Slide 1

This presentation is an overview of Montana’s IFSP procedures conforming to the Part C Rules and Regulations published September 28, 2011. The content is the combination of three learning modules created by the National Dissemination Center for Children with Disabilities and distributed to the Center for Parent Information and Resources (OSEP technical assistance providers). As Montana moves to results-driven accountability, it is especially important that improvement strategies are built on strong foundations. Hopefully, this resource will help you help Part C program provider(s) build and strengthen their foundations.

Slide 2

**Evaluation and assessment procedures:** Montana does not require the use of screening procedures with babies and toddlers referred to early intervention. Montana launches straight in and asks for parental consent to conduct an evaluation of the child. If parents provide their consent, the provider proceeds to conduct the evaluation, the results of which are used to determine the child’s eligibility for early intervention services. If the child is found eligible, the early intervention provider will then ask parents to provide consent for an assessment of the child and family. If parents provide consent, then an assessment of the child and family is conducted.

**When does Montana use screening?** During Child Find events to identify the need for a referral to the early intervention provider.

Slide 3

Part C Early intervention services are designed to meet the needs of eligible infants and toddlers who have a developmental delay or disability. Services may also address the needs and priorities of each child’s family, to help family members understand the special needs of the child and how to enhance his or her development.

Evaluation and assessment have long been a required part of the early intervention experience. Evaluation and assessment are not the same thing, even though the terms often appear together. Consider them in a sequence:

**Referral** – a baby or toddler is referred to early intervention when someone suspects he or she may have a delay or disability. With parental consent...

**Evaluation** – an evaluation is conducted to see if, indeed, the child has a delay or disability and whether the child is eligible for early intervention services. If the child is eligible, and with parental consent...
Assessment – An assessment of the child is conducted to identify his or her present levels of development and needs and what type of early intervention services are necessary to address those needs. An assessment of the family is also conducted (with the family members’ consent) to identify family priorities, resources, and concerns related to enhancing the child’s development.

Slide 4

Learning Objectives

Slide 5

The Part C program provider’s intention to conduct an evaluation of the child triggers the need for:

- Prior written notice to parents; and
- Parental consent.

Both are also required when the provider intends to conduct an assessment of the child and family.

Slide 6

Screening is usually completed in connection with a Child Find event and may result in a referral to a provider. Parent notification and parental consent are required before a child may be screened.

Evaluation is used to determine that a child has a delay or disability, which in turn is used to determine a child’s initial or continuing eligibility for Part C and to identify the child’s strengths and needs in all areas of development.

Assessment clearly goes into more depth than evaluation and includes identifying what early intervention services are needed, given the child’s present levels of development and performance. Assessment also focuses on the family, if parents or other family members choose to participate. One of the purposes of the family-directed assessment is to identify the family’s resources, priorities, and concerns with respect to enhancing their child’s development.

Notice and consent for evaluation – Prior written notice must be provided to the child’s parents before the evaluation. Among other things, the notice explains to parents why it seeks
to evaluate the child and what the evaluation will involve. Parents must give their informed written consent before the evaluation of the child may be conducted.

**Notice and consent for assessment, too!** – The same cycle of prior written notice and parent consent is required when the provider proposes to conduct an assessment of the child and the assessment of the family. (The notice explains to parents why it seeks to assess the child, what the assessment will involve and the same for the family assessment.)

**Evaluation comes first**, because it is used to determine a child’s eligibility for Part C services. The only time than an evaluation isn’t needed to establish eligibility is when a child’s eligibility can be established by using the child’s medical or other records (Type I, Established Condition, in Montana).

If the child is not found eligible for early intervention, the provider must give parents written notice as to that determination. The notice must let parents know that they have the right to challenge the non-eligibility determination through Montana’s Part C Dispute Resolution Process. No assessment of the child or family needs to be conducted, because he or she was not found eligible for Part C.

**Slide 7**

Montana’s requirements:

- Administering an evaluation instrument;
- Taking the child’s history (including interviewing the parent and other family members, as appropriate);
- Identifying the child’s level of functioning in each developmental area;
- Gathering information from other sources such as family members, care-givers, medical providers, social workers, educators; and
- Reviewing medical, educational and/or other records.

**What is this about medical and other records?**

Establishing eligibility through medical or other records is new in the Part C regulations. However, the provision is clear, if eligibility is established through medical or other records, the assessments of the child and family must still be conducted with parental consent.

**What does comprehensive mean?**
Comprehensive has the generally understood meaning of “complete.” Evaluating the child in each of the developmental areas is required, thus making evaluation “comprehensive” and “of large scope.”

**What does multidisciplinary mean?**

Evaluations of children must also be multidisciplinary meaning the involvement of two or more separate disciplines or professions and; with respect to evaluation of the child and assessment of the child and family, may include one individual who is qualified in more than one discipline or profession. People from *two or more* separate disciplines or professions must be involved during a multidisciplinary evaluation. In this context, the definition also permits *one* person to be qualified in more than one discipline or profession. Thus, evaluations of children are conducted by one or more professionals with expertise in different areas, bringing together complementary skills, knowledge, and experience in child development.

**What’s considered timely?**

A child changes quickly and infants and toddlers don’t stay in early intervention very long, so it’s critical that evaluations be conducted in a timely manner and that services needed by eligible children can begin as soon as possible. Timely is not a term that the regulations define. However, the regulations do stipulate a timeline for completing post-referral activities:

The timeline begins when the Part C program provider receives a child’s referral and includes the initial evaluation of the child. If the child is found eligible for Part C, the timeline also includes the initial assessment of the child and family, and the initial meeting to write the child’s IFSP. The duration of the timeline is 45 days from when the provider receives the child’s referral to Part C.

Thus the evaluation and assessment processes must be completed within that 45 day timeframe, which also includes holding the meeting to write the child’s initial IFSP. Exceptions apply to the 45-day timeframe, including if the parent or child is not available for the evaluation, assessment, and initial IFSP meeting due to exceptional family circumstances that are documented in the child’s early intervention records, or if the parent does not provide consent for any of the activities.

**Slide 8**

One of the required evaluation procedures is to identify the child’s level of functioning in each of the developmental areas. What types of information are gathered in the evaluation of a child?
Cognitive development refers to children’s ability to learn and solve problems, which typically grows dramatically between birth and three years old as children begin to make sense of the world around them.

Physical development includes a child’s gross motor skills, fine motor skills, and sensory and perceptual abilities. Interestingly, motor skills development in children generally progresses from head to toe, with babies gaining control of their body parts in the following order:

- Head and neck at about 2 months of age;
- Arms and hands, with grasping at about 3 months;
- Trunk, with sitting well by about 8 months; and
- Legs and feet, with most children walking by 14 or 15 months.

Communication development refers to the child’s ability to both understand and use language to communicate with people and express his or her own emotions.

Social or emotional development such as:

- Making friends;
- Showing anger in a healthy way;
- Figuring out conflicts peacefully;
- Taking care of someone who has been hurt;
- Waiting patiently;
- Following rules;
- Enjoying the company of others.

All of these qualities and more describe the arc of healthy social emotional development. Like any skill, young children develop these abilities in small steps over time.

Adaptive development concerns the ability to adapt to changing circumstances and take care of oneself. It’s a vital skill in life to be sure. For babies and toddlers, adaptive development includes learning the self-help skills involved in daily living – to eat independently (with fingers first, then with a spoon), to get dressed, use the toilet, and see to basic hygiene and grooming. Not surprisingly, as children acquire more adaptive skills, they become more independent.

How are these evaluated? Practices and evaluation tools vary from state to state. Under the Part C regulations, each state defines the term “developmental delay” and describes the evaluation and assessment procedures that will be used to measure a child’s development in each of the five developmental areas. The state must also specify the level of developmental delay in functioning (or other comparable criteria) that constitutes a developmental delay in
one or more of the developmental areas. Montana uses a combination of standardized, norm-referenced tools to identify 25% delay in two or more domains or 50% delay in one domain:

- Assessment, Evaluation, and Programming System for Infants and Children (AEPS)
- Battelle Developmental Inventory (BDI-2)
- Bayley Scales of Infant Development
- Brigance Diagnostic Inventory of Early Development III
- Developmental Assessment of Young Children (DAYC-2)
- Developmental Profile 3 (DP3)
- Early Learning Accomplishment Profile (ELAP)
- Infant-Toddler Developmental Assessment (IDA).

Gathering information from other sources may be necessary such as family members, other caregivers, medical providers, social workers, and educators to understand the full scope of the child’s unique strengths and needs.

Eligibility for Part C may be determined through medical or other records (Type I, Established Condition). In the current context as a procedure within the evaluation process; however, examining the medical and other records can contribute a lot of information about the child, especially in tandem with taking a child’s history. In many cases, the child’s records can help flesh out the understanding of the child’s unique strengths and needs.

No single procedure may be used as the sole criterion for determining a child’s eligibility under Part C. A child’s eligibility may not be determined based on the results of only one evaluation procedure. Multiple evaluation procedures are required, so that a comprehensive picture of the child’s functioning in the five developmental levels can be built and that child’s eligibility decided.

**Slide 9**

Part C defines “infant or toddler with a disability” as infants or toddlers who have either:

- A developmental delay; or
- A diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

Developmental delays can occur in one or more of the five developmental areas. Montana identifies 25% delay in two or more of the domains or 50% delay in one or more domain for Type II eligibility. Developmental delays are identified in the evaluation process.
Children under the age of three with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are eligible for Part C – Montana’s Type I category for Established Condition. Conditions such as chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the development of the nervous system; congenital infections; severe attachment disorders; and disorders secondary to exposure to toxic substance, including fetal alcohol syndrome are considered “conditions of established risk.” Children with these conditions are eligible for services under Part C of IDEA by virtue of their diagnosis, regardless of whether a measurable delay is present.

The regulations use the words “includes” before the list of conditions – which means that the conditions listed aren’t necessarily the only ones.

Naturally the results of the child’s evaluation play a part in determining that child’s eligibility for early intervention. Information about the child’s functioning in the five developmental areas has been gathered through multiple methods – what do the results indicate? Does the child meet Montana’s definition of developmental delay?

When conducting an evaluation of the child, qualified personnel must use informed clinical opinion. The Part C program provider must ensure that informed clinical opinion may be used as an independent basis to establish a child’s eligibility under Part C, even when other instruments do not establish eligibility. However, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility.

The Department of Education’s comments on the subject:

_The use of informed clinical opinion by qualified personnel is neither an objective criterion nor a separate assessment strategy. Rather, informed clinical opinion is the way in which qualified personnel utilize their cumulative knowledge and experience in evaluating and assessing a child and in interpreting the results of evaluation and assessment instruments..._

_All States must allow qualified personnel, when conducting evaluations, to use their informed clinical opinion to determine whether the child meets the State’s definition of developmental delay. Given the Department’s monitoring experience in States where qualified personnel are not permitted to use their informed clinical opinion as a separate basis to establish eligibility, we have set forth that such personnel must be able to use informed clinical opinion as an alternate basis for establishing eligibility. Permitting informed clinical opinion to serve as a separate basis to establish a child’s eligibility under Part C of the Act is important given that standardized instruments may not capture the extent of a child’s delay. The purpose is to alleviate the confusion and to expressly permit qualified personnel to use their clinical opinion to establish a_
child’s eligibility for early intervention services, even when other instruments fail to identify or confirm the level of developmental delay to establish Part C eligibility.

Who can provide informed clinical opinion in Montana? A physician or psychologist.

If an infant or toddler is determined not eligible, then the provider must inform the parents of that determination using prior written notice. The notice must include information on parents’ right to disagree with the “no” determination using Montana’s Part C Dispute Resolution process.

If yes, the infant or toddler is eligible, assessment of the child and family is the next step.

Slide 10

Parents will be asked to provide their consent for a multidisciplinary assessment of their child’s unique strengths and needs, which will also identify the services appropriate to meet their needs. Parents will be asked to participate in a family-directed assessment of the family’s resources, priorities, and concerns, an assessment which includes identifying the services and supports needed to enhance the family’s capacity to meet their child’s developmental needs. Given parental consent, the assessments of the child and family may be conducted.

Slide 11

Assessment of the child: each of these elements contributes to valuable information about the child’s needs, which in turn can be used to identify the types of early intervention services appropriate to address those needs.

The Part C regulations do not mandate or even suggest specific instruments to be used during the assessment of children in early intervention. Even within a State there may be different instruments or approaches used to conduct child assessments. As shared previously, Montana uses an assortment of assessment tools gathered from a list generated by the Early Childhood Technical Assistance Center (ECTA).

Family-directed assessment: the purpose of this assessment is to identify the resources, priorities, and concerns of the family; and the services necessary to enhance the family’s capacity to meet their child’s developmental needs. The family-directed assessment must be (1) voluntary on the part of each family member participating in the assessment; and (2) be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and (3) include the family’s description of its resources, priorities, and concerns related to enhancing the child’s development.
Montana uses the MT Routines-Based Interview. The point of conducting the family assessment is to find out what the family views as its resources, concerns, and priorities. Therefore, it’s considered best practice to hold the family interviews more as conversations than as formal sessions that include the filling out of a needs assessment tool. Family trust and comfort levels are critical factors in opening a continuing dialogue about:

- The family’s daily routines;
- Perceptions of their child’s development;
- What challenges the family faces day to day’
- The resources they have available to address those challenges; and
- What they consider most important for their child to learn or be able to do in the near future.

**Slide 12**

**Qualified Personnel:** this item responds to the question that many parents and families would naturally have about evaluation and assessment of their child, not to mention their own family-directed assessment: Who is going to conduct the procedure? Do they know what they are doing? Are they trained?

Per Part C regulations:

- Evaluation means the procedures used by **qualified personnel** to determine a child’s eligibility;
- Assessment means the ongoing procedures used by **qualified personnel** to identify a child’s unique strengths and needs;
- Assessment of each infant or toddler with a disability must be conducted by **qualified personnel**;
- **Qualified personnel** must use informed clinical opinion when conducting an evaluation and assessment of the child.
- All evaluations and assessments of the child and family must be conducted by **qualified personnel**;
- A family directed assessment must be conducted by **qualified personnel**.

How much clearer can the regulations make it? **Qualified personnel** must be involved throughout the steps of evaluation and assessment.

What do **qualified personnel** mean? Personnel who have met State approved or recognized certification, licensing, registration, and other comparable requirements that apply to the areas
in which the individuals are conducting evaluations or assessments or providing early intervention services.

**IDEA has long required that evaluation and assessment procedures and tools be nondiscriminatory.** When evaluating children who’ve been referred to the Part C system, it’s obviously important that the results yielded are reliable so that a comprehensive and accurate understanding can be built of the child’s strengths and needs. Eligibility determinations are based in large part on the results of the child’s evaluation, as are discussions and decisions about what early intervention services are appropriate to address the child’s needs. If the methods or tools used to collect information about the child are flawed, culturally or racially biased, or inappropriate for the child, then the results will be questionable at best.

What makes an inventory, an observation, an interview, or an instrument discriminatory or biased in terms of race, ethnicity, or culture? How can bias unintentionally creep into interactions with families and children, especially those who come from different background, culture, or country? Consider factors that can affect how the parents or the child communicate, behave, or respond during the evaluation or assessment process, including:

- Primary language of the parents and child
- Level of acculturation to the United States
- Familiarity with objects or activities used during evaluation or assessment
- Explanations concerning the causes and solutions or problems
- Social, cultural or religious mores that govern behavior, eye contact, dress, response to authority, and such.

Considering Part C’s requirement that evaluation and assessment be nondiscriminatory, it’s not surprising that the regulations also require use of the native language during evaluation and assessment. What could be more discriminatory than conducting every evaluation or assessment interview procedure in English, if that’s not the primary language of the child or family?

**Native language** is the language the parents normally use. For a child being evaluated or assessed, native language is the language the child normally uses if that’s considered developmentally appropriate by the personnel conducting the evaluation or assessment. For an individual who is deaf or hard of hearing, blind or visually impaired, or with no written language, native language is the mode of communication the individual normally uses, such as sign language, braille, or oral communication.
The native language of the child and/or the family must be used during evaluation and assessment, unless it’s clearly not feasible to do so. This is an important point. As the Department of Education observes:

_The “unless clearly not feasible to do so” standard acknowledges that there may be instances when conducting evaluations or assessments in the native language of the child, parent, or family member is not possible because, for example, interpreters for a particular language cannot be located, despite best efforts. If on-site interpreters cannot be located for a particular language despite best efforts, other methods of communication in the native language, such as using telephonic interpreters, should be explored when an interpreter is needed and appropriate, for the evaluation and assessment._

**Slide 13**

For each infant or toddler with a disability who is eligible to receive services under the Part C early intervention program, the provider responsible for establishing and implementing the Part C program must ensure the development, review, and implementation of what is known as an Individualized Family Service Plan (IFSP). The IFSP is developed by a multidisciplinary team, which includes the parent, and contains specific information about the infant or toddler, his or her needs and strengths, developmental and learning goals for the child, and much more. The process of developing this vital document is the subject of many of IDEA’s provisions.

**Slide 14**

What kind of things might the Part C program provider have to do before scheduling an IFSP meeting to develop a child’s IFSP?

**Slide 15**

Learning objectives

**Slide 16**

Needs first!

It is important to note that, for each and every child receiving early intervention under Part C, the reasonable goals (outcomes) that are set and the services that will be coordinated and provided are **based on the needs and the developmental status** of that individual child. With parental consent, information about the child’s needs and development is gathered in the evaluation and assessment processes, which seeks to discover and document the child’s current status in five developmental areas:
• Physical development (including vision, hearing, and health status)
• Cognitive development
• Communication development;
• Social or emotional development; and
• Adaptive development.

The team who writes the child’s IFSP (including the parents) documents in the IFSP the child’s present levels of functioning in each of these developmental areas. The team can then look at the child’s needs, set reasonable goals of the child’s learning and development, and state in the IFSP what early intervention services will be provided to help the child reach those goals.

**Slide 17**

Have you ever served on an IFSP team? Share one reason you need to know who is on the IFSP team.

Parents are critical members of the IFSP team. Parents are pivotal team members because the IFSP is being written for and about their infant or toddler. Parents have invaluable perspectives to offer on their child’s growth and development, areas of strength and need, and overall medical and personal history. They can also contribute substantively to IFSP development by sharing with the other members the priorities, resources, and concerns of the family unit.

Family members can be invited to participate on the team. The regulations clearly recognize the deep involvement and commitment that a child’s family members can bring to supporting his or her well-being. Family members can and often do play a variety of roles in enhancing a child’s development. That is why, when requested by the parent of the child and when feasible, family members may be included on the IFSP team.

Parents of the child may also request that an advocate or another person from outside the family unit be included on the IFSP team. An advocate typically helps the parent to articulate his or her perspectives and concerns, while a person from outside the family might contribute professional or personal knowledge about the child’s needs and strengths or the family’s needs regarding supporting the child’s development.

The Part C program provider designates a **service coordinator** (Family Support Specialist) to help the parents and family members understand and navigate the early intervention process. This is obviously a key role; not surprisingly, the service coordinator has many specific duties and responsibilities, including coordinating all services across agency lines and serving as the single point of contact for carrying out the early intervention services and activities identified in the child’s IFSP.
Those who have been directly involved in carrying out the evaluation and assessments of the child and family are also on the IFSP team. This may be one individual or several, with contributions being to explain the results of the evaluation and assessments process and to help the other team members identify the early intervention services appropriate to addressing the child’s developmental needs.

If the person filling this role cannot attend the IFSP meeting, the regulations state that arrangements can be made for the person’s involvement through other means, including one of the following: participating in a telephone conference call; having a knowledgeable authorized representative attend the meeting; or making pertinent records available at the meeting.

If appropriate, the team may also include one or more providers of early intervention services. Again, this may be one or more individuals who can speak directly to the question of which early intervention services are needed and what measurable goals or outcomes are appropriate for the child.

These participants are required at the initial and annual IFSP meeting. All these participants are not necessarily required for the six month review or any other periodic review of the IFSP. Only the first four listed members are expected to participate in the six month review or any periodic review of the IFSP:

- The parent(s);
- Family members requested by the parent;
- The advocate or person outside the family (if requested by the parent); and
- The family’s service coordinator.

Two members of the team are not necessarily expected to attend the six month review or any periodic reviews of the IFSP:

- The person(s) directly involved in the evaluation and assessment process;
- The provider(s) of early intervention services.

If conditions warrant, however, provisions must be made for the participation of these representatives as relevant.

**Slide 18**

§303.20: The Individualized family service plan or IFSP means a written plan for providing early intervention services to an infant or toddler with a disability under this part and the infant’s or toddler’s family.
The DPHHS and the Part C program provider must ensure the IFSP is developed, reviewed, and implemented for each infant or toddler with a disability served under Part C. Additional elements of that responsibility include ensuring that:

- The IFSP is developed by a multidisciplinary team;
- The multidisciplinary team includes the child’s parent; and
- The IFSP meets specific requirements laid forth in the regulations.

The specific requirements that must be met with respect to the IFSP are the focus of the upcoming slides. First, more information on the definition of the IFSP...

**Slide 19**

The shortest story – under the Part C regulations, a child’s IFSP must be based on the results of the evaluation and assessment, which are conducted to identify:

- The child’s strengths and needs;
- The early intervention services appropriate to meet those needs;
- The family’s resources, priorities, and concerns; and
- The services appropriate to build the family’s ability to meet their child’s developmental needs.

The IFSP includes specific content such as information about the child’s present levels of development, family information, the results or outcomes expected to be achieved for the child, what early intervention services will be provided and where, and so on.

The IFSP is developed according to specific IFSP procedures and include the following:

- The timelines for holding an IFSP meeting to develop the child’s IFSP;
- The required participants for the development of the IFSP;
- Actions the Part C program provider must take before holding an IFSP meeting;
- The required accessibility and convenience of IFSP meetings;
- Providing parents with a full explanation of the contents of the IFSP; and
- Securing parents’ informed written consent before any early intervention services may be provided to the infant or toddlers.

The IFSP is implemented as soon as possible after parent consent. IDEA requires that, before an early intervention service listed into the IFSP may be provided to the child, parents must give their informed written consent for that early intervention service. The regulations also give parents the right to accept or decline any early intervention service, at any time (even after first
accepting it), without jeopardizing their ability to receive other early intervention services listed in the IFSP.

After parents have given their consent for an early intervention service, that service must be provided “as soon as possible.” What does ASAP actually mean – within a day, within a week, within a longer period of time?

First of all, the timeline for ASAP begins when the parents have given their consent for a service. While IDEA does require the IFSP to include the “projected date for the initiation of each early intervention service,” such dates are just that – projected dates. As the Department of Education observes, “a parent may not have provided consent to the service, therefore, the service may not be provided.”

So it makes sense to begin the timeline for ASAP once parental consent is obtained. The Department of Education goes on to say:

*Currently most States (including Montana) have adopted a 30-day timeline that commences from the date of parental consent to the date the services in the IFSP are provided with some States adopting a shorter timeline and very few States adopting a slightly longer timeline.*

**Slide 20**

Once an infant or toddler is found eligible for early intervention services because of an identified disability or developmental delay, the Part C program provider is responsible for convening a meeting in which that child’s IFSP will be developed. As the slide indicates, this meeting must be held within the 45-day post-referral timeline. This is stated in the Part C regulations as follows:

§303.342 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.

§303.310 The initial evaluation and the initial assessments of the child and family under §303.312; and the initial IFSP meeting under §303.342 must be completed within 45 days from the date the provider receives the referral of the child.

The 45-day timeline does not apply for any period when –

- The child or parent is unavailable to complete the initial evaluation, the initial assessments of the child, and family, or the initial IFSP meeting due to exceptional family circumstances that are documented in the child’s early intervention records; or
• The parent has not provided consent for the initial evaluation, or the initial assessment of the child, despite documented, repeated attempts by the provider to obtain consent.

The Part C program provider must develop procedures to ensure that in the event of the circumstances described above, the provider must-

• Document in the child’s early intervention records the exceptional family circumstances or repeated attempts by the provider to obtain parental consent;
• Complete the initial evaluation, the initial assessments of the child and family, and the initial IFSP meeting as soon as possible after the documented exceptional family circumstances described above no longer exist or parental consent is obtained for the initial evaluation and the initial assessment of the child; and
• Develop and implement an interim IFSP, to the extent appropriate and consistent with §303.345.
• The initial family assessment must be conducted within the 45-day timeline if the parent concurs and even if other family members are unavailable.

All this is to say, for training purposes, that the initial IFSP meeting must be held within 45 days of the child’s referral to the Part C program. This is only necessary, of course, if the child has been found eligible for early intervention services.

Recognizing the rapid developmental changes common to infants and toddlers, IDEA requires periodic review of the IFSP – specifically at least every six months. The IFSP may also be reviewed more frequently if conditions warrant or if the family asks for such a review. The purpose of the periodic review is to determine the degree to which the child is making progress toward achieving the results or outcomes identified in the IFSP; and whether elements of the IFSP (i.e., the results, outcomes, or early intervention services) need to be revised or modified.

An annual meeting must be held to evaluate the IFSP giving the IFSP team (which includes the parent) a formal opportunity to revisit the IFSP and revise it, as appropriate, using current evaluations or other information about the child and family to determine what early intervention services are needed and will be provided.

**Slide 21**

Each Part C program provider must take steps to ensure that parents of a child eligible for Part C services are present at each IFSP team meeting or are afforded the opportunity to participate. One of those steps is to ensure that IFSP meetings are held in places and at times that are convenient to the family. Providers must make the meeting arrangements with the family (and other participants) early enough before the meeting date to ensure they will be able to attend.
The meeting must also be conducted in the family’s native language or other mode of communication (e.g., sign language), unless it is clearly not feasible to do so, purposely to ensure that the family can understand what is being said at the meeting and can participate in discussions and decision making.

Each Part C program provider must notify parents of the IFSP meeting early enough to ensure they have the opportunity to attend. Specific information must be included in the provider’s notification to parents, such as:

- The purpose, time, and location of the meeting;
- Who will be at the meeting; and
- That the parents may include and/or invite other family members, advocates, or another person outside of the family to participate in the meeting.

**Does the notice to parents have to be in writing?** Yes. It is not sufficient for the Part C program provider to notify parents of an upcoming IFSP meeting solely by text, email, or by documenting a phone call where the meeting was arranged with parents. As the Department of Education observes:

> Nothing in the regulations prohibits States from providing additional notice of the IFSP meeting by, for example, electronic mail or phone call, but, at a minimum it must provide written notice to the family and other participants to ensure that they can attend the IFSP meetings.

> It is extremely important for the provider of Part C to ensure that parents of the child can understand what’s being said at the IFSP meeting and contribute their own perspectives and knowledge. Therefore, unless it’s clearly not feasible to do so, IFSP meetings must be conducted in the parent’s native language or typical mode of communication (e.g., sign language, braille).

> Because Part C makes it clear that involvement of the family in the IFSP process is critical, providers of Part C must take whatever action is necessary to ensure that the parent understands the proceedings of the IFSP team meeting, including considering the “availability of native language resources” such as bilingual staff, arranging for an interpreter to be present at IFSP meetings, or utilizing available telephonic interpreter services. Nonetheless, as the Department of Education acknowledges:

> Given the US Census Bureau recognizes over 300 languages used in the United States (not including dialects), it may not be feasible, in every instance, to provide interpreter services with respect to a particular native language because an interpreter of that language may not be available.
Ensuring the contents of the IFSP are fully explained to parents interconnects with other provisions in the Part C regulations with respect to ensuring parents understand and can participate in the IFSP process. The regulations do not specify who is responsible for explaining the IFSP to parents, but in practice it tends to be the family’s service coordinator (Family Support Specialist). This is the person who is responsible for helping parents understand and be actively involved in the early intervention process.

 Whoever explains the contents of the IFSP to the parents in the end and answers any questions they may have, this step is meant to ensure that parents have the understanding they need to make an informed decision about providing consent for early intervention services or not.

 Parents will be asked to provide their informed written consent for each of the early intervention services specified in their child’s IFSP. No services may be provided without parental consent in writing.

 **Can the provider of Part C challenge the parents’ refusal to give consent?** No, the provider of Part C may not challenge a parent’s refusal to provide consent for early intervention services to be provided to the child. The parents’ refusal to give consent may not be challenged by the provider of Part C during several other points in time:

- Before conducting all evaluations and assessments of the child;
- Before using the family’s private insurance; and
- Before disclosing personally identifiable information about the child or family.

 However, in the face of a parent’s refusal to give consent, the Part C program provider does have an obligation, as follows:

 If a parent does not give consent, the Part C program provider must make reasonable efforts to ensure that the parent is fully aware of the nature of the evaluation and assessment of the child or early intervention services that would be available; and understands that the child will not be able to receive the evaluation, assessment, or early intervention service unless consent is given.

 Per §303.409(c), a copy of each evaluation, assessment and IFSP must be provided to parents at no cost as soon as possible after each IFSP meeting. This is a new requirement in the Part C regulations, and it’s intended “to help parents to be full and equal participants in the IFSP process.”

 The fact that these documents must be provided at no cost to parents is consistent with the fact that many other things in early intervention must be provided at no cost to parents,
including conducting evaluations and assessments, developing and reviewing IFSPs, and implementing procedural safeguards. As the Department of Education observes:

_Requiring States to provide a copy of evaluations, assessments, and IFSP to parents, from the child’s early intervention record, should not be a burden to States. As a standard practice, most States already provide these documents at no cost to parents._

**Slide 23**

Introduction to final section of training.

**Slide 24**

Learning objectives

**Slide 25**

Please suggest at least two types of information you would expect to be included in an IFSP.

**Slide 26**

As you can see, “**service coordinator**” is listed at #1 as a way of indicating that families are to be guided and supported through the IFSP process and while the child is receiving early intervention services. Understandably, the early intervention system begins as a mystery to them, and the **service coordinator** (Family Support Specialist) has an essential role to play in breaking down that mystery and smoothing the family’s path in Part C.

**Slide 27**

Under Part C regulations:

Each infant or toddler with a disability and their family must be provided with one **service coordinator** whose general mission is “to assist and enable an infant or toddler with a disability and the child’s family to receive the services and rights, including procedural safeguards,” required under Part C of IDEA.

The **service coordinator** must be from the profession that is most immediately relevant to the needs of the child or family, or otherwise qualified to carry out the duties of a service coordinator under Part C. The latter may include individuals who have as their profession “service coordination” which is Montana’s Family Support Specialist.
Montana IFSP Procedures Training Protocol

- The service coordinator is responsible for coordinating all services the family receives under Part C of IDEA across agency lines.
- The service coordinator serves as the single point of contact for the family in carrying out specific activities.
- Only one person may serve as the service coordinator for a particular family at a given time. This is meant to ensure that parents and early intervention service providers for a particular child have a single point of contact.
- The name of the service coordinator assigned to the family must be included in the IFSP.
- Service coordination may be referred to as case management.

The Part C regulations include a definition of service coordination services at §303.34 which is identical to Montana’s definition of service coordination services. It is a rather lengthy definition but an illuminating one, because it shows the wide range of activities and duties that service coordination involves. In addition to what’s already been mentioned, such activities include:

- The coordination of early intervention services and other services that the child needs or is being provided;
- Conducting referral and other activities to assist families in identifying available early intervention service providers;
- Ensuring the timely provision of services; and
- Conducting follow-up activities to determine that appropriate Part C services are being provided.

Slide 28

It makes perfect sense that the IFSP would require a description of the child’s present level of development, otherwise referred to as the “child’s status.” What, specifically, is the child’s disability or delay that makes him or her eligible for early intervention services? What are his or her developmental needs? It would surely be impossible to develop an appropriate IFSP for the infant or toddler without being able to answer such questions.

Early intervention programs are intended to address delay and disabilities that infants and toddlers can have in one or more key areas of development. The IFSP form and the Part C Regulations make clear that there are five developmental levels of concern:

- Physical development
- Cognitive development
- Communication development
• Social or emotional development
• Adaptive development.

These are the developmental areas on which evaluation and assessments of the child were focused, and the results of the evaluation process were used to determine the child’s eligibility for early intervention. If the IFSP team has gathered and is writing an IFSP for the child and family, then, clearly, the child has been found eligible; which means that he or she has a developmental delay or disability in at least one of these five developmental areas.

So what are the child’s developmental delays or disabilities? These must be described as concretely and thoroughly as possible in the IFSP. The IFSP Team typically relies on the results of the evaluation and assessment of the child which indicate which area(s) of development are delayed or adversely affected and to what degree.

Remember that the Part C regulations require that the IFSP team include one or more members who were involved with the child’s evaluation and assessment. So there will be someone present who can explain the results and help the team describe the child’s status of development accurately.

The child’s “present levels of development” drives decision making. As you already know, the IFSP must also include measurable results or outcomes for the child, as well as what early intervention services will be provided. What’s not so obvious yet is that, for each and every child receiving early intervention under Part C, the measurable results or outcomes that are set and the services that will be coordinated and provided are based on the needs and developmental status of the individual child.

The IFSP team writing the child’s IFSP (including the parents) must look at the child’s needs closely in order to set measurable results or outcomes for the child’s learning and development and determine what early intervention services will be provided to help the child reach those goals. Needs-Goals-Services are, thus, logically interconnected. But it’s needs first!

Slide 29

With the concurrence of the family, a statement of the family’s resources, priorities, and concerns related to enhancing the development of the child as identified through the assessment of the family under §303.321(c)(2) is included in the IFSP.

Let’s start with the basics about including “family information” in the IFSP.

During the evaluation and assessment phase, the family is typically asked to discuss their resources, priorities, and concerns for their child as those relate to enhancing their child’s
Family participating in this assessment is completely voluntary. They have the right to share as much or as little about their resources, priorities, and concerns as they like.

Where does this information come from? Family information comes from the assessments conducted with the child’s parents and perhaps other family members. The information typically emerges during interviews and informal contacts the family has with the service coordinator (Family Support Specialist) and other early intervention personnel. If they are willing, families respond to such questions as:

If you were to focus your attention on one thing for your family or child right now, what would it be? Because children learn best in the context of everyday activities, families are asked to describe their daily routines and activities, in terms of what interests and engages their child, what’s going well and what challenges they face during the MT Routines-Based Interview. Sharing this information helps to identify difficulties that providers may problem-solve with families.

When it comes to determining a family’s concerns, resources, and priorities, and listing this information in the IFSP, the family needs to be the decision maker, not the professionals on the IFSP team. Further, when documenting the family’s resources, concerns, priorities in the IFSPs, using vocabulary the family has used in generating the concerns makes it possible for everyone to view this list as the family’s list of concerns/needs.

It is useful to note that the family information included in the IFSP may change over time, especially as the baby or toddler and the family benefit from the early intervention program. The family information in the IFSP would need to be updated to reflect the family’s current concerns, priorities, and resources.

Important key components to reiterate:

- The child’s “present levels of development” drives decision making.
- Needs-Goals-Services are, thus, logically interconnected. But it’s needs first!
- The measurable results or outcomes that are set in the IFSP and the services that will be coordinated and provided are based on the needs and developmental status of the individual child.
- The family’s statement of resources, priorities, and concerns related to enhancing the development of the child is identified through the assessment of the family (MT RBI).
- Because children learn best in the context of everyday activities, families are asked during the MT RBI to describe their daily routines and activities, in terms of what interests and engages their child, what’s going well and what challenges they face.
Not surprisingly, the IFSP must include a statement about what outcomes or results are expected to be achieved by the child and family. These outcomes or results must be measurable, too. The IFSP team indicates how the expected results or outcomes will be measured.

This particular slide relates to **establishing** and documenting the outcomes or results that are expected to be achieved for the child and family in the coming months.

**Is there any difference between “outcomes” and “results”?** No. As the Department of Education notes, “there is little material difference, for IFSP content purposes, between the meaning of the terms “results” and “outcomes” and we use these terms in the regulation because they are both referenced in the section 636 of the Act.”

**Who decides what outcomes or results are important?** Members of the IFSP team, which includes the parents, work together to determine what outcomes or results are most important to the family. Parents discuss their child’s needs extensively and identify the functional things they most want their child to be able to learn or do. What’s working, what’s challenging in everyday routines and activities? What are the family’s priorities for the child? For themselves? These, then, become the outcomes or results sought by and for the child and family.

**Steps for Building IFSP Child and Family Outcomes:**

Pre-literacy and language skills are included in the statute passed by Congress; as pre-literacy and language skills emerge during infancy and, therefore, should be a measurable result or measurable outcome that is developmentally appropriate for a child served under the Part C program.

**What’s developmentally appropriate practice for building pre-literacy and language skills?** While pre-literacy may not seem like a skill that infants and toddlers would need to be working on, in fact, children start learning language as infants. They’re working on pre-literacy and language skills every day. They’re learning words, they are touching bunny rabbits and petting dogs, they taste sour or sweet things, all of which help them build their understanding of the world, their vocabularies, and their sense of self.

The Center for Early Literacy Learning (CELL) is an excellent place to find out how to enrich children’s environments and activities so that they support early language learning. CELL offers
free parent guides as well as practitioner guides, and a range of tools that we all can use in helping infants and toddlers acquire language skills.

**Slide 31**

For each result or outcome listed in the IFSP, the IFSP team (which includes the parents) must also identify the “criteria, procedures, and timelines” they will use to determine:

- How much progress is being made toward achieving the expected results or outcomes; and
- Whether modifications need to be made in the IFSP – expressly in the results that are being expected or the early intervention services that are being provided.

Keeping track of the child’s progress toward expected results is a critical element in the overall success of early intervention services for the child and family. If progress isn’t being made as expected, then the IFSP team will need to revisit and possibly revise its plan. Are the right services being provided, in sufficient amounts? Children grow and change so quickly, there’s no time to waste on something that isn’t working as anticipated.

**How to build progress monitoring into the IFSP?** To make sure that the IFSP team will be able to “tell” when and if the child has achieved expected results, the team has to agree on (1) what will be measured, (2) how it will be measured, (3) when and (4) where it will be measured, and (5) what constitutes success.

Montana’s IFSP form uses text boxes in Section V – Functional Outcomes as a way to organize and document the required information in the IFSP. The IFSP team fills out the text boxes during the IFSP meeting and each progress monitoring element must be addressed:

- What would your family like to see happen for your child/family? (The outcome must be functional, measurable and in the context of everyday routines and activities.)
- We will know we achieved this outcome when...(criteria)
- Family’s strengths and resources for this outcome.
- Steps that will be taken to address this outcome: (strategies/activities/revisions). This text should also include projected timelines for each step (procedures).

**Slide 32**
The next component of the IFSP – early intervention services – will be the topic of the next five slides. What early intervention services will be provided to the child and family to meet their unique needs and help them achieve the outcomes or results that have been established? There should be an unmistakable connection in the IFSP between the child’s developmental levels, skills, and functioning and the outcomes that have been identified as priorities. Now, given those expected outcomes, what types of services would be appropriate for the child or family? There should also be an unmistakable connection between the outcomes expected and the services to be provided.

Can you name a few early intervention services? What types of services are we talking about? What does “peer-reviewed research” mean? What about the phrase “to the extent practicable”?

The Part C regulations include a definition of “early intervention services,” which we won’t quote here in its entirety as it is very long and includes definitions of each of the services. That is identified verbatim in Montana’s compliance with the Part C Rules and Regulations document. For summation purposes, let us boil the regulations down to just the names of the services mentioned:

- Assistive technology device and service
- Audiology service
- Family training, counseling, and home visits
- Health services
- Medical services
- Nursing services
- Occupational therapy
- Physical therapy
- Psychological services
- Service coordination services
- Sign language and cued language services
- Social work services
- Special instruction
- Speech-language pathology services
- Transportation and related costs
- Vision services.
The services and personnel identified and defined in this section of the regulations do not comprise exhaustive lists of the types of services that may constitute early intervention services or the types of qualified personnel that may provide early intervention services.

When you read the definitions of each of these services, it’s very clear that early intervention services are intended to:

- Address the wide spectrum of children’s developmental needs, and
- Provide supports and resources to bolster the powerful role of families in children’s lives.

Peer-reviewed research is not defined in regulations although the Department of Education comments as follows:

*Peer-reviewed research generally refers to research that is reviewed by qualified and independent reviewers to ensure that the quality of the information meets the standards of the field before the research is published. However, there is no single definition of “peer-reviewed research” because the review process varies depending on the type of information being reviewed.*

In the context of these regulations, the term “to the extent practicable” has its plain meaning (i.e., feasible or possible). The phrase generally means that specific early intervention services should be based on peer-reviewed research to the extent that is feasible or possible, given the availability of peer-reviewed research on the early intervention services determined to be most appropriate to respond to the child’s needs and strengths identified pursuant to information from the child’s evaluations and assessments under §303.321.

To the extent that’s practical, early intervention services need to be based on research that’s been reviewed by the researchers’ peers and, thus, presumably has some credible evidence of effectiveness.

As part of Montana’s general supervision and monitoring duties, the DPHHS is largely responsible for ensuring (to the extent possible) that the early intervention services provided to children are based on peer-reviewed research.

*Slide 33*
Now it is time to dig into the specifics that must be included in the IFSP about the early intervention services to be provided to the child or family.

The IFSP must include a statement of the specific early intervention services, based on peer-reviewed research (to the extent practicable), that are necessary to meet the unique needs of the child and the family to achieve the results or outcome identified. This statement includes the beginning date, length, duration, frequency, intensity, method of delivering, and location of the early intervention services.

- Frequency and intensity mean the number of days or sessions that a service will be provided, and whether the service is provided on an individual or group basis.
- Method means how a service is provided;
- Length means the length of time the service is provided during each session of that service; and
- Duration means projecting when a given service will no longer be provided (such as when the child is expected to achieve the results or outcomes in his or her IFSP).
- Location means the actual place or places where a service will be provided.

With respect to duration, the Department of Education states:

_We appreciate that the IFSP Team will not always know how long a particular service will be needed to achieve the measurable outcomes or results in the child’s IFSP. What is critical is that the IFSP Team evaluates and re-evaluates whether the expected outcomes are being achieved at the appropriate pace. If the IFSP Team miscalculates how long a particular service will be provided, it can amend the IFSP during a periodic review. Due to the rapidly changing needs of infants and toddlers and the need for accountability in making sure the appropriate services are provided, it is important for families to participate in periodic and annual reviews in order to help make decisions about modifications to the IFSP based on the child’s present level of development._

**Slide 34**

According to §303.26, **natural environment** means settings that “are natural or typical for a same-aged infant or toddler without a disability” and may include home and community settings.
The definition is quite broad – necessarily so, to allow flexibility in how the term is implemented in a specific area and to avoid limiting the types of service settings that the IFSP team may consider appropriate.

While what’s a natural setting for an infant or toddler may vary from community to community, some examples might include playgrounds, libraries, parks, swimming pools, grocery stores, child care centers, or a daycare provider’s location. May clinics, hospitals, or a service provider’s office be considered the “natural environment” in cases when specialized instrumentation or equipment that cannot be transported to the home is needed? According to the Department of Education, typically, no. A clinic, hospital, or service provider’s office would not be a natural environment for an infant or toddler without a disability; therefore, these would not be natural environments for an infant or toddler with a disability. However, in very limited instances for a particular service, such as audiology evaluation, the evaluator’s office might be the natural environment.

**Slide 35**

How are decisions made? What may constitute an appropriate setting for providing early intervention services to an infant or toddler? The regulations indicate that the determination of setting is made by the IFSP team (which includes parents). Members base their decision on the expected outcomes or results the team has identified for the child as part of writing the IFSP. Determining the appropriate setting must be consistent with three specific sets of provisions in the Part C regulations, which are summed up on the slide as “consistent with IDEA’s natural environment provisions.” It’s possible that the IFSP team may determine that “the child cannot satisfactorily achieve the identified early intervention outcomes in natural environments.” If so, “then services could be provided in another environment” (e.g., clinic, hospital, service provider’s office). In such cases, however, a justification must be included in the IFSP.

On what basis does the IFSP Team (which includes the parents) determine the appropriate setting for providing early intervention services to an infant or toddler with a disability – including when a particular service won’t be provided in a natural environment? The determination is based on the child outcomes specified in the IFSP.

Determining the appropriate setting for early intervention services must be consistent with IDEA’s natural environment provisions. The provisions indicate that early intervention services: (1) are to be provided to the infants and toddlers with disabilities in natural environments, to
the maximum extent appropriate; (2) may be provided in settings other than the natural
environment only with the early intervention services cannot be achieved satisfactorily in a
natural environment. In this latter case:
The environment must be the most appropriate for the child and for the service being provided;
and the IFSP team (which includes the parent) determines what that setting will be. A
justification must be included in the IFSP as to why an early intervention service is being
provided in a setting other than a natural environment.

Slide 36

Let’s think about this situation. Based on the evaluation and the assessments, a child has a 52%
delay in communication. Should we identify an outcome on the IFSP to address this
developmental delay? (yes) Might specific speech/language services be identified to address
this developmental need? (yes) If the IFSP team (which includes the parents) identifies the
setting for this service to be in a service provider’s office once a month with justification, where
on the service page would this service be identified? The Summary of Services! The service
would be linked to the number of the outcome including the justification and include all the
required summary of service information.

If a child has an identified need based upon evaluation and assessment and the service matches
the list of services that are required under Part C, this service entry should not appear in the
Medical and Others services section.

Medical and other services addresses the basic requirements set forth in the Part C regulations:

*To the extent appropriate, the IFSP must also identify medical and other services that the child
or family needs or is receiving through other sources, but that are neither required or funded
under this part; and if those services are not currently being provided, include a description of
the steps the service coordinator or family may take to assist the child and family in securing
those other services.*

Many services are covered under Part C, including all of the services addressed in the prior
slide. There are many other services that Part C programs are not required to provide or pay
for but that are, nonetheless, helpful and important to the family. Examples include but are not
limited to services such as child care, foster are, well-baby checks, immunizations, WIC nutrition
program, and so on. This component of the IFSP is intended to identify those “other services”
that families need, could benefit from, and perhaps are currently receiving, but that Part C
programs are not required to pay for or provide. Refer back to the example presented at the beginning of this slide.

Listing of these non-required services in the IFSP does not mean these services must be provided. By listing them, the IFSP provides a comprehensive picture of the infant’s or toddler’s total service needs (not only Part C services but medical and health services as well), which can be helpful to both the infant’s or toddler’s family and the family service coordinator. As we will see on the next slide, it is appropriate for the family service coordinator to assist the family in securing these non-required services.

**Slide 37**

This slide indicates what additional information needs to be included – namely, to describe the steps to be taken to help the child and family secure the “other services” they are not currently being provided. Now that the IFSP team has identified “other services” that the family needs but is not currently being provided through sources other than Part C, the question becomes how to help the family secure these services.

The IFSP team must describe the steps that the service coordinator or family would take to do so. In past regulation, information also needed to be included in the IFSP as to the funding sources to be used in paying for those “other services.” This has changed in the current Part C regulations. Now, IFSP teams are not required to identify the funding sources for those services even though the IFSP Service page includes Funding Source for Medical and Other Services.

Note that the steps to be taken to secure these other services, as described in the IFSP, can fall to either the service coordinator or the family. For example, the service coordinator might assist the family in arranging for medical services or in preparing eligibility or insurance claims. Alternatively, the family may be given the contact information for a public program providing low-cost dental care, in-depth medical care, or low-cost housing. The responsibility to follow through would belong to the family.

**Slide 38**

Next component of the IFSP – and what an important one it is. How will the early intervention services be paid for?
The IFSP must identify each of the early intervention services that will be provided (with parental consent) to the child and family. It also identifies such details as the location where each service will be provided; how each will be provided; and the frequency, duration, intensity, and length of each. It is not surprising, then, that the IFSP also needs to include the payment arrangements (if any) for each of the early intervention services provided to the child and family.

What kinds of payment arrangements are there? Many! Public insurance, private insurance, an existing federal or state funding source such as Medicaid or the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT).

The fiscal aspect of providing early intervention services to eligible babies and toddlers is complicated and far beyond the scope of this module to explain in any depth. Part C funds may be used only as the payor of last resort for early intervention services. Therefore, it is critical for the DPHHS and the Part C program provider to work closely with all other public entities in the State that are involved with, and responsible for, providing services and supports to infants and toddlers (and their families). What agencies might be involved? While this varies from state to state, potential funding sources for Part C services and supports might be CAPTA (services for children exposed to domestic violence), Child Care and Development Block grant (child care subsidy), Champus/TRICARE (health care for military families), Child Welfare Services Grant (crisis intervention, screening and assessment), CHIP (health insurance for low-income children), Community Health Centers (for screening and assessment, treatment of health; minority families; low-income families); Community Mental Health Services Block Grant (mental health services), and EPSDT (health, vision and dental screening; immunizations), Head Start/Early Head Start, Healthy Start (low income minority mothers and babies), Indian Health Services (health care services), Maternal, Infant, and Early Childhood Home Visiting Program (health assessment, treatment services, special health care needs), Medicaid, TANF, WIC.

Montana established a System of Payments for funding Part C services. It describes policies for accessing public insurance or benefits of a family or child in Part C and policies for accessing a family’s private insurance.

There are specific aspects of early intervention that must be provided at public expense:

- Conducting child find
- Evaluation and assessment of the child and family
- Providing service coordination
• Activities related to development, review, and evaluation of IFSP and interim IFSPs
• Implementation of the procedural safeguards
• All Part C services if a family is determined “unable to pay.”

The IFSP must specify the funding source (or potential funding source) for each early intervention service to be provided to the child and family. This is clearly identified on the Services page of the IFSP.

**Slide 39**

Believe it or not, you’ve reached the final component of the IFSP – the transition plan for the child who is approaching his or her third birthday.

The transition plan in a toddler’s IFSP must include certain content – specifically, the “transition services” and “transition steps” that are necessary to ensure that the child and family make a smooth transition from Part C to the next setting or program.

Together the IFSP team members (including the parents) review the program options available to the toddler once he or she exits from Part C services. These options may include:

• Preschool services under Part B of the Act (if the toddler is eligible and such services are appropriate);
• Early education, Head Start, and Early Head Start or child care programs; or
• Other appropriate services.

These program options are examples of the types of “next services” or “next settings” to which the toddler may exit from Part C. The actual options will vary from community to community and from state to state.

The early intervention staff will sit down with the child’s parents and talk about what future placements are options for their child and will provide them with training as needed. In order to choose between the program options, and then prepare for the specific program option selected, parents may need information on such variables as each potential program’s:

• Eligibility criteria;
• Service delivery models;
• Location;
• Provision of transportation; and/or
• Staffing and program quality.
Some children will turn three in the summer, before the school year for school-aged children begins anew. For others, there may be a gap of time between when they turn three (say, February) and when the current school year ends. Transition planning still needs to take place for these children, regardless, and so discussion with the parents would include reviewing what program options exits in this context.
For Montana’s transition process:

The IFSP team (which includes the parents) is responsible for selecting the appropriate program option to which the toddler will exit. The IFSP team is also responsible for determining what transition steps will be taken to prepare both the child and the family for exiting Part C and moving onto the selected program option. It is also the responsibly of the IFSP team to determine what transition services are appropriate for each exiting toddler with a disability.

The Part C regulations do not define the term “transition services.” It’s the Department of Education’s position that it is not appropriate to define the term. “Given that transition services are based on the unique needs of the child and the family, States require flexibility to provide appropriate and individualized transition services for each child.”

IDEA requires that, as certain toddlers in Part C approach their third birthday, the Part C program provider must notify both the State Education Agency (Office of Public Instruction) and the child’s local educational agency (where the child resides) that the child will soon be reaching the age of eligibility for Part B services. The notification provides the LEA and SEA with basic information:
- The child’s name
- The child’s date of birth, and
- The parents contact information (including name, address and telephone number).

According to Part C regulations, this information is needed to enable the lead agency as well as LEAs and SEAs under Part B of the Act, to identify all children potentially eligible for services.

The notification to the LEA and the SEA must take place not fewer than 90 days before the toddler’s third birthday.

Montana has adopted an “opt-out” policy. This gives parents the opportunity to “opt-out” of an otherwise required action – in this instance, that the Part C program provider is required to notify the SEA and LEA about their child’s upcoming third birthday and potential eligibility for
Part B services. Parents have a specified time period in which to object to the disclosure of this information about their child. If parents do object, the Part C program provider would essentially be blocked from providing the LEA and SEA with notification that this toddler will soon reach the age of eligibility for Part B services.

Who determines if a toddler may be eligible for service under Part B? The determination of whether a particular Part C toddler with a disability is potentially eligible for Part B is made by that toddler’s IFSP team as part of the transition process.

So what confirmation goes in the IFSP? The IFSP must include confirmation that the child find information about that child has been transmitted to the LEA or other relevant agency (with parental consent); and additional information has been transmitted to the LEA, including a copy of the most recent evaluation and assessments of the child and family and the child’s most recent IFSP (with parental consent).

Montana’s IFSP Procedures training protocol and presentation materials are available on the Montana Milestones website under the Guidance Materials and Resources tab: http://dphhs.mt.gov/dsd/developmentaldisabilities/PartC-EarlyInt/Part-C-Early-Intervention-Guidance-and-Forms.