

Frequently Asked Questions (FAQ) Early Intervention (EI) Plan for Resuming In-Person Services

Authorizations, Offsite/Onsite, Rates

- 1. Can the team member who provides in-person visits obtain additional Individualized Family Service Plan (IFSP) development time to consult with the rest of the team in an effort to support each other in ongoing strategies provided during in-person visits as well as continued live video visit (LVV) and/or phone consultation time?**
Yes, IFSP development time should continue to be utilized for consultation as it always has been. As stated in the current guidance, in-person visits with other providers are not allowed and teaming/consultation is encouraged to keep team members up to date on progress toward outcomes and need for modification of strategies. Providers should review their authorizations to ensure they have sufficient time. If an existing authorization's maximum time is close to being used, the provider should contact their Service Coordinator to acquire additional time. Please note that all time used must be fully documented for monitoring purposes.
- 2. Will Early Intervention allow clinics for Developmental Therapy services and all other services? If yes, what is the rate, offsite or onsite?**
There is the ability to serve children/families in a clinic provided it is appropriate. The service delivery location must be determined by the team based on the functional outcome that the team is addressing. If the team determines that a "clinic" setting is best, then the authorization would be an on-site place of service and rate; and if the home or other natural environment setting is best, the authorization would be an off-site place of service and rate.
- 3. Will we continue to be paid at the same rate for in-person vs LVV and utilize the same authorizations?**
There have not been any adjustments to rates or the authorizations. Providers must ensure the place of service is off-site for in-person or LVV. Providing LVV will be paid at the off-site rate as long as the authorization is for an off-site place of service and the team agrees the place of service is appropriate for addressing the child and family's outcomes.
- 4. Providers of center-based services were required to obtain new authorizations (with offsite Place Of Service (POS) codes) in order to provide LVV services in order to get paid through the EI Central Billing Office (CBO) billing system. This limits the provider's flexibility of alternating between serving families via LVV and in-person as the family would have to choose a single modality to ensure the correct POS code is being used. What is the best way to handle this hybrid?**
There have not been any additional adjustments to how authorizations are issued. Providers must ensure the place of service on the authorization is off-site for LVV and onsite if the family is served in a clinic. Providing LVV will still be paid at the off-site rate as long as the authorization is for an off-site place of service AND the team agrees that the place of service is appropriate for the child and family's outcomes. This may require that the child has two authorizations for this service.
- 5. Will providers be able to use the same authorization if a family alternates between LVV and in-person support in an offsite location? What POS should be used when billing?**
If a family is served in an offsite location for in-person services, a single offsite authorization will work for both types of services. For billing purposes, the provider will need to use the POS indicated on the authorization for in-person service and use a POS of 02 when providing LVV support.

Assistants/Supervision/Interpreters

- 6. Please provide clarification on how the in-person evaluation process will work if a therapist has assistants. Is the therapist the one who has the 10 families total? Even if there are multiple assistants, it is still 10 kids under that therapist?**
To clarify, evaluations can only be performed by the licensed, credentialed supervising provider. Assistants, except those in their Clinical Fellowship Year, are not allowed to perform Evaluations/ Assessments.

When considering the caseload of the supervising provider with assistants, the caseload of assistants is considered in the universe of 10 in the same way the supervising provider's caseload is counted. The intent is to limit in-person

contact to no more than 10 families. The supervisor should have in-person contact with no more than 10 families. Supervisors are allowed, during the pandemic restrictions, to utilize LVV for supervision of their assistants.

7. Will there need to be different billing for assistants who bill under their supervisor to not look like a single provider is going over the 10 number?

It is not necessary to utilize a different billing process for the assistant. As outlined in the [EI Billing Booklet](#), when submitting a claim for a service by an assistant, the assistant's name is included on the claim form in box 19.

8. Are interpreters/supervisors held to the same limitations of no more than 10 families?

Yes, all early intervention professionals are held to the same limitations of no more than 10 families. Remember, the goal is to mitigate risk and reduce exposure. So, interpreters and supervisors can connect to an in-person visit through LVV.

9. When a family requires an interpreter, how do we collaborate with them and still ensure that only 1 provider is in the home at any one time. Should interpreters be present in the home for visits or should they always connect via LVV?

The team should discuss the unique needs of the child/family and make the determination of how to best serve the family while reducing the exposure to mitigate the risk for everyone. Teams must ensure only one provider is in the home at a time, following the guidance for all safety precautions. I can imagine that it would be most appropriate to have the interpreter participate through LVV and the provider be in-person. But, again, this should be an open, honest discussion with the family given that ONLY 1 early interventionist should be in the home at any time.

10. What if the interpreter is a sign-language interpreter who cannot provide the service via LVV, can there be two providers in the home at that time?

Given that this guidance limits the in-person attendance to only one person in the home and the interpreter cannot support LVV, the team should discuss options, such as whether the ongoing direct service provider could support LVV and be in the home with the Interpreter logging into the direct service provider's application.

Number of Providers in Home

11. How many providers can go to a family's house during the week? If the family requests, can more than one therapist do in-person visits, each on a different day if they are maintaining the 10-families limit?

This will be determined by a discussion among team members. It is important for the family to understand that for each provider that goes into the home, the risk to the family increases because providers are likely to be serving more than just their family each week. Teams should discuss the unique needs of the child/family and how these needs will be met while mitigating the risk for everyone. While teams must ensure only one provider is in the home at a time, they should also consider any other services the family may be utilizing to determine the best way to minimize exposure. Utilizing all available service delivery options is critical so that families get the support they need with the smallest number of people intervening in-person.

Consents/Waivers/Liability

12. Does the Service Coordinator need to get permission to return to homes similarly to how permission was needed for LVV?

No specific consent needs to be obtained to return to in-person services. The original consent for services already acknowledges the family's agreement and still applies as long as the family hasn't revoked their consent. As long as authorizations exist to support the in-person service delivery, in-person services can resume. The Service Coordinator will document the decision of the team and family as will the providers.

13. What if I am not comfortable and the family is ready to resume in-person visits?

Each provider has the option to determine if they are willing to resume in-person services with families. If the family's needs and the provider's availability do not match, the family may ask their Service Coordinator to look for an opening with another provider. You are not required to resume in-person services.

- 14. Is an updated informed written consent required for families who choose in-person visits?**
No. As all families are required to consent or decline EI services when they enter the system, the consent on file already acknowledges the family's agreement.
- 15. What legal protections do we have should we test positive after an in-person visit? How are we legally protected from possible negligence? Is there a standard waiver or will be required to create on our own?**
To be clear, EI providers are fee-for-service providers and are not contractors with the state. IDHS cannot provide legal counsel to EI Providers. IDHS cannot provide guidance on liability/risk. EI providers are encouraged to discuss these types of questions with their legal counsel and or insurance plans.
- 16. If a child's parent tests positive and we happened to be in their house for an intervention visit and less than six-feet apart and we both have masks on-do I still have to self-quarantine for two weeks?**
As stated in the guidance, any direct exposure to COVID-19 should result in contacting the individual's medical professional, seeking testing, and imposing a 14-day self-quarantine, even with following all protocols. If you have been exposed to COVID-19, you should contact your physician immediately, and inform the families you have worked with, so they can seek medical advice/testing and self-quarantine themselves. Lack of any symptoms after the 14 days would allow services to resume. . Anyone exposed to COVID-19 should inform the families they have worked with, so they can seek testing and self-quarantine. It is critical that all team members document the steps taken to inform the family, other team members, their physician, and test with results reported to the Illinois Department of Public Health (IDPH).
- 17. If one out of the 10 families test positive, then do all other families and the provider have to self- quarantine until they test negative? If one of the providers serving a family tests positive, do all providers serving that family, along with the family members self-quarantine? If a member of the family, service coordinator's family, provider's family or anyone having in-person contact with anyone tests positive, who does what?**
The Guidance provides the required steps to take beginning with Section 2: Personal Protective Equipment and Sanitation Requirements. This section describes the contact definition, the reporting, and the required self-quarantine by all affected parties. Any direct exposure to COVID-19 should result in reporting to the individual's medical professional and testing with a 14-day self-quarantine, whether masks were worn or not. Anyone exposed to COVID-19 should inform the families they have worked with, so they can seek testing and self-quarantine. It is critical that all team members document the steps taken to inform the family, other team members, their physician, and test-with results reported to the Illinois Department of Public Health (IDPH).
- 18. Will there be waivers for therapists whose doctor will not allow them to work in-person?**
No, there are no waivers needed for therapists who have any reasons (medical or personal) for not providing in-person services. The team discussion surrounding the needs of the family should include the supports needed and whether those supports require in-person or not, as LVV and Phone Consultation are also available. If the needs do require in-person services, the family may inquire about the possibility of using a different provider who can perform the in-person services that are needed.
- 19. Will therapists and service coordinators be supported by DHS if a family requests all services in-person, but the team does not feel they qualify as a priority family? Who will mediate these issues?**
Providers, Service Coordinators and families should discuss the unique needs of the child/family to determine the best service delivery modality to be used. Families may seek other providers if current provider availability does not meet their needs. As always, a family has the right to submit a complaint regarding any decision made about their services in EI. Each complaint is researched and addressed through the Bureau or the appropriate administrative agency as outlined in the Family Rights booklet.

Family Communication

- 20. What information will families receive related to this guidance?**
The EI Clearinghouse is developing and posting family resources, including FAQs and family-focused materials on a variety of topics. These materials are being developed by parent representatives from the Illinois Interagency Council on Early Intervention as well as Parent Training and Information Center staff to ensure family perspectives are included.

There is a Tip Sheet available on the Illinois Early Intervention Clearinghouse website entitled [Having Safe In-Person Early Intervention Visits](#) that provides parents with guidelines for In-Person visits with providers. Also, in Section 2 of the EI Plan for Resuming In-Person in Phase 4 of the Restore Illinois Plan, there are specific guidelines to share prior to each appointment.

21. Is there anything a provider should provide to the family as they make their decisions?

There are no specific documents that a provider should share to help the family make their decision, but the IFSP team should have a discussion where families can express their needs and providers can discuss options for how these needs can be supported.

22. Within guidance, it states that Service Coordinators and Providers should develop a written communication plan to be shared. Does this plan have to be signed by the family?

Families must be notified of the practice for resuming in-person services as outlined in the Guidance. This will be a helpful way to support the family in making an informed decision. There is no requirement to gather signatures at this time, but we remind all providers that proper documentation of all discussions with families and Service Coordinators must be maintained. Each provider will have to develop their own written communication plan.

23. Can providers begin seeing families effective August 1, 2020 even if service coordinators have been unable to reach the family?

If the provider has current authorizations and the family has requested in-person visitation, visits can begin but the provider and the family should both communicate this to the Service Coordinator and other team members.

Maximum of 10-Families Rule

24. If the therapist sees pediatric clients as a therapist and the clients are NOT in the State of Illinois EI program, do they still count towards the limit of ten families?

The goal is to minimize the risk to families, young children and early intervention personnel. Each additional person with whom you have sustained contact increases risk to you and to the children and families you are serving in EI. EI does not control how early interventionists spend their time outside of their EI work, but for our system and the families you serve, we ask that you consider all of your in-person contacts and have honest open discussions with families and IFSP team members to determine the level of risk and support the family in making informed decisions.

25. I am a school therapist and if school opens up, I will be seeing more kids. What is the significance for EI kids and going into the homes?

Obviously, the more exposure, the higher the level of risk. EI families will have the right to determine if they wish to allow you in their home with the heightened risk and providers should disclose important factors, such as other populations the provider serves, when working with their EI families to determine whether or not to resume in-person services.

26. Can we alternate families? For example, see 10 in-person and 10 LVV week one...then swap and see the ones that had LVV in-person and the in-person one's switch to LVV?

Early interventionists should not plan to have one set of ten families the first week and a different set of ten families the second week. The logic behind ten is to mitigate risk so seeing a different ten each week does not accomplish this goal.

27. Is it necessary to wait 14 days before doing another evaluation? I can see the same 8 families a week and also do 2 evaluations each week?

It is important to note that if a family moves off of your caseload and/or you are a provider who is seeing some families for evaluation, you will need to wait the 14 days per IDPH and CDC guidance before introducing a new family or another set of families. In this scenario, you could see the consistent eight families throughout but would need to wait at least 14 days between your rotating evaluation families to ensure you are minimizing risk to all families served.

- 28. What if a child lives with the mother part of the time and father part of the time, so in the past provided services to the family in both houses, is that considered one case or two?**
This would still be considered as two families as the child being served is spending time in both homes and has been exposed to the members in both households. In situations like this, all efforts should be made to limit sustained contact to the maximum extent possible as this second family home increases the provider's exposure to an additional adult caregiver.
- 29. Can providers see siblings in the same home, or 2 or more foster children that live in the same home and be counted as "1"?**
Children living in the same home are part of the same family and have likely been exposed to the same sources of risk, so seeing siblings (biological or foster) would therefore count as one family.
- 30. If one of the families I serve decides to go back to phone consultation or LVV after trying in-person visits, how long must I wait before adding another family to my "10 families" for in-person visits?**
In order to minimize risk and exposure, once a family transitions off of in-person visits, the early interventionists must wait 14 days, per IDPH and CDC guidance, before introducing a new family into your in-person families. This is to limit exposure.

Selection and Prioritizing Families

- 31. How do we prioritize which families may get the in-person services?**
There is no one size fits all response to this question, so discussion with team members will be necessary. The following are some points to be considered:
- The guidance states that priority is given to families who are unable to access support via phone or LVV.
 - The team might also consider prioritizing children who are closest to transitioning out of EI.
 - Since each provider can only see 10 families, it may be helpful to work on providing in-person services to more families rather than providing multiple interventionists to only a single family.
 - If families are requesting a change in service modality, consider which service the family feels they most need in-person support and whether some services might continue via the current modality.
- 32. There are a few references to the team deciding what services will be in-person and which will continue over LVV, so does every child in EI need a meeting with the team before in-person services resume? If no meeting is needed, will an email/phone call to Service Coordinator be sufficient documentation, or does this need to be a written report?**
Service Coordinators are currently attempting to contact families to assess needs. This may include continuation of services via their current modality or a switch to in-person services. Not every child will need a meeting to make this determination. If it is determined that a family would like to resume/begin in-person services, then a discussion should occur to make sure the family understands what in-person service delivery will look like and how to mitigate risk. Team members, as always, should document the outcomes of these discussions. Unless this discussion occurs during the context of an IFSP meeting/review, no report is necessary.
- 33. If I serve multiple families who all want to resume in-person services, how do I choose which 10 get in-person and which continue receiving support via phone/LVV?**
As stated in the guidance, if services can be successfully delivered via phone or LVV, this is the safest mode of service provision. In-person services should be prioritized for families not able to access services via phone or LVV or, secondarily, families who have been unable to make progress towards their outcomes via phone/LVV.

Personal Protective Equipment (PPE)

- 34. What are the Service Coordinator's roles in this process and how are they enforced? (Please note that there seems to be some confusion from the wording under PPE section 2 of the plan. People are interpreting the wording to indicate that providers have to provide PPE to the children and family they serve, and that they are responsible for the costs of those.)**
The Guidance is currently being revised as the language in the document was misleading. The use of PPE is

designed to be individualized based on the contact and the services provided that may require different or additional PPE to protect families, providers and Service Coordinators. We want to clarify that any early intervention professional doing in-person services must wear appropriate PPE and that the provider is responsible for the cost of their own PPE. Providers should not be asking families to provide PPE to the provider or passing on the cost to families.

35. Who will be supplying PPE for providers and families? Will providers and families be reimbursed for PPE?

There is an expectation that everyone will supply their own PPE. IDHS is currently researching options for obtaining PPE and/or reimbursing providers for the costs of PPE, but there will not be resolution to this by August 1st.

36. Regarding mask protocol in the home for the family, is it up to the provider/service coordinator to have that discussion ahead of time with the family about wearing a mask too? Who would be responsible for providing the mask to family members, reviewing questions with the family, taking temperatures, etc.? Would we be doing that?

Each person visiting the home should have a discussion with the family about safety protocols and expectations. This EI Clearinghouse [resource](#) may be helpful to share with families. Before each visit, the visiting individual should reach out to the family to perform the screening, with results of the screening documented in the child's file/record. Families are responsible for their own PPE but providers may share resources for PPE, if available. The [screening tool](#) used should ask the important and basic questions about symptoms and/or travel. Taking temperatures is not required but is a good practice for both providers and families to use.

37. Do I have to wear a mask the entire time or only when I cannot be more than six-feet apart?

All providers must wear a face mask during their time with children/families (additional face protection may be needed depending on the outcomes being addressed and the potential for aerosol transmission).

38. What if we are outdoors for our visit, do the same distancing guidelines apply?

Distances of more than 6 feet must be maintained outside. It is our recommendation that masks also be worn, as children are not likely to understand distancing requirements.

39. Do therapists have to screen the family each time before entering the residence? What if the provider or family traveled recently? What if one of them recently traveled to a Hot Spot?

Yes, the provider or Service Coordinator should perform a screening before each entry. The EI Training Program has developed resources that can help with [screening and decision-making](#). Providers and families should be honest about their recent travels to support informed decision-making and accurate assessment of risk.

Provider Communication

40. When will there be an open meeting for all providers to be able to listen to answers when they are provided?

There are currently no plans for an open meeting for all providers, however, the Bureau is responding via this FAQ. The FAQ will be updated as additional questions are received. In addition, the EI Training Program has posted recordings addressing some of the most pressing questions received from [Sections 1](#) and [Section 2](#) of the guidance document. Continue to check the [Provider Connections website](#) for additional updates.

41. Who might we ask questions to if more questions come to mind?

Questions are currently being collected by various stakeholders as well as the Bureau of EI and a formal FAQ is developed with this document and updates will occur as additional questions come in. If you have questions that you would like to have addressed, please send the questions to DHS.EIQuestions@Illinois.gov. While each submission may not receive an individual response, the submissions will be utilized to help inform the FAQ and future updates to the Guidance as appropriate.

Changing Circumstances/Compliance

42. How/where do I keep up to date on local, county or city ordinances and regulations as those are ever-changing too?

Providers, families and Service Coordinators should review current information located on the [Illinois Department of Public Health](#) and/or local Health Department websites to ensure accurate information/data on the status of the state as well as local data to help inform service delivery.

43. How will this be monitored to make sure all providers are in compliance and limit 10 families and the 14-day wait period before adding a new family?

The Bureau recognizes and supports the professional and ethical work all EI providers perform every day. There is currently no intent to confirm compliance, but the Bureau may exercise available information, e.g. self-reporting of families with Service Coordinators, reports indicating the number of billable hours for direct service, LVV or IFSP Development, as necessary, to ensure the mitigation of risk and the safety of the children and families being served.

Services in Other Settings

44. It says in the document that if in a childcare setting, the provider should be away from teachers and other children. What if we are around other children when providing EI services in the daycare and it cannot be avoided?

The Guidance indicates that service provision in the childcare setting will need to be a mutually agreed upon decision between the childcare provider, early intervention provider, and the family. Not all childcare settings may be able to safely accommodate early intervention providers at this time. The provider should limit the number of unnecessary participants (staff and children) involved in the visit, and all efforts should be made to minimize direct contact and use coaching with the staff to implement strategies.

45. If kids are in the same class in a childcare setting, can more than one be seen without it counting as more than 1 family?

Although children in the same classroom share some aspects of risk, serving children from differently families exposes the provider to the additional people that each child doesn't share. Unless the children in the same class are also siblings, serving two children in the same classroom would count toward two of your ten families limit.

46. If a school district is doing the Transition Planning Conference in-person and is only requiring face masks, can the Service Coordinator and/or EI provider participate by LVV?

Service Coordinators and providers have the option of determining what method of participation is appropriate given their personal level of risk. They are permitted to participate via phone, LVV and in-person at this time.

Decision-making

47. If in-person is for families where LVV did not work, are all families required to try LVV prior to transitioning or supplementing with in-person?

No, it is not required that a family try LVV prior to utilizing in-person services. It was, and continues to be, an option during the pandemic to promote as many options as possible for teams to safely support the needs of the families.

48. Who will be making sure therapists aren't passed over if they prefer LVV, and making sure coordinators are promoting LVV and not telling families to hold out for in-person?

All therapists and families have the right to make service modality decisions based on their individual level of risk at this time. As always, teams should work to support each other and discuss available options for meeting families' needs. The Guidance very clearly states that, to the maximum extent possible, LVV or Phone consultation should be used as the primary service modality while we await an effective treatment or vaccine for the virus.

- 49. There are a few references to the team deciding what services will be in-person and which will continue over LVV, so does every child in EI need a meeting with the team before in-person services resume? If no meeting is needed, will an email/phone call to service coordinator be sufficient documentation, or does this need to be a written report?**

Documentation of family and provider communication with the service coordinator in the child's record will be sufficient for the majority of services to resume in-person or continue using LVV. If a family or provider feels a team discussion is warranted, the Service Coordinator will make arrangements for a conversation.

- 50. Providers are asked to inform families of their procedures- does this document need to be turned into the CFCs/ Service Coordinator or just be available for monitoring? Do we need to have families sign that they have received this information?**

Families must be notified of the practice for resuming in-person services as outlined in the Guidance. There is no requirement to gather signatures or documents at this time, but providers are reminded that proper documentation of all discussions with families and Service Coordinators should be maintained.