

SERVICE COORDINATION (CASE MANAGEMENT)

Section C

Each child eligible under Part C and the child's family shall be provided a Service Coordinator who is responsible for coordinating all services across agency lines and serves as the single point of contact in helping parents/legal guardians to obtain the services and assistance they need.

FEDERAL POLICY (34 CFR 303.345 is the source of Federal Policies that appears in bold at the beginning of each section of the standards revised August 15, 2008.)

- 1. Service coordination means the activities carried out by a service coordinator to assist and enable a child eligible under Part C and the child's family to receive the rights, procedural safeguards and services that are authorized to be provided under the State's early intervention program.**
- 2. Each child eligible under Part C and the child's family must be provided with one service coordinator who is responsible for:**
 - a. Coordinating services across agency lines; and**
 - b. Serving as the single point of contact in helping parents to obtain the services and assistance they need.**
- 3. Service coordination is an active, ongoing process that involves:**
 - a. Assisting parents of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan (IFSP);**
 - b. Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;**
 - c. Facilitating the timely delivery of available services; and**
 - d. Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.**
- 4. Specific service coordination activities include:**
 - a. Coordinating the performance of evaluations and assessment;**
 - b. Facilitating and participating in the development, review and evaluation of individualized family service plans;**
 - c. Assisting families in identifying available service providers;**
 - d. Coordinating and monitoring the delivery of available services;**
 - e. Informing families of the availability of advocacy services;**
 - f. Coordinating with medical and health providers; and**
 - g. Facilitating the development of a transition plan to preschool services, if appropriate.**
- 5. Employment and assignment of service coordinators:**

- a. Service coordinators may be employed or assigned in any way that is permitted under State law, so long as it is consistent with the requirements of Part C.
 - b. A State's policies and procedures for implementing the statewide system of early intervention services must be designed and implemented to ensure that service coordinators are able to effectively carry out on an interagency basis the functions and services listed above.
6. **Qualifications of service coordinators:**
- a. **Services coordinators must be persons who have demonstrated knowledge and understanding about:**
 - i. **Infants and toddlers who are eligible under Part C;**
 - ii. **Part C of the Individuals with Disabilities Education Act (IDEA) and the Part C regulations;**
 - iii. **The nature and scope of services available under the State's early intervention program, the system of payments for services in the State, and other pertinent information.**
7. **The service coordinator must be an individual from the profession most immediately relevant to the child or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under Part C).**
8. **The name of the service coordinator must be included on the individualized family service plan for each child and family.**
9. **The service coordinator is responsible for the implementation of the IFSP and coordination with other agencies and persons.**

BABIES CAN'T WAIT (BCW) PROGRAM STANDARDS

Every child receiving early intervention services in BCW and the family will be provided with one service coordinator who is responsible for coordinating all services across agency lines, providers and settings. This service coordinator will serve as a single point of contact in helping parents to obtain the services and assistance to address their child's needs. Service Coordination takes place within a collaborative relationship between a family and a Service Coordinator (SC). Districts and County health department may choose to provide service coordination using a blended or dedicated model of service coordination. All service coordination will be implemented using a tiered/level of coordination. Service Coordination is offered at no cost to families. State Policies and Program Standards are applicable to the assigned Service Coordinators without regard to service provider or profession from which the assignment is made.

A. Assignment of Service Coordinator

When children and their families are referred to BCW, the Early Intervention (EI) Coordinators or his/her designee shall assign a Service Coordinator to 1) complete intake activities, and 2) coordinate child development evaluation, assessment, and eligibility determination processes.

If the child is determined eligible for BCW, a Service Coordinator will be assigned.

B. Intake Activities

1. When an ongoing relationship has previously been established between a child and family and personnel working in any Public Health program serving children Birth to Five, such as Children 1st, High Risk Infant Follow-Up, or Children's Medical Services, intake activities may be completed by Public Health staff with whom the relationship exists and who have received training in performing intake activities.
2. When no ongoing relationship or involvement with another Public Health program has been previously established, the BCW Service Coordinator shall complete intake activities, including scheduling the initial visit and all necessary subsequent visits with the client/family.
3. (For children who pass the screening process the following applies) Intake activities must include:
 - Ensuring the completion of the Maternal Child Health (MCH) Integrated Assessment with each family;
 - Providing information about Georgia's Birth to Five system of services;
 - Provision of all information regarding the BCW Program, including family rights and procedural safeguards under the law and provide each family a copy of "*Notice of Infant/Toddler and Family Rights under Babies Can't Wait*" and discuss and review the document with them;
 - Informing families of the voluntary nature of the program and their right to refuse consent;
 - Obtaining written informed parental consent for the completion of developmental evaluations and assessments by BCW, using the *Babies Can't Wait Consent for Evaluation Form*;
 - Obtaining written parental consent (using the standard Department of Human Resources (DHR) *Authorization Release of Information Form*) to obtain and share necessary information from the child's primary care physician (PCP), other appropriate medical specialists, health service providers, child care providers and other providers, as necessary;
 - Contacting the PCP must include a request for a completed *Physician's Health Summary Form*;
 - Completion of page 1 and 2 of the Determination of Eligibility Form (DOE);
 - Completion of a standard developmental screening tool, if one has not already been completed and provided to BCW, unless the child is determined to have a Category I condition;
 - A discussion of sections 3 and 4 of the Individualized Family Service Plan (IFSP);
 - Review and completion of Section 3 – Identification of Natural Environments and Section 4 – All About Our Child and Family of the IFSP;
 - Section 3 – Identification of Natural Environments
 - Begin gathering information about the family's everyday routines and

- activities and the child's behavior and interactions within those contexts;
- Section 4 – All About Our Child and Family (completed with family consent).
 - Gather information about family concerns, priorities and resources
 - Discuss the formal and informal supports the family uses or would like to use;
 - Complete Section B & C of the Determination of Eligibility Form
 - Section B – Topics of interest the family is interested in learning more about.
 - Section C – Medical Information – a listed summary of information about a child's providers and summary of medical status. (See Section C: Directions DOE Form)
- Explore and identify roles that the family may want to play in the evaluation and assessment process;
- NOTE: These sections must be completed with the family during intake and shared with individuals involved in the evaluation/assessment process and the IFSP team. (See IFSP pgs. 4 & 6 for specific instructions)

C. Initial Evaluation, Assessment, Eligibility Determination and IFSP Development

1. The Service Coordinator is responsible for:
 - Requesting a surrogate parent for any child that needs one;
 - Coordinating and ensuring completion of the initial developmental evaluations and assessments in order to develop the initial IFSP within 45 days of the receipt of the referral;
 - Requesting a written authorization from the physician for the developmental evaluation/ assessment; obtaining information necessary to establish a child/family history, and extending an invitation for participation in the of IFSP development;
 - Explaining to the family the roles and functions of the early intervention team members, including that of the individual who will provide service coordination;
 - Explaining to the family of an eligible child the IFSP process and what they can expect in each step of the process;
 - Informing the family, the child's primary care physician, and other participants of scheduled evaluation, assessment and IFSP meetings, no less than **five (5)** working days in advance, followed by written confirmation;
 - Ensuring that each child referred to BCW has been linked to routine health care services, and that informed written parental consent, using the standard *DHR Authorization For Release of Information* form has been signed, to allow the child's primary care provide to participate throughout the evaluation, assessment, eligibility determination and IFSP development processes;
 - Referring and/or linking parent(s)/legal guardian(s) of children who are ineligible for BCW to other agencies or relevant community resources as appropriate, and for refer child back to Children 1st for appropriate monitoring and follow-up, if informed, written, parental/legal guardian consent is given.

2. The Service Coordinator is responsible for facilitating and participating in the development, review, and evaluation of the initial IFSP for each eligible child. This individual:
 - Ensures that the initial evaluation/assessment is reviewed with the family so that the information/results accurately reflect their child and family;
 - Should act as a support on behalf of the family when no other identified advocate is in attendance;
 - Shall assure procedural safeguards are observed (especially parent/legal guardian right to participate fully) throughout the process;
 - Ensures that the IFSP meeting is conducted according to procedures and the IFSP document is appropriately completed;
 - Is responsible for obtaining parental/legal guardian consent for EI services by securing written signature on the IFSP document and reviewing their rights, opportunities, and responsibilities under federal law;
 - Is responsible for sending the Primary Care Physician the *Child Individualized Family Service Plan (IFSP) Summary Form* within 10 working days of the initial and annual IFSP;
 - Is responsible for having on-going review and discussion with the family of parental rights, using the “*Notice of Infant/Toddler and Family Rights Under Babies Can’t Wait*” booklet.

D. Service Implementation

When a child is determined eligible for BCW and an IFSP is developed, based on the evaluation and assessment results, with established intervention objectives and outcomes, a service coordinator links families to the Babies Can’t Wait team and other community resources for the provision of all needed services, monitors outcomes and ensures that the IFSP is reviewed and revised as necessary. The IFSP/PSP team will utilize a standard tiered approach to determine the frequency and intensity of service coordination.

1. Tiered Service Coordination: System of SC that determines frequency and intensity of activities.

- ❖ Based on or driven by the child and family needs rather than Medicaid billing policy
- ❖ Provides a child/family focused structure for IFSP team to determine frequency and intensity of services
- ❖ Is more criteria based than subjective in nature
- ❖ Provides a process to more effectively meet child and family’s needs

Tiered Service Coordination Processes:

- ❖ Initial IFSP: The multi-disciplinary team (IFSP/PSP) will determine the tier of service coordination for each child and family
- ❖ The IFSP/PSP must utilize the BCW Tier SC Work Sheet to determine the tier of SC
- ❖ The SC will transfer the total for each level to the BCW Tiered SC Summary Forms and file in the child’s primary record
- ❖ The BCW Tiered SC Work Sheet will also be kept in the child’s primary record

- ❖ Tiered Service Coordination tiers must be reviewed at six months review, at annual review
- ❖ CHANGES in tier of SC can be reviewed and revised (by the IFSP/PSP team/family) at anytime based upon the needs of the child and family

Four Levels of Tiered Service Coordination:

- ❖ Tier 1-Families will receive four units per year
- ❖ Tier 2-Families will receive six units per year
- ❖ Tier 3-Families will receive nine units per year
- ❖ Tier4-Families will receive twelve units per year

Note: One unit is a face-to-face visit and three ancillary contacts

2. The Service Coordinator must:
 - Participate as a member of the initial IFSP team (including the family) in determining the tier of service coordination for each child and family.
 - Assist parents/legal guardians of eligible children in gaining timely access to the EI services and other services identified in the IFSP.
 - Coordinate the provision of the identified EI services and other services documented on the IFSP.
 - Actively seek and link children and their families to appropriate providers, medical services, social and other support services as needed.
 - In collaboration with the IFSP/PSP team, monitor delivery and effectiveness of services identified in the IFSP, and review the outcomes and need for new, additional, reduced or modified services.
 - Inform the family of advocacy services and groups that assist families in accessing or relating to providers, and help them resolve their complaints including providing them information on available fair hearing or complaints resolution process as needed or requested.
 - Promote family centered services that respect family's decisions, values, beliefs and norms.
 - Collaborate with the IFSP/PSP team to provide continuity and coordination of care required across agency, providers and settings that are necessary to benefit the child development and outcomes.

3. The Service Coordinator must perform the following activities:
 - Assist the family in completing the Cost Participation Form to determine the assignment of family fees for some or all of their child's EI services.
 - Ensure that the family understands their rights, opportunities and responsibilities as they relate to the implementation of the child's IFSP.
 - Assure that the parent/legal guardian has all of the necessary and relevant information to access the services identified in the plan that they will access independently.

4. Service coordinators for families may request assistance and additional support from others when family/child needs are significantly increased in intensity or complexity.

E. Periodic Review and Annual Evaluation of the IFSP

A review of the IFSP for a child and family must be conducted every six months or more frequently if conditions warrant, or if the family requests a review. The purpose of the periodic review is to determine: 1) the degree to which progress toward achieving the outcomes is being made and 2) whether modification or revision of the outcomes or services is necessary.

The purpose of the annual evaluation is to evaluate the IFSP for a child and the child's family and as appropriate, to review its provisions and determine what services are needed.

The Service Coordinator is responsible for coordinating the process to ensure appropriate continuous assessment of the child and IFSP review to meet the child and family needs related to the child's development. This process includes the periodic and annual evaluation of the IFSP. The Service Coordinator will (see Individualized Family Service Plan (IFSP) Standards):

1. Provide written notice to the family and inform participants, including the child's primary care physician prior to the scheduled IFSP meetings.
2. Facilitate and participate in the monitoring, review, and evaluation of the IFSP and the development of the annual IFSP for children who continue to be eligible for BCW. The Service Coordinator:
 - Will ensure that current ongoing assessment information is available to the IFSP/PSP team to support annual and periodic review of the IFSP. Should act as a support on behalf of the family when no other identified advocate is in attendance.
 - Will routinely review and update information in the IFSP, Section 3 – Identification of Natural Environments, Section 4 – All About Our Child and Family
 - Section 3 – Identification of Natural Environments
 - Continue ongoing discussion regarding the family's everyday routines and activities and child's behavior and interactions within those contexts
 - Section 4 – All About Our Child and Family (completed with family consent).
 - Update the information about family concerns, priorities and resources.
 - Update the formal and informal supports the family uses or would like to use.
 - Review and update Section B of the Determination of Eligibility Form (use handout version).
 - Shall assure procedural safeguards are observed (especially parent/legal guardian right to participate fully) throughout the process.

- Ensures that the IFSP meeting is conducted according to procedures and the IFSP document is appropriately completed.
- Is responsible for obtaining parental/legal guardian consent for EI services by securing written signature on the IFSP document and reviewing their rights, opportunities, and responsibilities under federal law.
- If the IFSP is typed after the meeting, the typed copy must be taken back to the family for their review and re-signing within 10 working days.

F. Participants

The IFSP team members are selected based on competencies that match the needs of the child, and includes the parent(s), individuals involved in evaluation/assessment activities (in the case of initial IFSPs), and others who have information and input helpful in the design, development, and implementation of the IFSP for the child and family. At a minimum, the IFSP/PSP meetings (initial and annual) and periodic (six-month review or any requested reviews) must include:

- the parent(s) and anyone the parent wants to invite;
- the service coordinator;
- person(s) directly involved in conducting evaluations or assessments and/or persons who are or will be providing services to the child and family.

G. Transition Planning

The Service Coordinator shall:

1. Ensure that every IFSP includes documented steps toward transition
2. Initiation of formal transition activities must begin no later than 27 months of age. Only exception is when a child enters the program and is already older than 27 months.
3. Ensure that a transition conference is scheduled at least 90 days prior to the child's third birthday and as early as 9 months prior to the child's third birthday. Discussion at the transition conference may require changes to the transition plan that is already part of the IFSP and therefore may require revisions to the IFSP.
4. Assure that the family has all needed information about potential service options in order to make an informed choice.
5. Assist the family in understanding the differences between Part C and Part B eligibility criteria and programs as their child approaches age three.
6. Assure that the family understands all of their rights related to the transition process.
7. For those families seeking part B services the Local Education Agency (LEA) must be invited to the transition conference. For children transitioning to non-part B services, other community agencies should be invited to the transition conference as appropriate.
8. Provide family with Steps to Success booklet.

H. Service Coordination Qualifications, Training and Continuing Education

1. All individuals providing service coordination must have at least a bachelor's degree in a related field (see Personnel Standards).
2. All individuals providing service coordination (including the blended model of SC)

must successfully complete a state conducted service coordination orientation and a district conducted orientation and training prior to providing service coordination. Skilled Credentialed Early Interventionists (SCEIs) training must begin within six months and must be completed within two (2) years of initial date of hire or contract with BCW. Also, the Praxis II test is available for Level II professionals as an alternate to completing the six SCEI's modules. The two-year period begins on:

- The effective date of a contract with the BCW program through a local lead agency, or
- The effective date of contract, subcontract, or employment with any agency or organization which contracts with the BCW program through a local lead agency, or
- The beginning date of employment with the BCW program through a local lead agency.

3. Districts must report the names of all new service coordinators to the SCEIs office within thirty days of the service coordinator's beginning date.
4. All individuals providing service coordination regardless of licensure/certification are required to complete Continuing Education hours upon completion of the SCEIs Modules requirements, and to have twenty (20) contact hours of continuing education every two years which clearly focuses on:
- young children, birth to age eight;
 - families of young children, birth to age eight; and/or
 - a particular disability covered under Babies Can't Wait; ten (10) of these hours must be specific to young children with *disabilities* and/or their families.

Personnel who fail to comply with this policy in the timelines stated above will not be able to provide services for families and/or children through the Babies Can't Wait program until requirements are completed.

5. Continuing education requirements go into effect for an individual on July 1 after he/she has received a certificate of completion for the Project SCEIs modules.