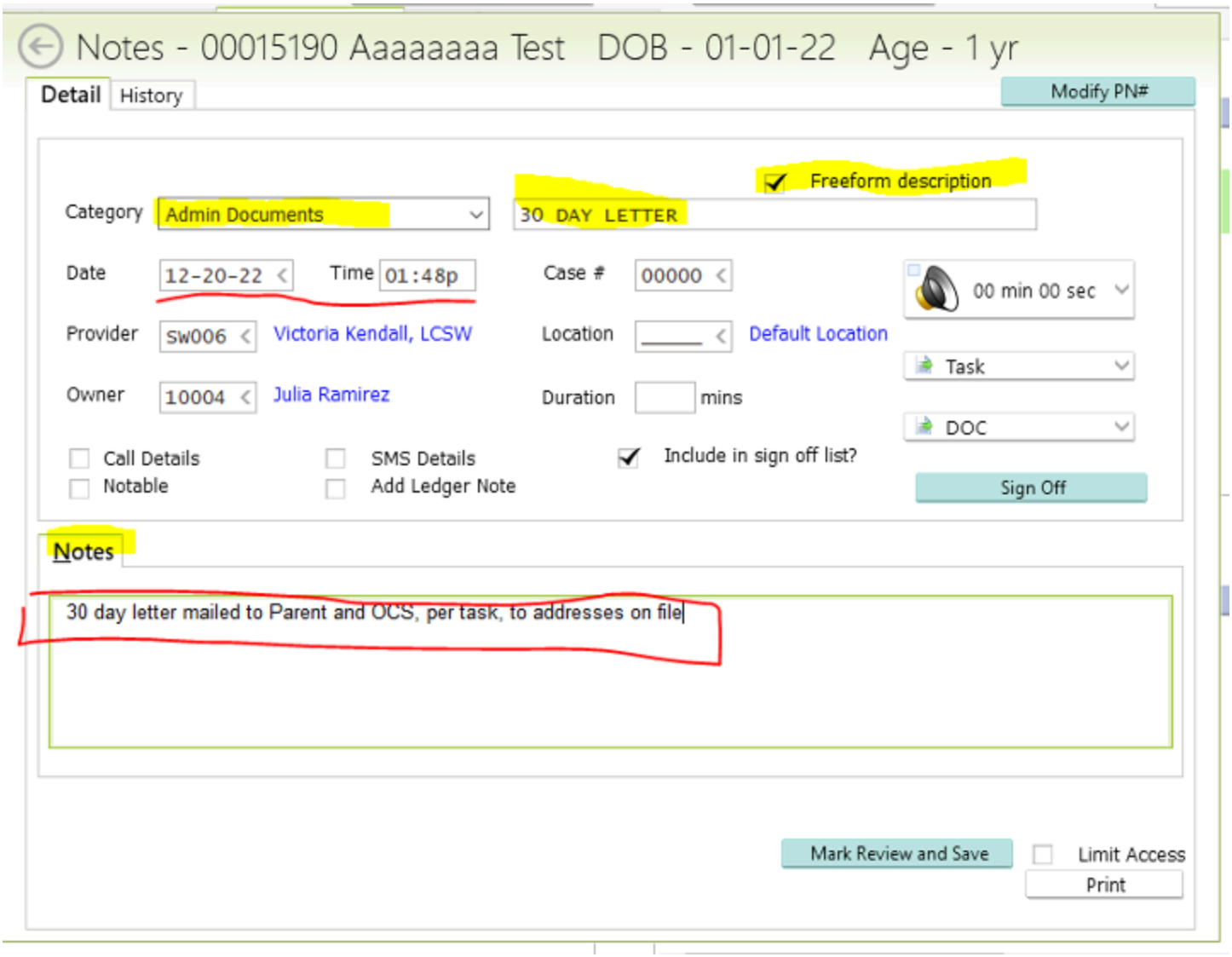


6. Then, click “Print”
7. Collect the printed letter, put in envelope and stamp with postage meter
8. The default setting is for a 1st class letter so you can place it on the weigh tray if sending additional papers and you think the envelope might be heavier than typical.
9. Go to the “Communication” tab and A to add call log note:

   Category: Admin Documents, then freeform description: 30 day letter

   Date auto selects for current date/time

Notes: “30 day letter mailed to (Parent name) to address on file, per task.”



10. Save or F10
11. Indicate that the task is completed.
12. **If the child is in OCS custody, also send OCS caseworker the 30 day letter.**

30-Day Letter Spanish

Date

Address

RE:

Querido Padres/Guardian,

Esta carta se trata sobre los servicios de intervención temprana para (childs name). Nuestros registros muestran que ha habido desafíos para brindar los servicios descritos en el Plan de Servicios Familiares Individualizados (IFSP). Sabemos que las situaciones familiares pueden dificultar la disponibilidad para las citas. Nos preocupa su disponibilidad reciente y no hemos tenido noticias suyas en los últimos 30 días. Nos comunicamos con usted por correo postal/correo electrónico porque:

__ Hemos dejado varios mensajes de voz/textos.

__ Se intentaron varias reprogramaciones y usted canceló o no se presentó.

__ Hemos intentado contactarnos, pero el número de teléfono registrado no está en servicio.

Puede acceder a sus derechos parentales en nuestro sitio web www.picak.org

Si está interesado en continuar con los servicios de intervención temprana, comuníquese con su proveedor de PIC dentro de los 30 días posteriores a esta carta: (Date). Si no tenemos noticias suyas antes de esta fecha, su hijo será dado de alta. En ese caso, esta carta servirá como notificación por escrito y confirmación del alta de los servicios de intervención temprana.

Si ya no está interesado en los servicios, puede completar el Descargo de responsabilidad para rechazar servicios y devolverlo a PIC utilizando el sobre con la dirección incluida.

Brindamos servicios de desarrollo para niños hasta los 3 años y puede volver a recomendarnos en cualquier momento antes del tercer cumpleaños de Yael.

Gracias y sinceramente,

Personal de PIC

Descargo de responsabilidad para rechazar servicios;

Elijo que mi hijo,_____sea dado de alta de los Programas para bebés y niños en este momento. Entiendo que puedo comunicarme con el programa en una fecha posterior si deseo volver a recomendar a mi hijo.

_____

Firma del padre/tutor Fecha

Family Custody

Practice
Parent Involvement Guidelines in RainTree

- One parent will serve as the primary contact for the child in RainTree. This is established at the time of referral and recorded in the RainTree Contact tab. Regardless of custody arrangements, RainTree can accommodate only one signing parent for documentation purposes.
- The treatment planning and intake process is centered on the child, and therefore only one set of documents is permitted.
- Providers should seek guidance from their manager if parents make requests that fall outside our usual processes.
- At referral, parents are informed of these practices when appropriate.
- Providers will more often encounter requests from separated or divorced parents during treatment. In these cases, providers should explain:
    - Only one parent's signature is required for forms; generally, this will be the parent who initiated services.
    - We work with the parent who has the child during the visit. In cases of 50/50 custody, providers may alternate visits between parents (e.g., one visit with Parent 1, the next with Parent 2).
    - If a parent is not custodial, the provider will share intervention progress and strategies with them, and if time allows, schedule an in-person intervention visit during the parent-child visitation.
    - Parents are responsible for coordinating which of them will attend each visit. If they wish to attend jointly, this can be arranged; otherwise, separate visits can be scheduled for each household.

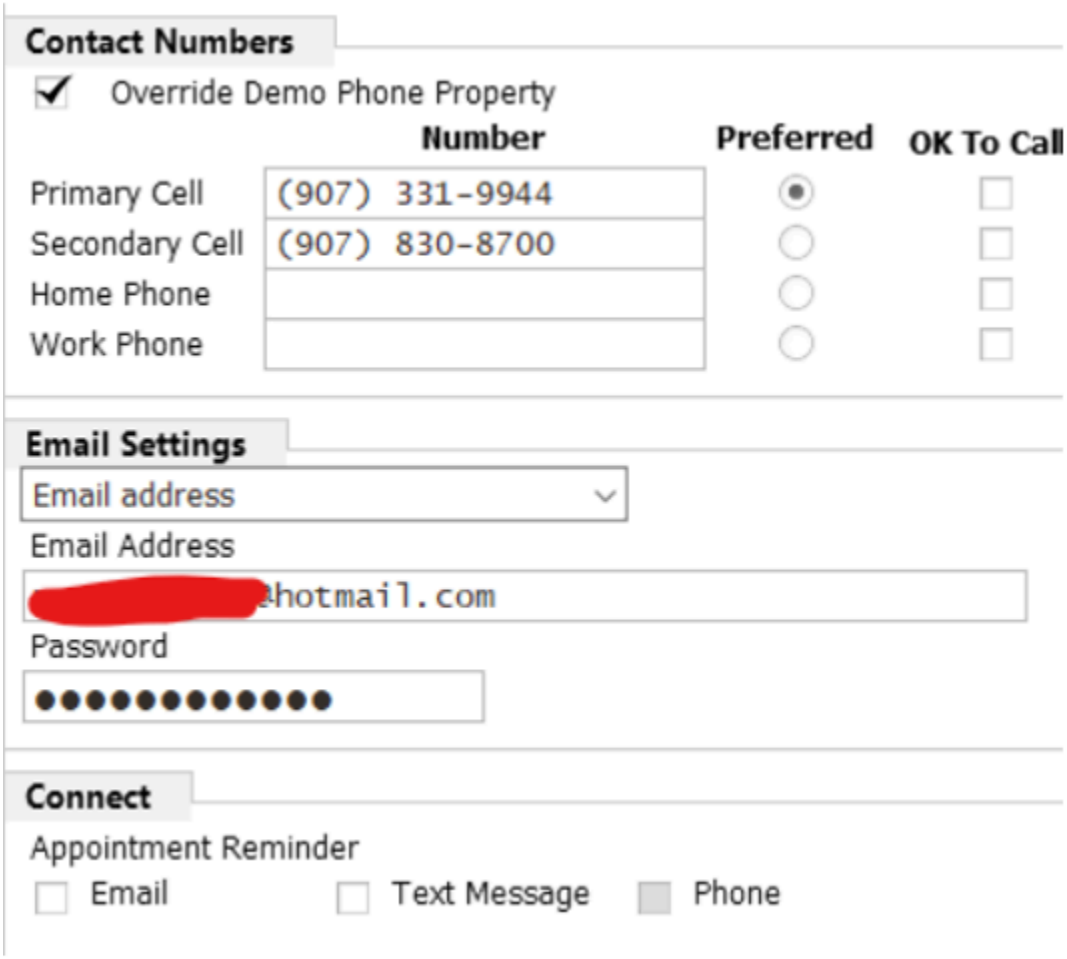
Documentation and Meetings

- **Evaluation:** Only one evaluation document is prepared. However, if parents report different behaviors in different environments, providers may opt to conduct the evaluation over two days as a clinical decision.
- **IFSP (Individualized Family Service Plan):** Only one IFSP is generated per child, but both parents are invited to participate in IFSP meetings and provide input toward each goal.
- Parents will be provided with all relevant documents.

Procedure

The child's primary contact will be set up in two places:

1. Patient Demographics – contact numbers can include both parents, however only 1 email can be listed.



2. Contact within the Chart. Providers, please note that if parent/guardians are struggling to connect to the signature pages, go to the RT patient demographics and check if the password is blank; the parent/guardian cannot reset this to access the signature pages. Assure that this is filled with a 'dummy' password and tell the parent to reset this upon accessing the patient signature forms portal.
3. If a parent makes an unusual request, provider(s) will follow up with a manager.

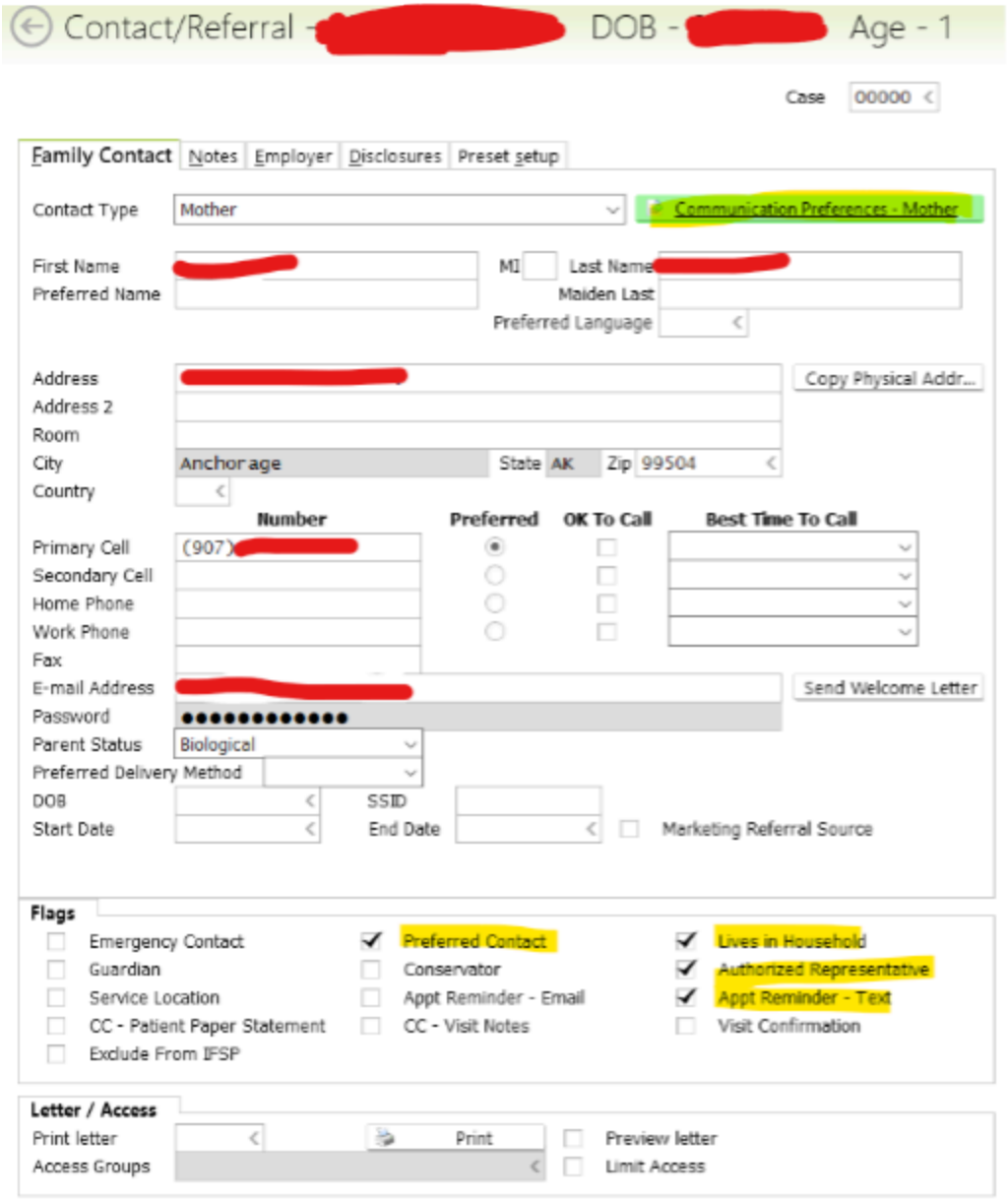
We do:

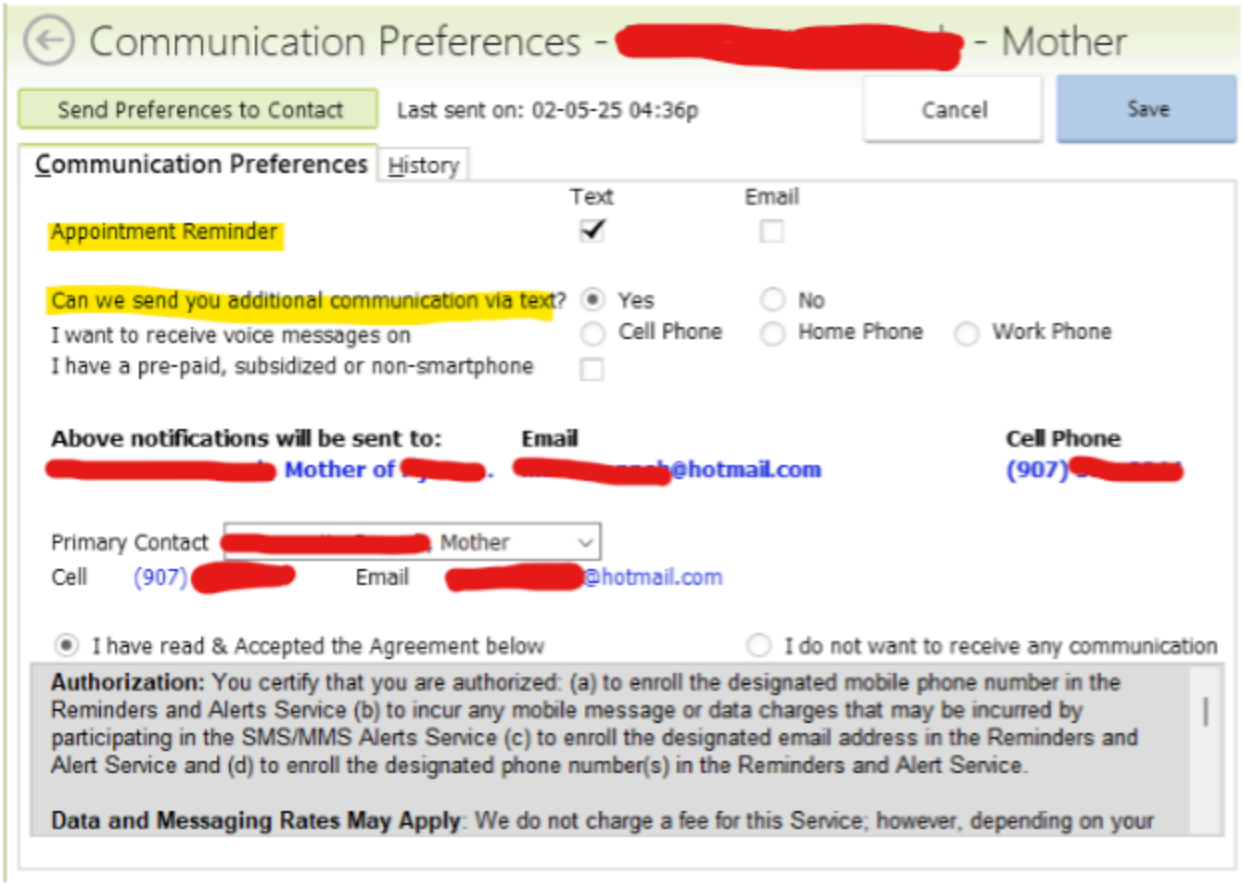
- Provide services to biological parents, per the law, however, there are circumstances that may prevent full release of information to parents, as well as a full array of services, such as when the parent is not custodial, is not present, is incarcerated and/or OCS has custody. ROI requests will go through OCS workers.
- Protect parents contact information upon request (from the other parent)
- Protect foster parent contact information. However, OCS has indicated that foster parent names can be included in the record as they have agreed to be the physical custodian for the child.

We do not:

- Communicate or act as go between for parents. Parents are expected to work out visits and schedules per their custody agreements.

- Unless instructed by OCS, or for safety reasons, we do not withhold information or records about the child from parents.





Medical Records

PIC adheres to HIPAA and FERPA regulations; providers obtain written authorizations from the legal guardian to release PIC records.

An Authorization to Release or Obtain Information (ROI) is considered valid when requesting information from one agency or person. The parent or legal guardian needs to complete a separate ROI for each person or agency from whom information is requested.

OCS currently uses an alternate ROI signed by the legal guardian (the OCS case worker).

Sending Medical Records

Procedure
Sending Records

PIC's standard practice for sending records to any outside agency entails including the signed ROI in the record set sent. This ensures that no records are released without a signed ROI. PIC does not accept verbal consent for releasing records.

Revocation

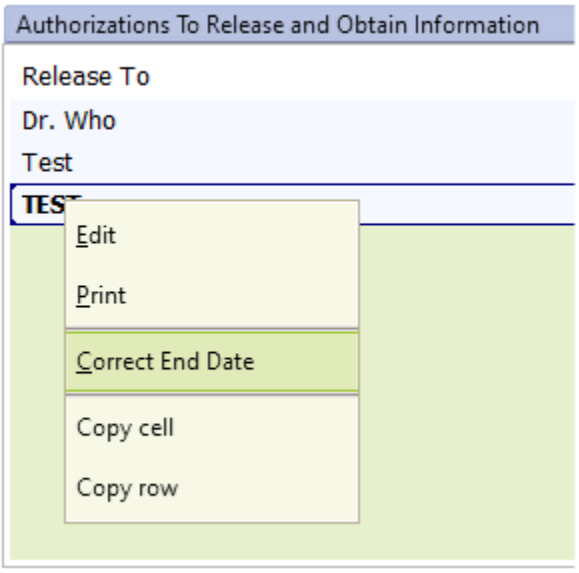
If the family wishes to revoke the ROI have the family sign the reverse or second page of a hard copy—there is not an e-revocation.

Admin will add an end date to the e-ROI in RT.

FOR OCS, when there is a change of placement: Notify Admin who will end the current ROI. Contact OCS for a new ROI with the new family. Contact Referral if you run into barriers with OCS. (source Authorization for ROI Purpose and Practice.pdf).

End Dates

When a child is exited from PIC services, the end dates for the ROIs on file are automatically updated to be 90 days from the date of exit status. Admin can manually update these from either a) a change in placement from OCS updated ROI or b) family signed revocation (hard copy) by right clicking on the specific ROI in the Admin tab of the child's chart and choosing "Correct End Date" (shown below)



Process

Initiating an ROI in RainTree in the Admin Tab:

a. Check the appropriate boxes indicating if information is to be release to or obtained from the stated individual.
b. Have the parent authorize. RainTree will date for the signature
c. Note: Providence and ANMC require a "wet" signature"; for families who cannot complete electronic forms, providers can obtain hard copies and have them scanned into RainTree.

Revocation of ROI (in hardcopy only, not available in RainTree):

a. If the family wishes to revoke the ROI have the family sign the reverse of a hard copy—there is not an e-revocation.
b. Admin will add an end date to the e-ROI in RainTree.
c. **FOR OCS**, when there is a change of placement: Notify Admin who will end the current ROI. Contact OCS for a new ROI with the new family. Providers may contact Referral if there are barriers contacting with OCS, or contact:

OCS Placement Search and Support Unit
1-855-603-8637
Press option 2
fcs.ocs.pssu@alaska.gov

Documents

Decision Tree

PIC Requesting Medical Records

Purpose

Purpose: Gathering a child's medical and developmental records is essential to gain an understanding of their health history and unique needs. All available information guides the early intervention team in developing personalized, effective services and ensures coordinated care among providers and families. Accurate records also support compliance with legal requirements and informed decision-making for the child's optimal development.

Practice

PIC adheres to HIPAA and FERPA regulations; providers obtain written authorizations from the legal guardian to release PIC records. We do not release any information by verbal consent, we must have a signed ROI for records released both written and verbally.

An Authorization to Release or Obtain Information (ROI) is considered valid for the duration of child's enrollment when requesting information from one agency or person. The parent or legal guardian needs to complete a separate ROI for each person or agency from whom information is being requested.

OCS currently uses an alternate ROI signed by the legal guardian (the OCS case worker).

Initiating an ROI: send email to admin@picak.org once ROI is created for family to sign. Admin gets a task for all signed ROIs and will request records once family signs specific ROI.

1. Check the appropriate boxes indicating if information is to be released to or obtained from the stated individual.
2. Have the parent authorize. RT will date for the signature.

ROIs are valid 90 days after discharge, unless revoked sooner by family, check end dates in RT.

Revocation of ROI:

1. If the family wishes to revoke the ROI have the family sign the reverse of a hard copy that you take out to them—there is not an e-revocation.
2. Admin will end the e-ROI in RT.
3. FOR OCS, when there is a change of placement: Notify Admin (admin@picak.org) who will end the current ROI. Contact OCS for a new ROI with the new family. Contact Referral if you run into barriers with OCS.
4. If OCS closes a case and child is either returned to family or is adopted, providers will notify notify Admin (admin@picak.org) who will end the current ROI. New ROIs/eforms in RainTree will need to be signed by the family.

Procedure

Admin Procedure

PIC Provider Requesting Records

1. Go to child's chart
2. Click on "Visit Info" tab

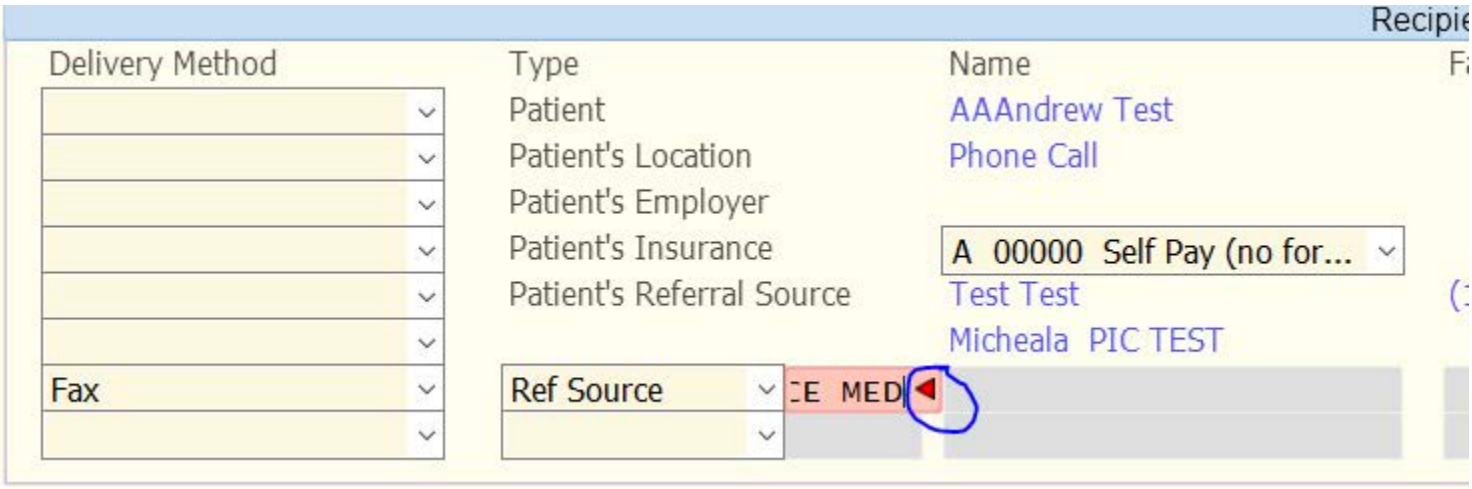
3. Click on white button “Fax/Email Notes”

4. Add cover sheet/special request information to “Comments” box, our typical message when requesting records is:

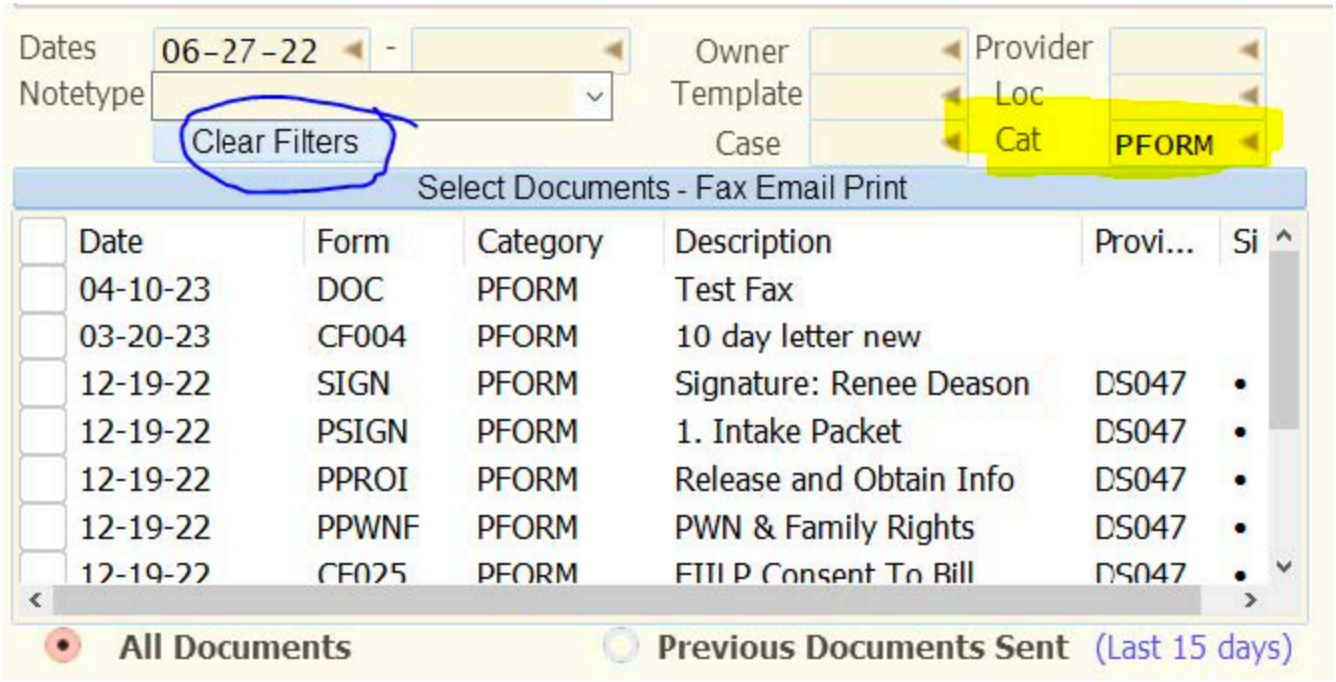
   Please provide us with pertinent medical records birth to current that will assist us in our evaluation such as your most recent evaluation(s) and diagnosis and well child checks. This is for early intervention services. Thank you for your assistance.

   (it’s in RainTree as a Global Abbreviation so you can just type “medrec” and hit the space bar and it will autofill, or you could save it as an electronic sticky on your desktop)
5. Add Disclosure reason: “Recipient” Record Request (this will auto populate if you are only sending 1 document with that document’s name)
6. Choose Fax, Ref Source, Name, Fax Number

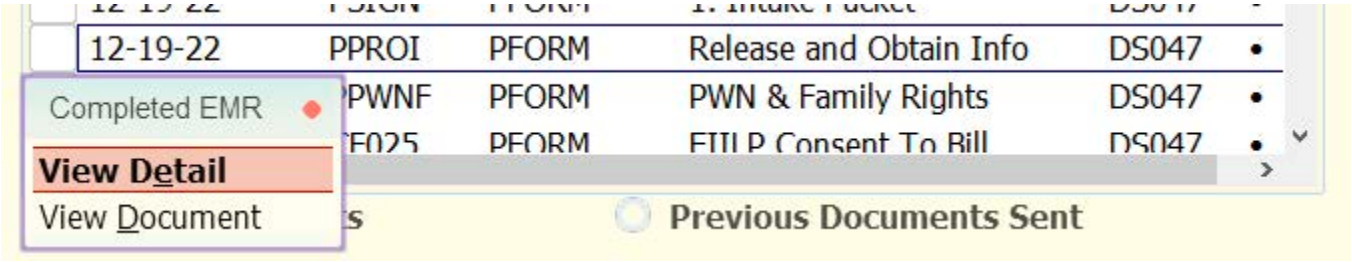
   Special note: the larger entities have a specific medical record fax, so those are saved in the REF SOURCE table as ANMC Medical Records and Providence Medical Records. You can type in the box next to Ref Source and it will search the whole table or click on the arrow and use F to find



7. Find applicable ROI by changing category to PFORM *or* clear filters to find wet signature scanned document and move to “Final Documents” Box by the right arrow next to the select documents box



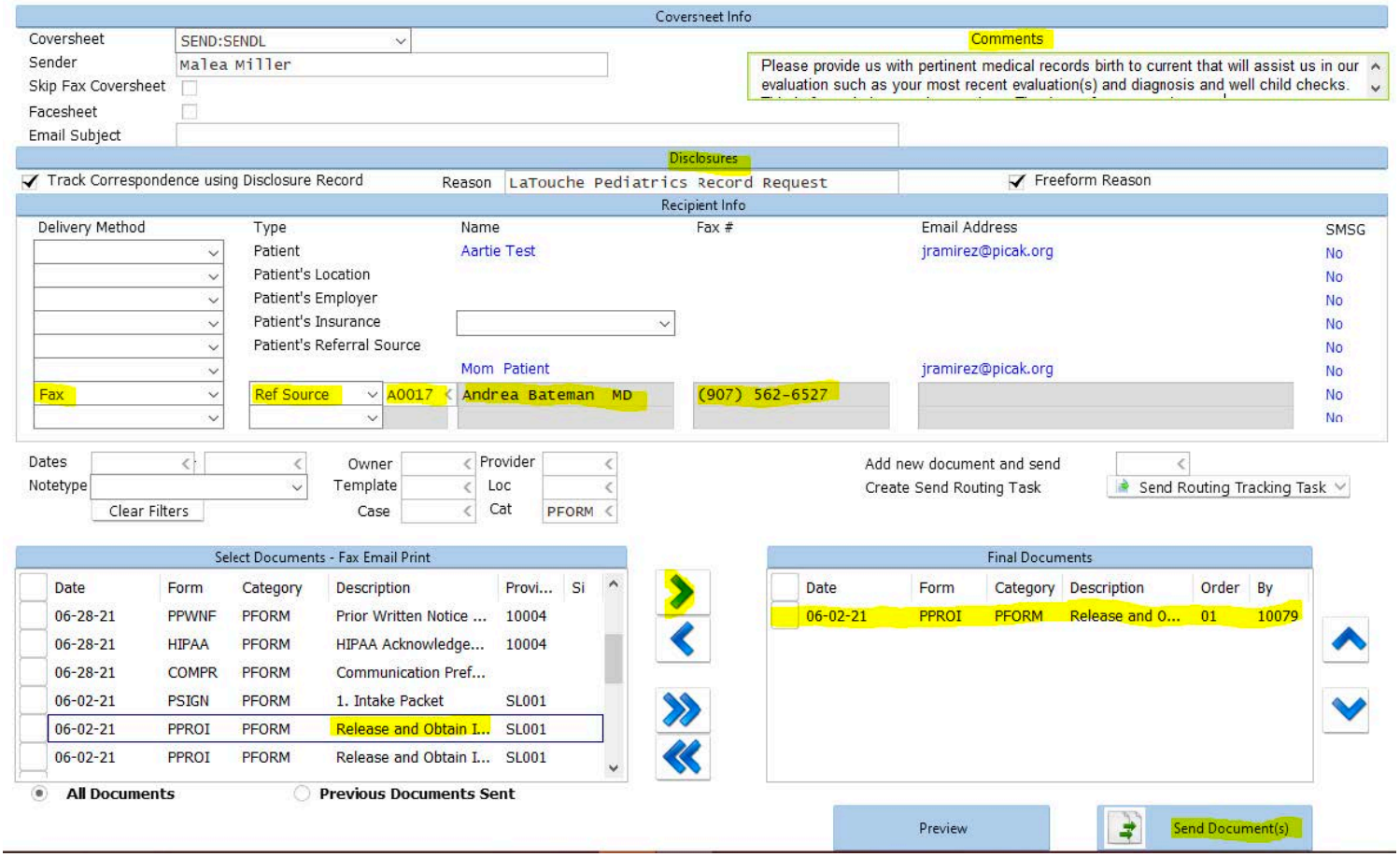
You can make sure it's the correct ROI by double clicking on the PFORM ROI and choosing either option.



8. Send Document

9. F10 or Save (if you F10 first, the document will NOT send)

It should look something like this:



Medical Record Review

Purpose

Medical records are required in some circumstances and provide valuable information about child history. Providers are encouraged to request medical records with ROIs and can do so with the support of their referral specialist, or admin.

Procedure

Documenting medical records review:

- More than 8 mins: providers will document the time spent in review in a daily note and apply charges to FSC.
- Less than 8 mins: providers will document the time spent in review in the communication log or in a cummulative FSC note at the end of the month.
- Providers will use the global abbreviation ‘recreview’ in RT notes and edit the text that appears here in red: “Reviewed patient medical records this day, from (pediatrician, hospital, NICU) and relevant information included: (diagnosis, child delay due to..., history of). Information will be used to inform eval and goals, as needed.
- Complete charges tab for time spent with FSC

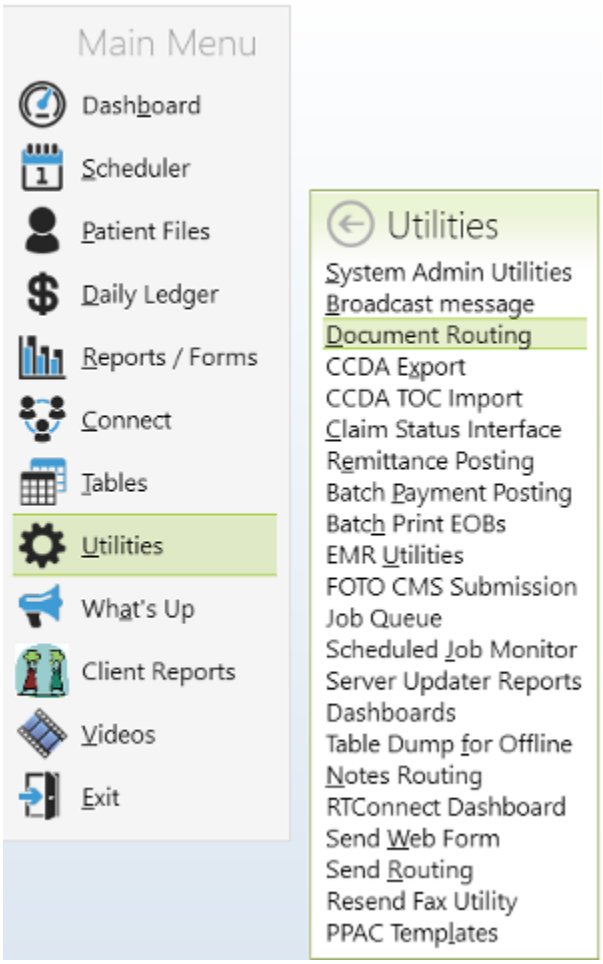
Admin Processing Records Requests

Procedure

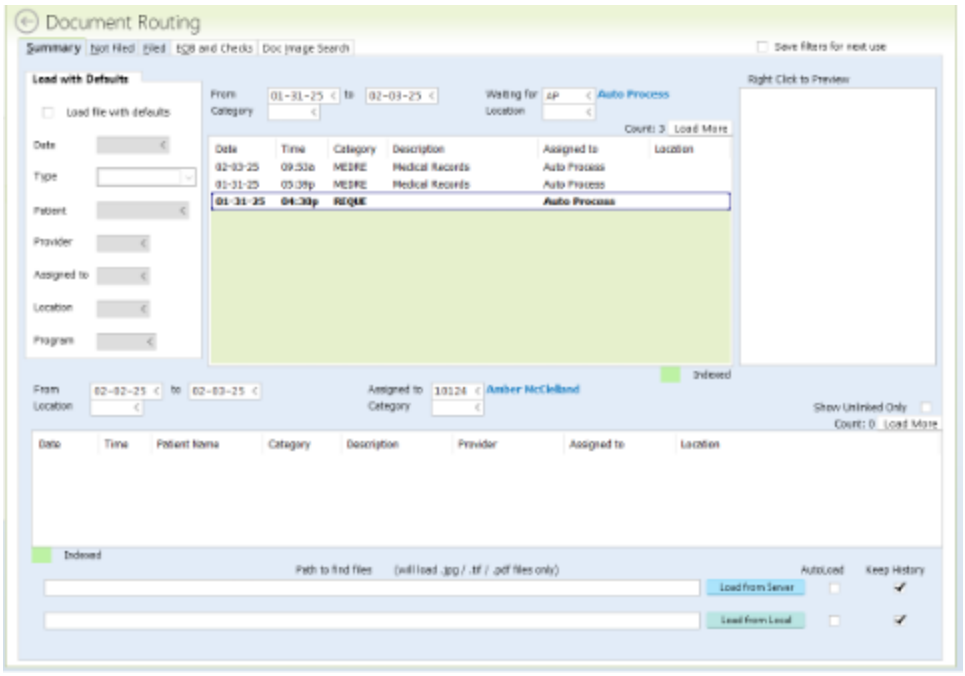
Admin Procedures

How To send records when ROI is Received

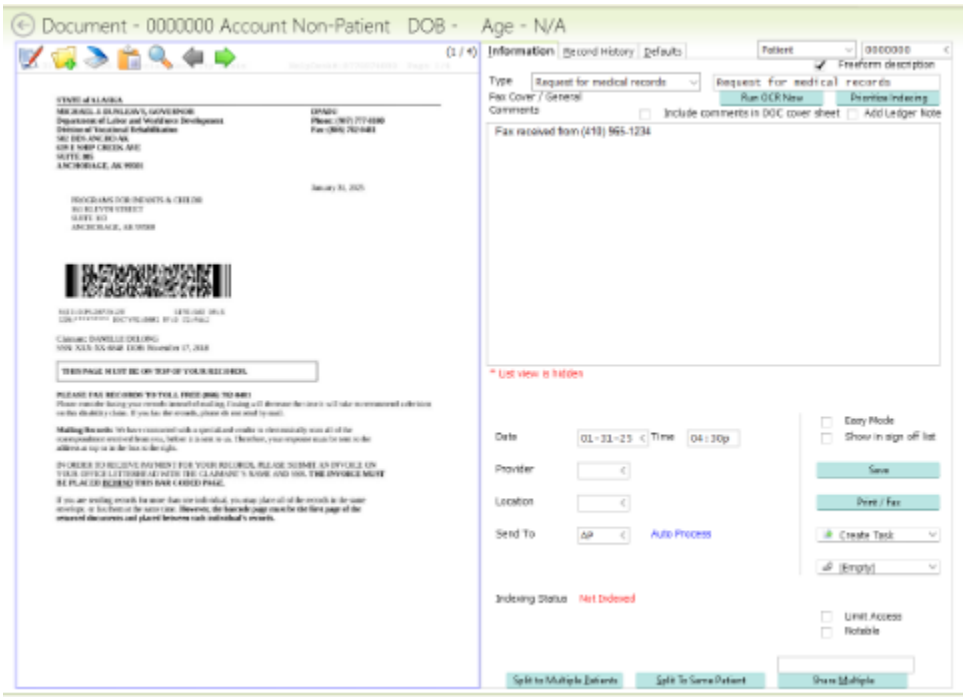
In raintree you will go the Utilities under Utilities you will click on Document Routing.



Once you open the document routing page you will see all the faxes that have been received. You may need to adjust the date range, depending on when the last time records requests were processed.



Select the medical records request



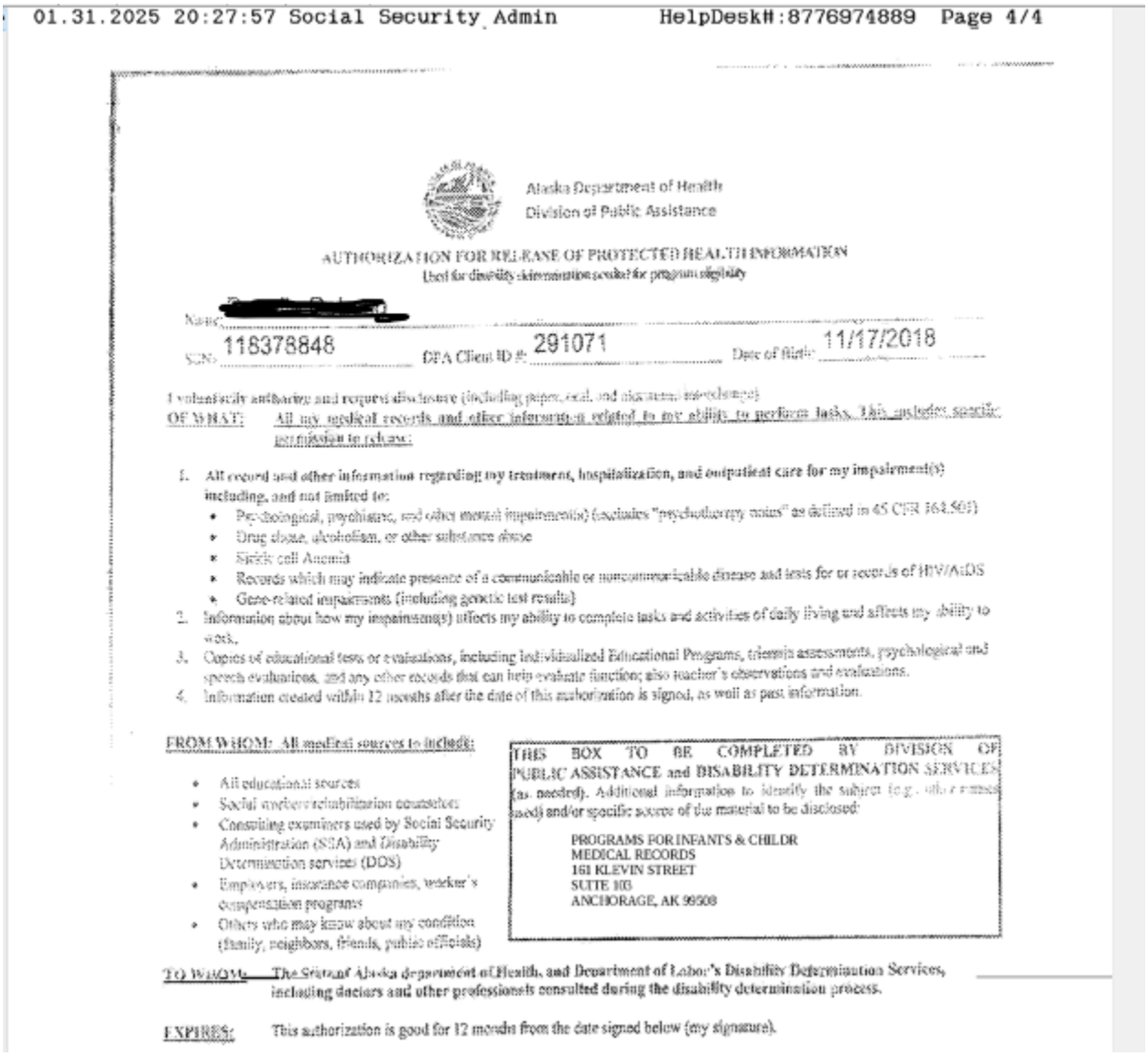
Click on the records request to open it. There you should have a fax cover sheet and possibly a letter stating what the request for records is asking for. Then you should then have a signed ROI make sure to check that it is signed.


01.31.2025 20:26:48 Social Security Admin HelpDesk#:8776974889 Page 1/4

STATE of ALASKA
MICHAEL J. DUNLEAVY, GOVERNOR
Department of Labor and Workforce Development
Division of Vocational Rehabilitation
502 DDS ANCHO AK
619 E SHIP CREEK AVE
SUITE 305
ANCHORAGE, AK 99501

DPADU
Phone: (907) 777-0100
Fax: (866) 782-0483

January 31, 2025


01.31.2025 20:27:57 Social Security Admin HelpDesk#:8776974889 Page 4/4

Alaska Department of Health
Division of Public Assistance

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
Used for disability determination cases for program eligibility

Name: [redacted]

SSN: 118378848 DPA Client ID #: 291071 Date of Birth: 11/17/2018

I voluntarily authorize and request disclosure (including paper, oral, and electronic exchange)
OF WHAT: All my medical records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All record and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric, and other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell Anemia
   - Records which may indicate presence of a communicable or noncommunicable disease and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, therapy assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Information created within 12 months after the date of this authorization is signed, as well as past information.

FROM WHOM: All medical sources to include:

- All educational sources
- Social workers/rehabilitation counselors
- Consulting examiners used by Social Security Administration (SSA) and Disability Determination services (DDS)
- Employers, insurance companies, worker's compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

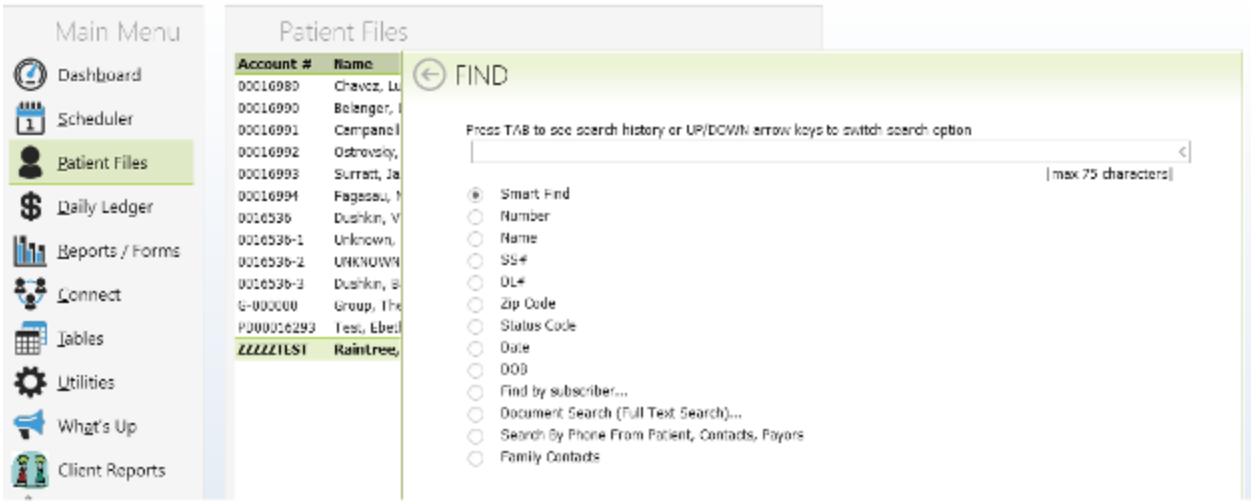
THIS BOX TO BE COMPLETED BY DIVISION OF PUBLIC ASSISTANCE and DISABILITY DETERMINATION SERVICES (as needed). Additional information to identify the subject (e.g., alias names used) and/or specific source of the material to be disclosed:

PROGRAMS FOR INFANTS & CHILDR
MEDICAL RECORDS
161 KLEVIN STREET
SUITE 103
ANCHORAGE, AK 99508

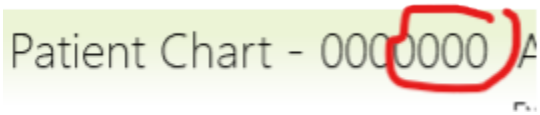
TO WHOM: The State of Alaska department of Health, and Department of Labor's Disability Determination Services, including doctors and other professionals consulted during the disability determination process.

EXPIRES: This authorization is good for 12 months from the date signed below (my signature).

Once you have verified that everything is there and correct you will open **another tab** in raintree. Go to Patient files, F to find , enter child's name that the records request was for.



Go into the chart and get the last 5 numbers of the child's chart number.

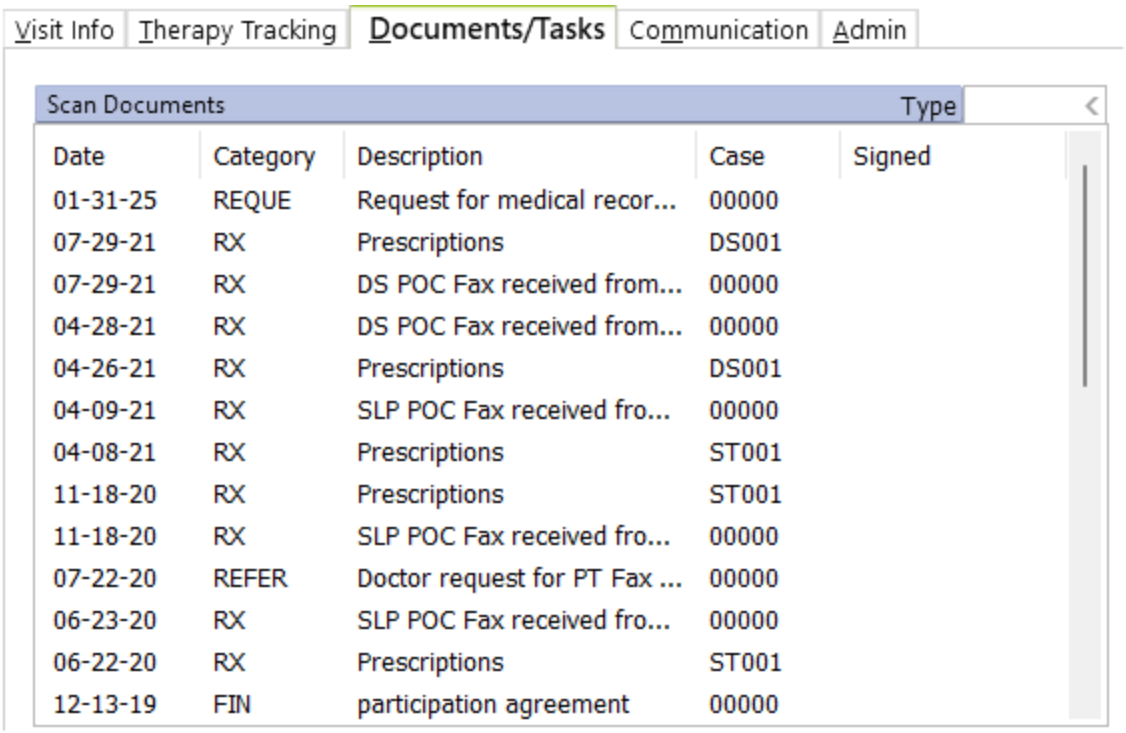


Then go back to the Raintree tab that has the open document routing page.

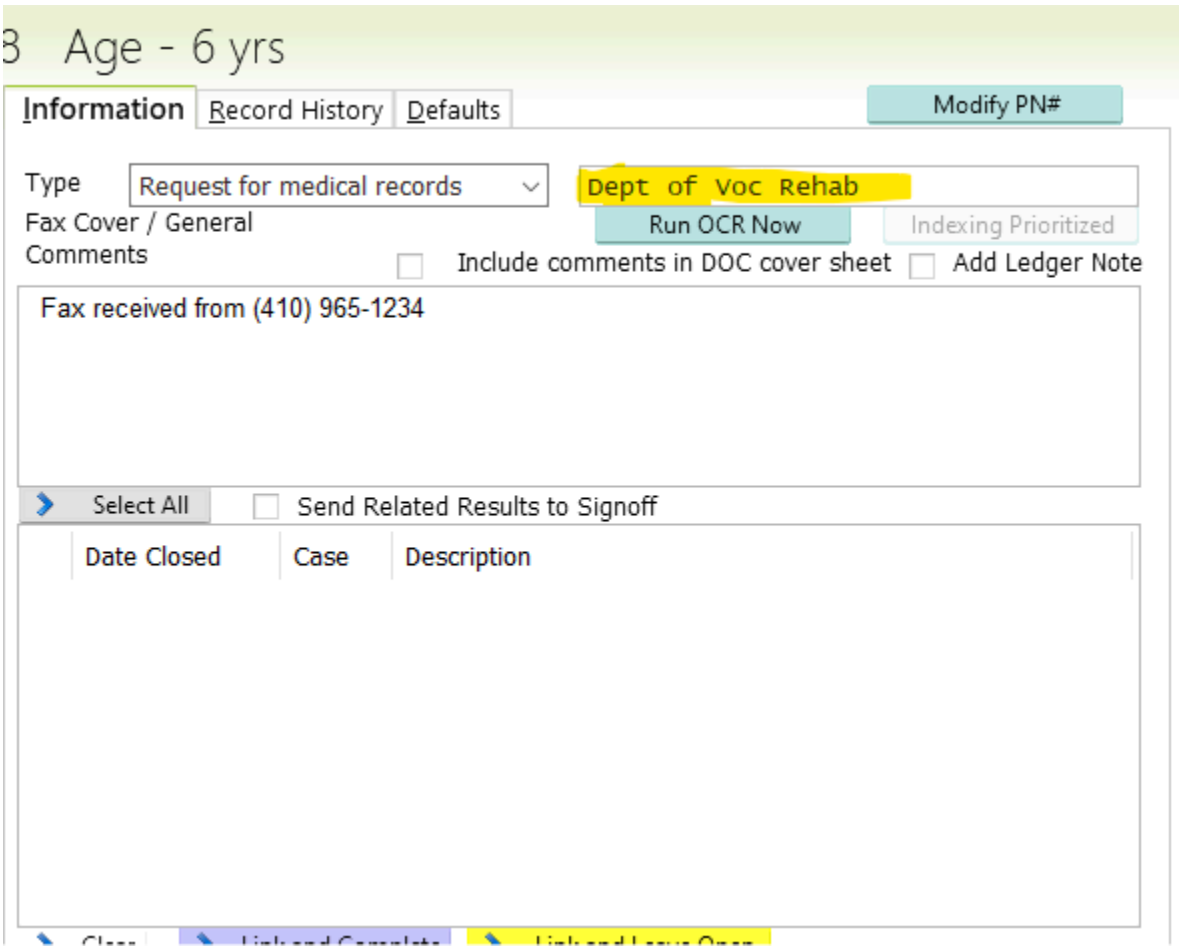
You will enter the 5 numbers from the chart and that will bring the child's name and chart up.

F10 to save the medical records request in chart.

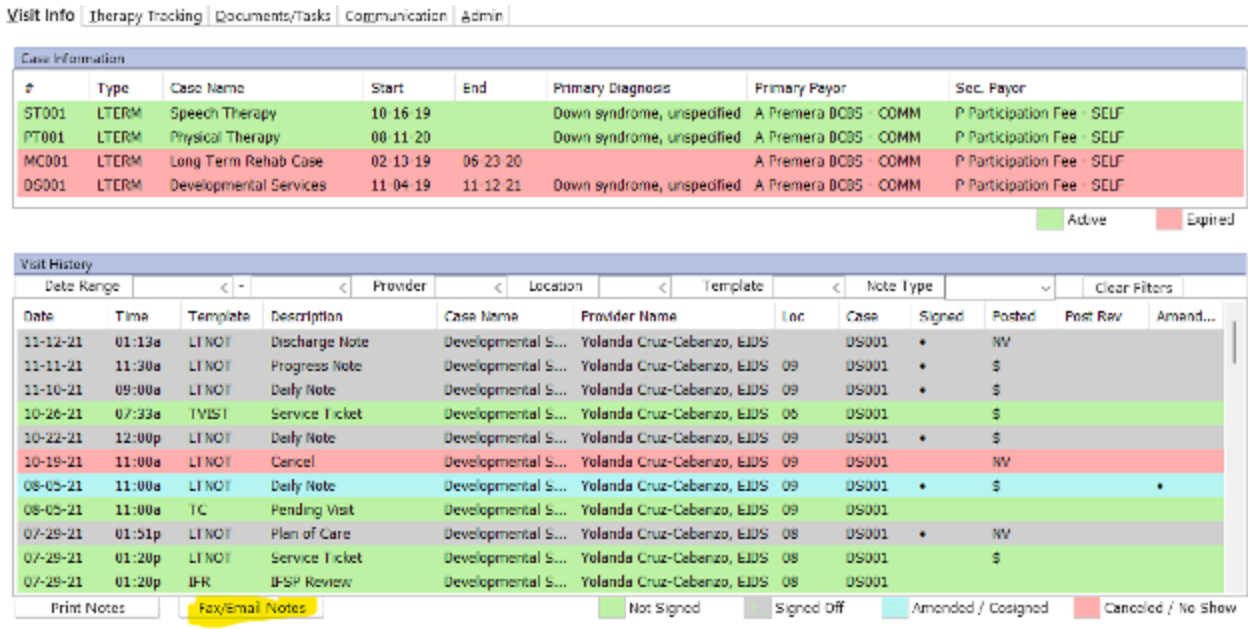
Go back to the Raintree tab that you had the child's chart open in and under the Documents/Task tab the medical records request will be there under scan documents.



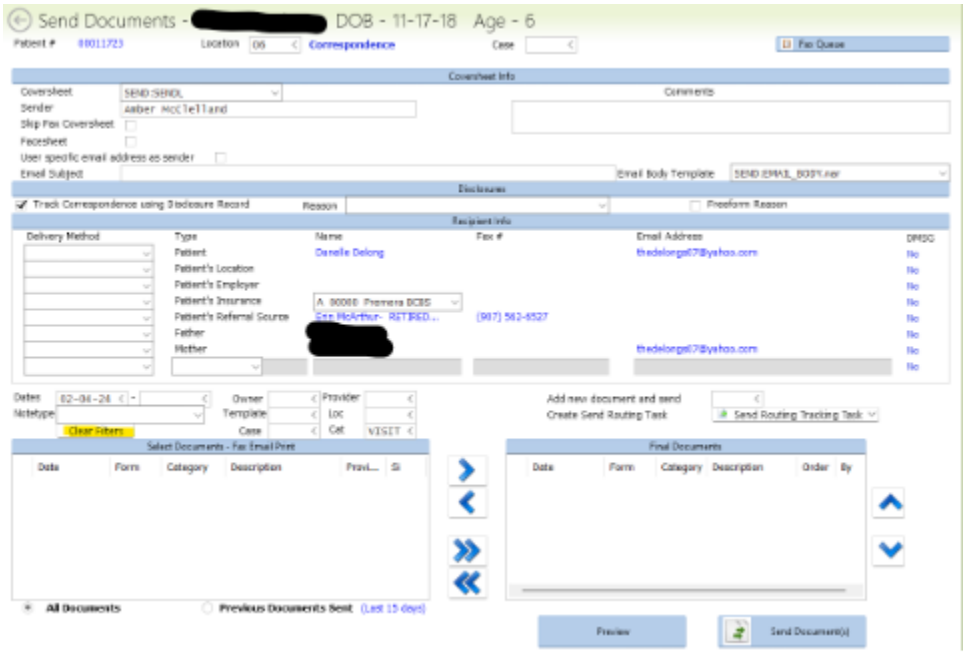
Double click on the Request to open it up. In the right corner you will enter the place that the request came from. F 10 to save.



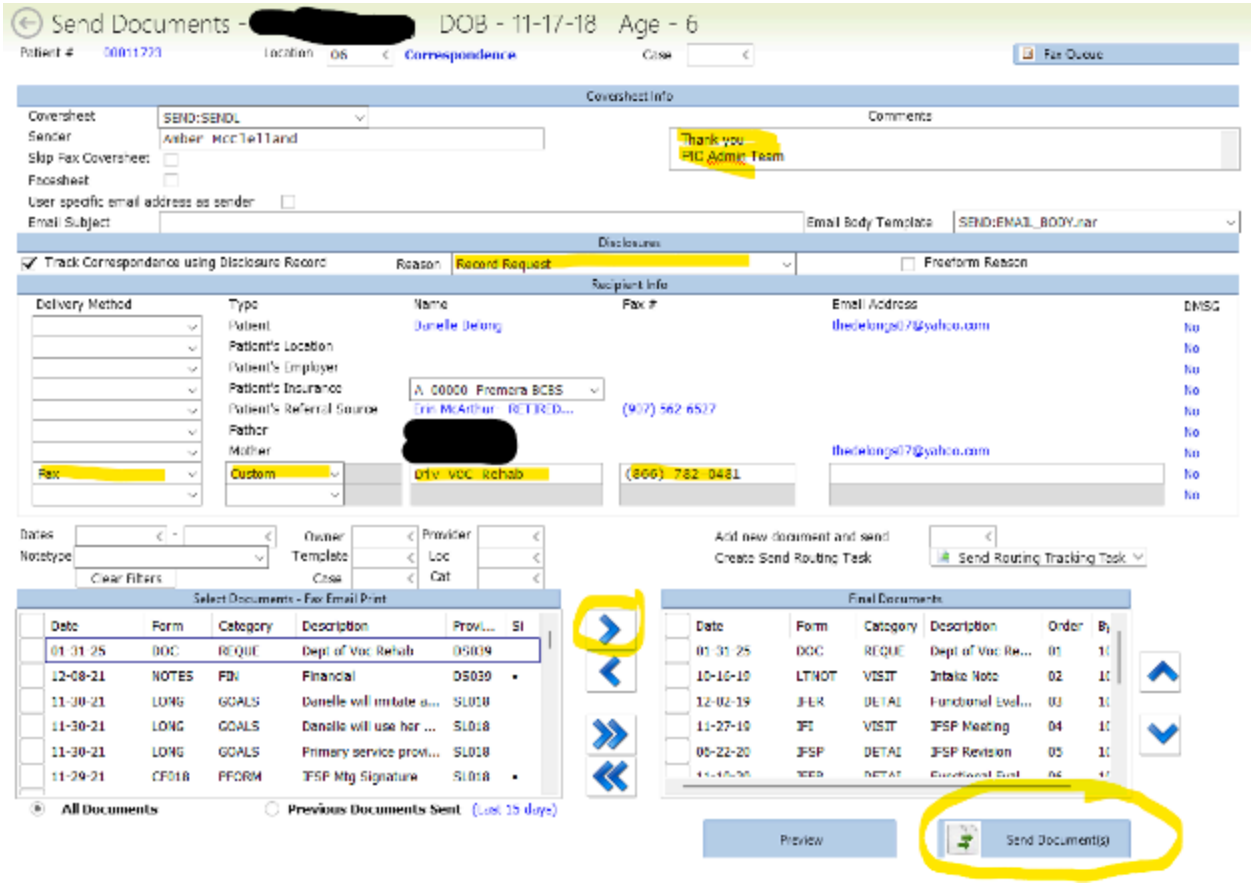
Then you will go to the Visit Info tab and click on the Fax/Email Notes tab.



The Send Documents page will come up and you will click on clear Filters.



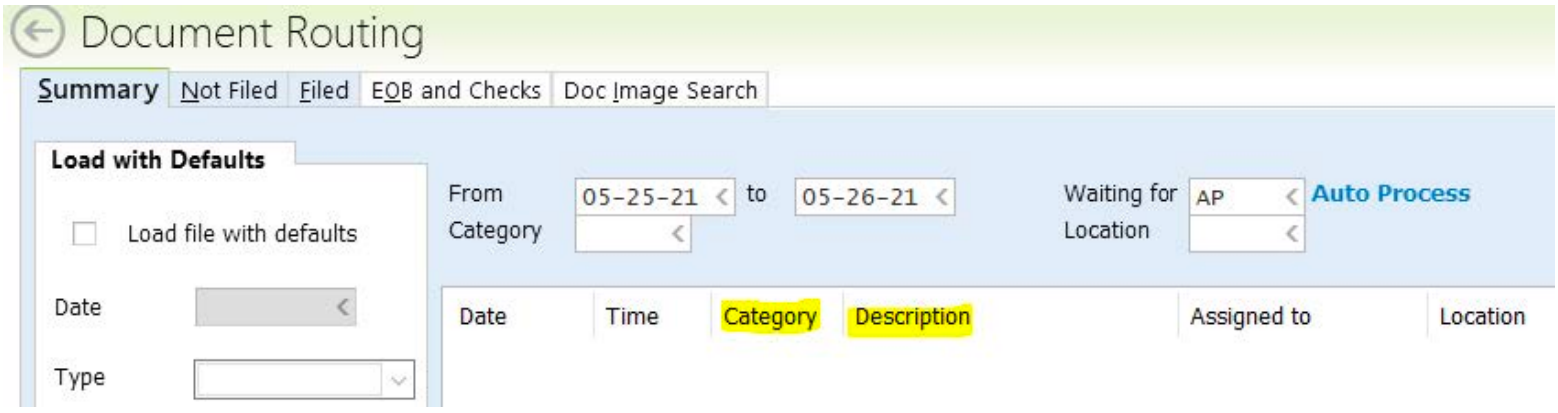
Once you click on Clear Filters all the records will come up. The First one that you should put in the records to be sent is the ROI requesting the records. From there you will more than likely only be sending Intake, Functional Evals, IFSP's, Progress, and Discharge Notes.



You can either send to a known Referral Source OR a custom. If you need to send to a custom fax or email, you will need to fill out the highlighted areas above on the Send Documents tab. Make sure that you are sending records back to the place that requested them. Once everything is entered you can then send records with ROI to the place that sent the request.

Affidavit/Court Order Requests:

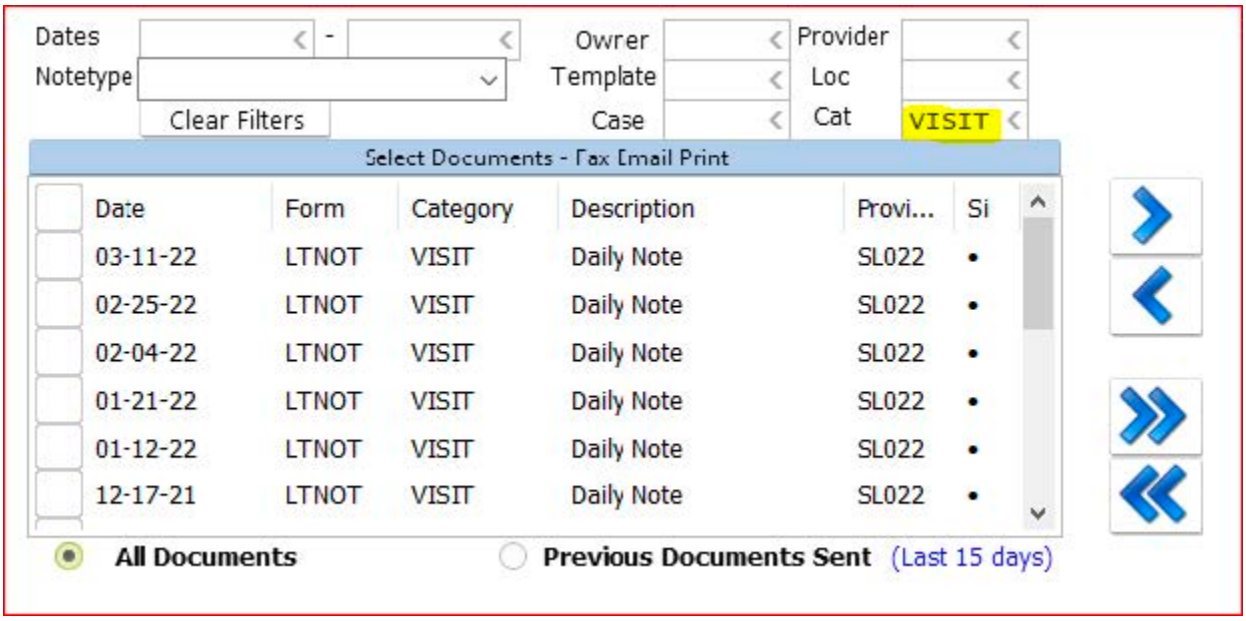
Go to Document Routing in RT:



Category: Request for Medical Records

1. Description: Change description to Name of Recipient
2. Find Child and file in child's chart in RT
   OR
   Admin email
   <u>Necessary Records to send to recipient(s):</u>

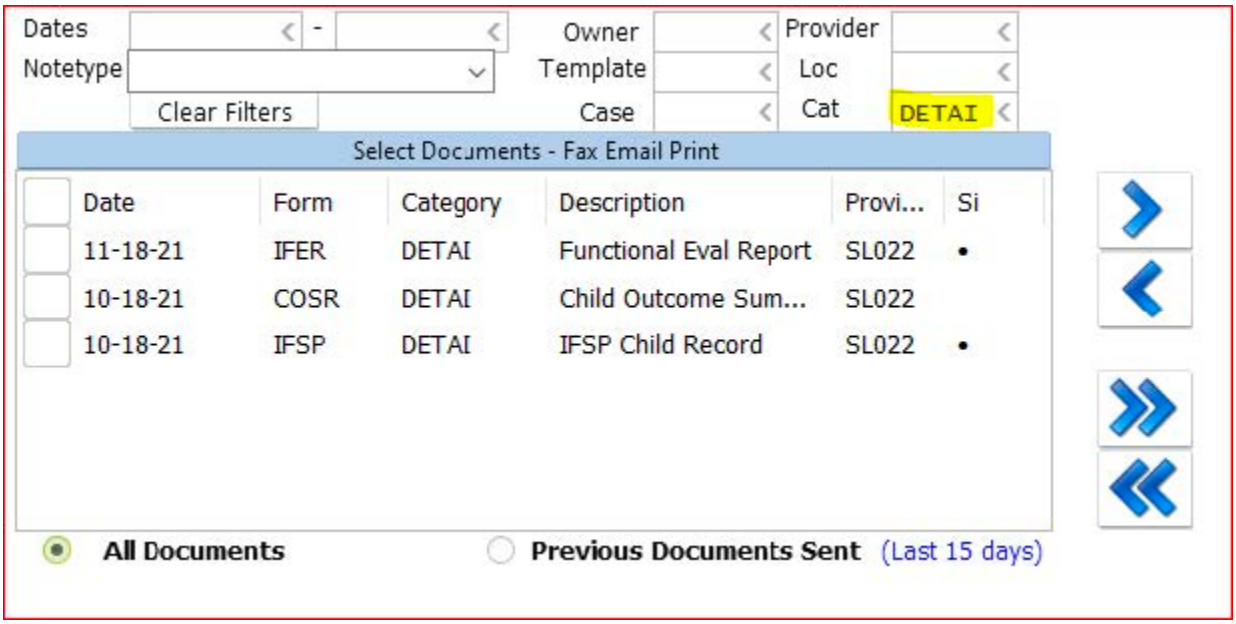
(CAT-VISIT):
Screenings
Intake Note
POC (if enrolled, the newest POC)
Discharge Note (if exited)
Consultations



(CAT: DETAI):

Functional Evaluation Report(s)

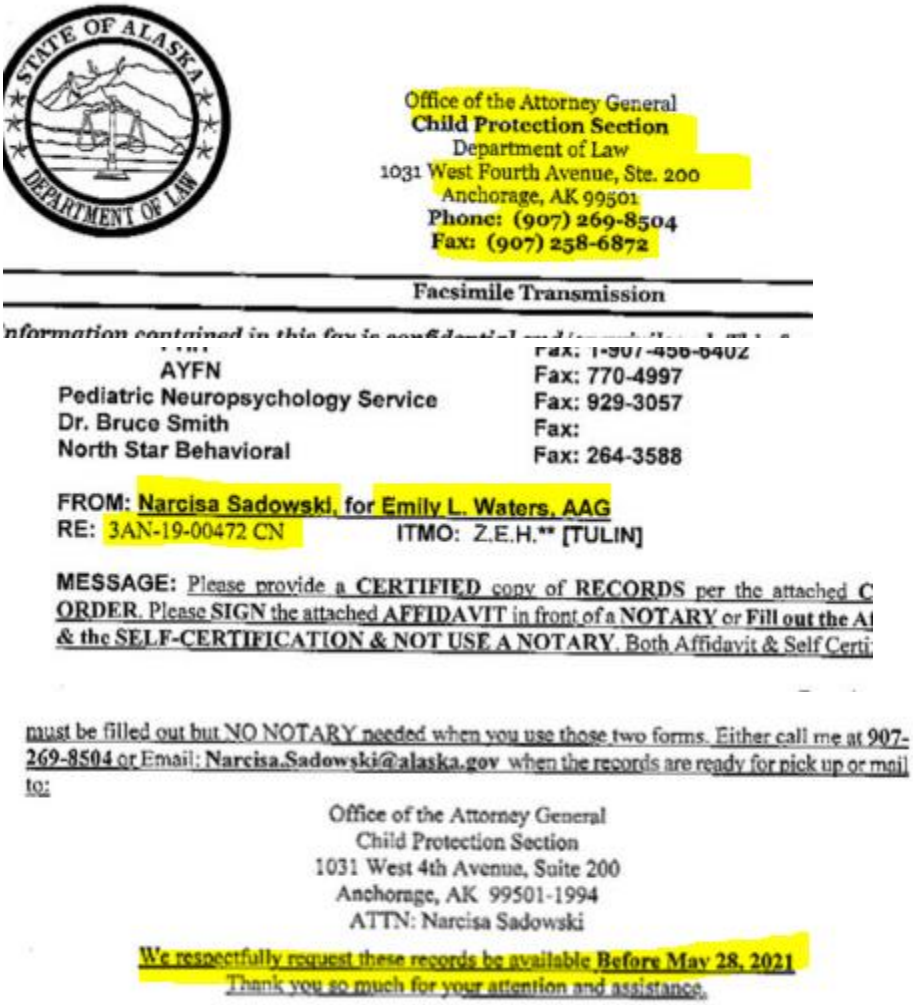
Combined IFSP Record (if enrolled)



Look for 5 things:

- Requestor
- Case #
- Date Requested By

- Judge Signature
- IF valid idea of ROI is in the document



Office of the Attorney General
Child Protection Section
Department of Law
1031 West Fourth Avenue, Ste. 200
Anchorage, AK 99501
Phone: (907) 269-8504
Fax: (907) 258-6872

Facsimile Transmission

nformation contained in this fax is confidential and

Fax: 1-907-456-6402

AYFN — Fax: 770-4997
Pediatric Neuropsychology Service — Fax: 929-3057
Dr. Bruce Smith — Fax:
North Star Behavioral — Fax: 264-3588

FROM: Narcisa Sadowski, for Emily L. Waters, AAG
RE: 3AN-19-00472 CN ITMO: Z.E.H.** [TULIN]

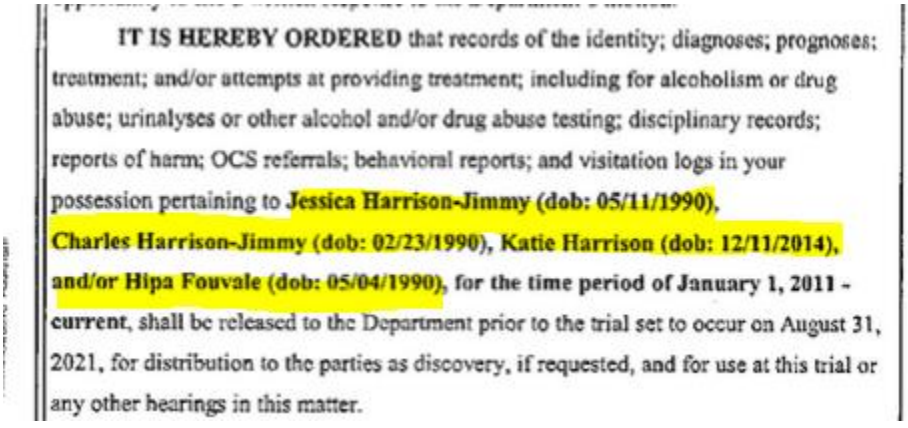
MESSAGE: Please provide a **CERTIFIED** copy of **RECORDS** per the attached C
ORDER. Please **SIGN** the attached **AFFIDAVIT** in front of a **NOTARY** or **Fill out the A**
& the SELF-CERTIFICATION & NOT USE A NOTARY. Both Affidavit & Self Certi

must be filled out but NO NOTARY needed when you use those two forms. Either call me at 907-269-8504 or Email: Narcisa.Sadowski@alaska.gov when the records are ready for pick up or mail to:

Office of the Attorney General
Child Protection Section
1031 West 4th Avenue, Suite 200
Anchorage, AK 99501-1994
ATTN: Narcisa Sadowski

We respectfully request these records be available **Before May 28, 2021**
Thank you so much for your attention and assistance.

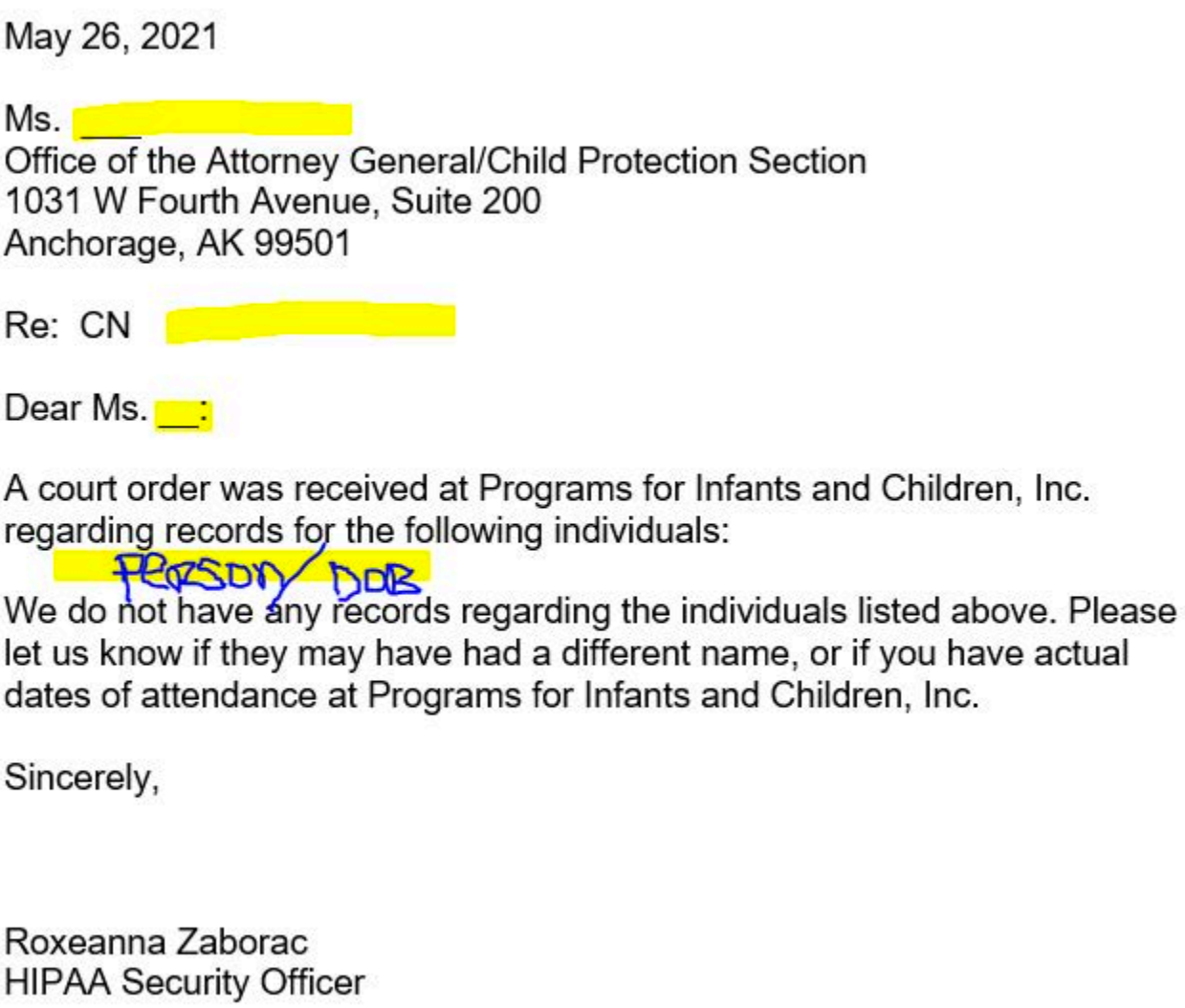
Identify child on request:



IT IS HEREBY ORDERED that records of the identity; diagnoses; prognoses; treatment; and/or attempts at providing treatment; including for alcoholism or drug abuse; urinalyses or other alcohol and/or drug abuse testing; disciplinary records; reports of harm; OCS referrals; behavioral reports; and visitation logs in your possession pertaining to **Jessica Harrison-Jimmy (dob: 05/11/1990), Charles Harrison-Jimmy (dob: 02/23/1990), Katie Harrison (dob: 12/11/2014), and/or Hipa Fouvale (dob: 05/04/1990), for the time period of January 1, 2011 - current**, shall be released to the Department prior to the trial set to occur on August 31, 2021, for distribution to the parties as discovery, if requested, and for use at this trial or any other hearings in this matter.

3. Go to child's chart to either fax/email necessary documents to recipient
4. If large stack of documents needs sent then mail to recipient; if moderate to small stack of records need sent then either fax or email to recipient.

5. Those who are parents/guardians listed on court order will be included on a *Letter of No Records* printed on letterhead:



May 26, 2021

Ms. ____
Office of the Attorney General/Child Protection Section
1031 W Fourth Avenue, Suite 200
Anchorage, AK 99501

Re: CN

Dear Ms. ___:

A court order was received at Programs for Infants and Children, Inc. regarding records for the following individuals:

PERSON / DOB

We do not have any records regarding the individuals listed above. Please let us know if they may have had a different name, or if you have actual dates of attendance at Programs for Infants and Children, Inc.

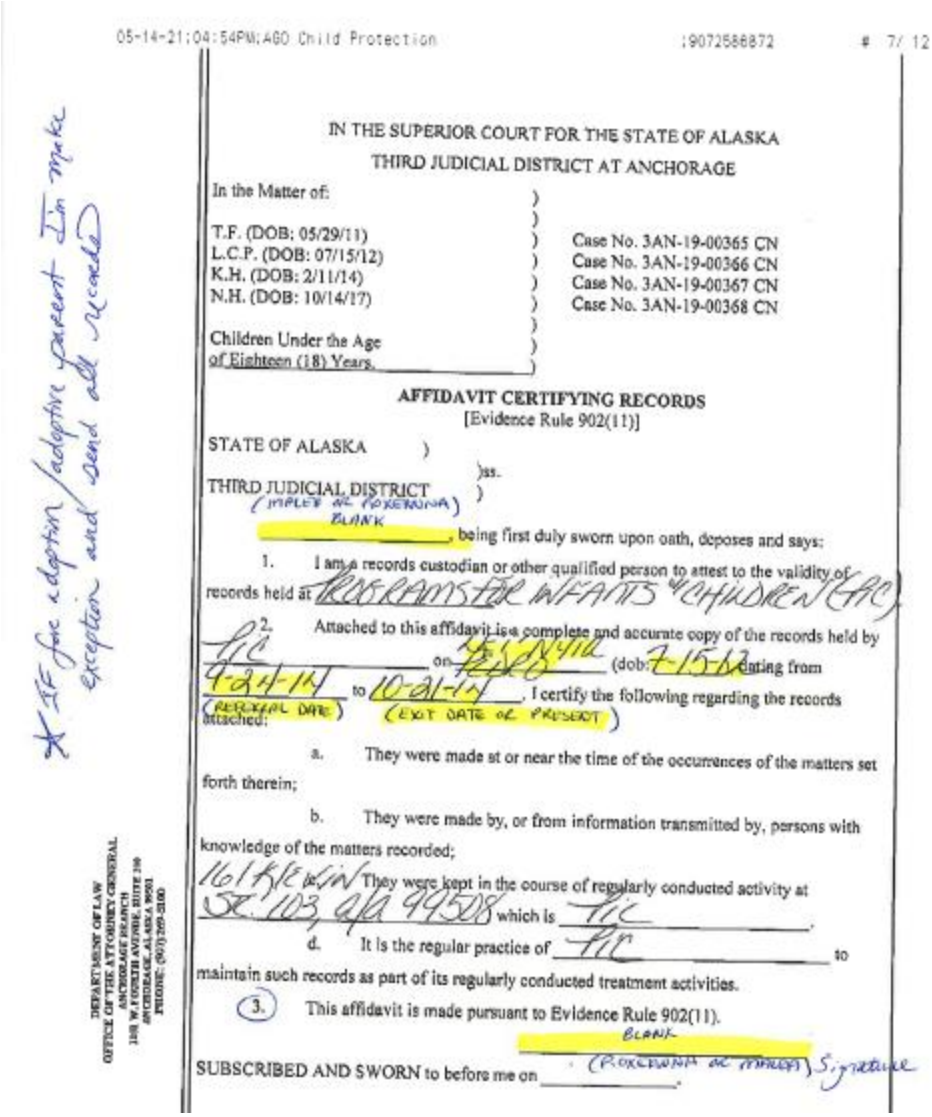
Sincerely,

Roxeanna Zaborac
HIPAA Security Officer

6. Make sure to print out *Letter of No Record* (if applicable) and send letter along with necessary documents or send via fax or email to recipient.
7. Scan *Letter of No Record* into Scan folder so you can put it into child's chart in RT.
8. If there is an Affidavit attached to court order then complete Affidavit/Self Certification. Scan affidavit into child's RT chart. **An affidavit must be mailed to the recipient in addition to faxing/emailing document to recipient.**

Court Records With Affidavit:

Fill out Affidavit as per example:



05-14-21;04:54PM;AGO Child Protection ;9072586872 # 7/ 12

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of:
T.F. (DOB: 05/29/11) Case No. 3AN-19-00365 CN
L.C.P. (DOB: 07/15/12) Case No. 3AN-19-00366 CN
K.H. (DOB: 2/11/14) Case No. 3AN-19-00367 CN
N.H. (DOB: 10/14/17) Case No. 3AN-19-00368 CN
Children Under the Age of Eighteen (18) Years.

AFFIDAVIT CERTIFYING RECORDS
[Evidence Rule 902(11)]

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)
(IMPLEMENTATION PERSONNEL)
BLANK, being first duly sworn upon oath, deposes and says:

1. I am a records custodian or other qualified person to attest to the validity of records held at PROGRAMS FOR INFANTS & CHILDREN (PIC)

2. Attached to this affidavit is a complete and accurate copy of the records held by PIC on PERSONNEL (dob: 7-15-12) dating from 9-24-14 (REFERRAL DATE) to 10-21-14 (EXIT DATE OR PRESENT), I certify the following regarding the records attached:

a. They were made at or near the time of the occurrences of the matters set forth therein;

b. They were made by, or from information transmitted by, persons with knowledge of the matters recorded;

c. They were kept in the course of regularly conducted activity at 161 KLEVIN STE. 103, AK 99508 which is PIC.

d. It is the regular practice of PIC to maintain such records as part of its regularly conducted treatment activities.

3. This affidavit is made pursuant to Evidence Rule 902(11).

SUBSCRIBED AND SWORN to before me on BLANK (PERSONNEL OR NOTARY). Signature

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

* IF for adoption/adoptive parent I'm make exception and send all records

- If adoption/adoptive parent request records it is the exception to send necessary records plus daily notes to recipient
- Call Recipient for notary if needed or use self-certification sheet
- Make copy of Affidavit and full set of records included once signed by notary/yourself (or self-certification) by scanning document into Scan folder so you can put into child's chart in RT
- Scan all sent documents and affidavits in chart to show that it has been sent

Family Signature Forms

The procedural safeguards required by the Individuals with Disabilities Education Act (IDEA) are intended to protect the rights of children with disabilities and their families and guide Early Intervention and Preschool Special Education systems and programs in meeting these requirements.

For a full review of Procedural Safeguards as listed under IDEA Part C please see: https://www.ecfr.gov/current/title-34/subtitle-B/chapter-III/part-303/subpart-E

Purpose

The procedural safeguards required by the Individuals with Disabilities Education Act (IDEA) are intended to protect the rights of children with disabilities and their families and guide Early Intervention and Preschool Special Education systems and programs in meeting these requirements.

For a full review of Procedural Safeguards as listed under IDEA Part C please see: https://www.ecfr.gov/current/title-34/subtitle-B/chapter-III/part-303/subpart-E

A summary of sections as they apply to PIC:

Confidentiality of Information (§ 303.415)

- Agencies must protect personally identifiable information at all stages (collection, maintenance, use, storage, disclosure, and destruction).
- A designated official in each agency is responsible for ensuring confidentiality.
- Personnel handling such information must receive training on state policies and procedures.
- Agencies must maintain a public list of employees who have access to this information.

Enforcement (§ 303.417)

- The lead agency must implement policies, procedures, and sanctions to ensure compliance with confidentiality and procedural safeguards.
- Individuals have the right to file complaints if policies are not followed.

Parental Consent and Rights (§ 303.420)

- Parental consent is required before screenings, evaluations, services, use of insurance, or disclosure of identifiable information.
- If a parent refuses consent, agencies must ensure the parent understands the consequences.
- Agencies cannot use due process hearings to challenge a parent's decision to withhold consent.
- Parents have the right to accept or decline services at any time without jeopardizing other services.

Prior Written Notice (§ 303.421)

- Parents must receive written notice before any changes in their child's identification, evaluation, placement, or services.
- The notice must explain the proposed/refused action, reasons for it, and available procedural safeguards.
- Notices must be in the parent's native language or mode of communication, with translation provided if necessary.

Practice

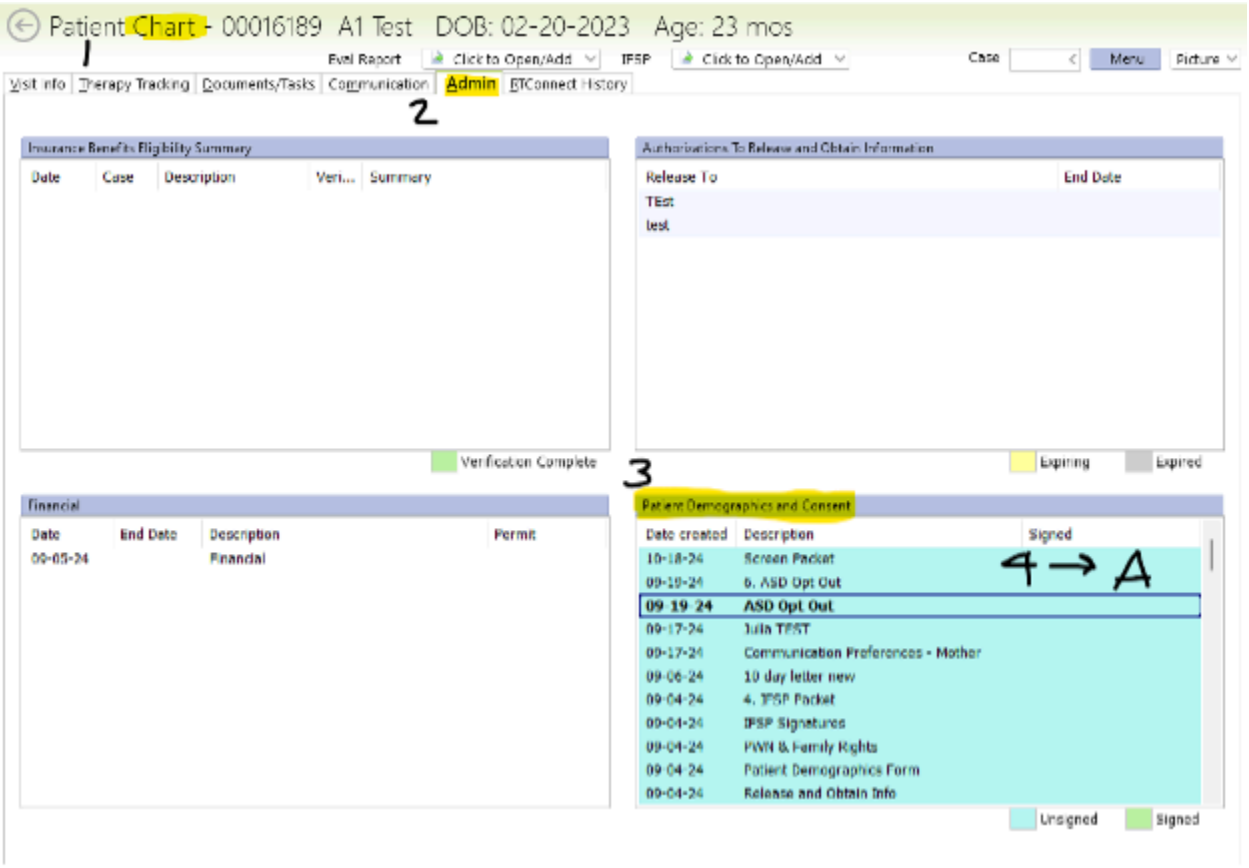
PIC's practice to ensure procedural safeguards are followed as IDEA law requires includes documenting verbal consent. Verbal consent entails reviewing the forms associated with each visit type in detail with families so that they can understand exactly what they are signing.

Verbal Consent is documented in the communication log of a child's chart and includes the name of the authorized representative for the child that the forms were reviewed with, as well as specifically what forms were reviewed. Two key aspects of verbal consent are 1) the provider feels confident that the family understands the forms they are signing 2) forms are reviewed prior to the associated visit/action taking place.

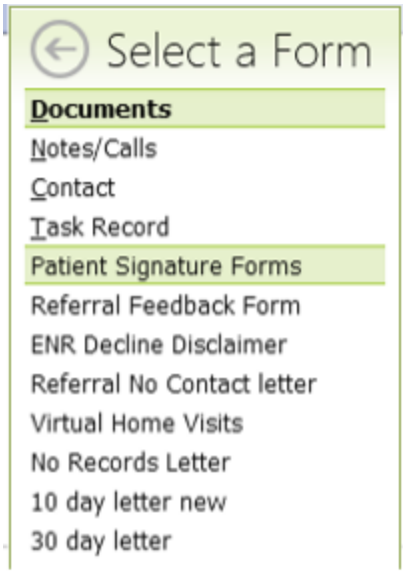
Procedure

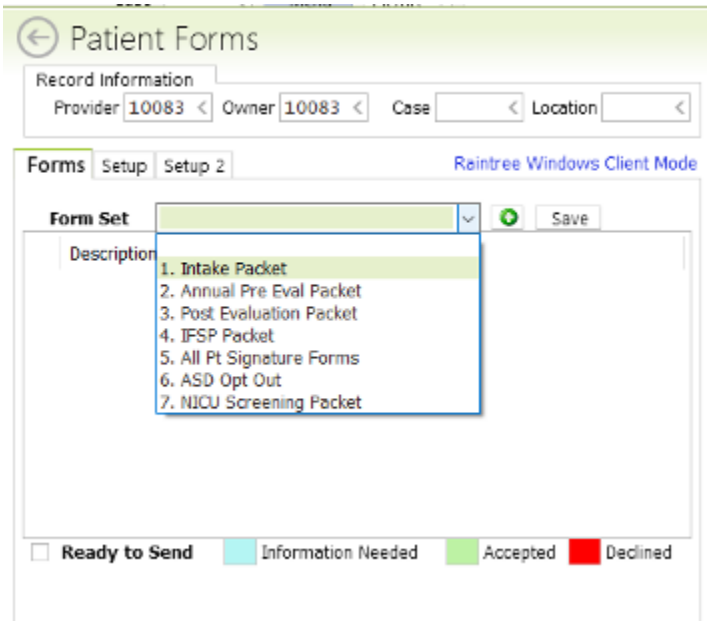
Sending Family Signature Forms

1. In RT go to the Admin tab of the child's Chart, in the Patient Demographics and Consent section and "a" to add



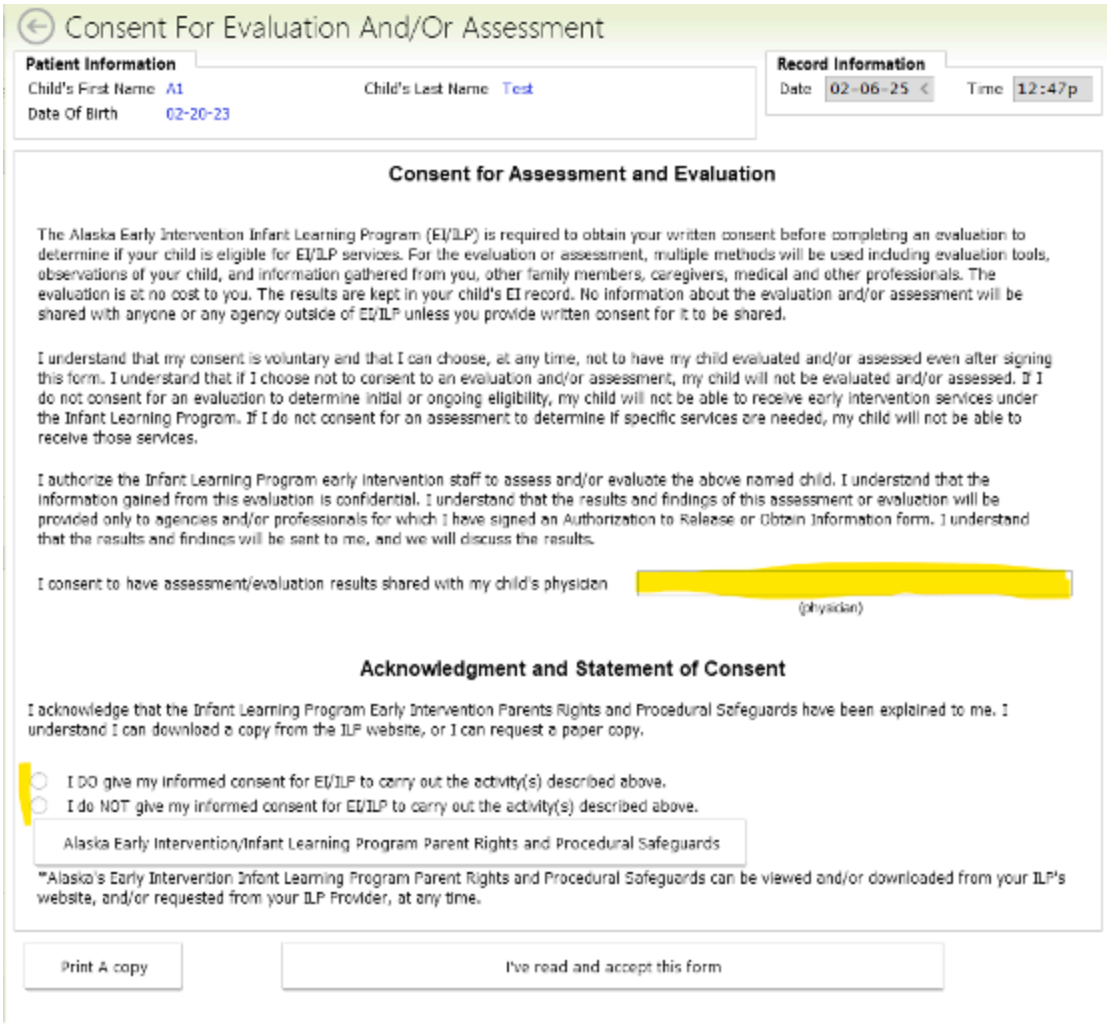
2. Select ”Patient Signature Forms” and then the corresponding form set



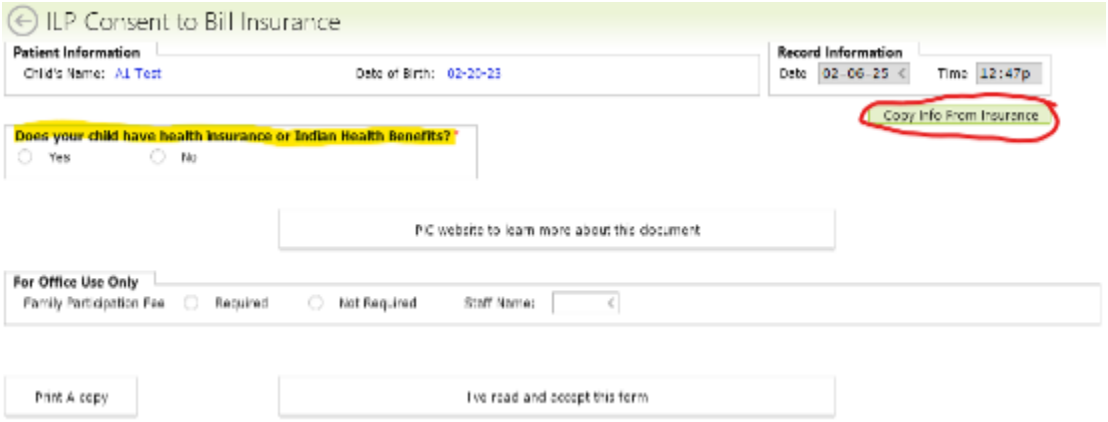


3. Many forms require additional information provided by the direct service provider. These include:

a. Consent for Evaluation/Assessment- requires the name of the child's primary care provider (PCP). If the family does NOT want the evaluation shared with the PCP or they do not have a PCP, then it should be left blank. If the family does not give consent for the evaluation, we should not proceed with the evaluation.



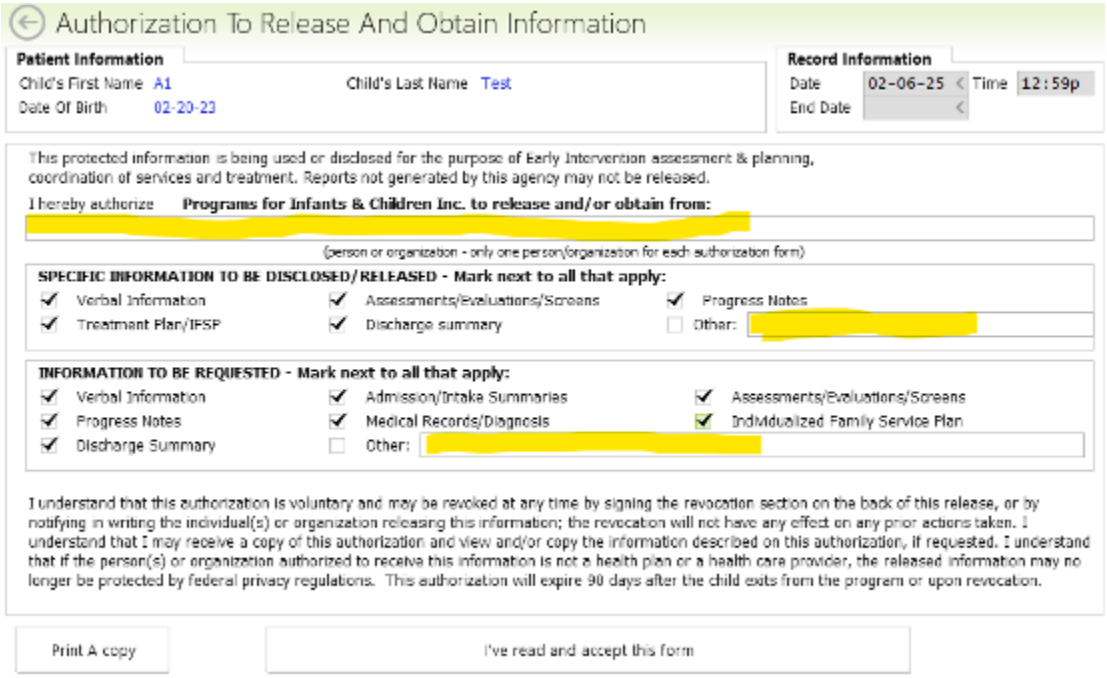
b. EIILP Consent to Bill- this is an expanding form based on the information given. We have a button in the top right corner "Copy Info from Insurance" to make this easier for the family, however if we do not have the information, the family is required to fill it out. There is a box to check if the family doesn't know the Medicaid/Denali KidCare number. All other insurances need to have, at minimum, the Insurance Name & ID number filled out. The last step is to denote if permission is given or NOT given before accepting the form. Consent to Bill a child's insurance is up to the family but does NOT impact the services the child will receive.



c. PWN & Family Rights- this is a multipurpose form that can be associated with the intake, eligibility determination meeting, IFSP meetings, and annual packets. It needs to be completed so that it corresponds with the appointment type it's concerning. It requires the name of the child's authorized representative (or family of [child's name]), the box checked for the reason notice is being provided, and someone

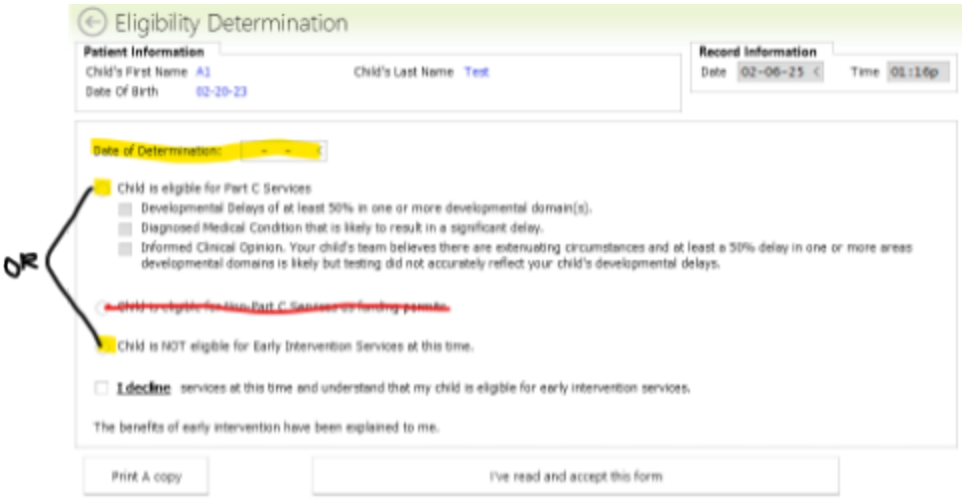
associated with PIC as the signer (this does not necessarily need to be the PSP, RT automatically pulls the current listed PSP and it can't be changed). Also, providing additional information for the family in the text box "The reason this action(s) is being proposed is) can be helpful for both the family and admin, but is not required.

d. Release and Obtain Information- this fulfills our HIPAA and FERPA requirements for safeguards of PHI. We need to specifically state what information can be released and requested by checking the boxes or filling in the "Other" boxes. This ROI is valid for the length of the child's enrollment + 90 days. The family may revoke the permission at any time by signing a hard copy ROI (the back side has a revocation section).



e. Eligibility Determination- this requires information from the evaluation, however, does NOT automatically pull. The Date of Determination is the date of the evaluation. If the child is eligible, the type of eligibility needs to be indicated. If the child is NOT eligible, the other radio

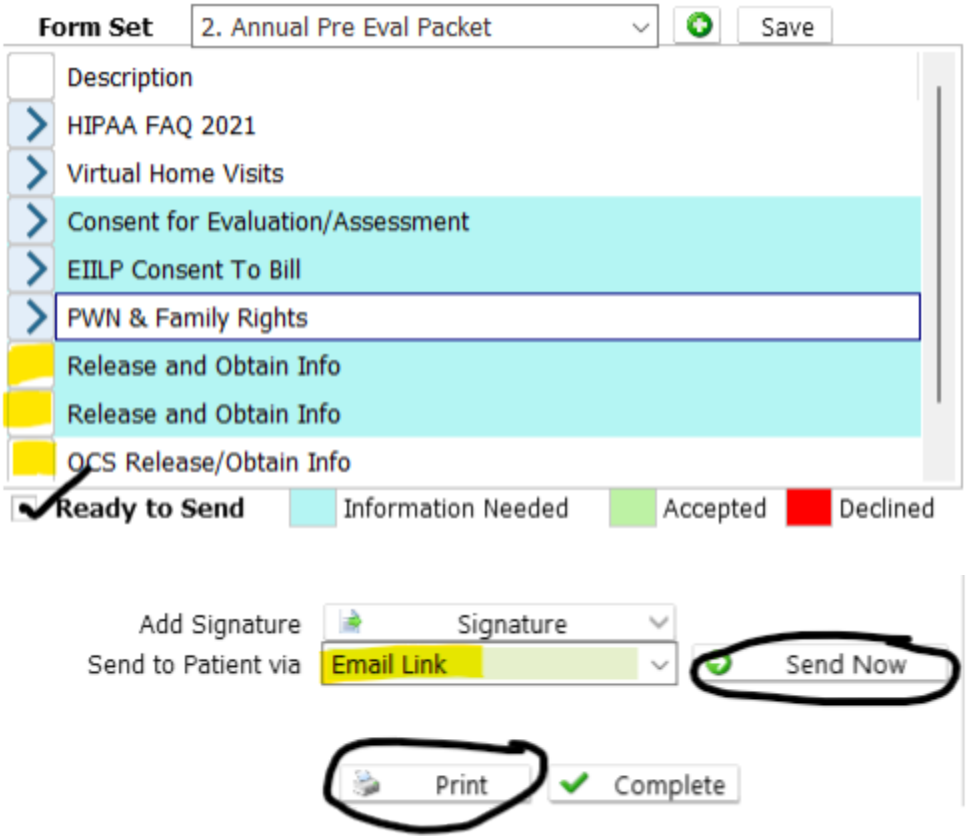
button needs to be selected. We do not enroll Non-Part C children, so that box should never be checked. The family can decline services at enrollment (or re-enrollment) by checking the “I decline” box.



f. IFSP Meeting Signatures- this requires the correct date of the IFSP Meeting, most important type of meeting (if combination IFSP of more than one “type” taking place at one meeting), and the full IFSP team. The IFSP team should include the primary and secondary evaluators if associated with an Initial or Annual IFSP since both providers impacted eligibility. The IFSP team should also include any outside attendees, most commonly ASD during the Transition Conference. Family members should always been included when present. The record date is again the date the document is created, not necessarily the IFSP date and CANNOT be changed.

4. Once all forms are completed to the best of the PIC provider’s ability, check the “Ready to Send” button. Any forms NOT needed (unchecked) will NOT be sent to the family. Choose the “Email Link” drop down option and then Send Now if sending electronically OR you can also print

hard copy forms for the family to sign with the “Print” button.



Prior Written Notice

Purpose

Federal and state laws require that families fully understand their rights throughout all early intervention processes. Providers must clearly explain each right within the context of services. Families must be notified in writing before any action affecting their child is taken, give consent for all service-related activities, and be provided a copy of the Family Rights booklet before the initial evaluation and assessment. If the child is eligible and has an IFSP, the booklet must be offered at least annually and can additionally be offered during evaluation, revision, review, or transition.

Explaining Parents Rights and Safeguards

Even though written materials are given to families at least annually, providers are aware that each right and safeguard has implications for a family’s experience with PIC and work to explain the rights to families throughout their child's enrollment. Further, because PIC is family-oriented and relationship centered, the rights and safeguards convey the IDEA’s central principles of respect for families’ privacy, diversity, and role as informed members of the IFSP team. Only to the extent that families understand their options can they fully exercise their decision-making authority as part of the IFSP team.

Prior Written Notice

Section 303.421 of the IDEA Part C regulations states that, Prior Written Notice (PWN) must be provided to parents within a reasonable time before the lead agency or a provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of their infant or toddler, or the provision of early intervention services to the infant or toddler with a disability and that infant’s or toddler’s family. Parents may exercise the right to decline or dispute the proposed changes as indicated in the PWN.

With this in mind, IDEA Part C requires that parents be given prior written notice on several occasions. Written notice must be provided to the family early enough before the initial eligibility evaluation to ensure that they will be able to attend. If the child is NOT eligible for early intervention the family must be given a prior written notice. For families with children who are eligible prior written notice must be given to the family in a reasonable amount of time before the IFSP meeting, in the event that families want to invite supports, or consider other options.

Proposing to exit a child from early intervention, for whatever reason, would be another example of such a change for which parents need PWN. Typically, this change would be proposed in the context of an IFSP meeting, but there are occasions when a program is unable to contact the family and must notify them of this proposed change.

Practice
Generally, if an enrolled client discharges, it is following the Initial evaluation, Annual evaluation, or after Transition events (Transition Plan/Transition Conference). PWN is delivered to provide families with notice of reducing, or discontinuing services. If PWN is provided at one of these events, further PWN is not required if the child is exiting as a result of that event.

If the guardian requests an evaluation that will take place prior to the next annual evaluation and that event will determine eligibility, the provider must initiate PWN.

For Late Referral (after 33 months), PWN will be given prior to the IFSP and at the time of enrollment for eligibility, and will indicate transition events are anticipated (Transition Plan/Transition Conference) so there is no need to do any additional PWN.

PWN Form is not required:

Parent or caregiver notifies PIC that they want to end services or, 'withdrawn by parent'. Not required because the parent is initiating discharge. (303.421)

A child who is discharged due to "attempts to contact unsuccessful", will be sent a written notification of the discontinuation of services with a 30-day letter found in RainTree.

Procedure
Documenting Prior Written Notice Form in RT

- Providers complete the PWN in the Admin tab in RainTree
- They will indicate what actions will take place at the proposed meeting (ie, eval, IFSP review, transition meeting)
- More than one action can take place at the same meeting
- Complete the reason this action is being proposed and the provider lists reasons (ie, eligibility eval due, 6 month review, transition conference is due)
- Parents will sign off on this via RainTree

Documents
Prior Written Notice Form

Declining Enrollment at Eligibility (Initial or Annual)

Purpose
The IDEA requires that providers present parents with consent forms in many processes. These forms act as safeguards for family rights and are the purpose of PIC's Eligibility Determination form.

§ 303.420 Parental consent and ability to decline services.

a. The lead agency must ensure parental consent is obtained before—
    1. Administering screening procedures under § 303.320 that are used to determine whether a child is suspected of having a disability;
    2. All evaluations and assessments of a child are conducted under § 303.321;
    3. Early intervention services are provided to the child under this part;
    4. Public benefits or insurance or private insurance is used if such consent is required under § 303.520; and
    5. Disclosure of personally identifiable information consistent with § 303.414.
b. If a parent does not give consent under paragraph (a)(1), (a)(2), or (a)(3) of this section, the lead agency must make reasonable efforts to ensure that the parent—
    1. Is fully aware of the nature of the evaluation and assessment of the child or early intervention services that would be available; and
    2. Understands that the child will not be able to receive the evaluation, assessment, or early intervention service unless consent is given.
c. The lead agency may not use the due process hearing procedures under this part or part B of the Act to challenge a parent's refusal to provide any consent that is required under paragraph (a) of this section.

d. The parents of an infant or toddler with a disability—
    1. Determine whether they, their infant or toddler with a disability, or other family members will accept or decline any early intervention service under this part at any time, in accordance with State law; and
    2. May decline a service after first accepting it, without jeopardizing other early intervention services under this part.

(Authority: 20 U.S.C. 1436(e), 1439(a)(3))

Practice
Families may decline enrollment in, or withdraw from, services at any time during their child's involvement with PIC. If a family decides not to enroll after eligibility has been determined, this indicates that evaluation results—and the child's eligibility—have already been reviewed with them. Prior to a family making this decision, staff are obligated to explain the benefits of Early Intervention and present the family appropriate information and options. However, participation in Early Intervention is entirely voluntary and families are not required to accept services.

Procedure
Initial: If the family Declines services prior to enrollment (after the evaluation) document the following:

Eligibility meeting: provider completes a daily note indicating family preference, then complete comm log note EXIT. This will send a RainTree task to Data Entry to exit the client elsewhere in the system.

Signature forms for family: completed at Intake: PWN

STILL NEED: Eligibility Determination obtain signatures at the time of post-eval/eligibility meeting

***With a family who is not in contact after the Eval and before Eligibility/IFSP complete a 10-day letter to inform of their status. In this case, if we don't hear back from the family, the child is considered Lost to Follow Up rather than a decline, and no further forms are needed from the family. ***

Annual: If the family Declines services after annual re-evaluation, but we still need to review the evaluation results with the family, document the following:

Eligibility meeting: daily note, discharge note

Signature forms for family: PWN, Eligibility Determination Form

***With family who is not in contact after the Eval and before Eligibility/IFSP complete a 30-day letter to inform of their status. In this case, when we don't hear back from the family, the child is considered 'Attempts to Contact Unsuccessful,' rather than a withdraw by caregiver and no further forms are needed from the family.

Consent to Bill

Purpose
The IDEA safeguards for billing are summarized below and are the purpose of PIC's Consent to Bill form.

Summary of § 303.520 – Policies on Public Benefits, Insurance, and Private Insurance for Part C Services

a. ***Use of Public Benefits or Insurance***
    - A State may use a child's or parent's public benefits (e.g., Medicaid) for Part C services only after providing written notification and ensuring certain no-cost protections.
    - Parents **cannot** be required to enroll in public benefits as a condition for receiving services.
    - Parental **consent is required** if using public benefits would:
        - Reduce available coverage or benefits.
        - Result in out-of-pocket costs for parents.
        - Increase premiums or discontinue benefits.
        - Risk loss of eligibility for Medicaid waivers.
    - If a parent refuses consent, the State must still provide approved Part C services.
b. ***Use of Private Insurance***
    - A State **cannot** use private insurance to pay for Part C services without parental consent unless a **State law** protects against:

        - Loss of benefits due to coverage caps.
        - Negative impact on insurance availability.
        - Increased insurance premiums.
    - Consent is needed when:
        - Private insurance is first used for a service.
        - There is an increase in service levels.
    - If parents may incur costs (e.g., co-pays, deductibles), these must be identified in State policies.
c. ***Inability to Pay***
    - If a family **cannot afford** private insurance costs and does not consent to its use, services **cannot** be delayed or denied.
d. ***Use of Funds from Public or Private Insurance***
    - Reimbursements from public or private insurance are **not considered** State or local funds.
    - Medicaid reimbursements are also not considered State or local funds.
e. ***Parent Payments Under a State's System***
    - Payments made by parents under a State's system of payments are **program income** and must be used for early intervention services but are not counted as State or local funds.

Practice
PIC's practice in regard to Consent to Bill (CTB) signature form is as follows:

1. At Intake, the form is reviewed by their primary service provider. PIC's HIT/billing team follows up with the family if more information is needed, if the family unexpectedly chose to deny consent (to confirm it was intentional), or to review visit limits if the family has private insurance and have OT, PT or ST on their IFSP.
2. Any time a billing service (PT, OT, or ST) is added **or** frequency is increased when the child has private insurance since this impacts billing of their private insurance. Again, PIC's HIT/billing team follows up with the family to review visit limits if needed.
3. If the child's insurance changes, a new form is needed. Again, PIC's HIT/billing team follows up to review visit limits if needed.
4. Annually at the child's re-evaluation. Again, PIC's HIT/billing team follows up to review visit limits if needed.

Families may revoke their consent to bill insurance at any time.

Procedure
Completing the CTB:

1. At Intake, send intake packet with the CTB to the family via the Admin Tab in RainTree for signature. Check that the form was signed at intake and if has not been, assure that the family is reminded. Data Entry and HIT also follow-up.
2. When a billable service (PT, OT, or ST) is added **or** frequency is increased, send a CTB to the family via the Admin Tab in RainTree for signature. Check that the form was signed at intake and if has not been, assure that the family is reminded. Data Entry and HIT also follow-up.
3. If the child's insurance changes, a new form is needed. send a CTB to the family via the Admin Tab in RainTree for signature. Check that the form was signed at intake and if has not been, assure that the family is reminded. Data Entry and HIT also follow-up.
4. Annually at the child's re-evaluation, send an annual re-eval packet with a CTB to the family via the Admin Tab in RainTree for signature. Check that the form was signed at intake and if has not been, assure that the family is reminded. Data Entry and HIT also follow-up.

When consent is denied:

The PSP will inform the HIT team via hit@picak.org and make a Call Log Note the day the consent is denied. Give the family a new Consent to Bill signature form and have them choose that they "DO NOT give permission".

Consent to Bill & PIC Families

- PIC services are free to families. This means that any service not covered by insurance is written off. It does not mean we are a free service, we send claims to all available insurance.
- Why should a family give consent to bill if they have Private Insurance?
    - PIC's services can help reduce their deductible, allowing them to pay less out of pocket.
- Why would a family deny consent to bill?
    - If kiddo has Private Insurance, they are seeing outside therapists and want to save visit limits.

- My family doesn't know if they have visit limits, what now?
  - Any time an IFSP is completed with new billable services the HIT team will research the insurance and try to contact the family to explain the visit limits and PIC's billing policy to them.
- What happens if a family has Private Insurance and Medicaid?
  - Any claims not paid by the Private Insurance will be sent to Medicaid. Anything not covered by Medicaid will be written off.
- A family I work with wants to revoke Consent to Bill, what do I do?
  - Inform the HIT team via hit@picak.org and make a Call Log Note the day the consent is denied. Give the family a new Consent to Bill signature form and have them choose that they "DO NOT give permission".

Consent to Evaluate

Purpose

The IDEA safeguards for parental consent are summarized below and are the purpose of PIC's Consent to Evaluate form.

§ 303.420 Parental consent and ability to decline services.

a. The lead agency must ensure parental consent is obtained before—
   1. Administering screening procedures under § 303.320 that are used to determine whether a child is suspected of having a disability;
   2. All evaluations and assessments of a child are conducted under § 303.321;
   3. Early intervention services are provided to the child under this part;
   4. Public benefits or insurance or private insurance is used if such consent is required under § 303.520; and
   5. Disclosure of personally identifiable information consistent with § 303.414.
b. If a parent does not give consent under paragraph (a)(1), (a)(2), or (a)(3) of this section, the lead agency must make reasonable efforts to ensure that the parent—
   1. Is fully aware of the nature of the evaluation and assessment of the child or early intervention services that would be available; and
   2. Understands that the child will not be able to receive the evaluation, assessment, or early intervention service unless consent is given.

(Authority: 20 U.S.C. 1436(e), 1439(a)(3))

Practice

PIC's practice in regard to Consent to Evaluate signature form is as follows:

1. At Intake, the form is reviewed by their primary service provider. With parent, guardian consent and confirmation, the medical home provider for the child is included in the form so that we can send a copy of the evaluation report.
2. Annually at the child's re-evaluation the form is reviewed again with the family since eligibility is determined based on the evaluation.
3. Upon consultation, the form is again reviewed and signed with the family since assessments can be used to determine if specific services are needed.

If for any reason the family does not give consent to evaluate the child, the PIC provider will ensure that they communicate with the parent or guardian that PIC will not be able to move forward in the referral process. Staff will answer any questions regarding the nature of both the evaluation and possible services. The child will be exited as "Declined."

Procedure

Documenting Consent to Evaluate form in Rain Tree:

- The PIC Provider will complete the Consent to Evaluate form as part of the appropriate packet in the admin tab of RT, including the child's PSP.
- Review the form with the family at either the intake or prior to the annual evaluation and document verbal consent in the communication log.
- If the family does NOT give consent to evaluate, then the PIC provider will document that the family does not want services in the communication log 'exit note' indicating the reason as "decline."
- Consent to evaluate is also used for the purpose of consent for any screening/assessment outside of the two-month window from intake or annual evaluation.

IFSP Signature Form

Purpose

The IDEA safeguards for parental consent are summarized below and are the purpose of PIC's IFSP Meeting Signature form.

§ 303.342 Procedures for IFSP development, review, and evaluation.

a. ***Meeting to develop initial IFSP—timelines.*** For a child referred to the part C program and determined to be eligible under this part as an infant or toddler with a disability, a meeting to develop the initial IFSP must be conducted within the 45-day time period described in § 303.310.
b. ***Periodic review.***
    1. A review of the IFSP for a child and the child's family must be conducted every six months, or more frequently if conditions warrant, or if the family requests such a review. The purpose of the periodic review is to determine—
        i. The degree to which progress toward achieving the results or outcomes identified in the IFSP is being made; and
        ii. Whether modification or revision of the results, outcomes, or early intervention services identified in the IFSP is necessary.
    2. The review may be carried out by a meeting or by another means that is acceptable to the parents and other participants.
c. ***Annual meeting to evaluate the IFSP.*** A meeting must be conducted on at least an annual basis to evaluate and revise, as appropriate, the IFSP for a child and the child's family. The results of any current evaluations and other information available from the assessments of the child and family conducted under § 303.321 must be used in determining the early intervention services that are needed and will be provided.
d. ***Accessibility and convenience of meetings.***
    1. IFSP meetings must be conducted—
        i. In settings and at times that are convenient for the family; and
        ii. 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.
    2. 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.
e. ***Parental consent.*** The contents of the IFSP must be fully explained to the parents and informed written consent, as described in § 303.7, must be obtained, as required in § 303.420(a)(3), prior to the provision of early intervention services described in the IFSP. Each early intervention service must be provided as soon as possible after the parent provides consent for that service, as required in § 303.344(f)(1).

(Authority: 20 U.S.C. 1435(a)(4), 1436)

Practice
Practice: IFSP Meeting Signature Form

- For **every IFSP meeting**, staff must complete an IFSP Meeting Signature form, documenting the meeting date, meeting type, and the members of the IFSP team.
- For **Initial and Annual IFSP meetings**, the IFSP team **must include the secondary provider** who participated in the child's eligibility determination.
- For meetings where more than one type of IFSP action occurs ("dual action" meetings), the meeting type of highest priority is recorded:
    - *Priority order (highest to lowest):* Initial > Annual > Transition > Revision/6-Month Review.
    - For example:
        - Initial IFSP + Transition Conference = record as Initial
        - Annual IFSP + Transition Conference = record as Annual
        - Revision IFSP + Transition Conference = record as Transition
        - 6-Month Review IFSP + Transition Conference = record as Transition
- For Transition-related meetings, use the "Transition" type for both Transition Plan and Transition Conference IFSPs; note that "Transition" is required for Transition Conference IFSPs.

Procedure

1. The Primary Service Provider completes the IFSP Meeting Signature Form within the appropriate packet, located in the admin tab of RainTree (RT). Ensure the date, meeting type, and attending IFSP team members are accurately entered.
2. At the IFSP meeting, review the completed form with the family and seek to ensure understanding.
3. Document the family's verbal consent by making a note in the communication log.

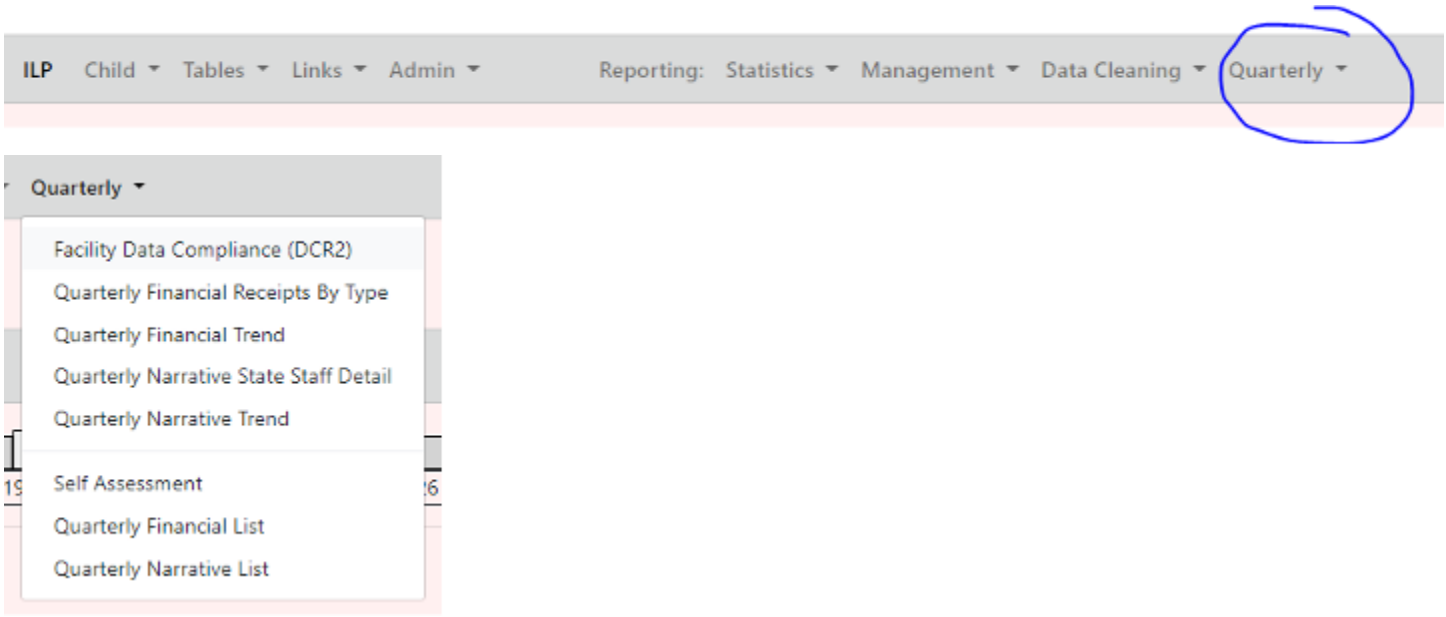
State Compliance

Data - Compliance Report (DCR)

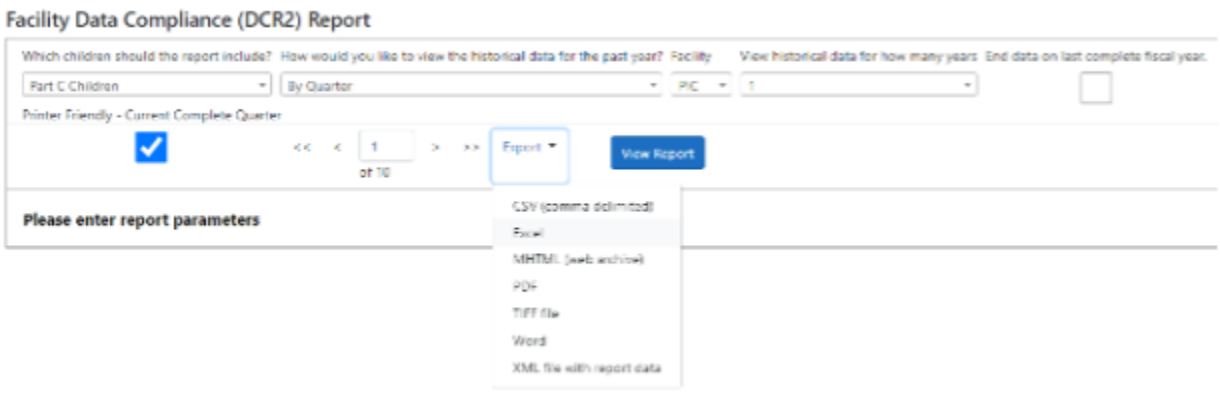
Procedure

How to adjust the DCR-2

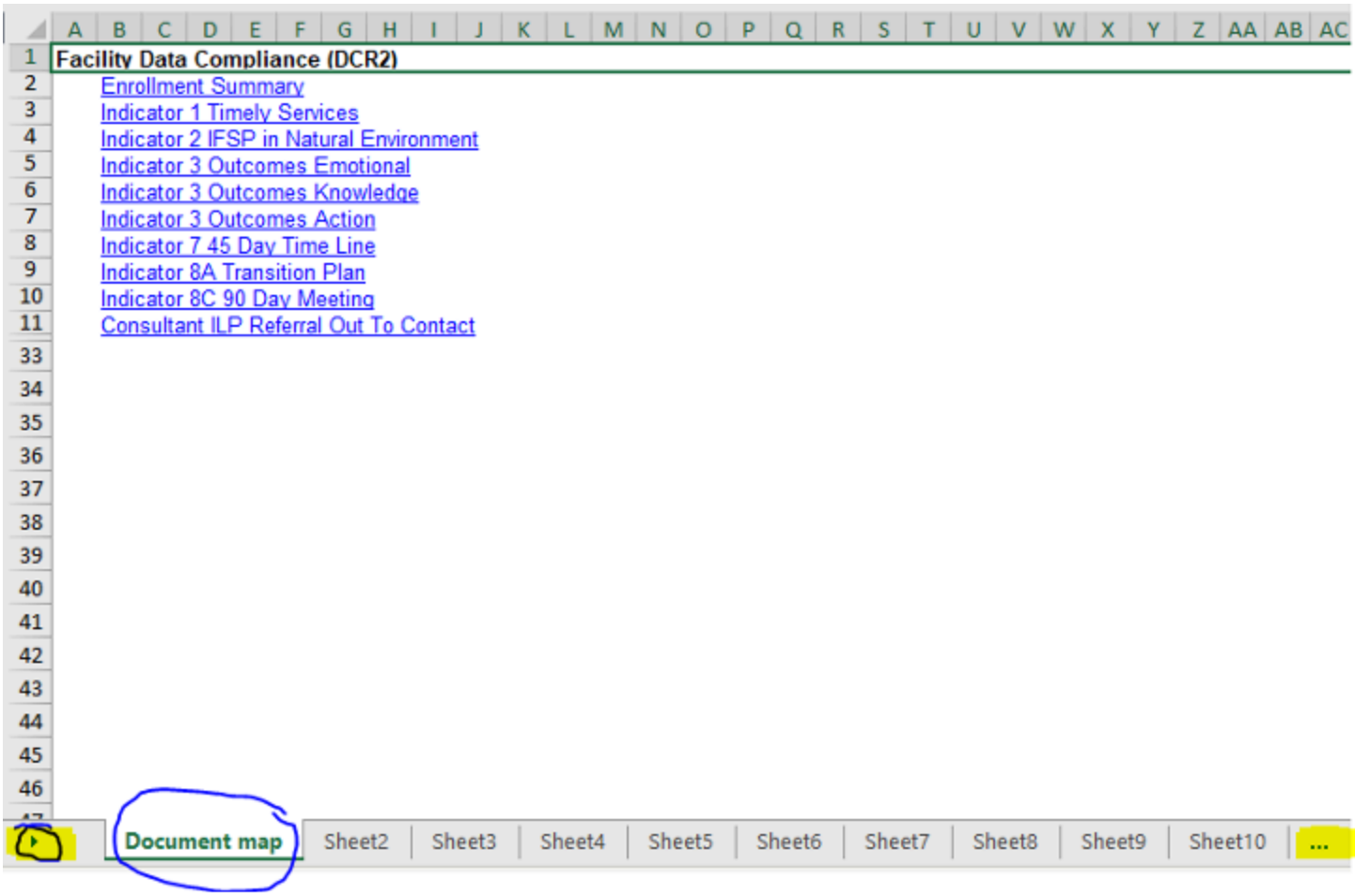
1. All DCR-2 information is kept on the State Database Sharepoint site: DCR-2 then categorized by fiscal year and quarter. The DCR-2 spreadsheet that is the “master” version gets pinned to the top name “MASTER….updated mm.dd”
2. The DCR-2 is pulled weekly from the database called “Facility Data Compliance (DCR2) from the top bar under “Quarterly”



3. The default is for Part C children, then I change the view historical data for how many years to 1 (default is 2) and Export to Excel to get the spreadsheet named, “Facility Data Compliance (DCR2)” there will sometimes be a number at the end if you haven’t renamed a previously downloaded version.

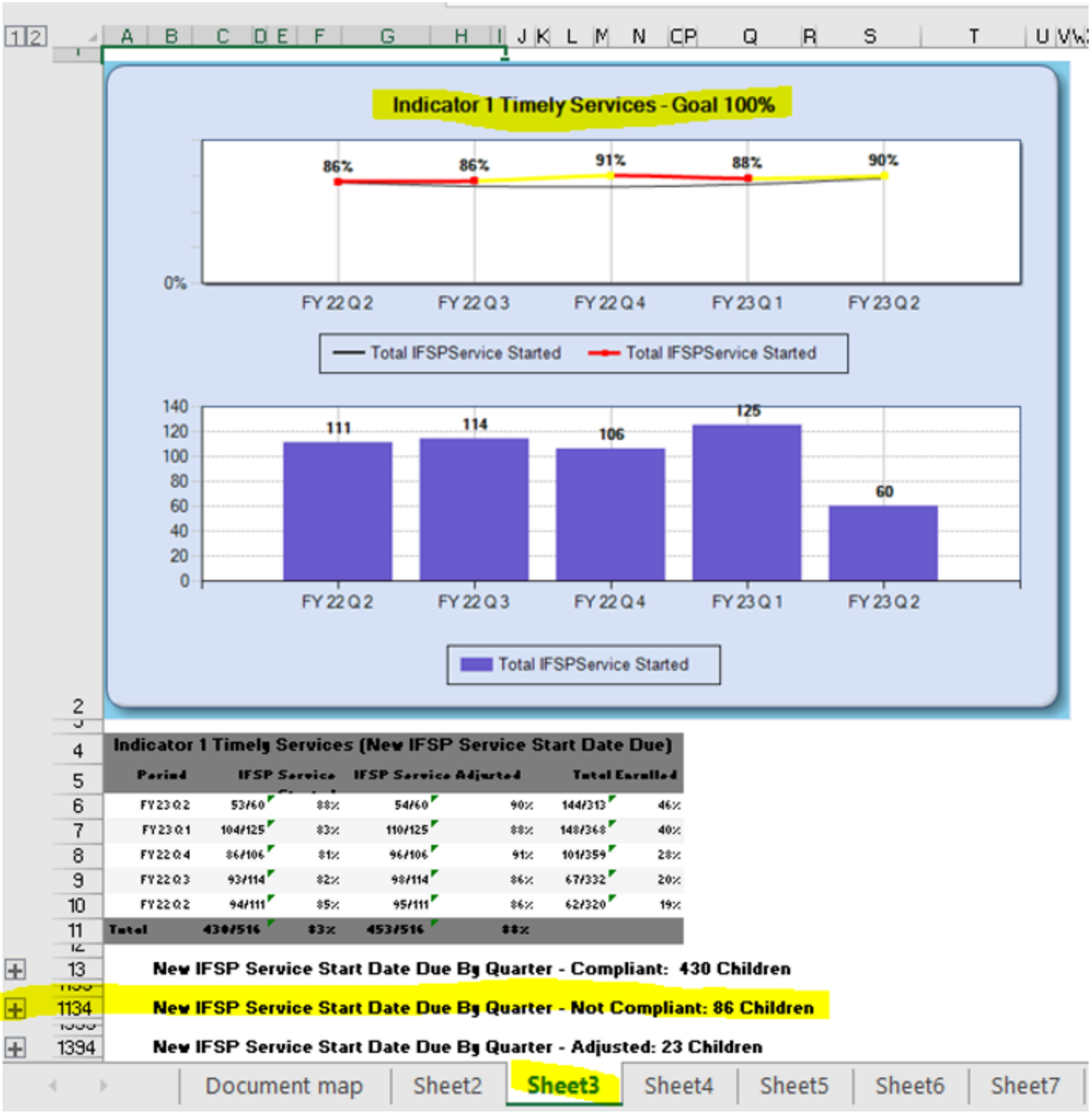


4. The spreadsheet is set up in tabs by indicators. I always have to scroll through to get to them all, using the arrow on the far left of all the tabs or the three dots on the far right (highlighted below)



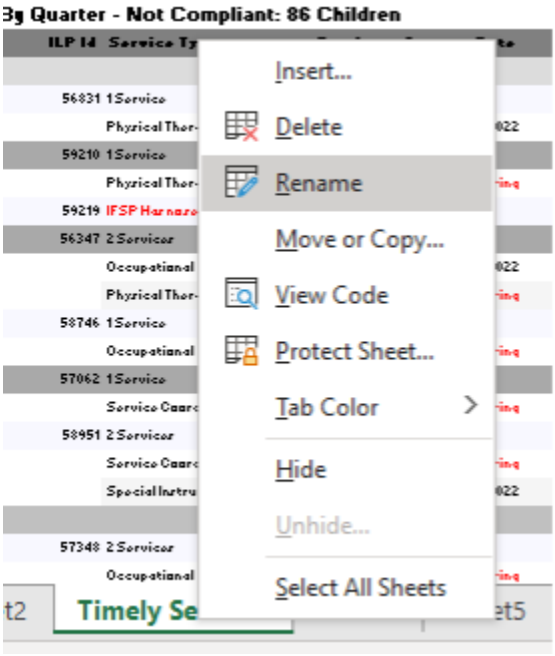
FOR CREATING THE MASTER VERSION

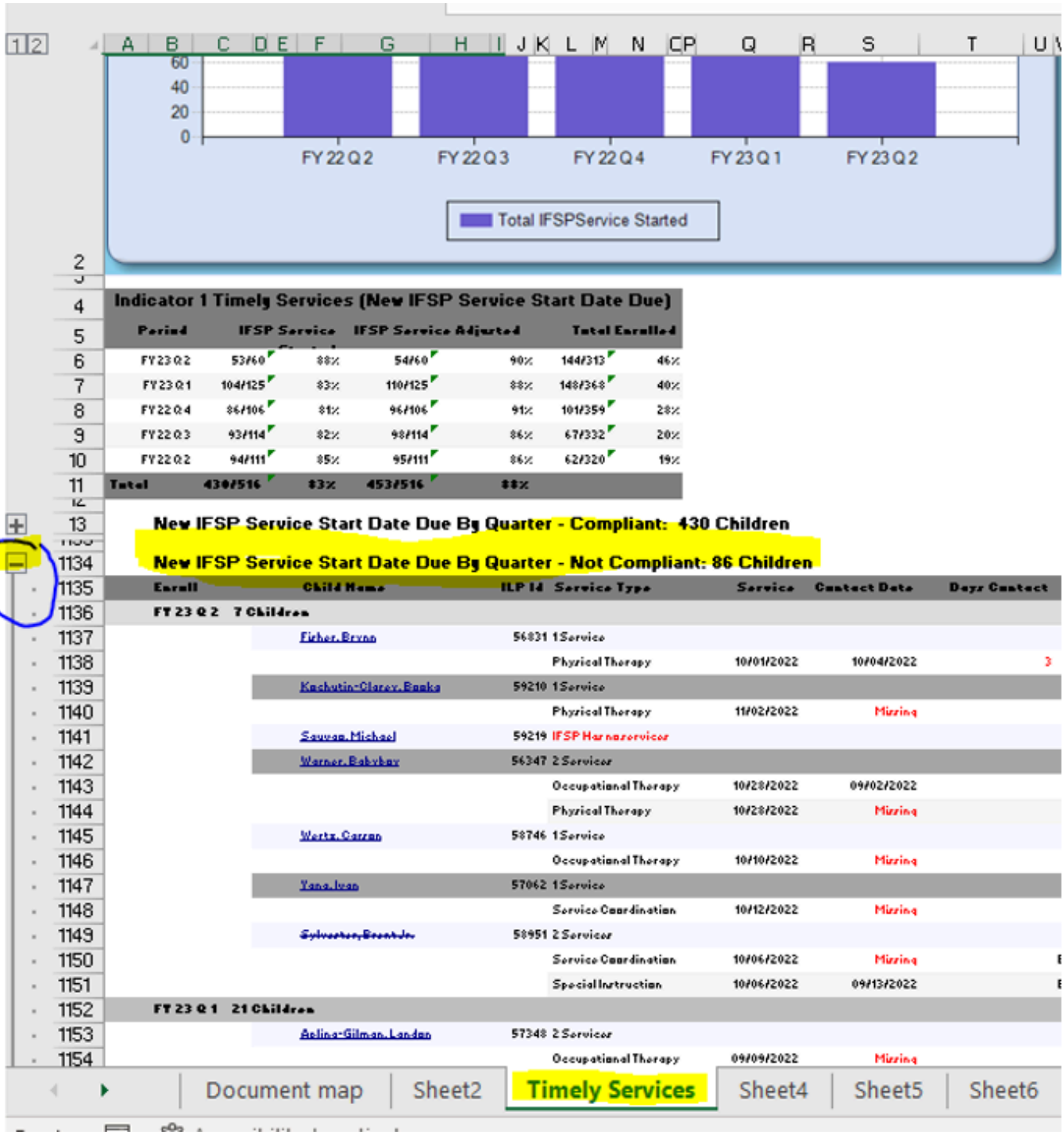
- Starting with Sheet3, I rename the tabs by what the Indicator is AND expand the + for the Not Compliant Children



- To rename the tab simply right click and choose “Rename” and start typing the Indicator. To expand the Not Compliant Children, you simply click on the + sign (highlighted).

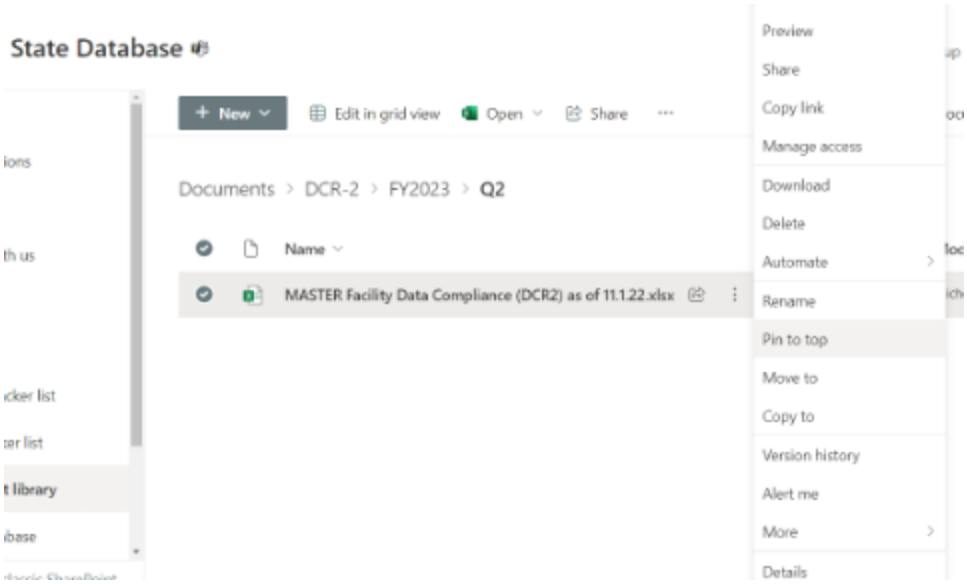
- **PRO TIP:** Use the Desktop version of Excel, since the web version, which doesn't always show the + easily.





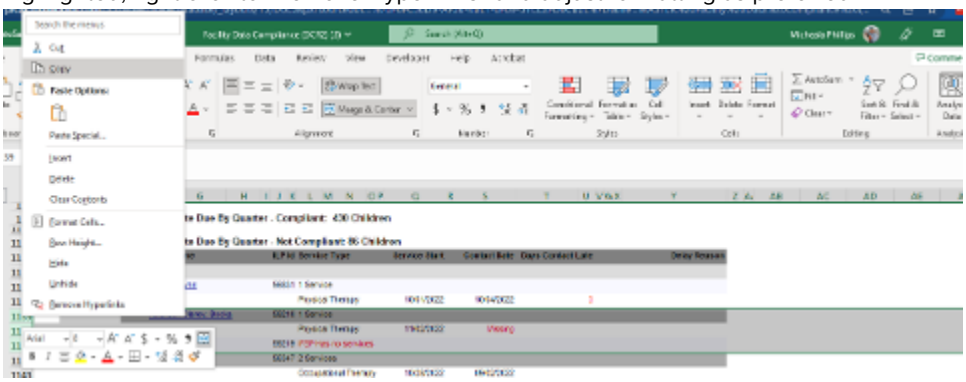
- **PRO TIP:** Ctrl + A highlights everything in a sheet and you can adjust the formatting in the following ways for usability:
  - Right click and “Remove Hyperlinks” to allow for copying and pasting of names and SDB#
  - Confirm the font and size in Home tab
  - Update the fill color to be appropriate (see key)
- In the document map tab, I usually give a color key of what each highlight means. Here’s an example:
  - Yellow highlight: needs to be addressed
  - Green highlight: should fall off/strike through
    name = has fallen off
  - Orange highlight: needs provider feedback
  - Pink highlight: needs to be adjusted by the state
  - Red highlight: will be non-compliant explanation given on Quarterly Narrative
- Repeat this process for tabs 3-10

- Save as “MASTER Facility Data Compliance (DCR2)updated mm.dd” with the current month and date in the correct fiscal year and quarter, then pin to the top of the folder in SharePoint



For updating the Master DCR-2 weekly

- Pull the DCR2 as usual and save it to the same SP site as “Facility Data Compliance (DCR2) as of mm.dd”
- Then for each tab I compare the Master spreadsheet to the most recent version and copy/paste any new kids onto the master, inserting them in alphabetical order.
  - **PRO TIP:** the easiest way to keep the formatting from causing issues (due to merged cells) is to insert the number of rows you’ll be copying in the Master version, then copying by the row number (the right click option) and pasting by Ctrl + V. While it’s still highlighted, right click to “Remove Hyperlinks” and adjust formatting as preferred

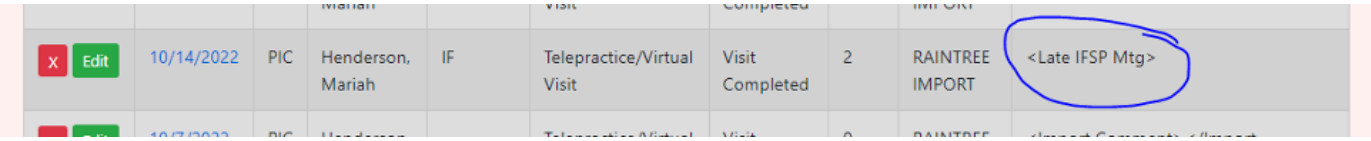


Adjusting Indicators

I. **Timely Services**
- This is looking at the start date listed for each service type on the child’s IFSP.
  1. Look the child up in RT to confirm the summary of services and start dates are correct in the Database (ruling out data entry error).
  2. Assuming the start dates and services are correct, go to Visit History to look for any cancellations or unposted charges.
     - We’re looking for Cancellation by Family or comm log notes detailing why services were lat
  3. Once the service has been delivered/started, then go to the Contact tab and re-enter the contact for that service

II. **45-day timeline**
- This is looking at if the initial IFSP, or enrollment, happened with 45 days of referral.

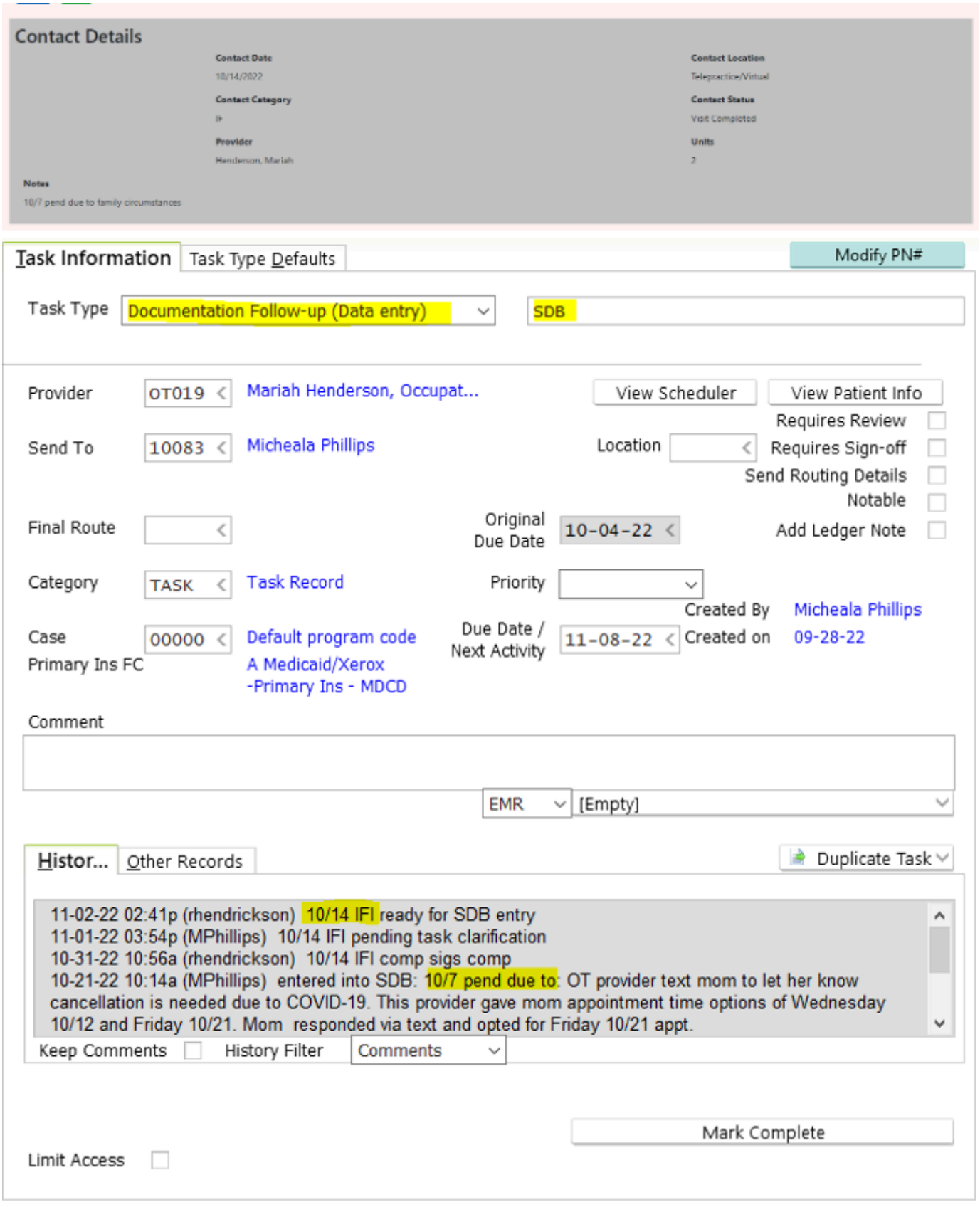
1. Copy the old contact with the <late IF>



2. Delete the old one (red X)
3. Remake the new one and you should get a pop up like this:

4. Validate

5. In the reason box fill out the reason plus include a timeline (found easily in the Documentation Follow up (Data entry)- SDB task in RT



6. **Copy the timeline before hitting okay**
7. Hit validate and then okay
8. Paste this into the notes and into the DCR-2 adding “contact updated as of mm/dd- Initials”

9. Mark it green

Documents

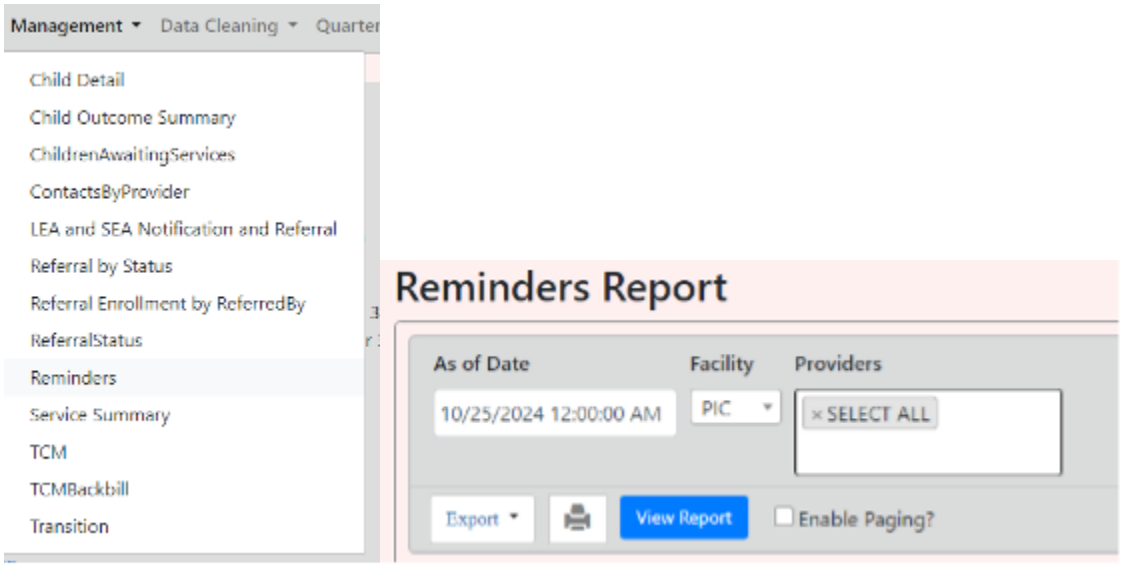
Practice for Compliance Indicators PowerPoint

Reminders Report

Procedure

How to- Reminders Report

1. All Reminder Reports information is kept on the State Database site: CURRENT Reminders reports (or the Archived subfolder). The current month is saved as - Reminders MONTH YEAR
2. To pull the Reminders report from the State Database under the Management tab “Reminders” with the default As of Date and “Select All” for the providers, then Export to Excel. This is a big report, so be patient as it loads to Excel.



3. Open in the Excel app and enable editing. No need for the Document Map tab (okay to delete). The categories on the Reminders Report as of 9/10/24 are:
    1. Initial IFSP Due
    2. Enrolled Children with No Completed Visit Contact Date in Past Month
    3. Transfer IFSP Revision Due -> not accurate

Transfer IFSP Revision Due (5 Children)

Name	ILP ID	FSC	Last Plan Type	Days	Due Date
Dobson, Kie'Maya	59768		Revision		11/04/2024
Lewis, Tracy	65194		Initial		11/04/2024
Wright, Mackenzie	60242		Annual/Renewal		11/04/2024
Pete, Atlantis	60569		Revision		11/04/2024
Jackson-Cummings, Jordan	62116		Annual/Renewal		11/04/2024

    4. IFSP 6 Month Review or Annual Renewal Due à for manager/provider review
       We don’t get State compliance review of this category, so reach out and remind the manager that it is still in the red for reminders-please review this
    5. IFSP Service Start Date Due
    6. IFSP Service Start Date Missing: usually do not have any data in this category
    7. Initial COSF Rating Due
    8. Exit COSF Rating Due
    9. Annual Evaluations Due -> for manager/provider review
       We don’t get State compliance review of this category, so reach out and remind the manager that it is still in the red for reminders-please review this
    10. Start Transition Plan by Age 30 Months
    11. 90-Day Transition Meeting Due

12. LEA Notification Due
13. Child Status
14. Enrolled Past 3rd Birthday

4. Anything highlighted yellow means that action was needed by the provider and should be confirmed that the action was taken before compiling next month's report.
5. Once reviewed, publish on the Intranet/send email out to all staff with a link to the report and a reminder, "please be sure to review the IFSP 6 Month Review or Annual Renewal Due and Annual Evaluations Due sections. Anything highlighted yellow has already had a task sent when needed."

Review Process by category:

Initial IFSP Due

Purpose: This category checks for the 45-day timeline and only pulls children who have NOT been pended, but it pulls any child in process (aka even those that just were referred the day the report is pulled)

Action needed: review any child that is overdue (negative red number for days), check for any reason to pend- i.e. cancel by family, no show, multiple attempts to contact family without response in comm log. If there is a reason to pend, add pend per How to-Pend.docx

If no reason to pend is found, send task to provider under "Reason for Delay" with free form reason "45 days was mm/dd). The body of the task is:

Hi PROVIDER

45 days for CHILD was DATE, however I don't see any cxf or reason to pend in the comm log. Can you please review the circumstances and let me know the reason for the delay?

Thanks,

Enrolled Children with No Completed Visit Contact Date in Past Month

Purpose: This category attempts to make sure no child falls off the radar. Check for frequency on the most recent IFSP matches, for children who have not been seen in the past **2 months**.

Action needed: review any child that is hasn't been seen in 2 months, check for any reason for the lack of visits- i.e. cancel by family, no show, multiple attempts to contact family without response in comm log and if no reason is found, send task to provider under "Reason for Delay" with free form reason "_____ Frequency not being met). The body of the task is:

Hi PROVIDER,

It looks like CHILD hasn't been seen since DATE, but the frequency on the IFSP is set to FREQ. I don't see any additional comm log notes or cxf. Can you please review and let me know the circumstances?

Thanks!

IFSP Service Start Date Due

Purpose: This category reminds providers about the Timely Services Indicator on the DCR. With weekly DCR-2 review and Transfer Report checks, there *shouldn't* be any new names on this list that haven't been caught, but it's a great double check.

Action needed: review the chart for any obvious reason for the delay- i.e. the family has cancelled or no showed, if nothing in the visit history or comm log to justify the delay send a task to the provider under "Reason for Delay" with freeform reason "SERVICE TYPE [ST/PT/OT/SI] due as mm/dd" The body of the task is:

Hi PROVIDER,

[Any circumstances found], but no other reason for delay since SERVICE was due as of mm/dd. Can you please review the circumstances and let me know the reason for the delay?

Thanks!

IFSP Service Start Date Missing

Purpose: In case an IFSP was added without a start date. This very rarely happens in PIC's process, but it's a great double check

Action needed: most likely would be missed data entry, since IFSP is reviewed before entered into the SDB. Review the IFSP in RT and add any missing data.

Initial COSF Rating Due

Purpose: Outcomes are required at enrollment and exit, so this checks for the enrollment outcomes (or COSF- Child Outcome Summary Form). This is part of PIC's functional evaluations. Again, this very rarely happens in PIC's process, but it's a great double check

Action needed: most likely would be missed data entry, since functional evaluations are reviewed before being entered into the SDB. Review the functionality in RT and add any missing data.

Exit COSF Rating Due

Purpose: Outcomes are required at enrollment and exit, so this checks for the exit outcomes (or COSF- Child Outcome Summary Form). Exit outcomes are not always required, so this is trickier. Exit COSF are needed when the child has been enrolled for more than 6 months. Even if the child has had a recent re-eval, we need to note if progress was made or not, so that will need to be noted on the Discharge summary, but the provider can roll those re-eval scores if the re-eval was within 3 months.

Action needed: This should be the same list of children as those Enrolled Past 3rd Birthday, but it also includes those upcoming discharges for providers to review. The task is "Discharge Summary" with freeform reason depending on whether or not exit IDAs are needed (if no recent re-eval then exit IDAs will be needed as well). The body of the task is:

Please complete discharge summary [with exit IDAs and] outcomes since more than 3 months since last eval and enrolled for more than 6 months.

Start Transition Plan by Age 30 Months

Purpose: The Transition Plan IFSP needs to occur when the child is between 24-30 months. Technically the Transition Plan IFSP isn't late until 33 months, but the state reminder is set for 30 months. This is a specific IFSP (but can be combined with a revision or annual IFSP) and is marked in the State Database with a check mark.

Action needed: If no Transition Plan IFSP is missed in data entry, review any cancellations or comm log notes with reason for the delay. The task for the provider is still Reason for Delay with freeform reason "Transition Plan IFSP due as of mm/dd." The body of the task is:

Hi PROVIDER,

CHILD's Transition Plan IFSP was due as of mm/dd. I don't see any cxf or comm log notes with the reason for the delay. Please review and let me know the circumstances of the delay, otherwise get the IFSP scheduled ASAP.

Thanks!

90-Day Transition Meeting Due

Purpose: Much like the TP IFSP, there needs to be a Transition Conference IFSP by the time the child is 33 months old. Usually, ASD is involved in this IFSP, however even if the family has opted out of ASD, they still are required to have a TC IFSP. The reminders report is the ONLY place this shows up, it is NOT on the DCR-2 until after the child has exited, so this is ESSENTIAL to check.

Action needed: Sometimes providers will document the Transition Conference as FSC with ASD rather than an IFSP, so be sure to check daily notes. The task for the provider is still Reason for Delay with freeform reason "Transition Conference IFSP due as of mm/dd." The body of the task is:

Hi PROVIDER,

CHILD's Transition Conference was due as of DATE. I don't see any cxf or comm log notes with a reason for the delay. Could you please review the chart and let me know what the circumstances of the delay are?

Thanks,

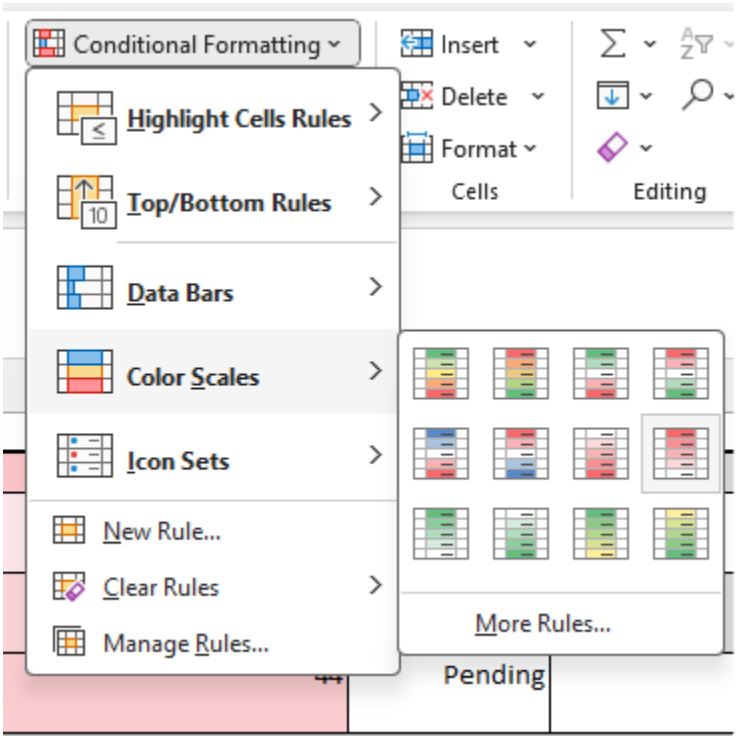
LEA Notification Due

Purpose: Notification to the Local Education Agency (LEA) is generated by the SDB report "LEA and SEA Notification and Referral Report" when the child turns 30 months. This is only for enrolled children, so those who enroll after 30 months get added to the list upon their Initial IFSP, however, this can get tricky when closer to the 33-month mark. LEA Notification does NOT have a reason for delay after 33 months, so we must catch our 30-32- and 29-days kids with a manual check when pulling the LEA report weekly by checking the waitlist children's DOB. If the child is enrolled (has their IFI) **AFTER** they are 33 months old, then we are exempt from LEA notification/referral.

Action needed: This is hopefully a double check, but if there is a name under this category, send a special notification over to ASD ASAP via Panda Doc. See instructional How To- ASD LEA Notification Report.docx

Child Status

Purpose: This category checks for extended pends. The Initial IFSP Due *should* catch all the kids who haven't been pended and have missed their 45 days, but this category is a more extended list. To make sorting this list easier, make a new tab and create a table (you'll have to delete the extra columns that inevitably pop up with creating the table). This allows the list to be sorted and conditional formatting to be applied. Under Conditional Formatting, Color Scales, Dark red to white (2nd row on the far right).



This is subject to judgement, but I recommend checking into (reviewing the chart for a reason for pend/delay) any child that is:

1. close to the 45 days and doesn't show as pended
2. pended for more than 100 days

Action needed: Send the provider a task checking in on either a reason for pending or long pend.

Reason for pending: Send task to provider under "Reason for Delay" with free form reason "45 days was mm/dd). The body of the task is:

Hi PROVIDER

45 days for CHILD was DATE, however I don't see any cxf or reason to pend in the comm log. Can you please review the circumstances and let me know the reason for the delay?

Thanks,

Pend for more than 100 days: Send task to the provider under “Reason for Delay” with the free form reason “long pend”. The body of the task is:

Hi PROVIDER,

I see that you have reached out to the family to schedule evaluation/review results, but without response from the family. Would it be appropriate to send a 10-day letter? Child has been pended over 100 days.

Thanks,

Enrolled Past 3rd Birthday

Purpose: Children cannot receive Part C services after age 3. It is expected that they are discharged within 10 days of their 3rd birthday. Our current discharge process is rather complicated and confusing, so it’s helpful to let the provider know if exit IDAs and exit outcomes are needed or if we just need a discharge summary.

Action needed: Review the chart for length of enrollment, recent eval, and if there’s already a progress note before tasking the provider for the Discharge Note task type and the body of the task as either:

A. Please complete discharge summary, no exit IDAs or outcomes needed since not enrolled more than 6 months.
B. Please complete discharge summary with exit IDAs and outcomes since more than 3 months since last eval and enrolled for more than 6 months.

**Staff and Data entry: Being enrolled in part B and Part C at the same time is considered “double dipping” or enrolled for duplicate services, which is not approved. We recognize that families may want to stay with PIC for services until age 3 (ie, not ready to enroll, services with PIC are the best fit until age 3, etc.). If parents choose to continue services with PIC, providers will document in the daily note or comm log depending on the circumstance.

Parent decided to continue with PIC services until age three and defer ASD enrollment until that time.

Send to Providers

Post to the Intranet, choose your type of post and image

Link to CURRENT Reminders reports folder (or that month’s specific report, the previous months’ reports should be moved to the ARCHIVED months folder).

As usual, please be sure to review the IFSP 6 Month Review or Annual Renewal Due and Annual Evaluations Due sections. Anything highlighted yellow has already had a task sent when needed.

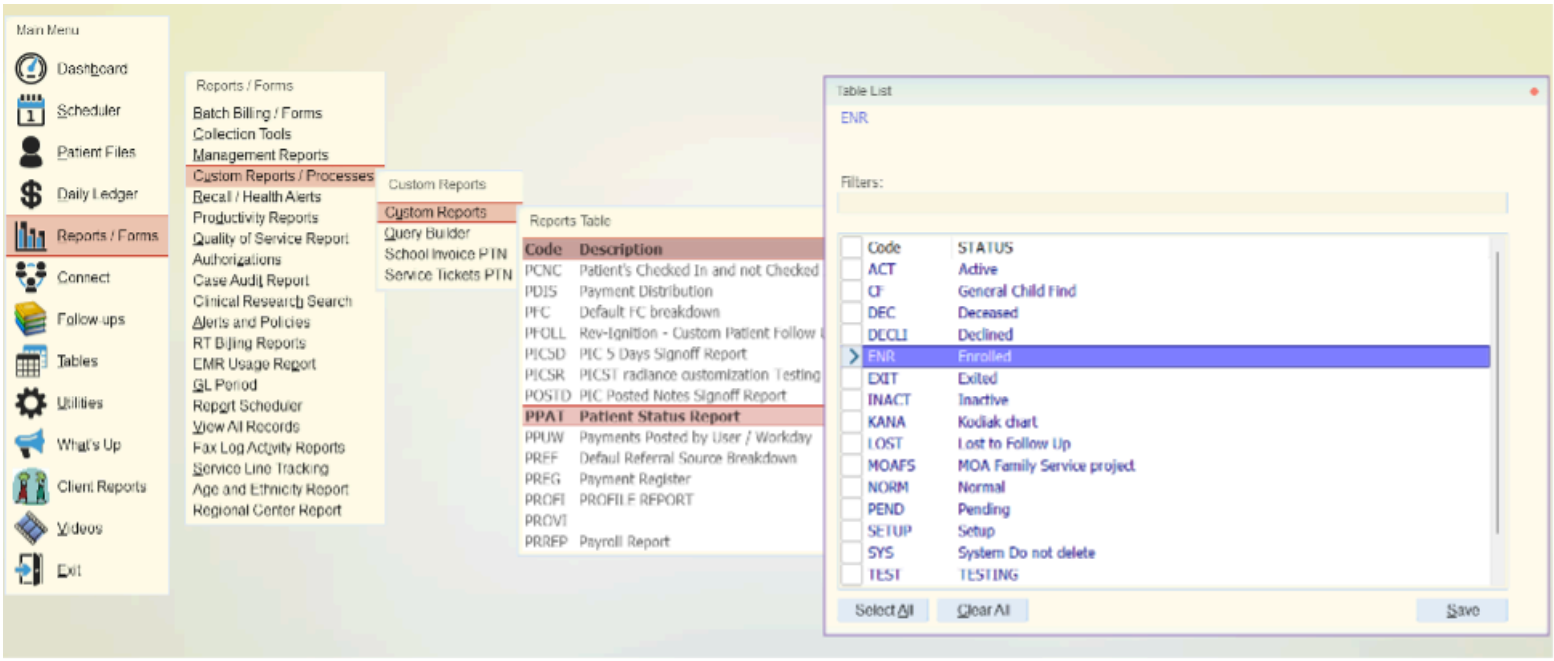
Post and send to PICEmployees@picak.org

Documents
Practice for Reminders Reports PowerPoint

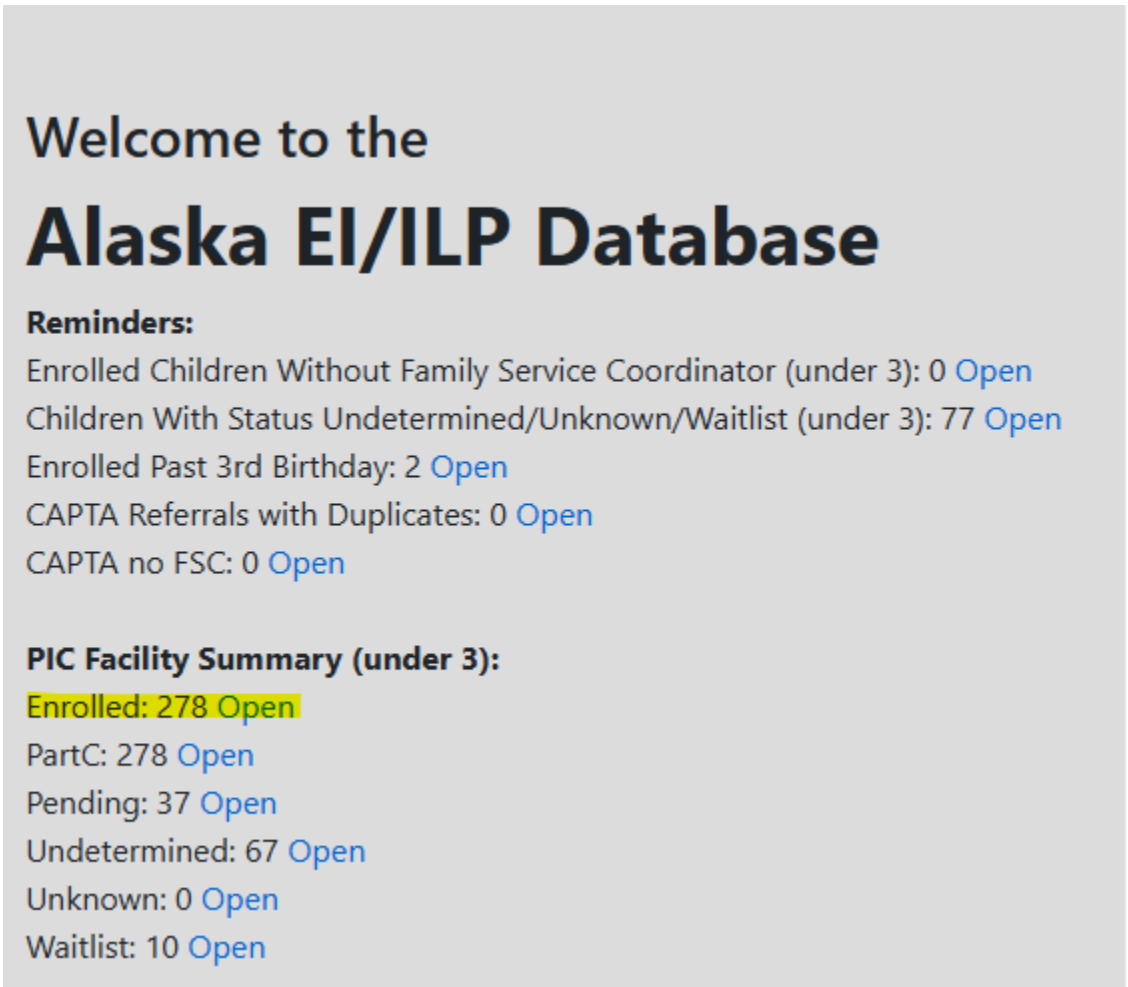
Child Count

December 1st Child Count-RT vs SDB

To check what children are enrolled as of 12/1 run the Custom Report PPAT (Patient Status Report) for Enrolled Children and export to Excel.



Use this to compare to the State Database list of enrolled children. The easiest way to pull the Enrolled Children list from the State Database is the home page and export that to Excel as well.



Documents

Child Count Procedures and Checklist

ILP Annual Review

Purpose

The State ILP requires that each ILP agency review a set number of files per year using the guidance here. PIC typically reviews 10 files that are pulled at random from the State DB, per instructions. Any non-compliance is addressed at time of review, each instance is considered in the context of possible need for training, and reported to the state. Forms and criteria occasionally change and are sent to the reviewing staff each year, as they may have been updated.

EI/ILP Self-Assessment FAQs

What is the Annual EI/ILP Self-Assessment (SA)?

The ILP SA is a way for us to monitor your program on compliance and quality items that are not part of the database compliance reporting for the SPP/APR. Items on the Self-Assessment are related to additional Federal compliance requirements and/or quality expectations for programs. A select number of priority Self-Assessment indicators are used as part of your annual agency Local Determination of Compliance.

How do I generate the Self-Assessment in the database?

In order to generate your annual SA in the ILP database, please refer to the Database Self- Assessment PowerPoint, which will guide you through the process step-by-step.

How is it determined how many records are program must review?

The number of records your program must review depends on your program size. In addition, programs must review a minimum of 5 records and a maximum of 10 records. The database will determine the number of records your program must review, based on a formula.

What forms should we use for the Self-Assessment?

We strongly recommend that you complete the SA for each record on paper or on an electronic document, rather than directly into the ILP database. There have been instances where data has been lost in the ILP database, and we wouldn't want you to lose track of all your hard work reviewing the child record. You can use the ILP Self-Assessment form to record your answers and comments. It is also nice to have this printed for each record, as an easy way to see updated state guidance.

Am I required to put comments in every box on the Self-Assessment?

You are not required to put a comment in every box but should put a comment for items that are marked "No." In addition, it is helpful for state staff to see notes on where you found information related to the item, especially if it is not in a place that is easy to locate.

Who should complete the Self-Assessment?

Many programs find it a useful activity to complete Self-Assessments as a team. Depending on your program size, you may have a small team that reviews all records together, or you may create a few small teams that each review several records. The ILP Coordinator is responsible for overseeing the process and should perform a final review on all Self-Assessment report to ensure accurate reporting.

What should I do if I have questions about the Self-Assessment?

You should feel free to reach out to your program TA with any questions about your Self- Assessment. In addition, feel free to invite your TA to sit in as you complete one or more of your Self-Assessments.

When is the Self-Assessment due?

The Self-Assessment is due on June 15th of each year, unless that falls on a weekend, in which case the SA is due the Friday before.

Question	Y/ N/ NA
1. Is there evidence that the parent was given written prior notice before each of the following events and that the content of the notice clearly described the action that will be taken and its purpose: (§303.400)	

Question	Y/ N/ NA
a. Initial evaluation?	
b. Initial IFSP meeting?	
c. Each subsequent IFSP?	
d. Each subsequent evaluation?	
e. Transition Conference?	
f. Discontinuing/exiting services?	
2. Was parental consent obtained prior to the following:(§303.420)	
a. Conducting screening, if completed?	
b. Conducting the Initial evaluation and assessment?	
c. Providing IFSP Services?	
3. Is there evidence that information is provided to families in their native language or other mode of communication used by the family unless clearly not feasible to do so including:	
a. Prior notice?(§303.421)	
b. Evaluation and assessment?(§303.321(a)(5))	
c. IFSP Meetings? (§303.342(d)(1)(ii))	
4. Is there evidence that two or more disciplines or professions were involved in provision of integrated and coordinated services, including each of the following: (§303.17)	
a. Initial Evaluation? (§303.321(a)(1)(i))	
b. Annual Evaluation/Assessment? (§303.321(a)(2)(i))	
c. Development of the IFSP? (§303.340)	
d. Service delivery? (§303.340)	
5. Are parent observations included in all evaluation and assessment reports?	
6. Does each rating on the child outcomes summary form include?	
a. Information from multiple sources, including recent evaluation/ assessment for age anchoring and parent observations and/or report?	
b. A description of the child's functional skills in everyday routines, across settings and situations, which includes sufficient detail to support the rating assigned.	
7. Did the family identify its resources, priorities and concerns related to enhancing their child's development and provide information about everyday routines and activities through a family-directed assessment, such as RBI,EcoMap, PATH, formal interview or other? (§303.321(a)(1)(ii)(B))	
8. Did the initial evaluation and assessment include a review of pertinent information from other sources in the following situations: (§303.321(3))	
a. If medical or other records were used to establish eligibility for services, including documentation of a diagnosed condition or a developmental delay, does the child's record contain medical records which reflect these conditions? (§303.321(3)(i))	
b. If Informed Clinical Opinion was used to establish eligibility, is the reason for eligibility clearly documented in the child's record, and supported by evidence such as team discussion, medical or other records, documented observations, or informal assessments? (§303.321(3)(ii))	
9. Did the initial evaluation/assessment identify present levels of functioning and the unique needs of the child in each of the following developmental domains (cognitive, physical, communication, social emotional, adaptive)? (§303.321(b)(3))	
10. If the IFSP has goals related to Child Outcome Area 1: Positive Social Emotional Skills, was there progress toward those goals or were those goals met? (SSIP)	
11. Was an annual assessment conducted in a timely manner to update the child's present levels of development section of the IFSP, looking at all areas of development, focusing on previous areas of strengths and needs and identifying progress, and to document the child's continuing eligibility for early intervention services?	
12. Do the IFSP goals, strategies or progress notes include statements that:	
a. Are measurable?	
b. Reflect family priorities, concerns, and resources?	
c. Are stated in terms of the child's participation in everyday routines and activities?	
d. Demonstrate the provider supports the family in working with their child?	

Question	Y/ N/ NA
13. Do the services listed on the IFSP seem appropriate to achieve the child and family outcomes identified given the developmental status of the child (unique needs) and the family's concerns, priorities, and resources? (§303.344(d))	
14. Is there evidence that all services were provided and correctly documented on the IFSP as described below: (§303.13)	
a. Were all services provided as specified on the IFSP?	
b. Was the correct payor source identified on the IFSP for all services, ensuring that Part C funds were only utilized if no other payor source was available?	
c. Is there documentation in the child's chart that the correct payor source was billed?	
15. Do the activity progress notes reflect strategies that incorporate the family's routines and community activities that the child and family are likely to do?	
16. If services are missed (due to inclement weather, provider, or family reasons), do contact or activity notes reflect that efforts were made to reschedule the visit?	
17. Does the child record document that the family received a primary Early Intervention provider who meets with the family regularly and ensures that team members of other disciplines are available for consultation, evaluation and/or services as needed?	
18. Does the child record, including visit notes, reflect the use of an evidence-based early intervention model and evidence-based intervention strategies?	
19. Does the child record reflect coordination of schedules with the school district, family, and other invited participants that provides the school district with at least 2 weeks' notice of invitation to the 90-day transition conference, unless the child's eligibility was determined less than 2 weeks prior to age 33 months?	
20. Is there evidence the consent requirements were met when accessing a parent or child's public or private insurance to pay for early intervention services, as described in the following: (§303.520(b))	
a. Was parental consent obtained prior to the use of public or private insurance to pay for the initial provision of an early intervention service in the individualized family service plan?	
b. Was parental consent obtained each time consent for services was required due to an increase (in frequency, length, duration, or intensity) in the provision of services in the child's individualized family service plan	
c. Was parental consent obtained when the use of private insurance is a prerequisite for the use of public benefits or insurance	
d. Were parents provided a copy of Alaska's System of Payment policies when parental consent is required for the use of their public or private insurance to pay for the initial provision of an early intervention service on an IFSP and each time consent is required due to an increase in the provision of services?	

Billing

Practices

Policy

PIC provides early intervention services to eligible children and their families. PIC complies with Part C of IDEA which requires all Alaska Infant Learning Programs to bill all available funding sources to help recover some of the costs of providing services. If your child has both public and private insurance, PIC is required to first bill the private insurance, before billing public insurance.

It is PIC's practice for all direct services, including Developmental Therapy and Social Work, to create a Plan of Care that aligns with your child's IFSP services.

Practice

Programs for Infants & Children (PIC) utilizes an electronic health record for all Early Intervention services provided by staff across all direct service provider disciplines. PIC's electronic record has many features and elements that make our documentation and billing procedures fully integrated. Included in this integration is your PIC's provider(s) treatment plan, or Plan of Care (POC) that is sent to your child's primary's physician and your family's Individualized Family Service Plan (IFSP). The POC and IFSP share the same Long Term Goals. Long Term Goals are created by your family and PIC's IFSP multidisciplinary team.

The program includes charge tables where each service is listed with the amount of the service. PIC's charge table is set with Medicaid approved rates. When or if a rate for a code changes, PIC is able to update the table with an effective date for that code. It is PIC's practice to bill at Medicaid approved rates for all services and for all third-party payers. PIC must bill private insurances prior to billing Medicaid for therapies (OT/PT/SLP).

PIC has health information technicians that bill for services, primarily pediatric therapies. PIC providers document within the electronic record details about the services. Included in documentations are:

- Type of services provided:

  Occupational, Physical and Speech therapies (OT/PT/SLP), Developmental Therapy and Social Work.

- CPT codes (Current Procedural Terminology: numbers that identify medical procedures/services)
- Date of service
- Time in and time out of services
- Goals addressed/progress on goals
- Plan until next service

The direct service providers e-sign off on their note and submit for billing review. PIC's health information specialists review the note and if all details are consistent with agency practices, the note is posted to the ledger for billing. Our practice is for policy is to complete documentation within 1 week of the date of service. Notes are typically reviewed and posted for billing within 1-2 weeks of being electronically signed.

Posted notes are sent securely and electronically to our contracted clearinghouse, which then sends a claim to the correct payer/insurance for payment. PIC bills all available payers for the services including Medicaid, when it is the primary payer or secondary.

Consent to Bill Insurance

PIC is required to have consent to bill Medicaid and/or any other insurance company for billable services provided by PIC's Occupational, Physical and Speech language therapists. When parents sign the Consent to Bill form, they give PIC permission to bill their insurance(s).

PIC does not bill parents for out-of-pocket expenses, like co-pays or deductibles. PIC will accept any payment from the insurance companies as payment in full.

Consent to Bill should be requested annually and if your child has private insurance: any time there is an increase in duration or frequency of services, as well as an additional new billable service added to your child's IFSP.

It is your decision to give consent to bill and PIC will not deny services if you do not give consent to billing your insurance(s). In regards to billing and treatment by Occupational, Physical, or Speech therapists, PIC also needs permission to share their treatment plans with your child's primary physician.

If your child does not have any health insurance, your child will still receive services listed on your families IFSP.

Types of Insurance

Public Health Insurance: Medicaid or Denali KidCare, Indian Health Service, Tricare.

Private Health Insurance: usually from the parent's employer or an individual policies from the healthcare marketplace 'healthcare.gov'. A few examples are Aetna, Cigna, EBMS and Premera.

PIC attempts to contact all families that have private health insurance and OT/PT/SLP on your child's IFSP, to briefly discuss general caps and limits according to their policy, and to answer any questions.

Services Available at No Cost to Family

Federal Part C Regulation 303.521(b) states that the following functions must be provided at no cost to families:

- Screening;
- Evaluation/Assessment;
- Family service coordination;
- IFSP development.

PIC appreciates the opportunity to work with your family, regardless of your insurance status. Please do not hesitate to ask any questions you may have.

Questions?

If you have any questions, please call PIC's main phone number at 907-561-8060 and ask to speak with the billing department.

Charges

2023 CPT Codes

Service	Code
SLP Therapy CPT Codes	• 92507 • 92508 • 92526 • 92606 • 92609 • 97129 • 97130
SLP Eval Codes	• 92522 • 92523 • 92610 • 92605 + 92618 • 92607 + 92608
Other Eval/Assessment Codes:	• Dev Eval: 96112 + 96113 • Health and Beh Assessment: 96156
OT Therapy CPT Codes	• 97110 • 97129 • 97130 • 97530 • 97533 • 97535 • 97760 • 97763
OT Eval Codes	• 97165 • 97166 • 97167 • 97168
Targeted Case Management Codes	• FSC • IFSP Dev • Transition Conference • Intake • Screening • NonBill Eval
PT Therapy CPT Codes	• 97110 • 97116 • 97129 • 97130 • 97530 • 97533 • 97535 • 97760 • 97763

Service	Code
PT Eval Codes	• 97161 • 97162 • 97163 • 97164
Special Instructions Codes	• Dev Services • Social Work • Vision SI

SLP CPT Code	Description	Notes/Example
92507	**Speech Therapy**: This code includes treatment of speech, language, voice, communication, and/or auditory processing disorders.[2]	The individual patient undergoes developmental programs with SLP under the direction of a physician: • Speech therapy • Sign language • Lip-reading instruction • Hearing rehabilitation[2]
92508	**Group speech-language**: Communication Disorders[6]	Group, two or more individuals. Reported when patients are not receiving direct one-on-one contact, but are being supervised by the therapist.[6]
92526	**Treatment of Swallowing**: addresses swallow dysfunction and/or oral function for feeding.[3]	• Muscle tone abnormalities that significantly interfere with feeding or swallowing; • Orofacial defects such as cleft palate that interfere with feeding or swallowing; • Delayed or abnormal oral motor development or patterns (tonic bite reflex, tongue thrust); • Hypersensitive to response to touch including consistencies and texture, and or temperature in and around the mouth; • Inability to properly coordinate feeding swallowing breathing due to prematurity, chronic medical or CNS damage; • Related medical conditions such as gastro esophageal reflux, pharyngeal dysphagia, aspiration or prior tube –feeding, that may affect willingness to eat; • Definite difference dysfunction are documented in standardized sensory testing in the area of oral sensory procession or sensitivity.[4]
92606	**Non-Speech Device Service**: Therapeutic Services for the use of non-speech generating augmentative and alternative communication device (AAC) including programming and modification.	You should use 92606 only if you are working with the patient on how to use the tool itself and/or are modifying or programming it for their use. If the patient uses a device during speech-language treatment, use 92507 for the billing code.[7]
92609	**Speech Generating Device Servi**: Therapeutic Services for the use of speech generating device including programming and modification.	You should use 92609 only if you are working with the patient on how to use the device itself and/or are modifying or programming it for their use. If the patient uses a device during speech-language treatment, use 92507 for the billing code.[7]
97129 *Can't be used on same DOS as 92507* +97130	**Therapeutic Interventions**: focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-to-one) patient contact; initial 15 minutes. Therapeutic interventions that focus on cognitive function; each additional 15 mins.1 Needs to be reported along with 97129.[5]	Cognitive function: attention, memory, reasoning, executive function, problem-solving, and\or pragmatic functioning Compensatory strategies: managing time or schedules, initiating, organizing and sequencing tasks [1] Once per day. Cannot be reported on the same DOS as 92507.[5]

SLP CPT Therapy Billing Resources

1. https://www.simplepractice.com/resource/top-cpt-codes-speech-therapy/
2. https://www.americanmedicalcoding.com/cpt-code-92526/
3. https://neolytix.com/medical-billing-services/
4. https://www.americanmedicalcoding.com/cpt-code-92526/
5. https://www.asha.org/practice/reimbursement/medicare/slp_coding_rules/

SLP CPT Code	Description	Notes/Example

6. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleID=54111
7. https://leader.pubs.asha.org/doi/10.1044/leader.BML.22022017.36

OT CPT Code	Description	Notes/Example
97110	**Therapeutic procedure**: Therapeutic exercise to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes). [1]	Functional mobility for ADLs or Mobility Related ADLs (MRADLs) are not included here. Remember, differentiate yourself form other professions here and explore how the therapeutic exercise translates and will help your client with their ADLs. [3]
97530	**Therapeutic Activities**: direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes. [1]	Generally involves intervention that includes -ing words: walking, running, climbing, throwing, with an emphasis on intervention focused fine and gross motor skills.
97535	**Self Care**: training and improving performance in ADLs (activities of daily living), working on compensatory strategies, using adaptive equipment, facilitating meal prep or self-feeding. 15 mins each. [1]	Generally ADLs and feeding. [3] Example: Instructing the patient on using sock aide for dressing. [6] Documentation requirements: • Objective measurements of the patient's activity of daily living (ADL)/instrumental activity of daily living (IADL) impairment to be addressed. • The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/assistive technology utilized, instruction given and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist. [6]
97533	**Sensory integrative** techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-to-one) patient contact, each 15 minutes. [1] Therapy sessions are play-oriented and may include using equipment such as swings, trampolines, slides. Therapies may include deep pressure, brushing, weighted vests, and swings.[5]	Supportive documentation requirements: Objective assessments of the patient's sensory integration impairments and functional limitations. Describe the treatment techniques used that will improve sensory processing and promote adaptive responses to environmental demands, and the patient's response to the intervention, to support that the skills of a therapist were required. [4] Treatment to promote increase in tactile sense, vestibular sense (balance) that tells us how to position our bodies and heads, and proprioceptive sense (awareness of body in space) that helps us know what we do with our joints, muscles, and ligaments.[5]
97760	Orthotic Management, first encounter: including assessment and fitting (when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes. [7] Clock times would only be for time spent training, and would not include assessing, measuring and/or fitting.[6]	This procedure may be considered reasonable and necessary, if there is an indication for education for the application of orthotics, and the functional use of the orthotic is present and documented. [7] Ongoing visits to apply the device would be considered monitoring. Once the initial fit is established, any further visits would be billed as 97763.[6] Not used for prefabricated/commercial (off the shelf) components like lumbar roll, non-customized supports, or multi-podus boots b/c they don't require the skill of a therapist and are non-covered. Minor modifications to prefabricated orthotics do not constitute a customized orthoric.[6]
97763	**Orthotic/Prosthetic Checkout**: An established patient obtaining the orthotic or prosthetic for use. [7]	Involves training with a prosthetic limb for walking, running, sitting, balancing, and standing with their prosthetic. Or if they have a new arm, they'd need to learn how to write, hold an object, wave, or grip. It also includes assessment for the prosthetic, fitting the patient for the limb, and teaching on how to remove it. However, the time it takes to create the prosthetic does not fall within this code for billing purposes. Involves evaluating the effectiveness of an existing device. A professional may recommend a change in the device or could determine a slight adjustment of the current one if it's necessary. [7]

OT CPT Code	Description	Notes/Example
97129 +97130	**Therapeutic interventions** that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-to-one) patient contact; initial 15 minutes. Therapeutic interventions that focus on cognitive function; each additional 15 mins. [2]	**Cognitive function:** attention, memory, reasoning, executive function, problem-solving, and\or pragmatic functioning **Compensatory strategies**: managing time or schedules, initiating, organizing and sequencing tasks. [2]

OT CPT Therapy Billing Resources

1. https://www.simplepractice.com/resource/occupational-therapy-cpt-codes/
2. https://www.centuryrehab.com/wp-content/uploads/2020/07/TOTM-Cognitive-Code-Billing.pdf
3. https://www.coremedicalgroup.com/blog/occupational-therapy-cpt-codes
4. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56566&ver=24
5. https://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Sensory-Integration-Therapy.aspx
6. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56566&ver=24
7. https://www.aapc.com/codes/cpt-codes/97760

PT CPT Code	Description	Notes/Example
97110	Therapeutic Procedure: Therapeutic exercise to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes). [2]	This is any type of exercise that develops strength and endurance in one or more areas. The exercises also help with range of motion and flexibility. [1]
97116	Gait Training: includes sequencing, training using a modified weight-bearing status, employing assistive devices, and completing turns with proper form. [2]	If you are using this code, make sure you are focusing on the biomechanics of the gait cycle in some form or another. Having a patient walk in order to improve cardiovascular health is not considered gait training. [2]
97530	**Therapeutic Activities**: direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes. [1]	Generally involves intervention that includes -ing words: walking, running, climbing, throwing, with an emphasis on intervention focused fine and gross motor skills.
97533	**Sensory integrative** techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-to-one) patient contact, each 15 minutes. [6] Therapy sessions are play-oriented and may include using equipment such as swings, trampolines, slides. Therapies may include deep pressure, brushing, weighted vests, and swings.[7]	Supportive documentation requirements: Objective assessments of the patient's sensory integration impairments and functional limitations. Describe the treatment techniques used that will improve sensory processing and promote adaptive responses to environmental demands, and the patient's response to the intervention, to support that the skills of a therapist were required. [5] Treatment to promote increase in tactile sense, vestibular sense (balance) that tells us how to position our bodies and heads, and proprioceptive sense (awareness of body in space) that helps us know what we do with our joints, muscles, and ligaments.[7]
97535	**Self Care**: training and improving performance in ADLs, working on compensatory strategies, using adaptive equipment, facilitating meal prep or self-feeding. 15 mins each. [1]	Generally ADLs, use of assistive technology devises or adaptive equipment, and feeding. [2] ADL training aims to strengthen muscles and improve endurance, flexibility, and balance. [1] Documentation requirements: • Objective measurements of the patient's activity of daily living (ADL)/instrumental activity of daily living (IADL) impairment to be addressed. • The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/assistive technology utilized, instruction given and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist. [5]

PT CPT Code	Description	Notes/Example
97129	**Therapeutic interventions** that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-to-one) patient contact; initial 15 minutes. Therapeutic interventions that focus on cognitive function; each additional 15 mins. [4]	**Cognitive function**: attention, memory, reasoning, executive function, problem-solving, and\or pragmatic functioning **Compensatory strategies**: managing time or schedules, initiating, organizing and sequencing tasks. [4]
97760	**Orthotic Management, first encounter**: including assessment and fitting (when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes. [3] Clock times would only be for time spent training, and would not include assessing, measuring and/ or fitting.[5]	This procedure may be considered reasonable and necessary, if there is an indication for education for the application of orthotics, and the functional use of the orthotic is present and documented. [3] Ongoing visits to apply the device would be considered monitoring. Once the initial fit is established, any further visits would be billed as 97763.[5] Not used for prefabricated/commercial (off the shelf) components like lumbar roll, non-customized supports, or multi-podus boots b/c they don't require the skill of a therapist and are non-covered. Minor modifications to prefabricated orthotics do not constitute a customized orthoric.[5]
97763	**Orthotic/Prosthetic Checkout:** An established patient obtaining the orthotic or prosthetic for use. [3]	Involves training with a prosthetic limb for walking, running, sitting, balancing, and standing with their prosthetic. Or if they have a new arm, they'd need to learn how to write, hold an object, wave, or grip. It also includes assessment for the prosthetic, fitting the patient for the limb, and teaching on how to remove it. However, the time it takes to create the prosthetic does not fall within this code for billing purposes. Involves evaluating the effectiveness of an existing device. A professional may recommend a change in the device or could determine a slight adjustment of the current one if it's necessary. [3]

PT CPT Therapy Billing Resources

1. https://etactics.com/blog/common-cpt-codes-for-physical-therapy#Therapeutic-Exercise
2. https://www.coremedicalgroup.com/blog/physical-therapy-cpt-codes-ultimate-guide
3. https://www.aapc.com/codes/cpt-codes/97760
4. https://www.aapc.com/codes/cpt-codes/97129
5. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56566&ver=24
6. https://www.simplepractice.com/resource/occupational-therapy-cpt-codes/
7. https://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Sensory-Integration-Therapy.aspx

OT Eval Codes	Description	Notes/Example
97165	**OT Eval Low Complexity**: Patient presents with no comorbidities that affect occupational component. Typically, 30 mins are spent face-to-face with the patient and/or family. [1]	This code requires an occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits that result in activity limitations and/or participation restrictions, and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. 1
97166	**OT Eval Moderate Complexity**: Patient may present with comorbidities that affect occupational performance minimal to moderate modification of tasks or assistance with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 mins are spent face-to-face with the patient and/or family. [1]	This code requires an occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits that result in activity limitations and/ or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. [1]
97167	**OT Eval High Complexity:** Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 mins are spent face-to-face with the patient and/or family. [1]	This code requires an occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 5 or more performance deficits that result in activity

OT Eval Codes	Description	Notes/Example
		limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes and analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. [1]
97168	**OT Re-Evaluation:** Requires an assessment of changes in patient functional or medical status with revised Plan of Care, and update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals, and a revised Plan of Care. Formal reevaluation is performed when there is a documented change in functional status or a significant change to the Plan of Care is required. Typically, 30 mins are spent face-to-face with the patient and/or family.[2]	Re-evals are separately reimbursable when the medical record supports that the patient's clinical status or condition required the additional evaluative service. When medical necessity is supported, a re-eval is appropriate and is separately billable for: • A patient who is currently receiving therapy services and develops a newly diagnosed related condition. • A patient who is currently receiving therapy services and demonstrates a significant improvement, decline, or change in condition or functional status which was not anticipated in the Plan of Care and necessitates additional evaluative services to maximize the patient's rehabilitation potential.[2]

SLP Eval Codes	Description	Notes/Example
92523	**SLP Evaluation (Language & Speech)**: Apply modifier 52 if eval of language only. [4]	Evaluation of speech sound production (articulation, phonological process, apraxia, dysarthria) WITH evaluation of language comprehension and expression (receptive and expressive language). [4] Cannot be billed on same DOS as 92522.[11]
92522	**SLP Eval (Speech Sound Production):**	Evaluation of articulation, phonological process, apraxia, dysarthria, etc. Cannot be billed on same DOS as 92523.[11]
92610	**Feeding consultation/swallowing**: Evaluation of oral and pharyngeal swallowing function.[7]	2 usually allowed per calendar year.[8] Included as part of the evaluation can be assessment with a continuum of food/liquid consistencies, time spent addressing compensatory strategies, and patient and family/ caregiver education. [12] Can be billed on the same DOS as 92526 if documentation clearly show the eval and treatment are separate and distinct services and that the treatment addresses an established POC.[12]
92605 +92618	**SLPEV RX NONSpeech-generat AAC**: Evaluation for prescription of non-speech-generating augmentative and alternative communication device (AAC); first hour.[13] For additional time in 30-minute increments.[13]	An AAC evaluation may include the following individualized assessments of the patient's: • communication skills • communication partners • communication demands • sensory skills and motor skills • evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc.[13]
92607 +92608	**SLP EV RX for face to face AAC**: Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour. [13] For additional time in 30-minute increments. [13]	This code describes the services to evaluate a child to specify the speech-generating device recommended to meet the needs and capacity. [13]

PT Eval Codes	Description	Notes/Example
97161	**PT Eval Low Complexity:** No personal factors and/or comorbidities, addressing 1-2 elements, stable clinical presentation with low clinical decision making complexity. Typically 20 mins face-to-face. [10]	For the typical patient, includes all the necessary eval tools, including range of motion and manual muscles testing. These codes are typically consultative, and it's expected that the administration of these tests will generate material that will be formulated into a report, which should clearly indicate the purpose and rationale for the test, the test performed with results and how the info affects the treatment plan.[9]
97162	**PT Eval Moderate Complexity**: 1-2 personal factors and/ or comorbidities, addressing 3 or more elements, evolving clinical presentation with moderate clinical decision making complexity. Typically 30 mins face-to-face.[10]	For the typical patient, includes all the necessary eval tools, including range of motion and manual muscles testing. These codes are typically consultative, and it's expected that the administration of these tests will generate material that will be formulated into a report, which should clearly indicate the purpose and rationale for the test, the test performed with results and how the info affects the treatment plan.[9]
97163	**PT Eval High Complexity:** 3 or more personal factors and/or comorbidities, addressing 4 or more elements, unstable clinic presentation with high clinical decision making complexity. Typically 45 mins face-to-face.[10]	For the typical patient, includes all the necessary eval tools, including range of motion and manual muscles testing. These codes are typically consultative, and it's expected that the administration of these tests will generate material that will be formulated into a report, which should clearly indicate the purpose and rationale for the test, the test performed with results and how the info affects the treatment plan.[9]
97164	**Physical Therapy Re-Eval:**	Re-evals are separately reimbursable when the medical record supports that the patient's clinical status or condition required the additional evaluative service. When medical necessity is supported, a re-eval is appropriate and is separately billable for: • A patient who is currently receiving therapy services and develops a newly diagnosed related condition. • A patient who is currently receiving therapy services and demonstrates a significant improvement, decline, or change in condition or functional status which was not anticipated in the Plan of Care and necessitates additional evaluative services to maximize the patient's rehabilitation potential.[2]

Other Eval Codes	Description	Notes/Example
96112 +96113	Developmental Eval: Developmental test administration, 1st hour. [4] Each additional 30 mins.	Includes assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed, with interpretation and report. [4]
96156	**Health and Beh Assessment**: (96156) Can only be used by a Clinical Psychologist (CP).[6] Health-focused clinical interview, behavioral observations, clinical decision making.[6]	(96150 is discontinued) RT automatically changes to CPT: 96156 per 1/1/20 code change. [5] Used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.[6]
T2023NB	**Non-Bill Eval**	Focuses on needs identification through the process of assessment, both to determine eligibility and the need for any medical, educational, social, and/or other services.

Evaluation/Assessment CPT Billing Resources

1. https://www.cms.gov/medicare-coverage-database/search.aspx
2. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53309
3. CPT codes used 1/1/22 – 11/1/22 per RT
4. https://www.asha.org/practice/reimbursement/medicare/slp_coding_rules/
5. https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior-codes-changing
6. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57754&ver=7&
7. https://www.asha.org/siteassets/uploadedFiles/2020-Medicare-Physician-Fee-Schedule-SLP.pdf
8. https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT34.pdf
9. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56566&ver=24
10. https://www.apta.org/contentassets/d3065561ef7643ad9a88f282c6083faa/apta-evalcodes-pocketguide.pdf
11. https://www.asha.org/practice/reimbursement/coding/new-cpt-evaluation-codes-for-slps/
12. https://leader.pubs.asha.org/doi/10.1044/leader.BML.23052018.26
13. SLP additional Eval codes to add to document

TCM CPT Code	Description	Notes/Example
T2023FSC	**FSC**	• Reviewing medical records. • Obtaining info from caseworkers, parents, and/or providers. • Attending ASD evals and/or ASD IEP meeting. • Attending TDMs at OCS. • Periodic check-in with family/providers concerning services in the community and to ensure the needs of the child are being met. • Linking eligible children with appropriate providers and services within PIC and/or the community. • Minigrant applications.
T2023IF	**IFSP Dev**	• Developing Initial, Annual and Revision IFSPs. • Beginning of Transition Planning.
T2023TR	**Transition Conference**	• AKA: 90-day meeting. • Set final transition steps. • Complete Transition Conference tab on eIFSP.
T2023IN	**Intake**	• Reason for referral. • Main concerns/priorities. • Background summary/daily routines/family assessment. • Any observations. • Plans/next steps.
T2023	**Screening**	• Screenings completed (ex: hearing, vision, developmental). • Results. • Next steps.

SI CPT Code	Description	Notes/Example
T1027	**Dev Services**	• Special Instructions. • Primarily used for DS providers. • OT/PT/SLPs can use if they give instructions outside of their discipline.
T2027S	**Social Work**	• Special Instructions. • Only used by LCSW, SW, BHS.
T1027V	**Vision SI**	• Special Instructions. • Only used by TVI.

Diagnosis Codes

The following can be used prior to enrollment only:

Z05.9 = Those under 1 years old > Dx code prior to enrollment (initial IFSP visit)

Z00.7 = intake notes of those over 1 yrs old and do not have a current diagnosis code prior to enrollment

Z00.70 = eval note of someone who didn't qualify and were within normal limits

When developing the Plan of Care the following codes that may be used for those children demonstrating a delay but records do not provide a diagnosis from the physician—this is not an exhaustive list:

- **R62.0** for delayed milestones
- **F84.0** for autistic disorder
- **F80.1** for expressive language
- **F80.2** for mixed receptive-expressive language

- **F80.4** for speech and language delay due to hearing loss
- **F82** for specific dev. delay of motor function
- **H90.__** for hearing loss codes

The following may be used with children under age 12 months:

- **P04**._ : newborn affected by maternal use of _____
- **P05**._ : newborn gestational age __
- **P07**._ : extremely low birth weight newborn ____ grams / preterm newborn gestational age ____

Helpful information about Down Syndrome/Trisomy-21

Q90.9 = down syndrome, unspecified

Medicaid Documentation Guidelines

Introduction to the MCD Audit:

Our MCD Audit is a review of billed notes to ensure compliance with billing policies and procedures. The MCD audit process is completed once per quarter for our internal audit, two to three weeks after notes are posted for the quarter, where 25 records for both Therapy and TCM are pulled for review and completed within a month. Any overpayments found would need to be sent via AK05 with an associated Backout Payment.

The mandatory MCD Self Audit process is completed once every two years. Agency is given a choice between two years to conduct our audit per MCD's email. The audit review must be completed and sent to MCD from our Director by the end of the year. Any overpayments found would be added to the spreadsheet and a check would be mailed with the results to MCD.

Therapy should be billed to Payors in order of hierarchy (Primary – Secondary – Tertiary), TCM should only be billed to MCD once per month per child, after a child is enrolled, and after the month of service is complete.

Updated Therapy fee schedules are supposed to be issued by MCD for claims with DOS July 1st through June 30th of the following year located on their website, MCD Therapy Fee Schedule. An updated TCM fee schedule will come from our Director via email issued by the state of Alaska for claims with DOS July 1st through June 30th of the following year to be billed starting in August.

FAQs & Overview

Overlapping clock times:

- A provider's clock times can never overlap with themselves.
- Provider's direct therapy clock times cannot overlap with each other.
- What can overlap with therapy? FSC, IFSP Dev, Transition, Intake, Screening, Evals, Consult with anything except therapy in the same discipline as the Consult (ie. PT Consult and PT therapy).

ICD-10 codes for intake/evals:

- Intakes can use Dx code Z04.9 if there isn't a more appropriate code based on observation, medical records, referral, etc.
- By the Evaluation a medical or developmental diagnosis code should be used, the HIT team will update any misused codes to Z00.71 (eligible) or Z00.70 (ineligible) if the Provider has not updated the DX for the kiddo to something more specific.

What to do if appointments need to be moved/amending notes after it's already been posted:

- If you need to move or amend a note after it's been posted, HIT should always be the first email/message/call to see if it's possible.
- If a claim was created from the note, it cannot be unposted.
- If needed, some things can be fixed with a Claim Correction Ticket, like the DOS, DX, CPT, number of units, location.
- Documentation can be changed even if the note is already posted, by double clicking the note and choosing the amend/correct option.
- HIT can update your case if the wrong one was picked, just let us know.

What to do if appointments need to be moved/amending notes when they are signed but haven't been posted:

- HIT can help providers move a note if the wrong date was selected on the Scheduler for a signed note, it has to be manually done, and the old note voided or deleted. If the note was created On Demand in the chart, the DOS can be changed by just amending the note!
- Very important to note that if you are changing the Note Type you must remove any clock times that you've input onto your note before the change. Not doing this creates ghost charges that we have to manually remove on the ledger side, we cannot remove these incorrect charges on your notes after you sign them.

What locations to use:

- Putting the location of the visit in the subjective of your note is incredibly helpful for finding errors in location codes and preventing a task asking for clarification when two providers have put different codes on collaborative visits.
    1. Home (including caregiver homes)
    2. Office- visits at PIC.
    3. Childcare Center
    4. Community- visits around the community like the library or the Dome.
    5. Clinic Visit- visits at another medical provider's office.
    6. Correspondence- visits done via email, or without the child present (like medical record review).
    7. Group
    8. Phone Call (including texts)
    9. Tele- visits done via Zoom.
    10. Program for Infants- should never be used

What our abbreviations mean:

- TCM – Targeted Case Management, once per month billing for FSC, non-billable Eval's, IFSP's, Intakes and Screenings
- CTB – Consent to Bill, needed at least once per year in order to bill our services. Even if CTB is declined, we need this filled out by families.
- MCD – Medicaid
- CLN – Call Log Note

Documents

HIT Overview

Data Entry

FAQs

Why do families need to indicate race, gestational age, and medical home on the demographics form?

This information is required by the State to comply with federal reporting requirements.

Why do I need to use the provided descriptions as the reason for discharge in the discharge summary?

Only one discharge reason can be selected, and it must be chosen from the standardized list provided.

Why do I need to update the Service Status in the Services Summary to "Continue"?

This status communicates with the family whether services have started, are ongoing, or have been discontinued. It serves as the documented service plan.

When is the best time to enter a Pend?

A Pend must be entered *before* the child's 45-day timeline expires. If a delay occurs due to family reasons *after* the 45-day window, it is not considered a valid reason under compliance guidelines.

When should I write a Discharge Note vs. an Exit Communication Log Note?

A **Discharge Note** is required for any child who has had an initial IFSP and is considered enrolled in PIC services. This includes children transferred from another ILP program as enrolled.

An **Exit Communication Log Note** is used when a child is *not* enrolled in PIC services and is exiting due to reasons such as Within Normal Limits (WNL), Lost to Follow-Up, or Declined services.

Enrollment occurs at the Initial IFSP.