

# North Carolina Infant-Toddler Program Procedural Guidance

Reference: Infant-Toddler Program Services Policy

## *Service Coordination*

### **Introduction**

One of the required services under the Infant-Toddler Program is service coordination. The Service Coordinator plays a significant role in the implementation of the Infant-Toddler Program, federal and state regulations. Therefore, it is required that children and families served by the Infant-Toddler Program have an assigned Service Coordinator. Service coordination services are 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 IDEA Part C.

The entitlement of the Infant-Toddler Program guarantees that service coordination, as defined by the Infant-Toddler Program, be provided regardless of restrictions imposed by funding sources. Service coordination may be billed to funding sources under a different service name and with a slightly different service definition. Service Coordinators must pay close attention to the service definitions of both the Infant-Toddler Program and any funding sources used to ensure that all applicable requirements are met.

### **Procedures**

#### **1. Designation of a Service Coordinator**

The Children's Developmental Services Agency must:

- assign a Service Coordinator within two working days of the child's referral to the Infant-Toddler Program to assist the family;
- coordinate with other providers to ensure that only one Service Coordinator under the Infant-Toddler Program is assigned;
- ensure that the assigned Service Coordinator does not provide other required Infant-Toddler Program services;
- assign the most appropriate Service Coordinator based on the needs of the child and family;
- accommodate a request from the family for a change of Service Coordinator to the best of its ability; and
- provide training and monitoring of Service Coordinators.

#### **2. Specific Roles and Responsibilities**

The Service Coordinator has primary responsibility to assist and support the family during referral, eligibility determination, service planning, service delivery, and transition. The Service Coordinator is the family's guide and support person at all times. In addition to the specific responsibilities outlined in the following sections, the Service Coordinator is responsible at each point in time to:

- establish and maintain communication among all Early Intervention service (EIS) providers involved with the child and family;
- ensure that procedural safeguards, including notification of Child and Family Rights, Prior Written Notice, Written Parental Consents, Native Language/Mode of Communication, Surrogate Parent, Confidentiality and Privacy Issues, Parental Access and Amendment to Records, and Individual Child Complaint Resolution, are followed; and
- ensure appropriate and timely documentation; include the reporting of relevant data and the submission of required forms, notations, and other information to the Children’s Developmental Services Agency.

**A. First Contacts**

- establish a relationship with the family on behalf of the Infant-Toddler Program;
- explain the Infant-Toddler Program include Program philosophy, child and family rights, referral and eligibility determination process, etc.;
- explain options and the intake process, gather necessary intake information, obtain consents signed by parent, and coordinate with the business staff of the Children’s Developmental Services Agency to gather financial information at necessary times;
- determine if the child is enrolled in other programs and coordinate next steps in the Infant-Toddler Program referral process with this program;
- provide information to the parent about selection of a Service Coordinator under the Infant-Toddler Program and the process to request a change, should the parent so choose; and
- begin a family-directed identification of family needs, strengths, concerns, priorities resources, daily routines, activities.

**B. Established Condition or Eligibility Evaluation and Determination**

- assist in gathering documentation on which to base eligibility decisions;
- if there is evidence of an established condition, move toward completion of the Child and Family-Directed Assessments.
- work closely with the parent and other members of the team who complete the initial evaluation and make the eligibility determination;
- coordinate the initial evaluation as appropriate, including recommendations regarding the other disciplines to be involved, scheduling evaluations, identifying with the family and other team members the most appropriate environments for the evaluations to occur;
- organize and manage discussion of evaluation results with the parent;
- notify the referral source and the child’s primary care physician of eligibility status, with written parental consent;
- if the child is deemed not eligible for Infant-Toddler Program services or if the parent declines enrollment in the Infant-Toddler Program, make referrals to other community resources, as appropriate.

### **C. Child and Family-Directed Assessments**

- work closely with the parent and other team members involved in the eligibility determination;
- coordinate the assessments as appropriate, including recommendations regarding the other disciplines to be involved, scheduling, identifying with the family and other team members the most appropriate environments for the assessment to occur;
- organize and manage discussion of assessment results with the parent.

### **D. Individualized Family Service Plan (IFSP) Development**

- identify IFSP team members and meeting place and time, based on child and family information and with parent input;
- provide the required notification to the IFSP team members about the meeting.
- if a team member is unable to attend the IFSP meeting, involve the team member in a manner convenient to him/her, such as having the team member calling in during the meeting, sending a designee, or obtaining a written summary to be read to the other team members;
- facilitate the IFSP meeting, include discussions of the evaluation team's functional developmental concerns, the child's present level of development, and child and family strengths and needs;
- facilitate the development of the IFSP with the parent and other members of the IFSP team;
- work with the parent and other IFSP team members to identify specific functional outcomes for the child and family and how to incorporate these outcomes into daily routines, activities and places;
- identify with the parent natural environments and supports in the community appropriate for the child and family;
- work with the parent and other IFSP team members to determine the level of assistance needed for the child to function successfully and achieve identified outcomes in such environments;
- work with the parent to select service providers once outcomes are identified;
- explain the content of the IFSP so that the parent understands the content and implications;
- determine with the parent the specific nature of assistance the Service Coordinator will provide to support and assist the family in implementing and monitoring the Individualized Family Service Plan;
- obtain required signatures and assure that the parent and other team members have a copy of the IFSP; and
- monitor the 45-day timeline and record documentation regarding the process and any delays.

### **E. Ongoing Individualized Family Service Plan (IFSP) Follow-up, Service Provision, and Assessment**

- authorize the provision of services by community-based providers, with the Children's Developmental Service Agency process;
- assist the family with timely access to services, include referral to services and arrange service provision with follow up, and document any delays in obtaining services;

- inform the parent and the Children’s Developmental Services Agency of all efforts;
  - work with service providers to meet identified child and family outcomes and give input as a part of the IFSP team;
  - complete reviews of the IFSP with the parent and other IFSP team members and modify the IFSP as appropriate;
  - actively monitor services for quality and recommended practices, talking with the parent as well as service providers regarding the provision of services, discussing progress made toward outcomes, identifying any new concerns, reviewing service delivery documentation, etc.;
  - arrange new or on-going assessments by providers as needed and complete child or family assessments, as appropriate;
  - gather the parent’s input on outcomes, service provision and parent’s satisfaction with the supports and services they are receiving; and
  - assess and monitor the ongoing consultation and support needs of persons who are providing services for the child and family, and provide or arrange for consultation and technical assistance, as needed.
- ❖ ITP Services added to the IFSP must start within 30 days after the parent signs the IFSP for that service. The Service Coordinator should work with the parent and provider to facilitate the acquisition of new services.

**F. Resource Specialist**

- identify other community individuals, agencies, programs, natural environments, supports, and services that may be resources for the child and family and how these can be accessed;
- provide the family with information and support related to understanding their rights;
- provide the family with information and support related to understanding and communicating the child’s special needs;
- provide the family with information and support related to helping their child develop and learn;
- provide the family with information about child health and development, include the need for well child care, immunizations, etc.;
- provide information and resources to the family and providers regarding evidence based practices; and
- facilitate communication and coordination with the child’s medical home and other specialty care providers involved with the child and family as necessary to support and assist the family.

**G. Transition at Age Three or Upon Exiting the Infant-Toddler Program**

- educate the parent regarding options, transition process, etc.;
- refer the child to appropriate community resources with written parental authorization.
- arrange and facilitate Transition Planning Conference in a timely manner and document efforts on child and family’s behalf;

- work jointly with Local Education Agency staff to ensure a successful transition to the public school system, if the child qualifies for the Preschool Disabilities Program;
- function as a liaison between the child and parent and the program to which the child is transitioning, as appropriate, including referrals, arranging transition planning meetings, providing information to the parent, facilitating visits, and providing information with parental consent; and
- work with the parent and service providers to arrange for appropriate services to continue for the child on his third birthday, as needed.