FOREWARD

NOTICE TO ALL PROVIDERS OF EARLY INTERVENTION SERVICES:

This Handbook is intended for interested, new, or current Early Intervention Program (El) Providers as a guide on the Part C Illinois EI Program and its expectations.

All EI Providers including credentialed and enrolled Providers, are required to review this Handbook regularly and become accustomed to the rules, policies, and procedures of the EI Program.

Chapters and formats that have been updated will include a revision date at the bottom of each page of the Chapter. Those Chapters that have not been updated will remain the date they were previously revised. A summary of changes will also be released for convenience upon each release.

Additionally, this Handbook will be updated as needed with changes being available on all of the EI Partner Websites. It is highly recommended you check the EI Partner’s website regularly but at least weekly to ensure you are aware of updates or changes to the EI Program.

If you require technical assistance, have questions about any information located within this handbook, locate errors or inconsistencies, or would like to make recommendations to the handbook, please email the Illinois Department of Human Services, Bureau of EI at dhs.eiquestions@illinois.gov.
Chapter 1: Welcome to Early Intervention!

Chapter 2: Early Intervention in Illinois
2.1 Laws and Regulations
2.2 Bureau of Early Intervention
2.3 Early Intervention Partners
2.4 Services Available to Early Intervention Children and their Families
2.5 Early Intervention Monitoring Reviews

Chapter 3: Early Intervention Providers in Illinois
3.1 Provider/Payee Agreements
3.2 Requests for Records
3.3 Provider Credentialing and Enrollment
   3.2.1 Illinois Medical Program Cloud Technology (IMPACT) Enrollment Requirements
   3.2.2 Initial Credentialing Requirements
   3.2.3 Initial and Future Enrollment
   3.2.4 Requirements for a Temporary Credential
   3.2.5 Tips for a New Credentialed Provider
   3.2.6 Requirements for an Evaluation/Assessment Credential
   3.2.7 Requirements for Renewal of a Credential
   3.2.8 Lapse of a Credential
   3.2.9 Provider Licensure
   3.2.10 DCFS Investigations
   3.4 Use of Associate-Level Providers
   3.5 Observation and Student Placement in EI
   3.6 Provisional Reimbursement Providers
   3.7 Inactivation of Credential and/or Enrollment
   3.8 Confidentiality
   3.9 Use of Internet-Based Facsimile Services
   3.10 Liability Insurance
   3.11 Mandated Reporting of Abuse/Neglect
   3.12 Evaluation/Assessment Activities
      3.12.1 Accepting Referrals
      3.12.2 Intake
      3.12.3 Family-Directed Assessment
      3.12.4 Provider Selection
      3.12.5 Authorizations
      3.12.6 Initial Evaluations/Assessments
         a. Review of Referral and Intake Information
         b. Eligibility Criteria
c. At-Risk Conditions
d. Appropriate Evaluation/Assessment Tool Selection

3.12.7 Service Delivery
a. Natural Environments
b. Authorization Frequency, Intensity, and Location of Services Adherence
c. Team Member Communication
d. Discontinuing Services

3.12.8 Transition
a. Transition Plan
b. Transition Planning Conference
c. IFSP Team Requirements for Transition Plan & Transition Planning Conference
d. Early Intervention/Extended Services
e. Individual Education Plan (IEP) Attendance

3.13 Reporting

3.14 Early Intervention/Extended Services (EI/ES)
3.14.1.1 Transition After Age 3
3.14.1.2 Transition Planning
3.14.1.3 Family Choice
3.14.1.4 Individuals with Disabilities Education Act (IDEA) Consent

Chapter 4: Family Rights & Expectations
4.1 Family Rights
4.2 Resolution of Concerns
4.3 Family Expectations
4.4 Family Outcomes Survey

Chapter 5: Individualized Family Services Plans (IFSP)
5.1 Description and Components
5.2 Important IFSP Timelines
5.3 EI Provider’s Role in the IFSP
5.4 Outcomes
5.5 Developmental Justification of Need
5.6 IFSP Development Activities
5.7 IFSP Development Time

Chapter 6: Billing Guidelines and Use of Insurance
6.1 Billing in Early Intervention
6.2 Billing Guidelines and Forms
6.3 Private Insurance Use in Early Intervention
6.4 Provider Responsibilities
6.5 Insurance Updates
6.6 Important Insurance Definitions

Chapter 7: Assistive Technology (Durable Medical Equipment and Supplies)

Chapter 8: Audiology, Aural Rehabilitation, and Other Related Services

N07/2022
Chapter 9: Developmental Therapy
Chapter 10: Health Consultation
Chapter 11: Interpretation and Translation Services
Chapter 12: Medical Services (Diagnostic/Evaluation Purposes Only)
Chapter 13: Nursing
Chapter 14: Nutrition
Chapter 15: Occupational Therapy
Chapter 16: Physical Therapy
Chapter 17: Psychological and Other Counseling Services
Chapter 18: Service Coordination
Chapter 19: Social Work and Other Counseling Services
Chapter 20: Speech Language Pathology Therapy
Chapter 21: Transportation
Chapter 22: Vision
  • Policy and Procedures for Authorization for Eyeglasses
Chapter 23: Glossary and Abbreviations

ATTACHMENTS
Attachment 1: Guidance and Format for Assistive Technology Letter of Developmental Necessity
Attachment 2: Guidance and Format for Discharge Report
Attachment 3: Guidance and Format for Evaluation/Assessment Report
Attachment 4: Guidance and Format for Six-Month Review Report
Attachment 5: Guidance and Format for Medical Diagnostic Report
Attachment 6: Guidance and Consent for Student Observation and Placement in Early Intervention (EI)
Attachment 7: Developmental Justification to Change Frequency, Intensity, and/or Location of Authorized Services Guidance and Worksheet
Attachment 8: Blank Individualized Family Services Plan (IFSP) (English/Spanish)
Attachment 9: Natural Environments Justification Worksheet and Guidance
Attachment 10: Overview of Early Intervention Referral to Transition Activities
Attachment 11: Sample Authorization with Descriptions
Chapter 1: Welcome to Early Intervention

Thank you for your interest in becoming an enrolled EI Provider with the Illinois Early Intervention (EI) Services System to serve eligible infants and toddlers under age three and their families.

Part C of the Individuals with Disabilities Education Act (IDEA) authorizes EI as a developmental program serving children birth to three with developmental delays, disabilities, and at risk conditions and their families. Services are determined based upon individualized, functional outcomes developed in partnership with the family that reflect the child and family’s strengths, priorities and needs. These functional outcomes are developmental in nature, rather than medical, and focus on supporting the child’s development and participation in family and community activities as well as the family’s needs and priorities.

Part C requires states to provide services in “Natural Environments”. Under Section 303.26 of Part C, Natural Environments is defined as “settings that are natural or normal for the child’s same age peers who have no disabilities.” Please see 3.12.7 a. for additional information.

EI utilizes the Principles of Early Intervention for service delivery. All plans for service delivery are based upon the unique needs of each child/family and focus on the coordination of capacity-building, developmental activities to promote their child’s optimal development and to facilitate their child’s participation in family and community activities.

These activities are designed to ensure that all members of the team involved in a child’s intervention, including the family and/or caregiver, are working together, whether in-person or by Live Video Visit, or a hybrid of the two.

Illinois’ EI Program is further informed by the DEC’s Recommended Practices (DEC RPs), the Agreed Upon Practices for Providing Services in Natural Environments (2008) and the practices reflected in Early childhood inclusion: A joint position statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC).

- https://divisionearlychildhood.egnyte.com/dl/7urLPWCt5U
- http://www.dec-spied.org/dec-recommended-practices

Principles of Early Intervention

1. The primary goal of Early Intervention (EI) is to build caregiver capacity by supporting their ability to promote their child’s optimal development and to facilitate their child’s participation in family and community activities.

2. The focus of EI is to facilitate the active participation of families in the EI process by engaging caregivers in the planning and implementation of services, including embedding intervention strategies into family life, such as routines, activities and interactions with their child. It is the family/caregivers who provide the real EI by creatively adapting their caregiving methods to facilitate the development of their child, while balancing the needs of the rest of their family.

3. EI requires a collaborative relationship between families and professionals, with equal participation by all those involved in the process. An on-going, equal family-professional partnership and dialogue is needed to develop, implement, monitor, and modify intervention strategies and services.
4. Intervention must be linked to specific, family-centered, functional, and measurable Individualized Family Service Plan (IFSP) outcomes that are developed using culturally and linguistically responsive and affirming practices.

5. Services and interventions shall be integrated into a comprehensive IFSP that requires families and professionals to work together to consistently exchange knowledge and information with each other. It also requires collaborating across disciplines within the broader early childhood system to increase the team’s capacity to jointly solve problems and implement interventions. The plan shall be built around family strengths, priorities, resources, routines and activities and avoid unnecessary duplication of services. Services and strategies are based upon the best available research, recommended practices in the field and special education laws and regulations.

6. Services, interventions and progress should be monitored periodically through ongoing observations and discussions with all team members to ensure that the strategies implemented are successful in achieving outcomes.

7. Ongoing communication and collaboration with EI professionals, family members and professionals in partnering systems outside of EI, who are supporting each family is encouraged. Ongoing communication among all team members allows for coordinated, culturally-relevant and comprehensive services within and across systems to best support families’ priorities, changing circumstances, and transitions.

8. Children and their families in the EI Program deserve to have services of the highest quality possible. High standards will be set for the training and credentialing of administrative and intervention staff. Training, supervision, and technology will be focused to achieve excellence.

*Adopted by the Illinois Interagency Council on Early Intervention (IICEI) – 10/2001, revised 07/2020, revised 01/2021*

Within the EI Program:

- The family is viewed as the primary interventionist in a child’s life and the expert in relation to the needs of the child and family.
- The family, Service Coordinator and EI Providers involved in a child’s intervention establish trusting, respectful partnerships based.
- The family who is supported to be an active partner is able to facilitate their child’s continued development and advocate for their family’s needs.
- Developmental strategies and learning opportunities are incorporated into a child and family’s everyday routines and activities to naturally emphasize the acquisition of functional skills.
- The EI process is dynamic, individualized, flexible, and responsive to each family’s preferences, learning styles, cultural beliefs, and unique circumstances.
Chapter 2: Early Intervention in Illinois

2.1 Laws and Regulations
The procedures outlined in this Handbook are based on federal and state regulations and the policies of the Illinois Department of Human Services (IDHS).

The Individuals with Disabilities Education Act (IDEA) as amended by the Individuals with Disabilities Education Improvement Act of 2004 [20 USC 1400 et seq.], Title I, Part C and 34 Code of Federal Regulations (CFR) 303 and related regulations can be viewed and downloaded on the EI website by selecting either Individuals with Disabilities Education Act or Federal Regulations under Resources, Laws and Rules.

State Statute - Early Intervention Services System Act (325 IL CS 20/)

State Administrative Code - Title 89: Social Services Chapter IV: Department of Human Services Subchapter E: Early Childhood Services, Part 500 Early Intervention Program
http://www.ilga.gov/commission/jcar/admincode/089/08900500sections.html

Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191, Title II, § 262(a), 100stat. 2024) http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html


Americans with Disabilities Act can be viewed by visiting: https://www.ada.gov/2010_regs.htm

Other laws, rules, and policies may also apply.

Additionally, each provider is required to operate as directed under specific regulations and statutes in regard to his or her licensure type, such as 225 ILCS 110/, the Illinois Speech-Language Pathology and Audiology Practice Act. Please consider visiting the Illinois Department of Financial & Professional Regulation at www.idfpr.com/profs/proflist.asp.

Most disciplines used by the EI Program have professional associations with extensive information on practice, licensure, education, research, and career development that EI Providers may find helpful.

For additional materials about the EI Program in Illinois, please review:
• Child and Family Connections Procedure Manual
  www.dhs.state.il.us/page.aspx?Item=75381
• Illinois Early Intervention Program: A Guide for Families
  www.eiclearinghouse.org/resources/familyguide/index.html
• State of Illinois Infant/Toddler & Family Rights under IDEA for the Early Intervention System
  www.eiclearinghouse.org/documents/family-rights.pdf
2.2 Bureau of Early Intervention
IDHS serves as the lead agency for IDEA Part C and has designated the Bureau of EI to administer the statewide EI Program. The main office is located in Springfield, Illinois and staff may be reached by phone at 217/782-1981 or by email at dhs.eiquestions@illinois.gov.

2.3 Early Intervention Partners
The following programs assist the Bureau of EI in fulfilling requirements described in Part C Regulations, State Statute, and Illinois Administrative Rule.

- **Child and Family Connections Offices**
The EI Program operates through 25 regional intake entities called Child and Family Connections (CFC) offices located throughout the state. All CFC offices may be located by going to the Office Locator found on the IDHS website at [www.dhs.state.il.us](http://www.dhs.state.il.us). CFCs are a family’s first stop for questions about EI services. The CFCs employ Service Coordinators which are assigned to families when they first enter the EI Program. Service Coordinators continue their involvement with the family through each stage of the Individualized Family Service Plan (IFSP) process and are also responsible for generating authorizations to the EI Providers who will be providing services to the child/family.

- **Illinois Early Intervention Central Billing Office**
The EI Central Billing Office (CBO) is the claims processing entity for the EI Program. The CBO approves payments based upon authorized services and established guidelines for EI Providers. The CBO also submits and reconciles the monthly EI Medicaid claim to the Illinois Department of Healthcare and Family Services (HFS), provides data to assist CFCs to complete an initial verification of family insurance benefits, maintains the family participation fee system, administers the collections process, is a source of data collection for the Bureau of EI, provides technical assistance to EI families and EI Providers, and administers the EI Insurance Billing Unit, a free service which bills insurance on behalf of individual and small groups of EI Providers. The CBO also maintains the EI Provider database. Upon first-time enrollment with the CBO, EI Providers will receive a welcome letter that explains many aspects of the EI Program. CBO staff are trained to answer questions from EI families and EI Providers regarding the service authorization process, billing inquiries, and family participation fees. CBO staff may be reached at 800/634-8540. The CBO also maintains an informative website that contains many resources including billing requirements and instructions, EI forms, use of electronic billing software, information on the CBO Insurance Billing Unit, and important policy/procedure updates. For more information, please visit [www.eicbo.info](http://www.eicbo.info).

- **Illinois Early Intervention Clearinghouse**
The EI Clearinghouse provides library and information services to residents of Illinois interested in EI topics and operate a website at [www.eiclearinghouse.org](http://www.eiclearinghouse.org). The EI Clearinghouse provides access to a large lending library of books, eBooks, videos, and articles and is a free resource to access information on health, educational, disability, and developmental concerns of infants and young children. Materials are available in English, as well as many in Spanish. Because families are the key to successful EI, the Clearinghouse’s mission is to provide families with vital information they need to support their children’s growth and development. For more information, please contact the EI Clearinghouse by phone at 877/275-3227 or email at [illinois-eic@illinois.edu](mailto:illinois-eic@illinois.edu).

- **Illinois Early Intervention Technical Assistance and Monitoring Program**
The purpose of the EI Technical Assistance and Monitoring Program (EITAM) is to ensure that state and federal regulations regarding the delivery of Illinois EI services to infants and toddlers with developmental delays or disabilities are met. All EI Monitoring staff have extensive knowledge of EI policy and procedure. EITAM provides reviews of payees and CFCs to ensure services adhere to established Early Intervention policies and procedures through compliance reporting, technical
assistance, and resource linkage. When issues arise, EITAM processes complaints received from families. The EI Monitoring Program has locations in Flossmoor and Springfield. Current contact information may be found at www.earlyinterventionmonitoring.org. Copies of all current documents utilized during the review process may be found on their website at www.earlyinterventionmonitoring.org.

• Provider Connections
Provider Connections is the credentialing and enrollment office for the EI Program. Provider Connections staff assist EI Providers in a variety of ways including initial, renewal and reinstatement of credentialing and enrollment, EI evaluator/assessment credentials, final acceptance into the IMPACT system, see Chapter 3: Early Intervention Providers in Illinois, section 3.2.1 for additional information, address updates and name changes, tax number identification status changes, and enrollment changes. EI Providers will receive a welcome email upon initially credentialing and upon renewal. Individuals interested in applying for an EI credential and/or enrollment, may download an application at https://providerconnections.org/. This website also includes important updates that are geared directly for EI Providers and is the primary location for IDHS policy, procedure, and payment updates. If you have any questions regarding your credentialing and/or enrollment, please contact Provider Connections at 800/701-0995 or email providerconnections@wiu.edu for assistance.

• Illinois Early Intervention Training Program
The Early Intervention Training Program (EITP) provides professional development and technical assistance for CFC personnel, EI providers, and other EI stakeholders supporting infants, toddlers and their families. The mission of EITP is to develop a comprehensive system of personnel development that is regionalized, responsive, accessible and reflective of evidence-based practices. EITP collaborates with local, state, and national partners to bring a wide breadth of resources, supports and information to Illinois early intervention stakeholders and offers opportunities which support early intervention personnel and other stakeholders in understanding and effectively implementing services aligned with the key principles and practices of EI services. EITP also supports the dissemination and data analysis for the Family Outcomes Project, Interpreter/Translator training and testing, and systems improvement activities through a focus on local, state and national trends impacting Illinois’ system. For more information, please visit eitp.education.illinois.edu. If you have questions regarding EI Training, please call 866/509-3867 or email eitraining@illinois.edu for assistance.

2.4 EI Services Available for Children and their Families
The EI Program offers a variety of services designed to meet the unique needs of each child in the following domains:

• Adaptive - i.e. eating, dressing
• Cognitive - i.e. thinking, learning, problem-solving
• Communication - i.e. talking, listening, understanding
• Physical - (including vision and hearing) i.e. reaching, rolling, crawling, walking
• Social or Emotional - i.e. relationship-building, playing, feeling secure and happy
Depending on the child and family’s individual needs, services available through EI may include:

- Assistive Technology
- Audiology - Aural Rehabilitation
- Developmental Therapy - Special Instruction
- Family Training and Support - includes Interpretation and Translation
- Health Consultation
- Medical Services (for diagnostic or evaluation purposes, only)
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Psychological/Counseling Services
- Service Coordination
- Social Work
- Speech Language Pathology
- Transportation
- Vision

Additional details on each of service category above are defined further within Chapter 7 through Chapter 22.

Credentialing and/or enrollment is required for all types of services and must be completed prior to providing any EI services in the EI Program. The only exception is if prior provisional approval or Secondary Reimbursement is granted by the Bureau of EI; see Chapter 3: Early Intervention Providers in Illinois, section 3.6 Provisional Providers.

2.5 EI Monitoring Reviews

EITAM reviews files of individual EI Providers to ensure compliance with applicable laws, regulations, and EI Provider Agreements and to provide technical assistance for EI Providers including “best practice” examples and resources to ensure understanding of EI service delivery practices. EI Providers are required to retain documentation for a period of six years and produce requested documentation at the request of EITAM, see 3.1 Provider/Payee Agreements. EI Providers that were active and billed the CBO during the prior state fiscal year (July 1 to June 30) are subject for reviews.

A monitoring review can also be initiated due to an inquiry from a parent, CBO or IDHS. EI Monitoring staff determines the type of review to be conducted and the number of files to be reviewed based on the type of review. To provide evidence of compliance with standards, providers submit documentation, most often electronically, to the assigned monitor to review. When electronic submission is not available, other accommodations can be made to facilitate the review successfully.

The following documents are the commonly requested items to determine compliance during the EI Monitoring process. All documents listed should be on hand prior to the monitoring review to meet EI best practices:

2.5.1 Administrative Directive

- An EI Payee must develop and implement written privacy policies and procedures that are consistent with HIPAA Privacy Rules.
- An EI Payee must also provide a notice of its privacy practices, separate from HIPAA Compliance Documents listed above, to all families receiving EI services at the initiation of services, for example, initial evaluation/assessment or the start of direct services.

The HIPAA Privacy Rule requires that the notice contains certain elements. The notice must:

- describe instances in which an EI Payee may use and disclose Protected Health Information (PHI);
• state the EI Payee’s duties to protect privacy;
• provide a notice of privacy practices and abide by the terms described in the notice;
• describe individuals’ rights, including the right to complain to the US Department of Health and Human Services (HHS) and to the EI Payee if the individual believes his or her privacy rights have been violated, and
• include a contact for further information and for making complaints to the EI Payee.

EI Monitoring Staff will ensure that the Administrative Directive and the Notice of Privacy Practices are two separate documents. It is the responsibility of the EI Payee/EI Provider to be familiar with the latest privacy rules.

For examples of Notice of Privacy Practices, visit www.hhs.gov/hipaa/professionals/privacy/guidance/model-notices-privacy-practices/.

2.5.2 Documentation of Liability Insurance
EI Providers are required to maintain Liability Insurance. EI Monitoring staff will ensure coverage for the dates of service during the fiscal year being reviewed is present, see Chapter 3: Early Intervention Providers in Illinois, under 3.8, Liability Insurance.

2.5.3 Documentation to Support Services Provided and Billed to the CBO
EI Providers are required to maintain supporting documentation for all procedure codes billed to and paid by the CBO. For more information about documentation requirements, see the definition in Chapter 23: Glossary and Abbreviations.

Documentation of services provided that will be reviewed can include:

• Documentation of direct service
• Documentation of IFSP development time
• Documentation of evaluation/assessment time
• Documentation of supervision of associate level providers

For more information about documentation requirements, see the definition in Chapter 23: Glossary and Abbreviations.

2.5.4 Review of Authorizations
All authorizations, except IFSP meeting authorizations, must be obtained prior to rendering any services. Additionally, an EI Provider who is a member of the child’s IFSP team and is requested to attend the IEP meeting, prior to the child’s 3rd birthday, must be pre-authorized, see Chapter 3: Early Intervention Providers in Illinois, under section 3.10.8 d. for additional information.

EI Monitoring staff will compare billing information from the CBO to the authorizations on file to ensure services are being provided according to the frequency, intensity, service modality, and duration/minutes listed in the authorization. Associate-Level Providers must be identified in the comment field of the authorization. All fully-credentialed/enrolled EI Providers, that are not Associate-Level, must receive authorizations under their name. If an EI Provider has been found to be providing services before the enrollment process was
complete, the EI Payee will be required to refund all dates of service billed prior to a provider being fully enrolled and/or credentialed.

**NOTE:** Occurrences are calculated in the CBO system based on start date of the authorization. This may affect actual number of services approved for payment. Best practice is to ensure timely delivery to begin with the start date.

2.5.5 *Physician’s Prescription*
EI Monitoring staff will review documentation to ensure EI Providers have an updated physician’s prescription on file. The physician’s prescription should be obtained prior to rendering services.

- A physician’s prescription is not required for initial/annual evaluations but must be obtained prior to direct service provision for audiology, aural rehabilitation services (when services are provided by a speech-language pathologist or audiologist), occupational therapy, physical therapy, speech-language pathology therapy, and AT devices/services. Prescriptions are valid for a maximum of **15-months**, unless a shorter time frame is noted on the prescription by the authorizing physician. Once obtained, the child’s Service Coordinator will route the prescription to the appropriate EI Provider and maintain a copy in the CFC’s permanent record for the child.

**NOTE:** Provider disciplines not mentioned above, are not required to obtain a prescription from the child’s physician.

2.5.6 *Individualized Family Service Plan (IFSP)*
The CFC is to send the entire IFSP document within 15-business days of the IFSP implementation date to all EI Providers. If an EI Provider does not receive the IFSP within this timeframe, he or she must contact the CFC immediately to obtain a copy.

2.5.7 *Associate-Level Provider & Supervision Documentation*
Unless exempt due to being a credentialed, Associate-Level Speech-Language Pathologist in his/her supervised professional experience, EI Providers who conduct supervision for a credentialed Associate-Level EI Provider are required to have an organizational chart or other document that includes the assignment of the Associate-Level EI Provider to a supervisor, documentation of the associate’s credentials and documentation of the direct service and IFSP implementation supervision. Direct supervision during associate-level EI Provider delivered services **must occur at a minimum of once every thirty-calendar days** from the start of services for each child served. For further information on supervision requirements see **3.4 – Use of Associate-Level Providers**.

Evidence of supervision must document all contact between the supervisor who is responsible for a child/family’s case and the Associate-Level EI Provider who is actually providing the direct service to the child. EI Monitoring staff will review documentation supporting required supervision visits to ensure strict adherence to the definition of supervision. Without documentation that clearly supports routine supervision visits, a refund for dates of service may be identified and required.

For more information about documentation of supervision requirements, see the definition in **Chapter 23: Glossary and Abbreviations**.
• **Evaluation and Assessment Reports**
  All reports should be completed following the required information listed in the IDHS-report format with a copy kept in the child’s file. The EI Provider must document time spent on all evaluation activities. This documentation is not part of the IDHS report format and is to be recorded separately. For more information about documentation of evaluation time requirements, see the definition in *Chapter 23: Glossary and Abbreviations*. All reports will be monitored for compliance with the 14-calendar day requirement, see *Chapter 3: Early Intervention Providers in Illinois*, section 3.13, Reporting for additional information. The exception to this rule is reports must be written on a date that is prior to the child’s third birthday.

  - EI Monitoring staff will ensure that reports were submitted to the CFC and met the required timeline. This can be documented in case notes, fax confirmations, CFC-specific request forms, or the start date of the evaluation or assessment authorization. EI Providers, who do not meet this timeline, may receive a violation for being untimely.

Evaluations/Assessment reports should be dated and billed the date the actual EI-approved tool or instrument was administered, and the Evaluation/Assessment was performed with the report signed and dated when it is fully complete. A progress note should also accompany the Evaluation/Assessment report within the child’s permanent file. Please ensure your authorization is correct for the date you perform the Evaluation/Assessment.

  **NOTE:** Payment will only be made for Evaluations/Assessments if the EI Provider attends the entire IFSP Meeting. Partial authorizations are not able to be given. EI Providers should make arrangements so that they allow for enough time to discuss and develop the IFSP. In the event that an EI Evaluating Provider cannot attend a scheduled IFSP Meeting, the EI Provider must work with the Service Coordinator to reschedule the meeting or forego payment of the IFSP Meeting.

2.5.8 **Items available to submit upon request:**
  - copies of all claims submitted to insurance and to the CBO;
  - copies of all Explanations of Benefit received from insurance and the CBO, and
  - any correspondence sent or received on behalf of the child.

2.6 **Monitoring Review Outcomes**
At the end of the review, EI Monitoring staff will address any violations found and provide immediate technical assistance. A finding of non-compliance will be identified when documentation to support a required standard was not submitted during the monitoring review process.

  - **Corrective Action Plans**
    A Corrective Action Plan (CAP) may be required for a finding of non-compliance. An CAP is a document written by the EI Provider that identifies the area of non-compliance (specific policy or procedure that was not followed), and strategies or practices that will be amended to regain compliance moving forward. CAP directives may be found at the EI Monitoring site under forms at [http://www.earlyinterventionmonitoring.org/](http://www.earlyinterventionmonitoring.org/).

  - **Refunds**
    Violations or findings of non-compliance that require refunds are generally due to lack of documentation, insufficient or duplicative documentation, inappropriate billing practices, billing for
non-billable services, billing in excess of the authorization, billing for canceled sessions, or use of non-credentialed or enrolled providers.

Refunds, due to any of the actions above, are to be submitted to the CBO directly. Sufficient instructions for the process will be sent with the findings of the review.

- **Private Insurance Refunds**
  In the event EI Monitoring, EI CBO or the IDHS Bureau of EI requests a refund for services funded by a third-party private insurance plan, the information will be given to the IDHS Bureau of EI for further follow-up. A request for refunding the private insurance plan and follow up instructions will be provided. Additionally, a letter will be sent to the private insurance plan explaining the cause of the refund request with information about the cause. The private insurance plan is allowed to take any additional measures it deems necessary to reduce fraud and abuse of private insurance plans.

- **Additional Monitoring Activities**
  When questionable service or billing practices are identified during a monitoring review, EI Payee/EI Providers may be required to comply with additional monitoring activities and requirements in addition to submission of any identified refunds. Additional reviews could also occur if requested by IDHS due to state complaints, appeals, etc.

- **Consistent Violations or Performance of Non-Compliance**
  If an EI Provider continues to violate specific policies and procedures and shows no signs of correcting the identified non-compliance items, payments may be withheld and/or inactivation of credential/enrollment may occur, see Chapter 3: Early Intervention Providers in Illinois under section 3.7, Inactivation of Credential and/or Enrollment for additional information.
Chapter 3: Early Intervention Providers in Illinois

It is important that EI Providers familiarize themselves with the Principles of Early Intervention as well as laws, regulations, credentialing and enrollment; DEC recommended evidence-based practices and additional processes in place to assist in navigating through the Illinois EI system.

3.1 Provider/Payee Agreements

EI Providers and/or Payees and IDHS enter into provider agreements that outlines the duties, responsibilities, and expectations, as well as the relationship between IDHS and the EI Provider. The Payee must be certified by the Illinois Office of the Comptroller to receive payment from the CBO as they make service(s) available to eligible children and their families according to the Illinois Early Intervention Services System Act, 325 ILCS 20/5 et. seq. (the Act); Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1431 et seq.); the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Family Educational Rights to Privacy Act (FERPA) and its rules, 34 CFR 99; and EI administrative rule, 89 Illinois Administrative Code 500 (Rule 500).

This agreement defines responsibilities of all EI Providers, including but not limited to:

- provide services only with authorization in hand;
- accept all families without discrimination and regardless of healthcare insurance benefits, private and public;
- not bill families directly for EI services;
- not bill insurance for services deemed as being at the public’s expense;
- bill within 90-calendar days of date of service or date of receipt of insurance benefit determination;
- accept EI rates as payment in full;
- adhere to claim submission requirements including resubmission when errors occur, using proper billing codes, etc.;
- adhere to the eligible child’s IFSP and services agreed upon;
- adhere and maintain credentialing and licensure requirements;
- maintain documentation of liability insurance;
- follow report timelines and formats as defined by IDHS/EI Program;
- securely maintain accurate records including daily documentation for all services billed and IFSP Development Time for a period of six (6) years from the child’s exit from the EI Program;
- never terminate services without a 30-calendar day written notice to the Service Coordinator and the family;
- comply with enrollment in the IL Medicaid Enrollment system (now known as IMPACT);
- participate in routine monitoring, supervision, reporting obligations, and complaint investigations;
- adhere to confidentiality requirements;
- have access to the internet and monitor the Provider Connections’ website on a weekly basis at a minimum, and
- understand that IDHS may terminate the agreement with at least 30 days prior written notice without cause, for failure to perform obligations and provisions set forth in the agreement.
This agreement also defines responsibilities of IDHS, including:

- though the CFC, production of timely authorizations to credentialed/enrolled providers;
- notification of any changes to rules, regulations, policy, procedure, directives and other program directives in a timely manner;
- reimbursement of pre-authorized services completed by credentialed and/or enrolled EI providers identified on the family’s IFSP staff, and
- compliance with HIPAA and FERPA regulations.

3.2 Requests for Records

As an EI Provider, you may receive requests for child-related records, due to:

- Subpoenas
- Processing of Social Security Disability Applications
- Transferring to other state Part C or Part B Programs
- Physician’s offices

Any concerns about responding to these types of requests should be addressed with the legal counsel of the agency or individual EI Provider to ensure you are meeting requirements stated within State and Federal Regulations, i.e., Illinois Student Records Act and HIPAA and FERPA, see Chapter 23: Glossary and Abbreviations for definitions.

3.3 Provider Credentialing and Enrollment

3.3.1 IMPACT Enrollment Requirements

The State of Illinois requires provider enrollment in IMPACT (Illinois Medicaid Program Advanced Cloud Technology), see Chapter 23, Glossary and Abbreviations, through the Illinois Department of Healthcare & Family Services (HFS). The requirements within the Affordable Care Act (ACA) required this new process.

3.3.1.1 Prior to any credentialing or enrollment with EI, enrollment with IMPACT is required. Once enrollment is complete with IMPACT, Provider Connections will approve the enrollment as part of the revalidation process or new enrollment process provided all EI credentialing/enrollment processes are followed. All EI Payee agencies and individuals who are seeking to enroll as EI Providers must first go through the IMPACT process prior to being approved before the next step may be completed.

3.3.1.2 Please refer to the IMPACT website, http://IMPACTinfo.Illinois.gov which outlines detailed information for all EI Providers in regard to the IMPACT enrollment/revalidation process, related activities and timelines and Provider Connections website under News, https://providerconnections.org/ for specific EI-related IMPACT guidelines.

3.3.1.3 IMPACT utilizes a web-based provider enrollment process application to allow any provider serving Illinois Medicaid-eligible citizens to confirm compliance with HFS requirements. This process is required for providers whether they are paid directly by HFS or, like EI Providers, are paid initially by the EI Program. The EI Program then submits claims for reimbursement from HFS for EI children who are eligible for federally-matching funds.
NOTE: Information within IMPACT should match the name registered with the EI Program to avoid any reimbursement issues.

3.3.2 Initial Credentialing Requirements
All new EI credential applicants are required to:

- complete the EI Credentialing application by going to https://providerconnections.org/application-new/;
- adhere to IMPACT requirements, see 3.3.1 above;
- document educational and licensure requirements for the specific credential;
- complete the EI System Overview Training (which includes an online training and one-day in-person, follow-up) at https://illinois.edu/blog/view/6039/175193;
- retain certificate upon completion of DCFS Mandated Reporting Training at https://mr.dcfstraining.org/UserAuth/Login!loginPage.action;jsessionid=7D0E4C988BED4600384456398898AAD8
- successfully complete background checks, including:
  - Live Scan Fingerprint-Based Criminal Background Check (at the provider’s expense)
  - Child Abuse and Neglect Tracking System (CANTS)
  - Sex Offender Registries

3.3.3 Initial and Future Enrollment
In order to receive payment for EI services, the individual provider must be enrolled under an EI Payee with the CBO. The EI Payee may be either an individual or an EI agency. The process of initial enrollment into the CBO requires the completion of a variety of documents compiled from several different state agencies, including the EI Provider Agreement in Chapter 3: Early Intervention Providers in Illinois, under section 3.1 detailed earlier in this document with IDHS, IMPACT Enrollment through HFS, mentioned in Chapter 3: Early Intervention Providers in Illinois under section 3.2.1 and a W-9 Taxpayer Identification form for use by the Illinois Office of the Comptroller (IOC). Enrollment documents may be found at: https://providerconnections.org/. All enrollment application forms, whether initial or otherwise, must be sent to Provider Connections for processing.

Once an EI Payee is enrolled with Provider Connections, additional EI Providers may be enrolled under that EI Payee. No EI Provider is to accept authorizations or provide any EI services until they are enrolled with their EI Payee, with the exception of Associate-Level Providers who are only credentialed, not enrolled, see Chapter 3: Early Intervention Providers in Illinois under section 3.4, Use of Associate-Level Providers for more information.

The fidelity of services delivered will be periodically reviewed through mechanisms such as re-credentialing, peer-review, video-taping and attendance at professional development offerings.

If at any time a provider’s enrollment ends with an EI Payee, Provider Connections must be notified via email at providerconnections@wiu.edu or by fax at 309/298-3066 to inactivate this provider’s enrollment under that specific EI Payee. This may be done by the provider directly or the EI Payee. Information to send to Provider Connections includes the provider’s name, discipline, name of the EI Payee and the last day of employment under that EI Payee. This practice ensures the data system is current and helps prevent a provider being chosen under an invalid EI Payee they no longer are employed under.
If at any time a provider’s enrollment ends with an EI Payee, Provider Connections must be notified via email at providerconnections@wiu.edu or by fax at 309/298-3066 to inactivate this provider’s enrollment under that specific EI Payee. This may be done by the provider directly or the EI Payee. Information to send to Provider Connections includes:

- Name of provider
- Discipline
- Name of the EI Payee
- Last day of employment under that EI Payee

This practice ensures the data system is current and helps prevent a provider being chosen under an invalid EI Payee they no longer are employed under.

Provider Connections staff will work with the CBO to inactivate the EI Provider’s enrollment status with the selected EI Payee. Adherence to this policy minimizes the risk of authorizations being placed under the incorrect EI Payee and possibly affecting payment or delaying services from beginning.

**NOTE:** A provider must be enrolled under at least one EI Payee, whether it be themselves, individually, or under another EI Payee. If there is no active EI Payee, the provider’s credentialling will also be automatically inactivated if they are removed from the EI Payee’s enrollment. If this happens, credentialling may easily be reactivated once a provider is successfully enrolled under another active EI Payee as described above, and credentialing continues to be in good standing.

### 3.3.4 Requirements for a Temporary Credential

- In addition to the requirements listed above, all new credentialed EI Providers who receive a temporary EI Credential, see [https://providerconnections.org/](https://providerconnections.org/) for definition, versus a full credential will have 18 months from the date their temporary credentials are issued to complete the required 240 hours of consultation verification. Developmental Therapy–Hearing (DT-H), Developmental Therapy –Vision (DT-V), and Developmental Therapy - Orientation & Mobility and EI Providers credentialed under the EI service categories of Clinical Assessment, Counseling and other Therapeutic Services, Nursing, Nutrition, and Social Services, need only document 120 hours.

- Documentation of this requirement must show that the individual participated in consultation with an appropriately experienced individual of the same discipline/EI service group who has experience working with children ages birth to three with special needs and their families.

- All new unlicensed EI Providers (except DTs) must complete the four-core knowledge areas during the 18-month temporary period. DTs are required to document the completed four-core knowledge area requirements upon application.

**NOTE:** A credential extension of up to six (6) months for credentialed and Associate-Level Providers may be granted due to non-compliance with Supervised Professional Experience and/or completion of training requirements established due to extreme hardship or extenuating circumstances. Such requests will be evaluated on an individual case basis and must follow the prescribed procedure by using the Credential Extension Request Form at: [https://providerconnections.org/temporary-credential-requirements/](https://providerconnections.org/temporary-credential-requirements/).
3.3.5 **Tips for a New Credentialed Provider**

Becoming an EI Provider may seem overwhelming. These tips and suggestions may help you successfully navigate the system:

- Understand that ongoing Professional Development requirements begin when the EI credential is issued.
- Understand the continuing professional education requirements for credential renewal.
- Ensure you have access to the Internet and monitor the Provider Connections’ website, at minimum, on a weekly basis for changes and/or updates that may affect the functions of the EI Program.
- Check the Provider Connections website at https://providerconnections.org/ regularly for updates.
- Become familiar with the CBO billing and claims process (see Chapter 6: Billing Guidelines and Use of Insurance)
- Contact your preferred CFC office(s), to introduce yourself and send them your curriculum vitae or resume so they know you are a credentialed/enrolled EI Provider and ready to receive referrals.
- Visit each of the Illinois EI Partners websites and bookmark them for easy access, see Chapter 2: Early Intervention in Illinois.
- Visit the EI Training Program’s website often as professional development opportunities sponsored through the EI system are posted regularly https://go.illinois.edu/EITPevents.

3.3.6 **Requirements for an Evaluation/Assessment Credential**

EI Providers seeking to provide Evaluation/Assessment services to determine initial eligibility and new services must go through a portfolio review process to obtain the EI Evaluation/Assessment Credential. EI Providers must have a current full specialist EI Credential before they can apply for the EI Evaluation/Assessment Credential. Additionally, it is preferred that the EI Provider has three (3) years full-time equivalent (FTE) of EI experience serving infants and toddlers. A person with only one (1) year experience of at least 750 hours of direct or billable services may be considered for the EI Evaluation/Assessment Credential. Applicants must also document at least six (6) months of pediatric post degree supervision. Additional requirements may be found on the Evaluator applicant’s page on Provider Connections’ website at https://providerconnections.org/application-evaluator/.

3.3.7 **Requirements for Renewal of a Credential**

EI Credentials are issued for three (3) year periods. It is recommended that you submit your renewal application 60 days before the date of expiration, because completion of background checks could take six to eight weeks. The EI Credential Renewal Application and Instructions may be found at https://providerconnections.org/application-renewal/.

3.3.8 **Lapse of a Credential**

EI Providers who allow their EI Credential to lapseexpire may continue to provide services under current authorizations they have previously received and have been providing services on prior to credential expiration. This applies to all EI Providers EXCEPT those holding Associate-Level Credentials.

If an Associate-Level Provider allows their credential to lapse, they are NOT allowed to continue providing services, even on existing authorizations. Therefore, Associate-Level Providers with
lapsed credentials must stop services effective the date of their Associate-Level credential expiration. EI Providers may reapply for their credential by following instructions located on the Provider Connections website at: https://providerconnections.org/application-reinstating/.

If a provider is seeking to apply for a new EI credential, he or she must have taken *Systems Overview Training* within three years of applying for the EI Credential. This also applies to current EI Providers who apply for an EI Evaluator/Assessment Credential. It will be verified that this training has been taken no more than three years prior to applying.

3.3.9 *Provider Licensure*
- In the event that an EI Provider’s professional license or national board certificate is inactivated or suspended, it is the responsibility of the provider to notify Provider Connections by phone within 14-business days at 1-800-701-0995.

3.3.10 *DCFS Investigations*
- For any EI Provider currently under investigation or with a new indicated report through DCFS, he or she is required to notify Provider Connections immediately by calling 1-800-701-0995.
- If an EI Provider is found indicated, all EI services must be discontinued immediately. Provider Connections will notify the Bureau who will work with the CFCs to locate other active providers.

3.4 *Use of Associate-Level Providers*
In order to enlist the widest pool of qualified EI Providers, EI supports the appropriate use of credentialed, non-enrolled Associate-Level Providers who function under the following guidelines and whose services are billed for by their credentialed and enrolled supervisor.

Individuals with a current “Assistant” license with the state of Illinois where they provide services to children may apply for an Associate-Level credential as an assistant within their discipline. The following are the minimum requirements for supervision of Associate-Level Credentialed Providers for EI services. No individual is exempt from compliance with any pertinent professional standards governing supervision in the individual’s discipline. When professional standards require supervision beyond what is described below, it is the responsibility of the individual for meeting any additional standards.

**NOTE:** Professional-license titles and EI titles may not always be the same.

3.5.1. Each EI Credentialed Associate-Level Provider must be supervised by a licensed, EI Credentialed and Enrolled Supervisor in the same discipline.

3.5.2. The Credentialed and Enrolled Supervisor must:
   a. evaluate/assess the child, develop the IFSP for intervention services required to accomplish IFSP outcomes and submit the evaluation/assessment report prior to IFSP development, updates, and/or reviews;
   b. instruct the Credentialed Associate-Level Provider about the EI services to be provided;
   c. reassess the child as required by the child’s IFSP and by the discipline-specific licensure requirements for the enrolled specialist or credentialed Associate-Level Provider at least once prior to each annual IFSP update and/or review;
   d. revise IFSP activities, as needed;
   e. review and approve all methods and materials selected to implement the IFSP;
f. conduct direct, in-person, supervision during the Credentialed Associate-Level Provider’s sessions at a minimum of once per **30-calendar days** for each child served;

Supervision must occur for one entire direct service session every **30-calendar days** and consist of the following types of review:

- review of IFSP developed by the team with the supervisor for use by Credentialed Associate-Level Provider to meet functional outcomes identified in each child’s IFSP to determine if the IFSP requires modifications;
- discussion with parent/caregiver about family priorities and concerns;
- observation of interaction between the Credentialed Associate-Level Provider and the parent/caregiver;
- observation of interaction between the Credentialed Associate-Level Provider and the child;
- observation of direct service with the child and family;
- review of child’s progress or lack thereof;
- any other duties as required by discipline-specific practice acts or licensure standards.

g. submit a summary report of direct services provided by his or her assistant prior to each IFSP update and/or review and more often if the child’s progress/lack of progress is warranted;

h. submit bills for services provided by the credentialed Associate-Level Provider;

i. participate in IFSP development, update, and/or reviews, this includes any and all meetings, and

j. follow supervision requirements as set forth in his/her licensure and/or other pertinent certification standards.

**NOTE:** Supervision practices that are not aligned with the EI Principles, and the guidelines outlined in this section is considered unprofessional practice. Those identified as not following the supervision requirements listed above, could lose their EI credential and/or enrollment and risk being reported to the Illinois Department of Financial and Professional Regulation.

3.5.3. The EI Credentialed Associate-Level Provider shall:

a. always identify him or herself to the family, caregiver and team as a credentialed (not enrolled) associate (assistant) working under the supervision of a fully credentialed/enrolled provider;

b. provide services only as instructed by the credentialed/enrolled supervisor;

c. document all EI services provided, including time in/time out;

d. not attend IFSP Meetings unless accompanied by the Supervisor;

e. report all changes in a child’s condition to the credentialed/enrolled supervisor,

f. ensure that the supervisor on record for you is kept up-to-date;

g. understand that monthly supervision is to be conducted with your supervisor and noted on your documentation on the dates that the supervisor conducts supervision, and
3.5.4. Associate-Level Providers who have a master’s degree in speech-language pathology, are in their Clinical Fellowship Year (CFY), and have a current Temporary Speech Language Pathologist license issued from the Illinois Department of Financial and Professional Regulation and are credentialed as an Associate-Level Speech-Language Pathologist Assistants, shall:
- provide services consistent with the “Illinois Speech-Language Pathology and Audiology Practice Act” (225 ILCS 110/1 et. seq.).
- perform evaluation/assessment (except initial evaluations/assessments),
- engage in IFSP development;
- provide services only as instructed by the credentialed/enrolled supervisor;
- always identify themselves as assistants to the family, caregiver and team;
- document all EI services provided, including time in/time out;
- report all changes in a child’s condition to the credentialed/enrolled supervisor, and
- ensure authorizations include Credentialed Associate-Level Provider’s name within the comment field of the authorization and if missing, contact the child’s Service Coordinator to request a corrected authorization.

NOTES:
- Associate-Level Providers who are in their Clinical Fellowship Year (CFY), are not required to meet the monthly supervision of one-time per session.
- Supervisory time is NOT billable time and is considered to be administrative time.
- Bill for Evaluation/Assessment report writing time using the evaluation/assessment code identified on the authorization. Bill for time to write direct service reports, which require no testing procedure, using IFSP Development codes.

3.5 Observation and Student Placement in EI
In order to ensure the greatest number of qualified EI Providers, EI supports increasing awareness of EI and the active engagement of students in the provision of EI services under the following guidelines and supervision of a fully-credentialed and enrolled EI Provider (not an Associate), see Attachment 6 for Guidance and Consent for Observation and Student Placement in Early Intervention.

Observation may be conducted by a student not yet registered in a specific Occupational Therapy (OT), Physical Therapy (PT), Speech-Language Therapy (ST), or Developmental Therapy (DT) program, as well as professionals considering a career in EI. Families who are interested in allowing observation must consent in writing and be ensured that the person observing has signed a confidentiality statement (not to disclose any Personally Identifiable Information (PII) about the family or the child) with their college or with the EI credentialed and enrolled EI Provider whom they will be observing. These observations are limited to one observation per person and can never occur without the credentialed and enrolled EI Provider present during the complete session (the observer is never alone with the family or child).

Student placement is for an individual engaged in a clinical internship, practicum, or field experience while completing a college/university program. The following items are the minimum requirements for
supervision of a student participating in EI services. No individual is exempt from compliance with any and all pertinent professional standards governing supervision in the individual’s discipline.

**NOTE:** Professional license titles and EI titles may not always be the same.

3.5.1. Each student must be supervised by a licensed, credentialed and enrolled supervisor in the same discipline.

3.5.2. The Credentialed and Enrolled Supervisor must:

a. after a clear and detailed explanation of the student’s role, obtain consent from the families with whom the student will be working;

b. instruct the student about the EI services to be provided;

c. review and approve all methods and materials selected to implement the IFSP;

d. conduct direct, in-person, supervision during all of the student’s intervention visits;

Supervision must consist of the following types of review:

- observation of direct service to the child (if applicable);
- observation of interaction between the student and the child;
- observation of interaction between the student, the interpreter (if applicable) and the parent/caregiver;
- review of child’s progress or lack thereof;
- discussion with parent/caregiver about family issues, priorities and concerns;
- review of IFSP to determine if the IFSP requires modifications;
- any other duties as required by discipline-specific practice acts or licensure standards.

e. review and co-sign any notes, reports, or documentation prepared by the student;

f. submit bills for any visits which included the student;

g. follow supervision requirements as set forth in his/her licensure and/or other pertinent certification standards.

**NOTE:** Inappropriate supervision is considered unprofessional practice. Those identified as not following the supervision requirements listed above, could lose their EI credential and/or enrollment and risk being reported to the Illinois Department of Financial and Professional Regulation. Supervisors are also required to follow Documentation policies described in Chapter 23: Glossary and Abbreviations.

3.6 **Provisional Reimbursement Providers**

Provisional Reimbursement Providers allows for the provision of services to eligible children when no other credentialed and/or enrolled EI Provider is available. If a credentialed and/or enrolled EI Provider is available, that EI Provider must be utilized first.

**Provisional Providers**

The Provisional Provider process is initiated when a CFC believes it is necessary and it can only be completed by the CFC. Provisional Providers must be approved by the Bureau of EI prior to providing any EI services.
Provisional Providers must complete the EI Credentialing and/or Enrollment packet found on the Provider Connections’ website and follow submission instructions. Providers must also complete Criminal Background Fingerprinting and the Online System Overview Training prior to becoming approved by the Bureau of EI and receiving authorization.

Additionally, EI families must sign an acknowledgement that they understand the Provisional Provider has not yet gone through all the required background checks, including CANTS, to become a Credentialed and/or Enrolled EI Provider.

Provisional Providers cannot submit their claims electronically to CBO as they are not entered in the CBO through the Provider Connections credential and/or enrollment process. Claims are required to be mailed to the IDHS Provisional Provider Coordinator. Provisional Providers will receive a memorandum upon approval of the request which will include detailed instructions on the process to bill for provisional services.

3.7 Inactivation of Credential and/or Enrollment
3.7.1. **Department Termination**

*Administrative Code 89, Part 500 Early Intervention Program, Section 500.60 Provider Qualifications/ Credentialing and Enrollment* states the activities that could lead to termination of an EI Credential/Enrollment status. Below is an overview of what is stated Credentialing/ Enrollment is not a license. Rights of credential and enrollment are set forth in the EI Provider Agreement. In addition to the provisions of this subsection (q), the Department may exercise any rights it has under the EI Provider Agreement to terminate its relationship with an EI Provider/Payee.

3.7.1.1. Additionally, the following shall result in immediate automatic termination of an EI Provider’s credential and enrollment:

   a. Failure to comply with the requirements of 500.60 g) *Education and/or 500.60 h) Consultation Requirement Either Prior to or During Temporary Credential* within the time period or within a Department-granted extension not exceeding the maximum extension time allowed.

   b. Failure to successfully enroll in, exclusion from or termination from participation in IMPACT and/or other programs of federal or State agencies.

   c. Lapse of credential/enrollment for over 1 year without complying with 500.60 l) *Restoration of Lapsed Credential* failure to bill for services for more than 12 consecutive months.

   **NOTE:** Lapse of credential/enrollment could also result if no authorizations have been generated under the provider’s name for 12 consecutive months.

   d. Suspension or termination of the license and/or certification required for the service for which one is credentialed.

   **NOTE:** If this occurs, the provider must cease providing services until the license may be reinstated. Services paid during an inactive license period, may be eligible for refund.

   e. Failure to meet or maintain other credential and enrollment requirements set forth in this Section.

3.7.1.2. The following shall also result in termination of an EI Provider's credential and enrollment:
a. Failure to comply with provisions of this Part, or with EI Service Provider Agreements, or with other laws and regulations relevant to the services for which there is a credential.

b. Unprofessional conduct.

c. Complaints the Department has determined are founded and significant including child and abuse and neglect investigations.
   i. If a provider is involved in an ongoing DCFS investigation, the provider will be temporarily suspended until a decision of unfounded is received.

d. Professional performance not consonant with recognized standard of care or adverse action of a professional society or other professional organization.

e. Lack of timely cooperation regarding the submission of and adequacy of reports, the development of appropriate goals and objectives and the development of multidisciplinary treatment plans.

f. Inappropriate billing practices.

3.7.1.3. The EI Provider shall be notified of the date of termination and the reason and shall help to transition children to new providers. The provider may request an informal hearing, but the request shall not affect the termination date, which may proceed prior to the informal hearing. The request must be made within 30 days after the notice of the termination.

3.7.1.4. The EI Provider may present relevant information, witnesses and evidence to the Secretary or his/her designee, in person or in writing. The Secretary or the designee will review the information presented and any supplemental investigation performed by the Department and issue a decision within 30 days after the informal hearing.

3.7.1.5. The decision of the Secretary or the designee shall be final.

3.8 Confidentiality
As an EI Provider, you are trusted with Protected Health Information (PHI) per HIPAA and Personally Identifiable Information (PII) per FERPA while working with families and their children in the EI Program. All information accessed and collected, must be kept confidential at all times and never be shared on any level without consent. PHI/PII should never be sent through electronic mail (email) or text nor can it be electronically stored on any device, i.e., laptops, computers, etc., without being securely protected and/or encrypted. With appropriate consent, email and/or text may be used for basic appointment communication.

Recording of services without Bureau approval and specific consent is prohibited. Use of virtual, public facing applications is prohibited as it is unsecure and unencrypted. Live Video Visits should be conducted on a secure platform, unless otherwise allowed due to a national public health emergency.

3.9 Use of Internet-Based Facsimile Services
Internet-based facsimile (fax) services, also known as eFax or online fax, are used for sending and receiving fax documents in digital format rather than a paper fax machine using a traditional telephone line.

As a covered entity, EI Providers must enter into a Business Associate Agreement (BAA) with each Internet-Based Fax Service vendor. Additionally, EI Providers utilizing an Internet-Based Fax Service
vendor are responsible for establishing an account with the vendor and ensuring all proper agreements are in place prior to use.

Criteria used in verifying that Internet-Based Fax Service vendors are HIPAA complaint, include:
• do not utilize third-party vendors to store or transmit data,
• offer executable BAAs which define the data as belonging to the provider not the BAA carrier,
• data storage is within the United States of America, and
• guarantee HIPAA-secure accounts for all customers with BAAs.

The list of Internet-Based Fax Service vendors can be found at: www.wiu.edu/ProviderConnections/policy/EIProviderUpdate.php?id=270

3.10 Liability Insurance
The EI Payee is required to maintain liability insurance sufficient to cover any potential liability such as loss, damage, cost or expenses, including attorney’s fees, arising from any act or negligence of the EI Payee or its’ enrolled EI Providers. Proof of this insurance is a requirement during EI Monitoring Reviews.

Interpreters and Translators are not required to maintain liability insurance, as it is understood, that no Interpreter or Translator will ever enter a family’s home without being accompanied with a fellow EI provider or Service Coordinator.

3.11 Mandated Reporting of Abuse/Neglect
As defined in the Early Intervention Services System Act (325 ILCS 20/), EI Providers are mandated reporters of child abuse and/or neglect as defined in 325 ILCS 5/ Abused and Neglected Child Reporting Act, which may be reviewed at https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapterID=32. If any EI Provider has reasonable cause to believe that a child known to them in their professional or official capacity may be abused and/or neglected, it is his/her responsibility to report the suspected abuse and/or neglect immediately to the Illinois Department of Children and Family Services (DCFS). The EI Provider shall report the suspected or alleged abuse and/or neglect by calling the toll-free DCFS Child Abuse Hotline at 1-800-25A-BUSE. The hotline is available 24 hours a day, seven days a week.

It is not the job of a mandated reporter to determine whether abuse and/or neglect has truly occurred, the reporter only needs reasonable cause to believe abuse and/or neglect has occurred. In the case of a team of people working with the same child and family, the person with the most direct contact and information should be the one filing a report with DCFS.

<table>
<thead>
<tr>
<th>Things to keep in mind when contacting the DCFS Child Abuse Hotline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Needed</strong></td>
</tr>
<tr>
<td>• Name of alleged victim, address, and siblings</td>
</tr>
<tr>
<td>• Relationship of victim to alleged perpetrator</td>
</tr>
<tr>
<td>• Description of abuse and/or neglect</td>
</tr>
<tr>
<td>• Any information that could help expedite the investigation</td>
</tr>
</tbody>
</table>
It is never easy to report abuse and/or neglect, especially if you know the family. You may not be the only person to recognize abuse or neglect is occurring and that a child is suffering, but you may be the only person to take action to stop the abuse or neglect.

For training support related to Mandated Reporting and/or Child Abuse, please visit the EITP website at [http://eitp.education.illinois.edu/](http://eitp.education.illinois.edu/) and look for Beyond Mandated Reporting: Recognizing and Responding to Child Abuse online module.

If an EI Provider is contacted by a DCFS Investigator regarding an active investigation case, as mandated reporters, EI Providers are required to comply. Please follow these procedures.

1) Verify it is a DCFS Investigator requesting cooperation and
2) Answer questions, supply records or other documents regardless of consent per Title 89 Admin Code 300, Reports of Child Abuse and Neglect, Section (h) 300.110, which may be reviewed here [https://www.ilga.gov/commission/jcar/admincode/089/089003000001100R.html](https://www.ilga.gov/commission/jcar/admincode/089/089003000001100R.html).

### 3.12 Evaluation/Assessment Activities

CFCs are responsible for performing a variety of activities prior to EI Providers receiving and performing Initial Evaluations and Assessments. Those activities are:

#### 3.12.1 Accepting Referrals

CFCs are responsible for accepting all referrals for all birth to three children while maintaining confidentiality under FERPA and HIPAA. Referrals may be made by any individual who has concerns for the child’s development, including Primary Referral Sources as outlined in federal and state law. Although families may decline, the CFC is still responsible for making contact. Referrals may be made via telephone, written correspondence or in person. The CFC is required to contact the family within two-business days after the date of referral to verify general eligibility requirements. If those requirements are met, the Service Coordinator will setup a face-to-face meeting to complete Intake responsibilities, including an Intake meeting separate from and prior to Evaluation/Assessment activities.

#### 3.12.2 Intake

At the Intake meeting, the Service Coordinator will explain the EI Program and the process to determine EI eligibility. This process includes review of numerous notices, requesting signatures for consent and releases of information to specific persons or organizations, explaining the use of public/private insurance, family fee participation, supporting the family in provider selection, and completing the Intake/Social History Summary sheet necessary to focus Evaluation/Assessment activities on the family’s concerns. The Service Coordinator will also assist the family with identifying, applying to and accessing any benefit programs for which they may be potentially eligible. The family will be provided with the option of having evaluations, assessments and IFSP development on the same or different days with the pros and cons for each option being explained, and an explanation of the IFSP process for eligible children. Once the family completes all necessary paperwork, the family will choose EI Providers for evaluations/assessments. With consent, the Service Coordinator will obtain and review any medical records, education records, existing evaluations, and/or therapy records.
to determine if eligibility has already been determined. Specific procedures may be found in the *Child and Family Connections Procedure Manual* in Chapter 9.0 Eligibility Criteria, *Evaluation and Assessment* of the. Unless not clearly feasible to do so, all evaluation and assessment activities must be conducted in the native language normally used by the child and family.

### 3.12.3 Family-Directed Assessment

As described in the *Child and Family Connections Procedure Manual, Chapter 8.0 Intake*, under section 8.1.8, with written parental consent, Service Coordinators will complete a voluntary family-directed assessment using the *Routines-Based Interview* assessment tool. The purpose of the family-directed assessment is to determine the supports and services necessary to enhance the family’s capacity to meet the developmental needs of the child based upon their functional outcomes. This requires full family participation throughout the process to ensure that the Service Coordinator’s observations are a meaningful reflection of the family’s perspective.

With parental consent, the Service Coordinator will also administer the appropriate *Ages and States Questionnaire- Social Emotional -2 (ASQ: SE-2)* based upon the child’s chronological age and record the results or pertinent information on the *Intake/Social History Summary Sheet* after the Intake meeting. The Service Coordinator will review the results of the ASQ:SE 2 with the family so that the family can use the information to make informed decisions of who should be involved in evaluation/assessment activities.

### 3.12.4 Provider Selection

EI Providers are selected in collaboration with the family. The Service Coordinator does not recommend one EI Provider over another based on personal preference. Families shall be offered a choice of EI Providers (unless insurance or other payer’s restrictions limit the provider choices) available to meet their family’s needs. Each CFC must follow the EI Provider selection flow outlined in the CFC Procedure Manual, *Chapter 3: Early Intervention Providers in Illinois*, under section 3.8. EI Providers are encouraged to partner with as many private insurance plans as possible. Also, ensuring all insurance plan provisions are met such as enrollment as well as enrollment in required electronic claims receipt helps broaden the choices for families.

**NOTE:** One person cannot provide services to the same child/family as two disciplines. This is a conflict of interest. The CFC must authorize any service type accordingly to individual EI Providers if using a single Payee entity. The EI Payee entity must not allow the same provider to serve the child as two disciplines, even under “Equally-Qualifying” status, see *Chapter 23: Glossary and Abbreviations* for definition.

*Example:* An EI Provider dually enrolled as a Developmental Therapist and a Physical Therapist cannot provide a developmental therapy global evaluation and Physical Therapy evaluation for the child/family.

### 3.12.5 Authorizations

Authorization is required for payment of all EI services and must be issued prior to service delivery. The only exception to this rule is the IFSP meeting. Providing services prior to receiving an authorization could result in non-payment. A sample copy of an authorization may be found in *Attachment 11* at the end of this Handbook.
It is the responsibility of the EI Provider to ensure the authorization is obtained prior to service delivery and that it is accurate by ensuring the correct payee, rendering EI Provider, procedure codes, frequency, duration and location.

The Service Coordinator will create and send authorizations prior to service delivery. Authorizations must be created under the Payee of the rendering EI Provider with the individual rendering EI Provider chosen. The Payee must identify the actual rendering EI Provider who will be serving the child/family. The Payee must not name a rendering EI Provider who is unavailable. If the direct service EI Provider is a Credentialed Associate-Level Provider, the authorization must be created under the supervising EI Provider’s name with the rendering Credentialed Associate-Level Provider listed in the comments field. If the Associate-Level Provider’s name does not appear in the comment field of the authorization, please contact the child’s Service Coordinator to request a corrected authorization.

Service Coordinators generate authorizations using their laptop computers for IFSP Meetings. If the Service Coordinator does not bring a laptop or a secure internet connection is unavailable, the authorization will be created when the Service Coordinator returns to his or her CFC Office. After attending the entire IFSP meeting, EI Providers should follow up with the Service Coordinator after the conclusion of the meeting to ensure that they receive an authorization for their participation in the IFSP meeting as quickly as possible. Failure to follow-up immediately may delay reimbursement of the Evaluation/Assessment and IFSP meeting attendance.

3.12.6 Initial Evaluations/Assessments

a. Review of Referral and Intake Information

A minimum of two or more separate disciplines are required to complete Initial Evaluations/Assessments to determine eligibility and they must be completed by EI Credentialed and Enrolled Evaluator Providers only.

Upon receiving the request, the EI Evaluator, with parental consent, should, at a minimum, be provided with the following documents for review prior to the initial evaluation/assessment:

- existing medical records and/or reports, if relevant
- Intake/Social History Summary Sheet
- signed CFC Consent for Release of Information made out to the provider
- CFC Parental Consent and Ability to Decline Services
- CFC Consent to Use Personally Identifiable Information (PII) & Bill Public Benefits
- authorization for services

The team’s evaluation of the child shall include:

- administration of the global and specific discipline’s evaluation and/or assessment tool;
- collection of the child’s history (including interviewing the parent);
- identification of the child’s level of functioning in each of the five developmental domains;
- gathering of information from other sources such as family members, other caregivers, medical providers, social workers and educators, if necessary, to understand the full scope of the child’s unique strengths and needs, and
• review of medical, educational, and other records.

b. Eligibility Criteria
Children residing in Illinois who are under the age of three-years old, and their families are eligible for EI services if a child has one of the following:

1. Physical or Mental Condition Resulting in Developmental Delay
   "A physical or mental condition which typically results in developmental delay" means a medical diagnosis or a physical or mental condition which typically results in developmental delay.

   The medical or mental condition must have been:
   • Approved by IDHS as an eligible condition (see the Medical Conditions Resulting in a High Probability of Developmental Delay list); or
   • Confirmed by a qualified family physician, pediatrician or pediatric sub-specialist as being a condition with a relatively well-known expectancy for developmental outcomes/within varying ranges of developmental disabilities. Pediatric sub-specialists include those such as pediatric neurologists, geneticists, pediatric orthopedic surgeons and pediatricians with special interest in disabilities. If a child exhibits a medical condition not approved by IDHS as being an eligible condition, the qualified multidisciplinary team may use informed clinical opinion by one of the physician categories identified above that the child’s medical condition typically results in substantial developmental delay within the varying ranges of developmental disabilities.

2. Developmental Delay
   Developmental delay means a IDHS determined eligible level of delay (30% or greater) exists in one or more of the following areas of childhood development also known as domains: cognitive, physical (including vision and hearing), communication, social or emotional, or adaptive as confirmed by a multidisciplinary team.

   Per federal and state regulations, eligibility decisions are based on a child’s domain level performance. While subdomain information, i.e., fine motor/gross motor, within the physical domain, can provide critical information regarding a child’s developmental strengths and challenges, can be used to inform intervention planning, and can help teams determine which team members have the necessary skills and experience to support the identified IFSP outcomes, determination of eligible levels of delay are based on the five identified domains.

   The eligible level of delay must have been:
   • Measured by IDHS-approved diagnostic evaluation and assessment instruments (as listed in the Early Intervention Approved Evaluation and Assessment Instruments) and standard procedures, or

   If a child is unable to be appropriately and accurately tested by the standardized measures available, informed clinical opinion of the qualified staff based upon multidisciplinary evaluation may be used to document the level of delay. The child is eligible if the clinical opinion of the level of delay meets or exceeds the Department-approved level of 30%.
c. At Risk Condition
At risk of substantial developmental delay means a child is not able to be determined eligible as stated above in b. 1. or b. 2. but certain conditions exist, and an eligible level of delay is probable if EI services are not provided.

This can occur when the child has a parent who has been medically diagnosed as having a mental illness or serious emotional disorder defined in the Diagnostic and Statistical Manual 5 (DSM5) that has resulted in a significant impairment in the parent’s level of functioning in at least one major life functional area or a developmental disability.

At risk of substantial developmental delay, based on informed clinical opinion, requires a consensus of qualified staff, based upon multidisciplinary evaluations and assessments, that a 30% or more level of developmental delay is probable if EI services are not provided due to the child experiencing three or more of the following risk factors:
- Current alcohol or substance abuse by the primary caregiver;
- Primary caregiver who is currently less than 15 years of age;
- Current homelessness of the child. Homelessness is defined as children who lack a fixed, regular and adequate nighttime residence, in conformity with the McKinney-Vento Homeless Assistance Act;
- Chronic illness of the primary caregiver;
- Alcohol or substance abuse by the mother during pregnancy with the child;
- Primary caregiver with a level of education equal to or less than the 10th grade, unless that that level is appropriate to the primary caregiver’s age, or
- An indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

d. Appropriate Evaluation/Assessment Tool Selection
Federal Regulations governing EI require processes to be in place to determine eligibility for children. These regulations specify that a child is eligible based on a multidisciplinary approach and that evaluation and assessment processes help teams determine eligibility, identify unique strengths and needs of a child and family, as well as the appropriate services to help meet those needs.

EI Providers credentialed as evaluators are skilled and experienced practitioners that possess:
- a strong foundation on infant/toddler typical and atypical development;
- in depth training on administering and interpreting the approved tools they use;
- the ability to conduct evaluations/assessments in a manner that is family friendly, culturally sensitive and honors the centrality of the parent-child relationship;
- the ability to successfully convey their findings in ways that are accurate and understandable to the family, and
- strong, effective communication and collaboration skills to communicate and work with others in a collaborative manner.
The selection of the appropriate evaluation/assessment tool(s) is done by the Credentialed Evaluator and is based on the information provided by the Service Coordinator. A list of approved tools entitled *Early Intervention Approved Evaluation and Assessment Instruments* is made available by the Bureau of EI to select from that may be used by any discipline/professional with training and credentials that meet the requirements specified within each of the particular test instruments. *Early Intervention Approved Evaluation and Assessment Instruments* may be viewed at: www.dhs.state.il.us/page.aspx?item=86067. Also, within this document are instructions on how to submit a request for additions/corrections to the list. Please also see the Glossary for those children who will need to have adjusted age calculated.

3.12.7 *Service Delivery*

a. **Natural Environments**

As the first EI Principle states, “Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.” In most cases, those familiar contexts are the home, childcare centers or homes, i.e., grandma’s house. These contexts are identified in the law as “natural environments”.

Part C of IDEA requires to the maximum extent appropriate to the needs of the child, EI services must be provided in natural environments, including the home and community settings in which children without disabilities participate. (*34 CFR §303.126*)

By definition, natural environment means *settings that are natural or typical for a same-aged infant or toddler without a disability, may include the home or community settings, and must be consistent with the provisions of §303.26.*

The exception to the rule reads *the provision of early intervention services for any infant or toddler with a disability occurs in a setting other than a natural environment that is most appropriate, as determined by the parent and the individualized family service plan team, only when Early Intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment.* (*34 §CFR 303.126(b)*)

The provision of EI services taking place in natural environments is not just a guiding principle or suggestion, it is a legal requirement.

b. After consideration by the team, if parents and other team members determine that Live Video Visits (LVV) are the preferred option as a service modality, LVV will be considered a Natural Environment when provided in the same defined environment using Off-site delivery place of service codes or non-Natural Environment when provided using On-site delivery place of service codes. This is also defined in IDEA Part C section 303.26.

c. **Authorized Frequency, Intensity, and Location of Services Adherence**

Recommendations for goals, outcomes, and strategies for services that include frequency, intensity, and location will be determined at the IFSP meeting in collaboration with the child’s family. These recommendations are based on the family’s identified priorities and concerns and the *Principles of Early Intervention*, see *Chapter 1: Welcome to Early Intervention* of this Handbook.

Eligibility for the EI Program is always a team decision, which requires the team, including the family to discuss the results of the evaluation/assessment. Eligibility is for
access to the EI Program, not for particular services within the program. Therefore, it is inappropriate for any individual EI Provider to discuss eligibility for EI services and/or recommendations for frequency, intensity, or location of services prior to or outside of the IFSP meeting. Prior to making any changes to an IFSP such as increasing/decreasing the frequency, service modality, or intensity of services that were originally identified as a need on the IFSP or changing the location from an offsite to an onsite location, an IFSP meeting must be held to discuss the recommendation and justification for the change. The Service Coordinator must facilitate the meeting and the parent(s) must be present. To request changes to existing authorizations, the Developmental Justification to Change Frequency, Intensity and/or Location form must be completed by the provider requesting the change.

If IFSP changes are requested within the first three months of an IFSP, the “initial” IFSP team must reconvene. The direct EI Provider recommending the changes must be present to discuss the recommendation(s) and the justification for the change. The Service Coordinator must facilitate the meeting and the parent(s) must be present.

Authorizations will end effective the day before the annual IFSP date entered into the system. If a new IFSP is written, new authorizations must be written and in-hand prior to any services being delivered in the new IFSP period. Meaning if a service is provided and billed using a previous authorization after a new IFSP is written, that service will be denied because the authorization would have ended.

In the event of an extended IFSP period, the existing authorizations must be extended as appropriate as well. The provider must ensure that those adjusted authorizations are received prior to delivering any additional services.

d. Team Member Communication

Communication is a two-way process of reaching mutual understanding, in which participants not only exchange information, news, ideas and feelings but also create and share meaning.

Teaming and collaboration among all EI team members, including the family, is critical in our efforts to support families and young children. Effective teaming requires frequent communication, collaboration, relationship building, and advanced planning. The family, caregivers and early interventionists from a range of disciplines are essential members of the team and as such, must establish ways of interacting and communicating with one another that are respectful, supportive, enhance the capacity of families, and are culturally sensitive. (Division for Early Childhood (2014). DEC recommended practices in early intervention/early childhood special education 2014. Retrieved from http://www.dec-sped.org/recommendedpractices)

To improve communication with those supporting families beyond EI, IFSP Development time/authorizations can be used to support team members’ interactions with certain people outside of the IFSP team when the family has consented to an exchange of information, please see Section 5.8 for IFSP Development Time and in Chapter 23: Glossary and Abbreviations for definition. This enhanced use of IFSP Development time is allowed to help families as they transition between EI services (change in team members); as they transition out of EI services, (to the Local Education Agency (LEA) for a child turning three, Early Head Start, or Head Start Programs) and as they participate
in other programs such as DCFS, DSCC and early childhood programs such as Home Visiting programs, Child Care, etc.

e. Discontinuing Services
As stated in 89 Illinois Administrative Code, Part 500.115(f) and the EI Provider agreement, all EI Providers are required to give a 30-day prior written notice to the child’s Service Coordinator AND the child’s family prior to terminating services for an eligible child.

If an EI Provider wishes to discontinue enrollment with an agency/EI Payee and enroll with another agency/EI Payee or as an individual EI Provider, the Service Coordinator must be notified 30-days prior to ending services to allow time to contact families and issue new authorizations to either the existing EI Provider under the new Payee or to another EI Provider, based on the family’s choice and ensuring all insurance plan issues are addressed. Also ensure proper enrollment procedures are followed as specified in Chapter 3, section 3.3.3.

3.12.8 Transition
The Service Coordinator is required to follow transition policies and procedures which help ensure a smooth transition between the EI Program under Part C and preschool services under Part B or other appropriate services for all infants and toddlers with disabilities under the age of three who have received EI services and their families.

Beginning January 2022, children who have birthdays between May 1 and August 31 may have the option to extend EI services until the start of the next school year. If a child might qualify for the Early Intervention/Extended Services (EI/ES) option, the additional steps required for this option are outlined in section 3.14.

A “toddler that may be eligible for preschool services under Part B” means any toddler in the EI Program at 25 months of age that has not yet achieved his/her IFSP developed functional outcomes determined by the IFSP team. No sooner than nine months, but no later than three months prior to the child’s third birthday, the Service Coordinator will begin to communicate with the child’s family about transition.

If the parent consents to transition, written parental consent must be obtained to make transition referrals and share information from the child’s permanent CFC record with the LEA and/or other community program(s) that the child may transition into.

a. Transition Plan
IFSP team meetings must be held not fewer than 90 days and, at the discretion of all parties, not more than nine (9) months before the toddler’s third birthday to develop/update a transition outcome(s) (Transition Steps and Services). It must include steps for the toddler with a disability and his/her family to exit the EI Program and any transition services needed by that toddler and his/her family. The Transition Steps and Services must be included in the IFSPs of all children exiting the EI Program not fewer than 90 days before the child’s third birthdays.

The Service Coordinator will facilitate an IFSP team meeting to establish or update a Transition Plan in the child’s IFSP. The Transition Steps and Services should include the steps the toddler and his/her family will take to exit the EI Program and the transition
services necessary to support the family’s connection to services and programs available for children who are three.

b. **Transition Planning Conference**
With the consent of the family, a Transition Planning Conference is convened for all toddlers that may be eligible for preschool services under Part B not fewer than 90 days and, at the discretion of all parties, not more than nine (9) months before the child’s third birthday to discuss any services the toddler may receive under Part B.

The Transition Planning Conference and the IFSP team meeting to develop the Transition Plan may be combined into one meeting. If held within 120 days of the toddler’s third birthday, the meeting can also be used to discuss and document progress towards IFSP functional outcomes and EI Levels of Development.

If combined and an EI Provider who is a member of the child’s IFSP Team attends a Transition Planning Conference in person, the authorization will be created using “offsite” IFSP Meeting procedure codes with the related modifier. If the EI Provider attends via telephone, the authorization will be created using “onsite” IFSP Meeting procedure codes with the related modifier.

c. **IFSP Team Requirements for Transition Steps and Services & Transition Planning Conference**
The IFSP team meeting to develop the Transition Steps and Services and the Transition Planning Conference must be held in settings and at times convenient for the family and in the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

Meeting arrangements must be made and written notice provided by the CFC to the family and other participants early enough before the meeting date to ensure that they will be able to attend.

The IFSP team meeting to develop the Transition Steps and Services must include the following participants: the parent or parents of the child, other family members as requested by the parent if feasible to do so, an advocate or person outside the family if the family requests that person participates, the Service Coordinator, persons directly involved in conducting evaluations and assessments, and persons providing EI services to the child or family. If a person or persons directly involved in conducting evaluations and assessments is unable to attend a meeting, arrangements must be made for the person’s involvement through other means, including participating in a telephone conference or having an alternative knowledgeable equally-qualified EI Provider attend the meeting.

The LEA must be invited to the Transition Planning Conference. Even if they cannot attend, the Transition Planning Conference must take place.

d. **Early Intervention/Extended Services**
Please see 3.14 for additional information.

e. **Individual Education Program (IEP) Attendance**
An EI Provider who is a member of the child’s IFSP team and is requested to attend an IEP meeting, prior to a child’s third birthday must be pre-authorized. These
authorizations are generated as direct service, IFSP development for offsite services. If the meeting is held in a setting where an EI Provider’s office is located, the authorization would be for onsite services. See section 3.14 for more information.

3.13 Reporting
All Evaluation/Assessment services must be performed within 14-calendar days from the date the request for an Evaluation/Assessment is received by the EI Provider. The authorization start date will serve as the request for the Evaluation/Assessment and should reflect the date that the service will be provided. The EI Provider must report the findings of the Evaluation/Assessment to the Service Coordinator within those 14-calendar days unless the actual service date of the evaluation is on day 12 to 14 of the 14-day authorization due to exceptional circumstances (family rescheduled, child ill, etc.).

If the service is performed on day 12 of the 14-day authorization, the written Evaluation/Assessment report is due to the Service Coordinator no later than four-business days from the date that the Evaluation/Assessment is completed (actual service date). If the required 14-calendar days cannot be met and is documented in the EI Provider’s notes, even with the additional four-business days, the EI Provider is to contact the Service Coordinator immediately to ask for an adjusted Evaluation/Assessment authorization due the unforeseen circumstances documented in the EI Provider’s notes.

Additionally, the claim for the service of Evaluation/Assessment for initial and annual eligibility determination must be submitted with the IFSP “IM” Authorization as proof that the entire process of eligibility determination is completed timely and correctly. To ensure that EI Providers comply with deadlines, CFCs are required to enter IFSP meeting authorizations into the EIDMS system but refrain from printing the authorization until after the Evaluation/Assessment report is submitted to the CFC. Families have the right to their children’s reports and billing shouldn’t occur until after the report has been prepared and submitted to the Service Coordinator. Printing the authorization triggers the transmission of the authorization to the CBO. Using this practice ensures that EI Providers are unable to bill for the Evaluation/Assessment and the IFSP meeting until the report is received.

All Evaluation/Assessment reports must be provided to the parent(s)/caregiver(s) in their native language.

All reports must be submitted following the requirements in the EI report formats (see the Attachments located at the end of this Handbook). Reports that are not fully completed, do not include the required information in the appropriate EI report formats, or have added components such as recommendations for frequency, intensity, length, and duration will be returned to the EI Provider with a request from the Service Coordinator to immediately correct and resubmit the report.

As a reminder, when an EI Provider accepts an individual authorization for an evaluation or assessment, an individual report is required regardless of whether the provider participates in an Arena evaluation. This is not a new practice. Any combined reports will be returned to the provider to complete an individual report for submission to the Service Coordinator, IFSP team and family.

NOTE: Medical Diagnostic reports may include medical recommendations for the family outside of the EI scope of services.

Recommendations for frequency, intensity, service modality, length, and duration of services are made at the IFSP meeting and must be based upon the functional outcomes developed by the IFSP team as a whole.

- EI Providers must submit a written Developmental Justification to Change Frequency, Intensity and/or Location of Authorized Services Worksheet (Worksheet) to the Service Coordinator for any requested changes to existing authorizations for the time period between annual IFSP meetings, see
5.6 Developmental Justification of Need. When requested, attend IFSP Meeting and sign off on Developmental Justification of Need when IFSP team agrees with the changes.

- The EI Provider should obtain a copy of the IFSP (annual and when changes occur) within 15-business days of the IFSP meeting.

- The EI Program does not pay an EI Provider to write reports other than those required by the EI Program for initial IFSP development, annual IFSP review, six-month review, discharge reports or others that may be required by the Service Coordinator due to additional evaluation/assessment activity required by the IFSP.

- All EI Providers are required to submit a Discharge Report, see Attachment 2, to the Service Coordinator following the requirements of the Discharge Report within 14-calendar days, if necessary, from the child’s exit from the EI Provider’s care. The report must be written prior to the child’s third birthday.

A Discharge Report is needed for each child who:

- exits the EI Program (whether by aging out, goals met prior to age three, transferring to a different CFC, resulting in a change of EI Provider, or moves out of state) or

- changes EI Providers.

NOTE: If a child has a six-month, annual, or exit meeting that is in close proximity of a child turning three or exiting the EI Program, your recently submitted report may serve as your Discharge Report as long as the child has had no significant changes in his/her development that are worth noting and documentation acknowledging the discharge is noted as well. Additionally, the provider should take into consideration what the team agrees upon, including the family, that the previous report representing the child’s level of development is still accurate.

Things to consider when determining if a new report should be submitted are:

- How much time has passed since the report was created?

- Has the child progressed, or regressed, in any way since the last report was created?

- Does the team, including the family, believe that the last report submitted represents the child’s current level of development?

Example: Nathan, a two-year, 10-month old boy, is having his Annual IFSP Meeting at the end of November, turning three-years old the 1st of January. An annual assessment, with documentation of the EI Provider’s Discharge Report summary may be combined into one report. The IFSP continues until Nathan turns three-years old. Upon Nathan’s final service with the EI Provider, the IFSP team has agreed no new progress or regression has occurred. The combined assessment/discharge report will suffice as the final report for Nathan.
When to complete a Discharge Report vs a Developmental Justification of Need Report to Change Frequency, Intensity and/or Location of Authorized Services Worksheet:

- **Discharge Report Rationale:**
  - Child ended all services with that EI Provider on the IFSP
  - A provider of the same discipline is changing, but no change to the IFSP service frequency, intensity or duration

- **Development Justification Worksheet Rationale:**
  - Child ends one service(s) on the IFSP, but other service(s) remain
    - EI Provider whose service is ending due to outcomes being met will submit the developmental justification worksheet (complete section 4 of the Developmental Justification of Need Worksheet; this will serve as the discharge report)
  - Service(s) on the IFSP change in frequency, intensity and/or duration
    - EI Provider who is recommending a service change on the IFSP will submit the Developmental Justification Worksheet

3.14 Early Intervention/Extended Services (EI/ES)

In Illinois, families have the option to continue EI services through an IFSP beyond the child’s third birthday, until the beginning of the school year following the child’s third birthday. If the child has a current IFSP and is determined eligible for early childhood special education and related services, the family may elect to continue services through the EI/ES program with an Extended IFSP or to begin services through ECSE as planned on the IEP. As part of initial transition planning, it is critical for service coordinators and providers to share information with families about these options.

Eligible families who wish to participate in educational services after their child turns three with two options:

- Option one allows for families to continue the services on their IFSP through the summer months with their current EI provider(s) and then begin early childhood special education services at the beginning of the school year following the child’s third birthday.

- Option two allows families to exit early intervention and begin early childhood special education services through their local school district as of the implementation date listed on their IEP.

**NOTE:** Once a family exits early intervention after their child reaches age 3, they cannot re-enter the early intervention system under the Early Intervention Extended Services option.

A family who is receiving EI services whose child meets all three criteria below, will be able to choose to continue EI/ES beyond the child’s third birthday until the start of the next school year following the child’s third birthday as outlined in 34 C.F.R. § 303.211 (a)(2)(i) and 325 IL CS Section 11, SB0820-002. If, in the same calendar year, a child’s third birthday occurs after the start of that school year, the child will not be eligible for EI/ES.

This option for extended services through Part C to children over age three applies only if the child:

- Has been determined eligible for early intervention with services identified and consented to on the IFSP, and
- has their third birthday between May 1 and August 31 and
- has been found eligible for early childhood special education services under IDEA and Section 14-8.02 of Public Act 102-0209 (Section 11h) and created an Individualized Education Program (IEP).
3.14.1. **Transition After Age 3**
Transition planning is also required after the age of three in preparation for moving ECSE services through an IEP. The Transition Planning Conference is held no later than 90 days prior to the beginning of the school year following the child’s third birthday. Families may request services from an IEP any time after an extended IFSP is in place, in which case a Transition Planning Conference should be scheduled at such time. Transition planning activities may include moving to ECSE services through an IEP or helping the child and family access community services and supports.

3.14.2. **Transition Planning**
Regardless of when a child transitions, (before, at, or after the age of three) the discussion needs to include planning notes and next steps, including who will do what to support the child and family to the new setting.

3.14.3. **Family Choice**
In Illinois, if a child and family have a current IFSP Early Intervention and the local school system has determined that the child is eligible for ECSE and related services, the family has the choice to continue receiving EI/ES through their current IFSP or to initiate ECSE as planned on their IEP.

The IFSP team is required to explain the extended service information to families. This begins with providing families with an annual written notice about this choice by distributing, Early Intervention/ Extended Services Parent Notice and obtaining consent. It is essential that the parent understands the content of this consent before making the choice to continue IFSP services or to terminate IFSP services after the child’s third birthday. The IFSP team should encourage parent(s) to read through the document in its entirety and address any questions of the parent(s) regarding the consent requirements.

3.14.4. **Individuals with Disabilities Education Act (IDEA) Consent**
The IFSP team is required to fully explain the contents of the IFSP and the authorization items in this section to the parent/guardian/surrogate (parent) and address any questions the parent may have. It is essential that the parent understands the content of the IFSP, and each item included in this authorization section. Written consent must be obtained from the parent prior to the provision or extension of an EI services. Authorizations must be obtained for initial IFSP Meetings, annual IFSP Meetings, and all other IFSP Meetings in which services are continued, added, or modified.

**NOTE:** Once a family exits early intervention after their child reaches age 3, they cannot re-enter the early intervention system under the Early Intervention Extended Services option.
Chapter 4: Family Rights & Expectations

4.1 Family Rights
The Individuals with Disabilities Education Act (IDEA) defines the rights of parents of children receiving EI services. Service Coordinators provide parents with a booklet entitled the State of Illinois Infant/Toddler & Family Rights under IDEA for the Early Intervention System that describes those rights. This booklet is provided to parents during different stages while their child is enrolled with the EI Program. A summary of those rights includes:

4.1.1. Informed Consent
Consent must be received from the parent to receive EI services. The parent also signs the IFSP document indicating understanding and agreement with the plan and services. Parents may be asked to sign consents to share information about their child and family with EI Providers or other necessary agencies or individuals.

4.1.2. Prior Written Notice
Written notice must be given to the parent before an agency or EI Provider makes a change in the child’s IFSP. Parents should receive written notice of any meetings with reasonable time to make arrangements to attend.

4.1.3. Review of Records
Parents have the right to review any records related to their child’s EI services. Records must be available to parents within 10 calendar days after the request. Parents may request changes in the record if the information is inaccurate or violates confidentiality.

4.1.4. Confidentiality of Records
All records about EI services are confidential. With consent, EI Providers of the same IFSP team may share information with each other only to provide the best services for families. When children prepare to leave the EI Program, parents are asked to give written consent before the records can be shared with the LEA or other agency.

4.2 Resolution of Concerns
As an EI Provider, you are also responsible to inform eligible families of their rights and procedural safeguards, regarding due process. Impartial administrative proceedings are described in 34 CFR 303.170 et. seq. and in Rule 500, which includes information on a family’s rights, and procedural safeguards. A parent may submit a request to facilitate resolution of a dispute about the evaluation, identification, placement, delivery of services, or provision of appropriate services for their child. If a parent is unable to resolve issues on their own, there are three methods of dispute resolution available, which include:

4.2.1. Request for Investigation of State Complaint
A parent may request to file a written, signed complaint if they believe that IDHS, a CFC, or an EI Provider has violated provisions of Part C of IDEA. The Complaint states that copies should be sent to IDHS, the CFC and to the agency/individual(s) listed within the complaint. IDHS has sixty (60) days from receipt of the complaint to investigate and provide a written decision. During that time, IDHS will carry out an independent investigation. Documentation will be requested from individuals listed to assist in determining the validity of the complaint. The final decision will include conclusions and findings of the investigation. If the complaint is considered founded, procedures to correct the cause of the complaint will be incorporated.
4.2.2. *Request for Mediation*
Mediation is a voluntary session facilitated by a qualified, impartial Mediator. The Mediator is a neutral facilitator, who is not an employee of any agency or other entity providing EI Services, who helps the parties agree to a resolution but does not compel action by the parties. The Mediator is responsible for contacting all necessary parties and arranging the mediation conference. The mediation conference will be conducted on a mutually convenient date and time. Discussions held during mediation are strictly confidential. If an arrangement is reached, a mediation agreement will be developed that will include the terms and approval of all parties.

4.2.3. *Request for Due Process Hearing Officer*
Due process includes an administrative hearing, similar to a court hearing. The hearing officer is authorized to conduct the hearing, administer oaths, issue subpoenas to compel testimony or production of documents, rule on motions, grant continuances, call or examine witnesses, and take such other action as may be necessary to provide the parties with an opportunity to be heard fairly and expeditiously.

An impartial, administrative hearing officer will listen to both sides of the disagreement. The hearing officer may not be an employee of any agency or other entity that is providing EI services.

Parents may bring an advocate to the hearing and be given the right to open the hearing to the public.

The hearing must be resolved within 45 days, with a final decision completed and mailed to all parties. The 45 days begin the day after one of the following:

- The parties agree in writing to waive the resolution meeting, or
- A mediation or resolution meeting starts but the parties agree in writing before the end of the 30-day period that no agreement is possible, or
- The parties agree in writing to continue with a mediation at the end of the 30-day resolution period, but a party later withdraws from the mediation process.

The parent has the right to appeal the final decision and obtain a copy of the hearing record, findings, and decisions at no cost.

During the pendency of a proceeding, unless the parent and IDHS agree otherwise, the child must continue to receive the appropriate EI services identified in the most recent IFSP that the parents consented to. If the Request for Due Process Hearing involves application for initial services, the child must receive those services, which are not in dispute. While any dispute is pending, undisputed services to the eligible child must continue as previously authorized. During any of these disputes, you may be requested to submit documentation, provide a response to allegations or be present for a conference or hearing. These requests are considered administrative functions and are not billable to the CBO.

After resolution is reached, you will receive a response in writing from IDHS. If the allegations are founded, additional requirements to prevent future occurrences may be required.
4.3 Family Engagement
While in the EI Program, the parent/caregiver agrees to:

- allow EI to verify coverage of private insurance plans (Plan) to determine potential use and benefits to assist in meeting the costs of EI services and/or AT devices;
- check and confirm coverage of the Plan and cooperate by providing current and up-to-date Plan information;
- assist in prompt processing of any claims submitted to their Plan including turning over payment made directly to the family, for EI Provider payments, and notification to EI Providers of any rejections;
- review Explanation of Benefits (EOB) from the Plan and CBO;
- allow EI Providers to submit claims for any covered services subject to private insurance billing;
- inform the Service Coordinator immediately of changes or discontinuation of insurance company coverage of benefits;
- participate in family participation fees, if the family meets the definition of ability to pay and understand that services subject to fees that are delinquent for a period of 3 months (90 days) or more will be discontinued;
- inform the Service Coordinator immediately of any changes to household size or income, that could affect the family participation fee calculations;
- actively participate in the process of incorporating intervention strategies into family routines, and
- develop and maintain an ongoing parent-provider relationship to develop implement, monitor, and modify activities.

NOTE: Family participation fee questions should be answered by the family’s Service Coordinator. EI Providers should refrain from making assumptions of whether a family should or should not have to pay their fee.

Effective coaching interactions are the foundation of successful outcomes for children and families in EI. Providers should work with families and engage in strategies that will strengthen existing skills as well as develop additional capabilities to support the child’s development. This can occur during in person and Live Video Visits with families. Five characteristics of effective coaching are:

1. joint planning-talking with the parent/caregiver about what they would like to work on today and referencing previous session strategies to determine progress
2. observation-allow the parent/caregiver the opportunity to demonstrate what they have been doing between sessions, including what has been successful and what has been challenging
3. action/practice-demonstrate additional strategies or coach parents to add steps or adjust current interventions and allow time for parent/caregiver to practice during session
4. reflection-allow parents to reflect on past or new strategies by using open ended questions about previous or current practices and
5. feedback- affirm the family’s strengths and capacity to support their child’s development by providing informative feedback.
4.4 Family Outcomes Survey
Shortly after exiting the EI Program, all families will receive a family outcomes survey. The survey asks about the three family-centered outcomes:

a. understanding child’s strength, abilities, and special needs;
b. helping child develop and learn; and
c. knowing their rights.

This is a very important survey because the families’ responses are analyzed and used not only to help the Bureau of EI learn about the families’ experiences while in the EI Program but to also develop changes to improve EI services and supports and to assist in determining the training needs of the EI Providers. As a trusted EI Provider, your encouragement to families to complete the survey reinforces its importance. EI Providers should encourage families to look for and complete the survey.
Chapter 5: Individualized Family Service Plan (IFSP)

5.1 Description and Components

What is an IFSP?
The IFSP is a written document that includes desired outcomes, intended services, and a plan for making the transition to additional services when the child is no longer eligible for the EI program. The IFSP is a family-centered plan that recognizes the family as the primary source of love and support for their child. Since EI services are intended to be collaboration between Service Coordinators, EI providers and family members, the IFSP should emphasize the significant role the family has in facilitating the child’s development. The EI Providers are on the team to support the family in ways that really work or function for them. Together, the family, Service Coordinator and the EI Providers determine appropriate services by reaching consensus. Team members help the family identify functional outcomes that address the family’s main concerns and priorities. IFSP outcomes describe the changes and benefits that the family wants to see for their child and family.

The team often begins IFSP development by asking two questions of the family, including: 1. What benefits does the family want the child to receive from EI? and 2. What will be different or better for the child and family when these changes occur? The answers to these questions help the team focus on developing a plan that will be meaningful to the family. During the meeting to develop the IFSP, the family should be given the opportunity to understand other team members’ perspectives, make informed decisions, and reach consensus about the process that will help them reach their goals for their child and family.

Service Coordinators lead the IFSP team discussion to identify and develop IFSP outcomes relying on information that has been gathered throughout intake, evaluation/assessment and eligibility determination. IFSP outcomes must be developed by the team, and must be functional, meaningful and written in terms understood by all team members, including the family and other caregivers. IFSP Outcomes should not be written in discipline-specific language and should not be written by individual EI Providers.

The IFSP contains the following:
- contact information for the family and other useful resources;
- a summary of the information that the family chooses to share about their child and family;
- the developmental status of the child;
- child outcomes which are a comparison of the child’s current performance relative to typically developing same age peer children;
- functional outcomes for the child and family based on their priorities, resources and concerns;
- strategies for building family capacity to meet those desired outcomes as part of everyday routines and activities;
- identification of necessary services and supports to achieve those outcomes. The supports and plans for meeting the identified outcomes should be flexible enough to accommodate the child and family’s changing needs;
- transition steps and services;
- an implementation and distribution plan, and
- the family’s consent for services.
5.2 **Important IFSP Timelines**
According to federal and state requirements, the initial IFSP for eligible children must be developed within 45 days of their referral to the EI Program. The IFSP is then to be reviewed every six months or more frequently, if requested by the family. A new IFSP is developed on an annual basis. Transition Steps and Services is to be included in the IFSP **no fewer than 90 days before the child’s third birthday**.

5.3 **IFSP Requirements**

**Initial/Annual IFSP Development Process**
A minimum of two or more separate disciplines are required to complete initial and annual evaluations/assessments to determine or re-determine eligibility and assess the child’s ongoing need for EI services.

a. **Evaluations/Assessments**
   The team’s evaluation/assessment of the child shall include:
   - administration of the global and specific discipline’s evaluation and/or assessment tool;
   - collection of the child’s history (including interviewing the parent and updating the child’s medical and social history);
   - identification of the child’s level of functioning in each of the five developmental areas;
   - gathering of information from other sources such as family members, other caregivers, medical providers, social workers and educators, if necessary, to understand the full scope of the child’s unique strengths and needs, and review of medical, educational, and other records.

   At the annual review, children may remain in the system if they meet any of the current eligibility criteria. Children who do not meet current eligibility criteria upon re-determination will continue to be eligible only if they:
   - Continue to have any measurable delay; or
   - Have not attained a level of development in each of the following domains: cognitive, physical (including vision and hearing), communication, social or emotional, or adaptive, that is at least at the mean of the child’s age equivalent peers; and
   - Have been determined by the multidisciplinary team to require the continuation of EI services in order to support continuing developmental progress, pursuant to the child’s needs, and provided in an appropriate developmental manner. The type, frequency, and intensity of services will differ from the initial IFSP because of the child’s developmental progress, and may consist of only service coordination, and assessment

b. **Six-Month Reviews**
   The IFSP must be reviewed at least every six months. It can be reviewed more frequently if conditions warrant or upon request of the family. EI Providers should prepare a report that summarizes the child’s progress towards IFSP outcomes and the child’s response to intervention. This report should be provided to the family and service coordinator prior to an IFSP meeting. No formal evaluations are required for six-month reviews. Six-month reviews must include, at a minimum, the family and the service coordinator. If changes to IFSP outcomes are services are being recommended, the full IFSP team must be convened and the *Developmental Justification of Need to Change Frequency, Intensity or Location of Authorized Services Worksheet* must be completed.
5.4 **EI Provider’s Role in the IFSP**
EI Providers play an integral role in the development of a child’s IFSP. In order to facilitate the development of a quality IFSP, providers should submit their evaluation/assessment and/or progress reports to the Service Coordinator prior to the IFSP meeting. After the IFSP meeting, the Service Coordinator, in turn, should send the IFSP to the ongoing service providers within 15 days of the plan’s development. The Service Coordinator will schedule IFSP meetings in order to maximize the participation of required team members.

Each IFSP meeting must include the following participants:
1. the parent or parents of the child
2. other family members, as requested by the parent, if feasible to do so
3. an advocate or person outside of the family, if the parent requests that the person participate
4. the Service Coordinator responsible for implementation of the IFSP
5. EI Providers directly involved in conducting the evaluations and assessments
6. EI Providers who will be providing EI services to the child or family

IFSP meetings must be held in settings and at times that are convenient to the family and in the family’s native language or other mode of communication used by the family, unless it is clearly not feasible to do so.

EI Providers are required to attend the entire IFSP meeting in order to receive authorization for payment, whether attending the meeting in person or participating via a telephone conference call. EI Providers who are directly involved in conducting the Evaluation/Assessment that cannot attend the IFSP meeting due to exceptional circumstances, will need to make arrangements to participate in the meeting by telephone conference call. EI Providers must accept responsibility for telephone charges for IFSP conference calls but attendance via telephone should not be allowed if done for their convenience.

**NOTE:** Payment will not be made for “partial” meeting attendance, nor should it be requested.

EI Providers, who attend IFSP meetings, should request a copy of the IFSP meeting authorization from the Service Coordinator prior to leaving the meeting, or the IFSP meeting authorization number if the Service Coordinator is unable to print the authorization. If internet access is not available, EI Providers should follow up with the Service Coordinator immediately after the conclusion of the meeting to ensure that they receive an authorization for their participation in the IFSP meeting.

The IFSP will contain the team’s recommendations for service delivery, including discipline, intensity, frequency, and location. EI Providers are required to check their authorizations for accuracy. Authorizations should match the team’s recommendations listed on the IFSP. EI Providers should contact the child’s Service Coordinator immediately if an error is identified and should not provide services to a child/family without an accurate authorization in their possession.

5.5 **Outcomes**

5.5.1 **IFSP Functional Outcomes**
As mentioned earlier, IFSP functional outcomes describe the changes and benefits that the family wants to see for their child and family. In general, the functional outcomes describe changes that are likely achievable in the next six to twelve months. The number of IFSP functional outcomes that are developed on an IFSP depends on the priorities that the family most wants to address immediately. The team needs to reflect what is reasonable and not overwhelming to the family. Functional Outcomes should be developed through a team
process and should be worded in a way that is understandable to the family as well as other team members.

High quality IFSP functional outcomes:

- are necessary and functional for the child’s and family’s life
- reflect real-life contexts/settings
- integrate developmental domains and are discipline-free
- are jargon-free, clear, and simple
- emphasize the positive, not the negative
- use active rather than passive words

It is expected that IFSP functional outcomes will be addressed in the context of the child’s natural environment. If the team determines that a functional outcome cannot be achieved in the child’s natural environment, the team must complete a Natural Environments Worksheet which will describe where the service will be provided, why the functional outcome cannot be achieved in the natural environment, and a plan for transition to the child’s natural environment.

The IFSP will also list the strategies that the family and other team members can utilize to help the child and family achieve the identified functional outcomes. IFSP strategies specify who will do what in which everyday routines, activities and places. Ultimately, these strategies help the family facilitate their child’s development when interventionists are not present.

IFSP strategies:

- help achieve the identified outcome
- are based on how all children learn throughout the course of everyday life, at home, in early care and education settings, and in the community
- are developmentally appropriate for the child
- focus on naturally occurring learning opportunities
- support primary caregivers’ efforts to provide the child with everyday learning experiences and opportunities that strengthen and promote the child’s competence
- support learning that occurs in the context of activities that have high levels of interest and engagement for both the child and family

5.5.2 Child Outcomes

Illinois has established an early childhood outcomes (accountability) system which enables the lead agency to monitor children’s development in order to support effective intervention, demonstrate system impact, and inform decisions about program improvement. Early intervention supports young children with disabilities and their families. For children, the ultimate goal of this support is to enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings. The early childhood outcomes system allows us to respond to federal requirements for reporting

---

child outcomes to the Office of Special Education Programs (OSEP). States are required to collect annual data on the extent to which the children served are making or are not making progress as a result of receiving services relative to three functional outcomes. The three child outcomes assess the degree to which we are meeting the program’s goals by reviewing children’s progress (reference section in Appendix with child development and age anchoring resources):

1. **Positive social-emotional skills (including social relationships)** - this outcome involves relating to adults, relating to other children, and for older children following rules related to groups or interacting with others. The outcome includes concepts and behaviors such as attachment/separation/autonomy, expressing emotions and feelings, learning rules and expectations in social situations, and social interactions and social play.

2. **Acquisition and use of knowledge and skills (including early language/communication)** - this outcome involves activities such as thinking, reasoning, remembering, problem solving, number concepts, counting, and understanding the physical and social worlds. Earlier on, this may be seen through cause and effect games, obtaining objects for play, and exploring the environment.

3. **Use of appropriate behaviors to meet their needs** - this outcome involves behaviors like expressing needs, taking care of basic needs, getting from place to place, using tools (such as forks, toothbrushes, and crayons), and, in children 24 months or older, contributing to their own health, safety, and well-being. Early in life, this includes crying to get needs met, learning to use motor skills to complete tasks; and participating in self-care such as dressing, feeding, and grooming.

Illinois examines child outcomes using the Child Outcomes Summary (COS) process. Each CFC is responsible for collecting the COS data and reporting child outcomes for every child with an active IFSP. This summary relies on a team process conducted within the IFSP meeting that utilizes information from the various family member(s) and professionals who know the child. The accuracy of the summary is dependent on dialogue between all team members in order to understand the child’s functioning across settings and situations. SCs are responsible for facilitating the discussion among team members in a way that is respectful, supportive, and enhances the capacity of the family.

Families/caregivers are vital members of their child’s IFSP team and play an important role in the COS process. Parents and caregivers are experts on their child’s everyday development and hold key information and unique insights about their child’s behavior across settings and situations. In order for a meaningful COS discussion that includes parents/caretakers to occur, the following should be considered.

<table>
<thead>
<tr>
<th>Event</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>• SC explains to the family what the child outcomes are, why child outcomes</td>
</tr>
<tr>
<td></td>
<td>data are collected, and how they are used</td>
</tr>
<tr>
<td></td>
<td>• SC provides information about how the family can contribute to the COS</td>
</tr>
<tr>
<td></td>
<td>discussion</td>
</tr>
<tr>
<td></td>
<td>• SC helps family understand that COS process is necessary for determining</td>
</tr>
<tr>
<td></td>
<td>the impact of early intervention services on the child’s development</td>
</tr>
<tr>
<td></td>
<td>• COS data required for federal accountability; all children are to be included</td>
</tr>
<tr>
<td></td>
<td>in annual reporting</td>
</tr>
</tbody>
</table>

R07/2022
• Let family know that the COS information is for evaluating the program, not their individual child

| IFSP Preparation | SC will review the information that has been collected to make sure that it provides a comprehensive picture of the child’s functioning across the three outcomes. Possible sources of information include reports from parents and/or other caregivers, information collected during intake (RBI and ASQ: SE), information from the referral source, evaluations, observations, and progress reports.
• SC ensures that, between all contributing team members, there will be enough information about age-expected development, the child’s skills and behavior across settings and situations, and how many of the child’s skills in each outcome area are age-expected, immediate foundational, or foundational to complete the COS process.
• SC reminds family that COS discussion is part of IFSP development
• SC prepares resources to be used to facilitate discussion

| IFSP Meeting | SC reminds family why COS data is collected and how it will be used
• SC reviews information about the breadth of the three outcomes and the focus on functional performance across developmental domains
• SC reminds every one of the importance of all team members’ input in the COS process
• SC provides any resources necessary for successful team discussion, e.g. outcome definitions and child development information
• SC ensures that family’s questions have been answered and that family is ready to participate in discussion

5.5.2.1 Child Outcomes Summary Process
In order to obtain an accurate picture of the child’s development, the following process should be used.
• Once the outcomes are described, the service coordinator should invite the family to share information about their child’s functioning for each outcome area, calling attention to, or asking questions about, any differences in the child’s behavior across settings or situations.
• Other team members should also share information about the child’s current functioning in each outcome area using multiple sources of information, e.g. parent interview, observations, evaluations/assessments, progress reports.
• Team members should discuss the child’s functioning for each outcome area by focusing on how the child uses functional skills in meaningful ways.
• This discussion should also include information about age-expected development and how close the child’s skills and behaviors are to age-expected development.
• Based on all this information, the SC will facilitate the discussion that leads to team consensus about the child’s performance in each outcome area, resolving any differing opinions about the rating. Full team participation is essential for valid ratings.
• The SC will summarize this consensus by picking the appropriate descriptive statement, as listed in the Appendix, for the related point on the rating scale, confirming with the group, and documenting the discussed supporting
information on the IFSP in the space provided for questions 8, 9, and 10 on the EI Levels of Development screen.

- A properly completed EI Levels of Development screen will have narratives that contain the following information:

  1. Questions 1 and 2 should capture the information discussed about the strengths and priorities of the family and the overall health status of the child, including hearing and vision information if it is available.

  2. Questions 3 through 7 should include the results of evaluations/assessments, parent interviews, record reviews, and observations that help describe the child’s functioning in the 5 domains.

  3. Questions 8 through 10 should capture the Child Outcomes Summary information discussed by the team. For Part A of each question, indicate the rating number from the team discussions at initial IFSP, annual IFSP and exit review. Part B of each question must be answered at annual and exit to indicate the team’s decision on progress. Remember, the answer to the progress question should reflect new skills and behaviors acquired since the child’s INITIAL child outcomes summary discussion. It is possible for a child’s numerical rating to stay the same or go down with the answer to the progress question still being ‘yes’. The narrative section under Part B is to be completed each time a COS is completed. This narrative should capture the team discussion around each outcome, highlighting functional skills (not just evaluation/assessment tasks) across the domains that are related to each outcome, describing the child’s performance across settings and situations, and indicating how close the child’s skills are to age expectations (see Appendix XX for examples).

  4. The Sources tab should also be completed indicating the Source (who), Assessment Instrument, if applicable (what) and Date (when) of the team discussion.

- If input for the COS discussion is provided by someone who is not attending the meeting, that should be indicated in the SC case note for the meeting.

5.5.2.2 Timeframe and Participants for Completion of the COS Ratings

Initial IFSP - The child outcomes will be collected at the initial IFSP after eligibility is determined by the IFSP team.

  1. During the process of creating the Initial IFSP, the SC should conduct the COS team discussion in conjunction with gathering information about the child’s present levels of development.

  2. The team should utilize information gathered as part of the COS discussion to create meaningful Functional IFSP Outcomes based on the unique strengths and needs of the child and family and the information discussed by the team.

  3. The team should include, at a minimum, the child’s family member(s), Service Coordinator (SC), and evaluators. Team may also include others who the parent feels may be important sources of information about the child and who may be part of the child’s caregiving team, e.g. childcare provider, extended family member, non-system service provider.
**Annual IFSP -** The COS information is reviewed at each annual IFSP meeting along with a review of the child’s progress.

1. As part of the annual IFSP review, the team should discuss the child’s current levels of development and the child’s progress towards IFSP Outcomes. Then, the team should determine if the existing IFSP Outcomes need updating or if they should continue based on that discussion.

2. The team should use the COS process to frame the discussion on the child’s current functioning as this can help the family and other team members think about how IFSP Outcomes can support continued development.

3. At annual meetings, the team should include, at a minimum, the child’s family member(s), SC, and all direct service providers. The team may also include others who the family feels may be important sources of information about the child and who may be part of the child’s caregiving team, e.g. childcare provider, extended family member, non-system service provider.

**Exit IFSP -** Exit data needs to be reported for children as they prepare to exit and/or transition to other programs or services outside of EI.

1. For children exiting prior to age three who met their Functional Outcomes and no longer require EI services, collect COS data during the exit meeting to assess the impact of program services and identify next steps for the child’s development.

2. For children exiting and transitioning at age three to Special Education or other appropriate programs, collect COS data at the exit meeting. *Please note that exit COS data (for children exiting for either reason) must be collected within 120 days of exiting the program.* The exit COS can be collected in combination with meetings for other purposes, e.g. transition planning conference, as long as the participants and timing meet requirements.

3. At the exit meeting, the team should include, at a minimum, the child’s family member(s), SC, and all direct service providers. Team may also include others who the parent feels may be important sources of information about the child and who may be part of the child’s caregiving team, e.g. childcare provider, extended family member, non-system service provider.

5.5.2.3 Important points to consider for meaningful child outcomes summary discussions:

- The COS information can play an integral role in helping the team understand the child’s strengths and needs and how intervention can build on these strengths and address the needs.

- The COS process is intended to be part of the IFSP meeting and utilize much of the same information, e.g. evaluations, observations, progress reports, that will help inform other parts of IFSP development.

- The COS discussion is likely to be most meaningful if the service coordinator facilitates the discussion in conjunction with the portion of the IFSP meeting that includes the child’s present levels of development. This helps to reinforce information shared during the review of evaluations and may help ensure shared understanding of the child’s overall developmental strengths and needs.

- The Decision Tree is a tool that, when used well, can guide the team to consensus on each individual outcome. If used as a resource, the Decision Tree
is not be used as a “checklist” and teams are encouraged to be sensitive to how the discussion might occur when the child’s functioning is farther from age-expectations. As meeting facilitator, the service coordinator can use this tool to help the team consistently determine ratings by leading them through a series of yes/no questions about the child’s functioning relative to age-expected, immediate foundational, and foundational skills.

- It may also be helpful to keep the following developmental information in mind during the COS process:

1. Children develop new skills and behaviors and integrate those skills and behaviors into more complex behaviors as they get older.

2. These skills and behaviors emerge in a somewhat predictable developmental sequence in most children, thus allowing for descriptions of what two-year olds generally do, what three-year olds generally do.

3. Since skills and behaviors build on earlier skills and behavior in predictable ways, interventionists can use these earlier skills to help children move to higher levels of functioning. Earlier skills that serve as the base and are conceptually linked to age-expected skills, are referred to as “immediate foundational skills.” For example, children play alongside one another before they interact in play.

4. Some children’s functioning is farther from age-expected development. These children may acquire skills and behaviors at a substantially slower pace than other children and their functioning may look like that of a much younger child. When children demonstrate skills that are not immediately linked to age-expected skills, they are considered to be demonstrating foundational skills.

5. Some children’s development is atypical in that their functioning is not typical for children at any age. Teams will need to consider how much atypical behavior exists in relation to each of the three outcomes.

5.6 Developmental Justification of Need

Decisions about services and their related location, intensity, and frequency are to be made by the IFSP team. It is not uncommon for a change in one service on the child’s IFSP to impact other services. In order to ensure that teams are in compliance with federal legislation, are addressing the Principles of Early Intervention and other important policies, rules, regulations, and guidelines required, EI Providers must submit a written Developmental Justification of Need and the EI Provider Developmental Justification to Change Frequency, Intensity and/or Location of Authorized Services Worksheet (Worksheet) to the Service Coordinator for any requested changes to existing authorizations for the time period between annual IFSP meetings.

EI Providers who wish to request an increase or decrease in the frequency, intensity and/or change the location of an existing authorization must submit a written Developmental Justification of Need to the child’s Service Coordinator. Upon receipt of a written Developmental Justification of Need that contains all required information found in the Worksheet, the Service Coordinator will convene an IFSP team review meeting. If changes are requested within the first three (3) months after the development of an IFSP, the original multidisciplinary IFSP team must reconvene. If changes are requested more than three (3) months after the development of an IFSP, the child’s current multidisciplinary IFSP team must participate in the IFSP review meeting. The EI Provider who is recommending the change(s) must be in attendance and the IFSP team must agree that a change from the team’s original recommendation(s) is
needed and is in the best interest of the child/family. Instructions for completion and the Worksheet are listed in Attachment 10.

5.7 **IFSP Development Activities**

IFSP development activities allow the IFSP team to develop and enhance implementation of the child’s IFSP. These activities primarily support the development of the IFSP, reporting of child progress, communication among team members, adjustments to the IFSP, and transition planning. These activities must be completed by the credentialed, enrolled EI Provider. IFSP development includes:

1. attendance at the initial/annual IFSP-meeting as a member of a child/family’s service team to assist in the completion of a written document on the statewide IFSP form detailing individualized outcomes for the child and family, services as well as the determination of service modalities based upon the unique needs of the child and family, and transition strategies;

2. periodic review of a child’s IFSP (every six months or more frequently if conditions warrant, or if the family requests such a review) to determine if adjustment of the IFSP is needed;

3. attendance at the transition planning conference meeting, if not combined with IFSP, if required.

4. attendance at a child’s IEP meeting if the meeting occurs prior to the child’s third birthday, required due to the Early Intervention/Extended Service option;

   **NOTE:** The EI Program does not pay for attendance at pre-IEP meetings.

5. development of a direct service progress report required for the six-month review;

6. development of a discharge report;

7. development of an Assistive Technology Letter of Developmental Necessity written by an Audiologist, Occupational Therapist, Physical Therapist, or Speech Therapist for the CFC to submit to IDHS for Assistive Technology (AT) prior approval;

8. conversations with the vendor concerning the fit and/or use of the AT device after the child/family has received the device;

9. completion of written justification by an EI Provider who is requesting a change to the frequency or intensity of an existing service authorization that will be attached to the form entitled Developmental Justification to Change Frequency, Intensity, and/or Location of Authorized Services Worksheet, and

10. EI Provider-to-EI-Provider consultation performed by the credentialed, enrolled EI Provider among members of the child’s service team who are identified on the IFSP as EI Providers of EI services, the CFC parent liaison, the CFC social emotional consultant, the Service Coordinator and the child’s physician concerning the child’s developmental needs, or the impact of special health care needs on services.

11. IFSP Development activities can support team members’ interactions with certain people outside of the IFSP team when the family has consented to an exchange of information. This enhanced use of IFSP Development time is allowed to help families as they transition between EI services (change in team members); as they transition out of EI services, (to the LEA for a child turning three, Early Head Start, or Head Start Programs) and as they participate in other programs such as DCFS, DSCC and other early childhood programs such as Home Visiting programs, Child Care, etc.

A list of activities that are not considered IFSP development and important notes for documentation of IFSP development time may be found in Chapter 23: Glossary and Abbreviations, under **IFSP development time**. Additional instructions about billing may be found in Chapter 6: Billing Guidelines and Use of Insurance.
### 5.8 IFSP Development Time

IFSP Development time must be supported with detailed case notes, see additional information in Chapter 23: Glossary and Abbreviations for definition.

<table>
<thead>
<tr>
<th>IFSP Development Activity</th>
<th>What it DOES looks like…</th>
<th>What it DOES NOT look like…</th>
</tr>
</thead>
</table>
| **IFSP EI Provider-to-EI Provider Consultation** | *All consultation should revolve around the child’s and family’s needs, IFSP functional outcomes, health, services, development, transition, progress, etc.* | Consulting with EI Providers that are identified on the IFSP regarding the child’s progress, outcomes, etc. **Note:** Detailed documentation of discussion are required.  
- Team members may also include:  
  - CFC Parent Liaison  
  - CFC Social Emotional Consultant  
  - LIC Coordinator  
  - Family’s CFC Service Coordinator  
  - Child’s Physician  
  - Early Childhood Professionals, Home Visiting, DCFS, Child Care, etc.  
  - This time may be bundled together, meaning one day you talked for five minutes and the following day you talked for 10 minutes, you then may bill for 15 minutes using the last date for billing. | Talking on the telephone with parents about scheduling or regarding the child’s progress, with the exception of emergency situations using phone consultation  
- Leaving voicemails  
- Speaking to interpreters  
- Staff supervision time  
- Routine preparation time (review of record notes, creation of learning materials, etc.)  
- Consulting with EI Providers not identified on the IFSP, without specific consent, or not described within 3.12.7. d. |
| **Meeting Attendance** | Attendance at:  
- Initial and Annual IFSP meeting as a member of the team (in person or by telephone)  
- IFSP 6-month review meetings  
- Transition meetings  
- IEP meeting if before the child’s 3rd birthday | Billing for full IFSP meeting time, when only called in for a portion of the meeting time  
- Billing at an *offsite* rate for participating by telephone, which is considered onsite  
- Attendance of Associate-Level EI Providers in meeting without Supervisor’s presence.  
*This does not apply to SLP Assistants in their Clinical Fellowship Year (CFY).*  
- Attendance at school eligibility meeting  
- Attendance at child’s IEP after his or her 3rd birthday |
| **Report Writing** | Creation of the:  
- Six-month Review Report  
- Discharge Report  
- Developmental Justification to Change Frequency, Location and/or Intensity worksheet  
- Assistive Technology Letter of Developmental Necessity | Rounding time, meaning billing for 60 minutes when it took 50 minutes to write any report  
- Billing for writing reports not related to EI services  
- Revisions of reports due to EI Provider errors |
<table>
<thead>
<tr>
<th>IFSP Development Activity</th>
<th>What it DOES looks like…</th>
<th>What it DOES NOT look like…</th>
</tr>
</thead>
<tbody>
<tr>
<td>(completed by Audiologist, OT, PT or SLP)</td>
<td>• Private Insurance verifications or recertifications, as required</td>
<td></td>
</tr>
</tbody>
</table>

*IFSP development must always be completed by the credentialed and enrolled EI Provider.*

*Phone Consultation for provider to family may be used to discuss progress with provided strategies during a Pandemic only.*
Chapter 6: Billing Guidelines and Use of Insurance

6.1 Billing in Early Intervention
After the EI Provider is enrolled with an EI Payee, they are required to bill the CBO for reimbursement for services provided. Listed below is a brief outline of billing procedures. A more detailed document entitled “Billing Information for Providers” can be found on the CBO website at https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf.

6.2 Billing Guidelines and Forms
EI Providers should bill the CBO at their usual and customary rate. The amount billed to the CBO must match the amount billed to the insurance company, if applicable. By signing the EI Provider agreement, an EI Provider accepting the EI authorization also agrees to:

- Not bill the family directly for authorized direct services unless the insurance payment was paid to the family versus the EI Provider, and you have a copy of the signed Child and Family Connections Consent to Use Private Insurance/Healthcare Plan Benefits and Assignment of Rights form in hand.
- Accept the insurance payment in full unless the payment is less than the EI rate. If the insurance payment is less than the EI rate, bill the CBO the same rate that was billed to the insurance company and the CBO will process payment for the difference in the insurance paid rate versus the EI rate.
- Not bill the family directly or their insurance for screening, evaluation, and assessment services or IFSP development. These are services that must be provided at no cost to the family per Federal law (Part C of the Individuals with Disabilities Education Act).
- Maintain accurate records, including daily documentation of services for each date of service billed, including IFSP time, for a period of at least six years from the child’s completion of EI services (please see documentation definition found in the Glossary section of this document).

NOTE: In a monitoring review or audit it is the entity that submits claims and receives payments (payee) for each date of service and each procedure code billed to and paid by the CBO who is responsible for providing documentation for review. Failure to provide documentation will result in a refund. Therefore, it would be to the advantage of the payee to require all employees or contracted employees to submit documentation to support billing and payment prior to submitting claims to the CBO for payment.

- Electronic Billing
Electronic billing is the preferred method of claim delivery to the CBO. Providers should submit claims to the CBO electronically if the service does not get billed to private insurance. If the authorization states No Private Insurance, Private Insurance Declined or Not Billable to Insurance, submit the claim to the CBO. Claims may be submitted directly to the CBO using the software of the EI Provider’s choice that is compliant with the CBO system or by sending claims through the Qclaims billing software provided at no cost to the EI Provider. Information on how to sign up for Qclaims is available on the CBO website at: https://eicbo.info/providers/qclaims/.

NOTE: Electronically billed claims may not be transmitted into the CBO system the same day they are transmitted by the provider. Due to the 90-day filing limit, please allow ample time for claims to be received at the CBO. Electronic systems may have process that take up to two (2) days for the claim to be received by the CBO. Best Practice is to bill well before the filing limit. The CBO will also accept typed paper claims submitted on the CMS-1500, printed claim forms from Qclaims and UB-04 claim forms only. Refer to the service description for your discipline for the EI payment.
rates but remember the EI Provider must bill using their routine and customary rate regardless of payment rates.

- **Transportation Billing Form**
  Providers and parents who bill for transportation services must use the *DHS Transportation Billing* form when submitting claims to the CBO. Insurance is not required to be billed for this service nor is a diagnosis code required on Transportation claim submissions. For more detailed information on transportation billing requirements, please review:

  - *Chapter 21: Transportation* of this handbook
  - *EI CBO Billing Information for Providers*  
    [https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf](https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf)
  - *Electronic Transportation Claim*  
  - *Transportation Billing Forms and Instructions*  
    [https://eicbo.files.wordpress.com/2017/05/transportation-billing-form.pdf](https://eicbo.files.wordpress.com/2017/05/transportation-billing-form.pdf)

- **Interpreter/Translator Billing**
  Interpreters must indicate the type of service provided in Box 23 of the CMS-1500 form when submitting claims to the CBO. Insurance is not required to be billed for this service nor is a diagnosis code required on Interpreter/Translator claim submissions. For more detailed information on interpreter and translator billing requirements, please review:

  - *EI CBO Billing Information for Providers*  
    [https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf](https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf)
  - *Billing Tips for Interpreters, Translators and Interpreters for the Deaf*  
    [https://eicbo.files.wordpress.com/2017/05/billing-tips-for-interpreters-translators-and-interpreters-for-the-deaf1.pdf](https://eicbo.files.wordpress.com/2017/05/billing-tips-for-interpreters-translators-and-interpreters-for-the-deaf1.pdf)

- **Direct Deposit of Payments**
  EI Providers are strongly encouraged to sign up for Direct Deposit which allows for electronic payments through the Illinois Office of the Comptroller (IOC). To enroll, contact IOC directly at 217/557-0930. By enrolling, EI Providers also have access to more innovative tools offered by IOC, such as Enhanced Vendor Remittance at [https://illinoiscomptroller.gov/vendors/enhanced-vendor-remittance1/](https://illinoiscomptroller.gov/vendors/enhanced-vendor-remittance1/) and ILPays mobile application at [https://illinoiscomptroller.gov/services/ilpays-app/](https://illinoiscomptroller.gov/services/ilpays-app/).

  Additionally, Public Act 97-0969 stipulates that an itemized voucher for under $5 that is presented to the IOC for payment shall not be paid except through electronic funds transfer (direct deposit). In other words, any EI payment processed and approved for payment for an amount under $5 cannot mailed to the payee.

- **Non-Billable Activities**
  Unauthorized services - All EI services are pre-authorized. Providers should never deliver any service without an authorization in hand. Services provided prior to receipt of the authorization are not guaranteed for payment. Services provided prior to the begin date and after the end date of the authorization are considered non-authorized services and will not be paid by the CBO.
Additional non-billable activities include, but are not limited to:

1. Weekly or daily preparatory activities for direct service sessions. This is considered to be administrative time that is built into the rate.
2. Preparing claims to submit to the CBO or for private insurance, including verification and re-certification of benefits;
3. Child/family no shows;
4. EI Provider no shows;
5. Partial service sessions. EI Providers should never bill for a full-service session if they did not actually provide a full-service session. Only bill for the time actually spent with the child/family.
6. Development of “Picture Communication Programs”. A therapist can provide family training, education and support services to teach a family how to develop a picture communication program during a direct service session only. The EI Program does not pay for therapists to develop picture communication programs for a child/family;
7. Auditory Integration Training (AIT) and other Listening Programs;
8. Professional research and training;
9. Time spent speaking with a parent to talk about non-EI related issues (parent may need to be referred to a professional counselor outside of the EI Program to manage social emotional issues);
10. Services provided via the telephone. The EI Program does not pay for EI Providers to deliver services to a child/family via the telephone. The exception is for Social Work and other Counseling Service providers who are charged with “identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services”;
11. Time spent helping the parent/caregiver to identify and/or access other services and/or resources that the EI Program does not pay for (i.e., temporary housing, applying for SSI benefits). This service falls under the role and responsibility of the Service Coordinator and/or a Counselor. Notify the Service Coordinator of the family’s needs;
12. Services over the frequency/intensity that has been identified as a need in the child’s IFSP. If service needs require an increase in time over the authorized frequency/ intensity identified on the IFSP, adjustments must be made to the IFSP and authorization prior to billing;
13. Services that fall within the frequency/intensity identified on a child’s IFSP, but were never documented or provided;
14. Time to attend a medical appointment with the parent/caregiver;
15. Time to collect medical documents or other written medical information from physicians, hospitals, nurses, etc. This is the responsibility of the Service Coordinator.
16. Time to attend an appointment with another EI Provider unless you are the Interpreter for the EI Provider/parent/caregiver or co-treatment has been identified as a need and has been written into the child’s IFSP;
17. Verbal interpretation for non-EI services;
18. Written translation of non-EI documents such as Supplemental Security Income (SSI) applications, Woman, Infants, and Children (WIC) applications, Medicaid applications, car seat applications, medical records, insurance explanation of benefits, recipes, newsletters, or any other type of document that is not considered an EI document. Examples of appropriate EI documents include the IFSP, EI evaluation/assessment reports and letters to the parent/caregiver from the Service Coordinator or the EI Provider;

19. Clerical duties such as scheduling/canceling appointments and notifying the EI Provider of such, (the exception to this rule are services provided by an Interpreter) accessing voice mail, leaving voice mails messages, etc.;

20. For Interpreters, time to relay information from a EI Provider via a telephone call to a family other than scheduling information. Calls to parents/caregivers to discuss issues and concerns on behalf of the EI Provider are not allowable services. EI Provider should speak to the parent/caregiver about any issues or concerns they might have during direct service sessions. For Service Coordinators, Interpreters may speak to the family via the telephone (conference call) or in person about other issues if the Service Coordinator is present with the family. The responsibility of the Interpreter is to simply interpret the words of the Service Coordinator to the parent/caregiver and the parent’s/caregiver’s words back to the Service Coordinator.

21. Transporting the child/parent to a medical service. EI pays for authorized transportation services, by enrolled transportation EI Providers only, to and from authorized EI Services only;

22. For Transportation EI Providers: Non-loaded mileage - Transportation procedure codes can only be billed for loaded mileage. Loaded mileage means that the child is in the vehicle and is being transported to or from an EI service;

23. For Transportation EI Providers:  Employee attendants – EI pays for non-employee attendants only;

24. Lekotek services;

25. Lunch/snack time;

26. Nap time;

27. Loading a child into a vehicle to transport;

28. Rounding up units of service (i.e. provided 50 minutes of service but billed for 60 minutes);

29. Time spent to read an article that will be discussed at an agency staff meeting;

30. Attendance at an agency staff meeting - EI only pays for attendance at IFSP meetings, six-month or annual reviews or more frequent reviews called by the Service Coordinator if required, transition meetings, child outcome meetings as a member of a child’s service team which has been identified on a child’s IFSP, and IEP meetings that occur prior to a child’s third birthday;

31. Supervision time;

32. Provider travel time to or from an offsite location;

33. Extended warranties for assistive technology equipment and devices; and

34. Anything not listed as a billable service in this document.
35. Use of non-approved evaluation/assessment tools not listed on Early Intervention Approved Evaluation and Assessment Instruments listing which may be found electronically at: www.dhs.state.il.us/page.aspx?item=86067. A refund for any payments made will be required.

6.3 Private Insurance Use in Early Intervention
Private insurance use is mandatory in the EI Program unless, the following occurs:

• a pre-billing waiver or exemption has been approved before the start of services;
• a post-billing waiver has been issued after an acceptable insurance EOB shows services not covered or maximum sessions have been reached, or
• the parents/caregivers have private insurance that is employer self-funded and has declined use of their private insurance.

If a child’s parent/caregiver has a primary insurance, it must be billed before seeking further reimbursement from the CBO. When billing a child’s primary insurance all Payees should bill based upon the EI Providers treating diagnosis ICD code and treating CPT and/or HCPCS codes. They should not bill based upon information found on the EI IFSP, EI authorizations or from the physician’s medical diagnosis. The primary insurance EOB must accompany all claims submitted to the CBO for further reimbursement and for claims paid in full by the primary insurance.

Parents/caregivers whose children are enrolled under private insurance plans that are not employer self-funded are required to use their benefits to assist in meeting the costs of covered EI services and Assistive Technology devices unless an insurance exemption or pre-billing waiver has been approved prior to services being rendered or post billing waiver based on approved insurance EOB received showing services not covered or maximum benefits received. Insurance exemptions and Pre-Billing Waivers cannot be backdated and only cover dates of service after the approval date. Families whose children are enrolled in private insurance plans that are employer self-funded must provide informed consent prior to use of their plan to assist in meeting the costs of covered EI services and AT devices or may choose to decline insurance use.

Private insurance plan benefit verification must be done by the EI Provider to ensure compliance with all insurance requirements as well as knowledgeable of the plan and the coverage and/or reimbursement for the EI Provider. Based on EI policy and procedures to exempt certain insurance plans if the plan has any type of “tax savings account”, commonly called Health Savings Accounts or Medical Reimbursement Accounts, that automatically withdraw funds when claims are processed, the EI Provider must know to ask appropriate questions during their benefit verification contact. If anything indicates a need for a waiver or exemption, the EI Provider must contact the Service Coordinator immediately to take the necessary steps.

Once insurance use has been established, it must be used unless an insurance exemption or pre-billing waiver has been approved prior to services being rendered, or a post-billing waiver has been approved following the receipt of the EOB. Insurance exemptions and Pre-Billing Waivers cannot be backdated and only cover dates of service after the approval date.

For extended services, insurance benefit verifications (BV) are only needed when the family’s insurance changes or a new/revised IFSP is completed. Meaning, if a new service is added to a current IFSP, that service would require a new BV/Waiver, if applicable. If original recommendations for services remain on a current IFSP and that IFSP is then extended, no additional BVs will need to be done. No new waivers/exemptions are needed as they will be extended also. It is important to keep in mind, that if at any time, a family has a change of insurance, a new BV/Waiver will be required. As a friendly reminder,
the Service Coordinator is able to submit the annual BV up to 30 calendar days in advance prior to the annual meeting. This will allow for any necessary waivers or exemptions to be issued prior to the beginning of the new IFSP. This will in turn help prevent any gaps in the effective dates. Quick way to help remember this is: New IFSP = New Waiver(s). Extended IFSP = Extended Waiver(s).

**Services Billable to Insurance**
- Assistive Technology
- Aural Rehabilitation and other related services
- Health Consultation
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Psychology and other counseling services
- Social Work and other counseling services
- Speech Therapy
- Vision Services

An EI Provider must complete and document the results of their own benefits verification when receiving a referral. An EI Provider must contact the insurance company to obtain a detailed verification of benefits before accepting the referral. If the EI Provider does not meet the mandates of the insurance policy, such as enrollment, precertification or electronic enrollment, etc., the EI Provider must give the referral back to the CFC. If an EI Provider thinks an Insurance Exemption or Pre-billing Waiver is necessary but one has not already been requested and/or issued, the EI Provider must contact the CFC office immediately. This contact with the CFC must occur prior to rendering services.

**Services Not Billable to Insurance**
- Assessment services
- Audiological Exam
- Deaf Mentor
- Developmental Therapy (DT)
- DT-Hearing
- DT-Orientation/Mobility
- DT-Vision
- Evaluation services
- IFSP development services
- Interpretation
- Medical Services (for diagnostic and/or evaluation)
- Parent liaison services
- Service coordination
- Translation
- Transportation

### 6.4 EI Provider Responsibilities

The EI Provider will complete the following steps to document insurance benefits verification and billing as required by EI policy.

1. All EI Providers are required to bill private insurance for direct services prior to billing the CBO except in the following situations:
   a. an insurance exemption or pre-billing waiver has been approved prior to rendering services;
   b. the EI Provider is a DT, Interpreter, Deaf Mentor, Transportation EI Provider, Parent Liaison or a Physician providing Medical Diagnostic services only, or
   c. the service is for evaluations, assessments, IFSP development, or anything else that is not considered a direct service to the child/family. The family and the EI Provider, in cooperation with the insurance company, will determine insurance benefits for direct service provision purposes.
   d. The direct service authorization flag indicates insurance use declined.
2. The EI Provider must verify that services identified on the IFSP are a covered benefit under the insurance plan. There may be multiple plans. For example, vision or speech-related services might be covered in a separate policy. The EI Provider must thoroughly review private insurance EOBs for accuracy and for additional requests as needed. Duplicative submission of claims without corrections will cause delays in payment. Reviewing the EOB descriptions for approval or denial will provide details on the next steps, if needed.

**NOTE:** The Insurance Benefit Verification form issued by the CBO is not to be given to the EI Provider, nor does it replace the more detailed insurance benefit verification that must be completed by EI Providers. It is the responsibility of the EI Provider to verify benefits with the insurance company on a regular basis. Failure to verify benefits may result in the EI Provider’s inability to receive payment from the insurance company and/or the CBO.

3. EI Providers must always check with the family to determine if a child’s private or public (All Kids) insurance coverage has changed and **must notify the child’s Service Coordinator immediately** if there has been a change. Best practice would be to **confirm with each direct service visit**, similar to going to a licensed-physician appointment and verifying your insurance at each visit. Failure by the EI Provider or family to inform the Service Coordinator of the insurance change may result in the EI Provider’s inability to receive payment from the insurance company and/or the CBO.

4. Upon receipt of new or conflicting information, the EI Provider must immediately contact the CFC and/or the CBO to determine future steps or risk non-payment of services rendered during the resolution of the new or conflicting information.

6.4.1 **Time to Bill**

Claims must be received by the CBO no later than **ninety (90) calendar days** following the date of service delivery. For claims where primary insurance is involved, the claim must be submitted along with a copy of the Explanation of Benefits (EOB) from the private insurance(s), no later than ninety (90) calendar days from the date identified as processed on the insurance EOB. **The CBO will not use a fax date or computer print-out date to determine timely filing.** If the private insurance pays the charges in full, a claim, along with a copy of the insurance EOB, must be submitted to the CBO to ensure posting to the child’s authorization. The CBO Claims system may not receive the claim if sent the same day or day before. Ensure sufficient time for electronic systems or United State Postal Service delivery to have the claim at the CBO by day 90.

Providers must follow the billing requirements of the authorization.

- For authorizations labeled “insurance billing not required” claims must be received by the CBO no later than ninety (90) calendar days from the date of service.

- For authorizations labeled “bill insurance first” the claim must be received no later than ninety (90) calendar days from the date of service or no later than ninety (90) calendar days from the date identified as processed on the insurance EOB.

- EI Providers, who choose to bill insurance although they have been issued a Waiver, must still submit claims within ninety (90) calendar days from date of service. If an insurance denial is submitted along with claims for payment to CBO after ninety (90) calendar days from the date of service, payment will be denied.

- EI Providers must bill corrected claims within 90 days of the date of the Provider Claim Summary (PCS) that the denied or improperly billed/processed claim appears on.
• **EI Providers must never** bill insurance if they have an Insurance Exemption in place. Use of insurance may risk funds or plan coverage for the family.

6.4.2 **Provider Claim Summary**

Once a claim has been processed by the CBO, a “Provider Claim Summary” or PCS will be sent to the Payee showing all claims submitted and whether they were approved or denied for payment. The family will receive a “Parent Explanation of Benefits” or Parent EOB showing any and all services processed by EI, even if not subject to insurance billing or Family Participation Fees. Questions regarding these documents should be directed to the CBO Help Desk at 800/634-8540.

EI Providers must review all PCSs to adjudicate their claims. If a denial is received, the code explaining the denial reason is listed. Ensure the authorization matches the claim submitted. For a cross walk of the denial codes, go to https://eicbo.info/providers/ and click on Denial Codes.

**NOTE:** It is the responsibility of the Payee/Agency to distribute copies of the PCS to appropriate offices, personnel, etc. EI is not responsible for splitting or sending these documents to multiple addresses/locations.

6.4.3 **Insurance Billing Service**

The EI Program provides a free insurance billing service for EI Providers through the CBO Insurance Billing Unit. This service is specifically designed to aid in the billing of commercial insurance companies on behalf of individual Payees or those with fewer than seven rendering providers under one Payee. This service is for new child referrals only. Any approved payments from the private insurance plan will go to the EI Provider.

EI Providers must register themselves (and their company, if applicable) one time with the CBO Insurance Billing Unit. Once they have completed the Provider Registration process, they submit required enrollment information to register the child with the Billing Unit. Once the EI Provider receives notification of approval for that child, the EI Provider may begin to submit encounter forms for those children enrolled and approved for direct services only.

Evaluations and IFSP time must be billed by the EI Provider directly to the CBO. The purpose of the encounter form is to provide sufficient documentation of the visit so that CBO staff can correctly code insurance claim(s) using treating level ICD and CPT/HCPCS codes. Therefore, it is extremely important to submit thorough and accurate documentation on all encounter forms. The CBO will bill the primary insurance company on behalf of the EI Provider and the EI Provider, in turn, will receive insurance payment/CBO payment for the claims submitted. Providers registered with the insurance billing unit are responsible for submitting a copy of the EOB or Electronic Remittance Advice (ERA) upon receipt from the insurance carrier to the CBO Insurance Billing Unit so that the claims may be completed by CBO.

More detailed information regarding this service can be found on the CBO website at http://www.eicbo.info/providers/FreeBillingService.htm.

6.4.4 **Plans Types and Provider Restrictions**

Certain private insurance plans are “exempt” from use by EI policy and procedure. EI excludes the requirement to use these plans based on the potential risk of loss or reduction of benefits to the family. These plans include:
- Individually purchased/non-group plans. These are plans purchased privately by a family and not under any “group” (such as employer). The use of these plans could jeopardize the future health coverage for the members or even cause the plan administrator to terminate the plan. The Affordable Care Act is eliminating most of these plans, but some are still temporarily in existence.

- Tax Savings Accounts (automatically withdrawing only). These are typically called Health Savings Accounts or Medical Care Accounts, etc. The account is affiliated with the healthcare plan and allows approved expenses to be paid from the plan. Per El policy and procedure, we exempt the use of these plans if the automatically withdraw from the account to pay for EI. The exemption is to protect the family’s account. The family does have the option to decline the automatic exemption and allow use of the account. For additional information, the family should be directed to contact their Service Coordinator.

No provider choice/payment restrictions apply in the following situation:

- The insurance company does not limit which providers the family may choose for direct service provision. Under this situation, the CFC may refer the child to any EI Provider that a family chooses for direct service provision.
  - When making the referral to the EI Provider, the CFC will explain that the initial benefit verification indicated that the plan does not limit which EI Provider may provide direct services. However, it is still the responsibility of the EI Provider to verify with the insurance company that the services they will be providing, as outlined by the IFSP, are consistent with the provisions of the plan and to determine if any special considerations must be made prior to providing services.
  - The insurance plan may have varying levels of coverage such as a Tier coverage which allows out-of-network EI Providers but at varying payment levels, deductibles and sometimes other enrollment criteria. Understanding the details of the plans is instrumental in the submission and processing of claims.

Provider payment restrictions **do** apply in the following situations:

- The insurance company requires EI Providers to enroll in order to receive payment from the insurance company directly. If the EI Provider does not enroll, payments are rendered directly to the insurance policy holder (family). This could be enrollment as In-Network EI Providers or enrollment in Electronic Claims processing. Each plan should be reviewed carefully to ensure compliance.
  - The insurance company has indicated that EI Providers must enroll before payment can be made directly to the EI Provider.

- Providers may be able to provide services without enrolling however, payment and Explanation of Benefits will be sent directly to the insurance policy holder (family). The EI Provider would then be responsible for working with the family in order to obtain the insurance payment and copies of the EOBs.

**NOTE:** In this situation, it is critical for the EI Provider to obtain copies of the EOBs in case the EI Provider is required to seek additional payment from the CBO, as IDHS policy requires that such claims be accompanied by an insurance company’s EOBs.

Providers may be able to print insurance EOBs from the insurance company’s website. Providers may need to register or create an account with the insurance company on the website to be permitted to have access and print insurance EOBs.
• EI Providers should also obtain copies of EOBs for their records in the event that an insurance company performs a review and determines the need for a refund. If the EI Provider has received the insurance payment directly from the insurance plan or from the family, the EI Provider is responsible for refunding the payment to the insurance plan or working with the family to make the required refund. Then, with the appropriate documentation from the insurance company, the EI Provider can submit claims to the CBO for payment by EI following timelines specified for submitting claims.

• The family is responsible for supplying any EOBs or payments made directly to the policyholder to the rendering EI Provider as outlined in the Consent to Use Private/Healthcare Plan Benefits and Assignment of Rights form signed by the family. The EI Provider is responsible for obtaining a copy of the Consent to Use Private/Healthcare Plan Benefits and Assignment of Rights form from the CFC and for ensuring that the policyholder reimburses them in the event the payment goes directly to the policyholder.

• The EI Provider is also responsible for submitting claims to the CBO even in the event the EI Provider receives reimbursement from insurance.
  • By signing the EI provider agreement EI Providers agree to the following: “The EOB and a completed claim shall be submitted to the CBO for all EI children even if the entire claim was paid by private insurance.
  • The purpose of this requirement is to ensure that the services identified on a child’s IFSP are being provided and that EI Providers are being reimbursed. This allows EI to un-encumber dollars for services for which insurance is providing payment. These dollars can then be used to pay for other services that insurance is not paying for.

Provider choice/payment restrictions do apply in the following situations:
1. Exclusive Providers Only (Exclusive Provider Organization-EPO). Typically, with HMO plans, different from EPO policies, but could also be tier plans under PPO guidelines.
   a. The insurance company has indicated that EI Providers must apply and become an in-network EI Provider or claims will be denied.
   b. The CFC is only allowed to make direct service referrals to EI Providers included in the insurance company’s network.
   c. If none of the insurance company’s in-network providers are able to see the child for one of the Pre-Billing Waiver reasons, the CFC will request a Pre-Billing waiver from the CBO in order to make a referral to a non-insurance required EI Provider. Reasons for a Pre-Billing Waiver are:
      • EI Provider not available: no in-network providers have openings to accept the referral.
         o EI Provider not enrolled: no in-network providers are also EI credentialed/enrolled.
         o Excessive Travel Time or Distance: insurance enrolled, clinic-based (to meet specific Outcome(s) of child) EI Provider would make family travel more than 15 miles or 30 minutes from their home.
   d. If a pre-billing waiver is requested, the CFC will not make a referral for direct service provision until the approval/denial for the insurance waiver has been received from the CBO.
NOTE: No EI Provider should render any service prior to receipt of notification of waiver approval from the CFC.

2. Primary Care Physician (PCP) Referral Required
   a. The insurance company may provide payment to insurance non-enrolled or insurance preferred providers as long as the child’s PCP has referred the child to that specific provider prior to beginning services.
   b. The family should assist the EI Provider in obtaining the PCP referral if necessary.
   c. If a referral from the PCP is required for the family to see providers other than those mandated by the insurance company, but one is unable to be obtained, the family will be required to utilize the insurance mandated provider unless a Pre-Billing Waiver Request is applicable (insurance mandated providers are not EI credentialed and/or enrolled) and approved prior to service provision.

3. If during the CBO’s limited Benefits Verification, it is determined that no insurance mandated providers are EI credentialed/enrolled, CBO will automatically provide a pre-billing insurance waiver to the CFC. At that point, the CFC may choose any EI credentialed/enrolled provider.

6.5 Insurance Updates
Families experiencing changes in their private insurance must immediately inform their Service Coordinator to ensure continuance of services and reimbursement.

If a family informs you that their private insurance benefits will be changing, direct the family to notify their Service Coordinator and contact the Service Coordinator directly to ensure a smooth transition.

For families obtaining insurance for the first time or changing benefit plans, Service Coordinators will receive a 45-day exception from billing insurance, beginning the day the CBO receives the change of insurance request from the CFC. This 45-day exception allows the services to continue and the EI Provider to bill the CBO directly for a period of time while the CBO, the CFC and the EI Provider all process the benefits verification information to determine benefits coverage. The CBO will verify insurance benefits and provide the result to the CFC within 5 working days. As soon as the results of the benefits verification are received by the CFC, or once the 45-days are over, the services must be delivered in the manner that matches the benefits verification results, including any need for a waiver or exemption.

NOTE: The EI Provider should verify that the authorization correctly indicates Bill Insurance First.

6.6 Important Insurance Definitions

Private Insurance
- Individual (may also be HMO, PPO or POS)
  Health insurance is purchased out-of-pocket directly from an insurance company to cover one or more members of a family. Coverage varies widely with each plan. This type of plan is eligible for an Insurance Exemption.
- Group (may also be HMO, PPO or POS)
  Group Insurance is usually offered through an employer. The employer may purchase a policy from an insurance company or may administer its own (self-insured) plan. Group health insurance may also be offered through other organizations or special-interest groups. Coverage varies with each plan.
• **Enrolled Provider**  
  A provider that is credentialed and/or enrolled in the EI Program to provide direct service to children.

• **Explanation of Benefits – EOB**  
  An explanation of benefits (commonly referred to as an EOB) is a statement sent by a health insurance company to cover individuals explaining what treatments and/or services were paid for on their behalf.

• **Exclusive Provider Organization – EPO**  
  A modified version of the Preferred Provider Organization (PPO) contract with a network of preferred providers that will not reimburse out-of-network providers.

• **Government-Sponsored Health Plans**  
  Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Civilian Health and Medical Program of the Veterans Administrations (CHAMPVA).

  These are federal programs to cover health expenses of the dependents of military personnel and veterans. They are secondary to commercial health plans. Military medical-care providers are to be used if available. Prior authorization may be required for use of civilian providers. Administered by TRICARE.

• **Health Maintenance Organization – HMO**  
  An HMO relies heavily on their network of providers and will typically require documentation and a standardized process to cover providers outside the network.

• **Illinois Comprehensive Health Insurance Plan – ICHIP**  
  ICHIP is a state-subsidized program for Illinois residents who cannot otherwise purchase major medical insurance due to a pre-existing condition or disability. It is administered by Blue Cross/Blue Shield of Illinois.

• **In-Network Provider – Plan Specific**  
  Provider who has followed all steps within the plan to be a qualified provider to perform services and bill the plan following all of the requirements of the plan.

• **Out-of-Network Provider – Plan Specific**  
  This usually refers to health care providers who are considered nonparticipants in an insurance plan. Health plans may allow providers who are not “in-network” to provide services following their criteria. Out-of-Network providers may not receive corresponding EOBs or payment directly. The plan may also place financial restrictions of reduced payments based on network status.

• **Point-Of-Service – POS**  
  A POS plan combines an HMO and PPO. A provider may subscribe to one or both plans. Because of the PPO component, out-of-network providers may be used. When requesting a list of network providers make certain both HMO and PPO providers are being included.

• **Preferred Provider Organization – PPO**  
  PPO contract with a network of preferred providers but will reimburse at a lower rate for out-of-network providers.

• **Referrals**  
  Health plans may require referrals from the Primary Care Physician for any other service. The provider is responsible for ensuring all proper procedures are in place prior to service provision to ensure payment from the plan.
• **Tax Savings Account** (numerous titles such as Health Reimbursement Account, Medical Care Account, Health Savings Account, etc.)

A separate account of funds furnished by the plan holder or by an employer which can be used to pay for qualified medical services or supplies. The funds are not taxed and may or may not carry over from year to year.

**Public – Sponsored Health Plans**
All Kids is a comprehensive health insurance program that is available to uninsured children in the State of Illinois. It is administered by HFS and includes the following:

• **Medicaid/All Kids Assist**
Medicaid is a federally assisted program to help with the medical expenses of eligible low-income families. It is administered through HFS.

• **Managed Care Organizations (MCO)**
These entities are contracted through HFS – there are a number of MCO plans that are contracted through HFS to serve Medicaid-eligible children/families. These are considered Public Insurance plans. EI is a fee-for-service program that pays the EI Provider for EI authorized services and submits claims to HFS for reimbursement of that payment. If an EI Provider also serves children or families outside of EI through another agency or program which bills HFS or the MCO directly, the EI Provider must be enrolled in the MCO’s network of providers. Documentation and a standardized process to cover providers outside the network is normally required.

Classification of a funder of coverage: Typically has more case-management involvement in the healthcare decision of the participant. Illinois also utilizes MCOs to manage much of the Medicaid populations across the state. EI and the HFS MCOs work well together and the HFS MCO does not impose any restrictions if services are EI authorized.
Chapter 7: Assistive Technology

DEFINITION OF ASSISTIVE TECHNOLOGY
The definition of Assistive Technology (AT) includes both AT devices and AT services. An AT device is any durable item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with developmental delays and/or disabilities.

An AT service is any service that directly assists an eligible EI child in the selection, acquisition, or use of an AT device. The term includes:

a. An assessment of the needs of the child, including a functional assessment of the child in the child’s natural environment;
b. Purchasing, leasing, or otherwise providing for the acquisition of AT devices by children with developmental delays/disabilities;
c. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing AT devices;
d. Coordinating and using other therapies, interventions, or services with AT devices, such as those associated with existing education rehabilitation plans and programs;
e. Training or technical assistance for:
   • a child with a developmental delay/disability or, if appropriate, that child’s family; and
   • professionals who provide services to eligible children through the EI Program.

ASSISTIVE TECHNOLOGY DEVICES
AT devices range from low-technology (low-tech) to high-technology (high-tech) items. Low-tech devices are items that rely on mechanical principles and can be purchased or made using simple hand tools and easy to find materials, such as homemade or modified items already used in the home. High-tech devices include sophisticated equipment and may involve electronics.

Consideration of the types of AT devices and services available through this system is continually monitored. Determination of what equipment and services falls within these guidelines will be updated periodically as these considerations are reviewed. Eligible devices and services refer to items and services for which payment can be made. A written recommendation (order), signed and dated by the child’s physician (often a prescription form) is required for all devices requested.

EI AT devices do not include a medical device that is surgically implanted or the replacement of such device.

Only devices and services that are directly relevant to the developmental needs of the child will be considered as EI AT. Devices and services that are necessary to treat or control a medical condition or assist a parent/caregiver with a disability will not be approved through EI equipment/devices must be developmentally and age appropriate to be considered eligible for EI funding.

ELIGIBLE DEVICES
As the term AT covers so many different types of devices, it is often useful to divide the devices into functional categories. The following are examples of the types of AT devices that may be provided to eligible children and their families under the EI Program. The range of AT devices available to young children is changing and expanding at a rapid pace, and it should be noted that this list is not an exhaustive list of AT devices, but is
intended to provide guidance. There may be other items not listed that would appropriately meet the needs of children in the EI Program.

Category 1 devices are items that might be recommended by ongoing EI Providers with consultation and consensus of the IFSP team. These are items that can be easily incorporated into the child and family’s routines and do not require additional trials for determining appropriateness.

Category 2 items require trials and more specific assessment of need. Additional justification that describes the child’s current functional status, trials, measurements that include height and weight, and any additional information necessary to support the request are also included in Section 5 of the AT Assessment report. These might be assessments that are completed by individuals that have expertise in particular areas of AT.

Types of AT devices/services could include:

- Adapted Swings/Scooter Boards
- Communication
- Developmental Play
- Durable Medical Equipment
- Hearing Aids and Accessories
- Oral-Motor Items
- Orthotics
- Miscellaneous

- **Aids for Daily Living.** Self-help aids are designed for use in activities such as bathing, eating, dressing, and personal hygiene, i.e., Bath chairs, seating devices.

- **Assistive Listening.** Assistive listening devices to help with auditory processing, i.e., hearing aids.

- **Assistive Toys and Switches.** Assistive devices such as switch-operated toys serve a vital role in the development of young children with developmental delays and/or disabilities, i.e., single-use switches, switch battery adapters, switch adapted toy items.

- **Augmentative Communication.** Augmentative communication devices are items that should be used across all-natural settings so that the child learns how to communicate with a variety of different people in different circumstances. Strategies may include a program that uses signing, device, gestures, and communication pictures and boards, i.e., symbol systems, picture or object communication boards, electronic communication devices, and communication enhancement software.

- **Computer Access.** Input devices can include switches, touch windows, head pointers, etc. Output devices include any adaptation that may be needed to access the screen display.

- **Mobility.** Mobility devices include braces, certain types of orthotics, self-propelled walkers and crawling assist devices.

- **Positioning.** Positioning is typically achieved by using padding, structured chairs, straps or supports to hold the child’s body in a stable and comfortable position, i.e., standers, walkers, floor sitters, chair inserts, trays, side-lyers, straps, rolls, weighted vests and garments, etc.

- **Visual aids.** General methods for assisting with vision needs include increasing contrast, enlarging images, and making use of tactile and auditory materials, i.e., optical or electronic magnifying devices, low-vision aids such as hand-held or spectacle mounted magnifiers, and vision stimulation devices such as light boxes.
• **Repair and Maintenance.** Repair, alteration and maintenance of necessary equipment.

It is important to realize that within each of these categories, there is a continuum of device choices ranging from simple to complex that should be considered when attempting to find the appropriate AT device to use with a particular child for different tasks and in different settings.

When an infant or toddler’s needs are being assessed for the possible use of AT, there are usually several options that can and should be explored. The selection of devices should always start with simple, low-tech, or mid-tech resources to meet the child’s needs. If a low-tech device, such as a laminated picture for making a choice, meets the child’s needs, then that should be the device selected. Different devices should also be carefully matched to the different environments in which the devices will be used, appreciating that while a device may be useful in one setting, it may not be appropriate or effective in other settings.

When choosing an AT device, it is important to note that trials with a variety of different devices can actually help determine the child’s or family needs, preferences, and learning styles. A device might be one of many other assistive items for the child and may be overwhelming for the family. The family may not have the physical space or adequate training to utilize the device appropriately. Parent’s preferences and feelings about the role it plays in their child’s development could significantly impact implementation.

**LIMITATIONS**

- EI limits approval of multiple devices that are the same or similar in nature, such as switches, adapted switch toys, computer software, therapy balls, rolls, bolsters, wedges, sensory items, etc.

Certain devices/services are not covered in the scope of AT and payment will not be made for their provision. The following are examples of devices or services that are not considered appropriate AT items under EI. For specific lists of items, see Attachment 1 for Guidance at the end of the handbook.

- Devices/services that are prescribed by a physician, primarily medical in nature and not directly related to a child’s developmental needs, i.e., helmets, oxygen, feeding pumps, heart monitors, apnea monitors, intravenous supplies, electrical stimulation units, beds, etc.;
- Devices requested for children over 32-months of age, as devices requested during this time would not be available long enough to achieve identified outcomes. Request must be identified on the IFSP and received by the Bureau of EI prior to the child turning 32-months of age;
- Devices/services for which developmental necessity is not clearly established;
- Devices/services covered by another agency;
- Devices/services where IDHS prior approval (when applicable) has not been obtained;
- Typical items, materials, and supplies related to infants and toddlers utilized by all children, and which require no special adaptation, i.e., clothing, diapers, cribs, highchairs, car seats, infant swings, typical baby/toddler bottles, cups, utensils, dishes, infant monitors, etc.;
- Toys that are not adapted, but used by all children and are not specifically designed to increase, maintain, or improve the functional capabilities of children with developmental delays/disabilities, i.e., building blocks, dolls, puzzles, balls, ball pits, tents, tunnels and other common play materials;
- Mobility devices such as car seats, strollers, wheelchairs or any part thereof;
- Devices/services which are considered duplicative in nature, generally promoting the same goal and/or objective with current or previously approved equipment/services;
• Devices/service if a less expensive item or service is available and appropriate to meet the child’s need;
• Frequency modulation (FM) systems;
• Replacement equipment if original device has not been returned to vendor or if payment for the device has not been returned to the CBO by the supplying vendor, and sales tax, shipping and handling charges.

ASSISTIVE TECHNOLOGY AND THE IFSP

As stated in the CFC Procedure Manual, Chapter 12.23, all children with developmental delays/disabilities who are eligible for EI services must be provided with AT devices and services, if appropriate, as part of the IFSP. AT devices should be considered if interventions are required to aid in the developmental tasks such as interaction with the environment, communication, and cognition. These AT devices and services are required, however, only when they relate to the developmental needs of infants and toddlers and their families.

Inclusion of AT in the IFSP must occur on an individual basis and must be based on the child’s needs, the family’s concerns and intervention priorities and goals. AT devices/services must be included in the IFSP as agreed upon by the family and other team members. At minimum, the IFSP should have the following information:

1. The outcomes that will be achieved for the child and family, including the way in which the AT device is expected to increase, maintain, or enhance a child’s functional capabilities.
2. A description of the specific AT device(s) needed by the child, the projected dates for acquisition of the device, and the method of acquisition.
3. The methods and strategies for use of the AT device to increase, maintain, or improve the child’s functional capabilities, the individuals (including parents, other caregivers and family members, and qualified personnel) who will be assisting the child in using the device, and the settings in which the device is to be used.
4. The qualified personnel who will be providing the AT services (training to family and other direct service providers of the child) and the frequency, intensity and method of delivery recommended.

The IFSP team, which includes the family, should be made aware of the need to complete the IDHS prior approval process for AT.

OBTAINING ASSISTIVE TECHNOLOGY

The procedure for obtaining AT is outlined below:

1. The IFSP team member identifies the need for AT, contacts the Service Coordinator to schedule an IFSP meeting and brings the information to the IFSP team for consideration. The need for AT devices/services may be identified:
   a. Through direct service provision;
   b. As part of the initial or annual multidisciplinary evaluation/assessment, and/or
   c. As part of supplemental assessments included in the child's IFSP based on an anticipated or emerging need and as agreed upon by the IFSP team.
2. If the IFSP team agrees with a need, the provider who is recommending the AT must identify a functional outcome relating to the AT need and appropriate strategies for the Service Coordinator to incorporate in the IFSP.
3. Required AT assessment for the identified need and completion of the Assistive Technology Letter of Developmental Necessity must be completed by a credentialed EI evaluator. The team may authorize an evaluator separately if no direct service provider on the IFSP team is an evaluator. If appropriate, the AT assessment can be completed during direct service visits if the ongoing provider is a credentialed evaluator. If the ongoing direct service provider is not a credentialed evaluator, the Service Coordinator will provide a list of available EI-credentialed evaluators for the family to select. The selected EI evaluator will be issued an AT Assessment (AS) authorization and must have this authorization in hand prior to developing the Assistive Technology Letter of Developmental Necessity. To distinguish the AS authorization from discipline-specific assessments, “AT assessment” is written into the comment field. Time for the EI evaluator/EI Provider to make AT devices for families is not an authorized service, unless this is done as part of the direct service time.

4. The EI Provider will then provide the Service Coordinator with all necessary items. The Service Coordinator will work with the CFC AT Coordinator to compile the documentation to be included in the prior approval request packet. A sample packet may be found in the Child & Family Connections Manual.

   NOTE: For loaner or existing (non-EI) hearing aids, approval for ear molds and hearing aid batteries requires documentation and physician order or prescription for the hearing aid and must not be more than one year old.

5. Once the AT request has been received, it will be reviewed by the AT Coordinator and/or the Bureau of EI for the above information within 14-business days from the date of receipt.

   a. If missing or additional information is required after a Bureau review, a notification memo identifying what information is needed will be sent to the CFC AT Coordinator. The CFC AT Coordinator will have 10-business days to provide the Bureau with the missing information for processing. If the missing information is not received by this time, the request will be denied due to lack of information.

   b. Once all required information has been submitted, the request will be reviewed, and a decision will be made within 10-business days from receipt.

6. For approved device(s), the Service Coordinator enters an authorization(s) as indicated in the approval notice

   a. The information for the authorization must be entered exactly as written in the notification, noting HCPCS code, quantity and amount, and must be checked for accuracy prior to saving the authorization in Cornerstone.

   b. The Service Coordinator will send the authorization to the EI Payee/EI Provider. If the authorization information is known to be or appears to be incorrect, contact the Service Coordinator for clarification prior to AT device or AT service delivery.

7. If the AT request is denied, no authorization is entered.

   a. The Service Coordinator must inform the family and EI Providers of the denial.

   b. The Service Coordinator and vendor should assist the family in pursuing any and all other funding resources (including recycled devices). Typically, parents and providers look at private insurance, Medicaid, Division of Specialized Care for Children (DSCC), Illinois Assistive Technology Project, local civic organizations, and parent contributions. Actual funding may include a combination of fund sources.
8. The Service Coordinator notifies the family, reviews the IFSP for accuracy, and, if necessary, sends the revised IFSP to all team members.

Any requests received without the above information may experience delays in processing. As with any other EI service, AT devices/services must be related to one or more functional outcomes in the IFSP. EI does maintain the right to request the substitution of a less expensive device of comparable function if a substitution is deemed appropriate.

NOTE: Requests for children over 32-months of age may be denied as equipment requested during this time would not allow the child to achieve substantial benefit while in the EI Program.

Typically, private insurance, Medicaid, and DSCC funds pay for equipment and devices that fall under the category of “Durable Medical Equipment.” This includes equipment such as daily living aids, standers, positioning systems, wheelchairs, prosthetics/orthotics, augmentative communication devices and hearing aids. Many times, coverage does not include learning tools like switch-operated toys, assistive play equipment, and computer equipment.

ASSESSING THE NEED FOR AT
The need for AT devices/services differs somewhat from “typical” assessments conducted as part of eligibility. There are virtually no standardized tests to “find out” what kind of technology a child needs to use. Instead, a good AT assessment looks at the results of all recent assessments, along with the current IFSP functional outcomes and strategies. The EI evaluator should talk with the child’s parents, as appropriate, interview people who work with the child and would interact directly with the child and the AT devices. The environment should be carefully examined, especially when the AT device has to work in a variety of settings. The actual assessment process consists of considerable observation coupled with trials with a full range or continuum of possible AT devices from low-tech to high-tech. Data is gathered from these trials about the effectiveness of various technologies to meet the child’s needs.

Information is collected concerning the child’s ability and accuracy when using various technologies, including the positioning and settings that work best. The child’s and family’s feelings about the actual devices should be considered, as even very young children can show what they like and dislike by how they interact with different devices.

There is additional information as well as a detailed explanation of the information that each IFSP Team should consider when determining how and what AT would best suit a child and family in need available in the Child and Family Connections Procedure Manual in Chapter 12, Individualized Family Service Plan (IFSP).

ASSISTIVE TECHNOLOGY LETTER OF DEVELOPMENTAL NECESSITY
The Assistive Technology Letter of Developmental Necessity provides the information required for the consideration of prior approval by the Bureau of EI. The document includes information regarding the identified AT device requested, the justification of need and how the AT device will support IFSP functional outcomes. This information will assist the Bureau and any other potential payers (such as insurance) in determining if the AT request can be approved for payment.

A copy of the Assistive Technology Letter of Developmental Necessity and detailed instructions for completion can be found in Attachment 1 of this Handbook.

EI will pay for AT devices at rates comparable with the Illinois HFS, Save Medicaid Access and Resources Together (SMART) Act rate structure. For those items requiring individualized pricing, EI will reimburse at the rate of vendor wholesale (acquisition) cost plus 50% up to the manufacturer’s suggested retail price (MSRP). For
devices in which there is no wholesale (acquisition) discount to vendors (such as equipment marketed direct to consumer/catalog companies), rate may be increased by 25% if no alternative is available pending approval. All rates submitted are subject to the approval of the Bureau of EI. Pricing information submitted by AT Vendors must include manufacturer’s pricing information either by providing with the quote copies of the catalog page depicting the item with printed price easily readable or a copy of the separate pricing sheet along with picture and description of the item. For items that are marketed direct to consumer, the AT Vendor price quote must explain any variance between manufacturer or catalog pricing submitted.

**AT PROVIDER RESPONSIBILITIES**
For consideration to be given by EI to approve AT devices/services, the EI Provider (vendor) must be properly enrolled in the IMPACT system as a Facility/Agency/Organization, with a Durable Medical Equipment (DME) specialty. AT Vendors are responsible to ensure approved and correct devices are ordered and received by the family in a timely manner, prior to billing private insurance and/or the CBO. EI will not replace lost or stolen devices.

The AT Vendor should also ensure that they have procedures in place for safe delivery of AT devices such as:
- Delivery to EI therapist office locations
- Delivery to CFC offices
- Requiring signature receipt
- Purchase of insurance through delivery agent, i.e., UPS, USPS, FedEx, etc.
- Direct service session delivery

**CHANGE IN HCPCS CODES/AT VENDOR**
At times, especially with orthotic requests, the AT Vendor will quote the orthotics based on the evaluator’s *Assistive Technology Letter of Developmental Necessity*. When the AT Vendor sees the child, it may be necessary to change the HCPCS code(s) originally requested or even change the AT Vendor. If one or both of these situations occur, the provider must contact the Service Coordinator immediately to complete the process to revise the AT request.

**AT RETURNS**
If a device is received by the family and is determined by the EI Provider to not appropriately meet the child’s needs, the AT device must be returned to the AT Vendor immediately (no more than 30-calendar days from delivery) so that appropriate AT device may be obtained. The Service Coordinator must be informed so that they can work with the family to determine how to return the AT device. If the AT Vendor shipped the wrong AT device, it is the AT Vendor’s responsibility to pay for the return.

The EI Program will approve payment of a “restocking fee” if the manufacturer that the AT Vendor obtained the device from submits an established (prior to order/delivery of device), written policy.

**EI AT Funding:**
The EI Payee is responsible for ensuring:

1. Prior approval of AT device/service
2. Private insurance benefits verification is completed and followed when applicable.
3. The EI Provider bills private insurance (if appropriate) and/or CBO for the AT device based on the EI authorization.
4. The EI Provider must never bill HFS/Medicaid directly for an EI-approved AT device.
5. If the AT device is not eligible for EI funding, the CFC AT Coordinator will be notified after the Bureau review is completed. If appropriately denied by EI and the child has aged out and is Medicaid eligible, the EI Provider may then pursue HFS funding outside of the EI Program.

6. If the device is not eligible for EI funding, the provider may work with the Service Coordinator for any additional funding resources.

The CFC AT Coordinator, working with the family’s Service Coordinator, must follow-up with the EI Provider and/or family to ensure the approved AT device has been received from the AT Vendor in a timely manner.

**NOTE:** Please see *Chapter 22 - Vision* on policy and procedure for ordering eyeglasses.
Chapter 8: Audiology, Aural Rehabilitation, and Other Related Services

Service Description
Audiology, aural rehabilitation, and other related services include:

1. identification of children with hearing loss using appropriate screening techniques;
2. determination of the degree, type and configuration of hearing loss by use of audiological diagnostic evaluation procedures;
3. referral for medical testing and other services necessary for the rehabilitation/ habilitation of children with hearing loss;
4. evaluation and assessment;
5. determination of the child’s need for individual amplification including selecting, fitting, and dispensing appropriate listening and vibrotactile devices; and
6. evaluation of the effectiveness assistive technology devices.

A Developmental Therapist-Hearing (DT-H) may be asked to perform a specialized A/R assessment, conduct a global evaluation required for eligibility and still be able to recommend for his/her specialized service. A DT-H may also recommend regular DT if it is determined that the child’s hearing concern doesn’t require specialized services and that DT could assist the child in reaching his/her functional outcome(s).

Family training, education, and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to audiology and aural rehabilitation services and enhancing the child’s development are integral to this service. For Family Education, training and support, the eligible child is not required to be present but may be, if appropriate. Family training, education, and support may include such services as support groups, individual support and other training or education for the family.

Deaf Mentors
Deaf Mentor Services provided by a previously enrolled language mentor for the deaf who interacts with the child by modeling language in the chosen communication mode, shares information about deaf culture and provides firsthand knowledge of deafness with the family and introduces the family to the local deaf community.

NOTE: Enrollment for Deaf Mentors is no longer available due to training for this service is no longer available. Additionally, Deaf Mentors do not provide evaluation/assessment services to determine a child’s eligibility for services.

Services must be consistent with the provider’s qualifications and licensure. For information about, please see AT please see, Chapter 7: Assistive Technology.

NOTE: The EI Program does not pay for therapeutic services required for a child to recover from medical procedures such as surgery, etc., or for pre-surgery therapeutic services required by a physician to prepare a child for surgery.

Qualified Staff
1. EI Specialists credentialed and enrolled as:
   a. Licensed Speech/Language Pathologist
   b. Developmental Therapist/Hearing (DT-H)
2. Non-credentialed provider enrolled as:
   a. Audiologist (who can provide audiological and/or aural rehabilitation/habilitation services) (See Chapter 3: Early Intervention Providers in Illinois, under section 3.3, Provider Credentialing and Enrollment for requirements.)

Billable Activities with Authorization
Audiological evaluations which include screening to determine possible hearing loss and testing to determine the range, nature and degree of hearing loss and communication functions, hearing aid assessment and aural rehabilitation (A/R) and other related services, IFSP development (see Chapter 5: Individualized Family Service Plan (IFSP) for additional information about IFSP) and direct services.

NOTE: Audiologists who have completed an evaluation prior to the initial IFSP meeting with test results that were obtained within the normal range may choose not to participate in the initial IFSP meeting. If the audiologist chooses not to participate, he/she must complete the Child and Family Connections Individualized Family Service Plan Meeting Attendance Waiver for Audiologists and attach it to the audiological evaluation claim for the CBO to process payment.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5010</td>
<td>N/A</td>
<td>Hearing aid assessment</td>
<td>$70.75</td>
</tr>
<tr>
<td>V5008</td>
<td>N/A</td>
<td>Hearing Screening</td>
<td>$59.01</td>
</tr>
<tr>
<td>92551</td>
<td>N/A</td>
<td>Screen test, pure tone, air only</td>
<td>$15.66</td>
</tr>
<tr>
<td>92552</td>
<td>N/A</td>
<td>Pure tone audiometry (threshold), air only</td>
<td>$15.66</td>
</tr>
<tr>
<td>92553</td>
<td>N/A</td>
<td>Audiology, air and bone</td>
<td>$15.66</td>
</tr>
<tr>
<td>92555</td>
<td>N/A</td>
<td>Speech audiometry threshold</td>
<td>$15.66</td>
</tr>
<tr>
<td>92556</td>
<td>N/A</td>
<td>Speech audiometry threshold; (with speech recognition)</td>
<td>$15.66</td>
</tr>
<tr>
<td>92557</td>
<td>N/A</td>
<td>Comprehensive audiometry; (includes 92553 and 92556)</td>
<td>$38.52</td>
</tr>
<tr>
<td>92567</td>
<td>N/A</td>
<td>Tymanometry</td>
<td>$15.66</td>
</tr>
<tr>
<td>92568</td>
<td>N/A</td>
<td>Acoustic reflex testing; threshold</td>
<td>$14.11</td>
</tr>
<tr>
<td>92579</td>
<td>N/A</td>
<td>Visual reinforcement audiometry (VRA)</td>
<td>$22.81</td>
</tr>
<tr>
<td>92582</td>
<td>N/A</td>
<td>Conditioning play audiometry</td>
<td>$22.81</td>
</tr>
<tr>
<td>92583</td>
<td>N/A</td>
<td>Select picture audiometry</td>
<td>$15.60</td>
</tr>
<tr>
<td>92585</td>
<td>N/A</td>
<td>Brainstem evoked response rec. (no anesthesia)</td>
<td>$55.31</td>
</tr>
<tr>
<td>92587</td>
<td>N/A</td>
<td>Evoked otoacoustic emissions: limited (single level, either transient or distortion products) (no anesthesia)</td>
<td>$54.28</td>
</tr>
<tr>
<td>92588</td>
<td>N/A</td>
<td>Evoked otoacoustic emissions, comprehensive or diagnostic evaluation (Comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)</td>
<td>$62.83</td>
</tr>
</tbody>
</table>

Audiologist should complete testing as follows:
- The Service Coordinator will provide an authorization to the Audiologist with procedure code EIAE – Audiological Examination. The Audiologist will complete a hearing screening and submit claim using V5008. If a documented hearing screening was performed just prior to referral, you may use previous hearing screenings completed prior to referral to the EI Program.
• If the child fails the hearing screening, the Audiologist may proceed to complete additional testing to determine the range, nature and degree of hearing loss and communication function. This will ensure that all testing can be completed on the same date of service so that families will not have to schedule multiple visits.
  o The Audiologist will bill the CBO for the hearing screening using the procedure code V5008. If a previous hearing screening was utilized, do not bill for a duplicate service; only bill for the additional tests performed.
  o When additional testing is needed to determine the degree, type and configuration of hearing loss, the Audiologist will bill for the additional testing using the procedure codes identified above. The EIAE authorization will cover testing procedure codes above that are performed with the exception of V5010.
  o If the Audiologist completed any of the tests identified above when completing the hearing screening (V5008), do not bill again for that same test to determine range, nature, and degree of hearing loss. If there is a necessity to continue monitoring the determine range, nature, and degree of hearing loss, additional testing may be authorized.
  o All testing must be completed on the same date of service and must be billed to the CBO on the same claim.
  o If testing cannot be completed on the same date, the Audiologist must obtain a new EIAE authorization from the child’s Service Coordinator prior to completing further testing.
  o For children who have not passed a hearing screening or who have a suspected hearing loss, the Service Coordinator will generate one authorization using procedure code EIAE for audiological services. Audiologists will choose the most appropriate test(s) for each child based upon the list of billable services identified above.
  o For children who require a Hearing Aid Assessment to determine the possible need for hearing aids, Service Coordinators will generate an authorization using the procedure code V5010. This procedure code will be identified on the authorization to provide a hearing aid assessment. You can only bill this code to the CBO if you have an authorization that identifies this code.
  o The EI Program does not pay for therapeutic services required for a child to recover from medical procedures such as surgery or pre-surgery therapeutic services required by a physician to prepare a child for surgery.
  o The EI Program does not pay for medical testing that requires anesthesia, sedation or medical monitoring. If these services are required, prior to scheduling such testing, please refer the parent/caregiver back to the Service Coordinator who will explain this information to them. The parent/caregiver may be referred to DSCC for assistance with services that require medical testing.
  o Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.
  o Enrolled Audiologists may bill for time required in writing the assistive technology letter of developmental necessity using IFSP development codes.
  o Credentialed evaluators may bill for time required writing reports.

Once a child’s hearing aid(s) have been dispensed, that all follow-up visits to provide instruction to the parent/caregiver and to measure, fit, and adjust the hearing aid(s) to work most appropriately for the child. The EI Program will pay for hearing aid checks every three months or more frequently if the Audiologist provides a written justification of need to the child’s Service Coordinator. This type of justification does not have to be written on a particular form but must be sent to the Service Coordinator to justify and request an authorization.
The procedure codes and rates include the following.

LICENSED AUDIOLOGY PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92592</td>
<td>N/A</td>
<td>Hearing aid check; monaural</td>
<td>$15.66</td>
</tr>
<tr>
<td>92593</td>
<td>N/A</td>
<td>Hearing aid check; binaural</td>
<td>$15.66</td>
</tr>
<tr>
<td>92594</td>
<td>N/A</td>
<td>Electroacoustic evaluation for Hearing aid; monaural</td>
<td>$15.66</td>
</tr>
<tr>
<td>92595</td>
<td>N/A</td>
<td>Electroacoustic evaluation for Hearing aid; binaural</td>
<td>$15.66</td>
</tr>
</tbody>
</table>

- Procedure and billing notes:
  - The Service Coordinator will provide a Hearing Aid Check (EIHAC) authorization.
  - The Audiologist will be allowed to bill up to two procedure codes on one authorization but must be completed on the same day.
  - The Audiologist will choose either binaural or monaural codes to bill.
  
  **NOTE:** Do not bill two codes unless you completed two procedures.

  - The Audiologist may have an EIHAC authorization at a minimum of every three months. If it is identified that a child may need to have a hearing aid check prior to three months from the date of the previous check, the Audiologist must submit a written justification of need to the child’s Service Coordinator to request an authorization.

  **NOTE:** The EI Program will not pay for hearing aid checks more than one time per month. The Audiologist is required to submit a written document to the Service Coordinator to justify receipt of an EIHAC authorization if a hearing aid check is needed prior to three months from the previous check.

- Description for Aural Rehabilitation/Habilitation services in individual and/or group settings include:
  - participation in the evaluation and assessment;
  - participation in IFSP meetings and development of outcomes related to frequency, duration, and intensity of specialized services;
  - consultation with IFSP team members;
  - specialized instruction to promote child’s participation in everyday interactions, activities and routines;
  - parent education and support;
  - implementation of specialized communication strategies and modes (which may include listening skills development, spoken language development, cued speech, pictures, speech reading, American Sign language and total communication);
  - assistive listening device orientation and troubleshooting, and
  - referral for medical testing and other services necessary for the habilitation/rehabilitation of children with hearing loss.
## AURAL REHABILITATION (A/R) PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92626</td>
<td></td>
<td>15 minutes</td>
<td>A/R assessment - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>92626</td>
<td></td>
<td>15 minutes</td>
<td>A/R assessment - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>SC</td>
<td>15 minutes</td>
<td>A/R IFSP development</td>
<td>$14.97</td>
</tr>
<tr>
<td>99499</td>
<td>SC</td>
<td>15 minutes</td>
<td>A/R IFSP meeting</td>
<td>$18.68</td>
</tr>
<tr>
<td>92507</td>
<td>TL</td>
<td>15 minutes</td>
<td>A/R services - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>92507</td>
<td>TL</td>
<td>15 minutes</td>
<td>A/R services - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>92508</td>
<td>TL</td>
<td>15 minutes</td>
<td>Group A/R services (multiple families or group not to exceed 4 children)</td>
<td>$8.12</td>
</tr>
</tbody>
</table>

## DEAF MENTORS PROCEDURE CODES

**FOR USE BY DEAF MENTORS, ONLY**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99499</td>
<td>HT</td>
<td>15 minutes</td>
<td>IFSP development</td>
<td>$11.03</td>
</tr>
<tr>
<td>99499</td>
<td>HT</td>
<td>15 minutes</td>
<td>IFSP Meeting</td>
<td>$13.91</td>
</tr>
<tr>
<td>T1027</td>
<td>TL</td>
<td>15 minutes</td>
<td>Family training and support - onsite</td>
<td>$11.03</td>
</tr>
<tr>
<td>T1027</td>
<td>TL</td>
<td>15 minutes</td>
<td>Family training and support - offsite</td>
<td>$13.90</td>
</tr>
<tr>
<td>T1027</td>
<td>TL, HQ</td>
<td>15 minutes</td>
<td>Group family training and support (multiple families)</td>
<td>$2.76</td>
</tr>
</tbody>
</table>
Chapter 9: Developmental Therapy

Service Description
Developmental Therapy (DT) includes global evaluation and assessment, IFSP development, (see definition of IFSP development) and individual or group therapy services. DTs may also be called Special Instruction, which includes the design of learning environments and activities that promote the child’s acquisition of skills in a variety of developmental areas and provision of information and support related to enhancing the skill development of the child that enables the child to attain maximum functional levels. These activities are coordinated with all other services within the plan and provide assistance with acquisition, retention, or improvement in skills related to daily living activities, such as feeding and dressing, communicating with parents/caregivers, and the social and adaptive skills to enable the child to reside in his/her home or non-institutional community setting.

Aural Rehabilitation services for EI are defined under the service description within Chapter 8: Audiology, Aural Rehabilitation and Other Related Services. For a DT to provide and bill Aural Rehabilitation services, the DT must be credentialed and enrolled as a DT-Hearing (DT-H) and have an authorization for Aural Rehabilitation services.

Vision services for EI are defined under the service description within Chapter 22: Vision. For a DT to provide and bill for Vision Services the DT must be credentialed and enrolled as a DT - Vision (DT-V) and have an authorization for Vision services.

A DT-H and DT-V may conduct global evaluations required for eligibility and still be able to recommend for their specialized (hearing or vision) service. A DT-H or DT-V can also recommend regular DT if it is determined that the child’s hearing or vision concern doesn’t require specialized services and that DT itself could assist the child in reaching his/her outcome(s).

Services must be consistent with the provider’s training and qualifications.

NOTE: The EI Program does not pay for therapeutic services required for a child to recover from medical procedures such as surgery, etc., or for pre-surgery therapeutic services required by a physician to prepare a child for surgery.

Qualified Staff
Enrolled Specialist credentialed as a Developmental Therapist, including DT-H, and DT-V.

NOTE: There is no Associate-Level Developmental Therapy Credential. The credentialed/enrolled Developmental Therapist is responsible for personally providing services to a child/family.

Billable Activities with Authorization
Global evaluation, assessment, IFSP development, and direct services.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.
<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96112</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment - onsite</td>
<td>$11.69</td>
</tr>
<tr>
<td>96112</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment - offsite</td>
<td>$14.74</td>
</tr>
<tr>
<td>99499 TL</td>
<td>TL</td>
<td>15 minutes</td>
<td>IFSP Development - onsite</td>
<td>$11.69</td>
</tr>
<tr>
<td>99499 TL</td>
<td>TL</td>
<td>15 minutes</td>
<td>IFSP Development - offsite</td>
<td>$14.74</td>
</tr>
<tr>
<td>99499 TL</td>
<td>TL</td>
<td>15 minutes</td>
<td>IFSP Meeting</td>
<td>$14.74</td>
</tr>
<tr>
<td>T1027</td>
<td></td>
<td>15 minutes</td>
<td>Individual DT - onsite</td>
<td>$11.69</td>
</tr>
<tr>
<td>T1027</td>
<td></td>
<td>15 minutes</td>
<td>Individual DT - offsite</td>
<td>$14.74</td>
</tr>
<tr>
<td>T1027 HQ</td>
<td>HQ</td>
<td>15 minutes</td>
<td>Group DT (multiple families or group not to exceed 4 children)</td>
<td>$2.93</td>
</tr>
</tbody>
</table>

- Billing codes for Vision Services for EI are found under the service description entitled “Vision”
- Billing codes for Aural Rehabilitation and related services for EI are found under the service description entitled “Audiology, Aural Rehabilitation and Other Related Services”
Chapter 10: Health Consultation

Service Description
Health consultation is consultation by a licensed physician, as identified in the IFSP, who has provided medical treatment to the child within the past year, with members of the child’s IFSP team or the child’s family concerning the impact of the child’s special health care needs on the provision of services.

Consultation services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
System-enrolled Physician licensed in the state where he or she provides services to Illinois children. (Physicians are not required to obtain an EI Credential but must be enrolled to provide EI services.)

Billable Activities with Authorization
Physician consultation regarding impact of the child’s medical status on provision of EI services.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

HEALTH CONSULTATION PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>Office or other outpatient visit (Approximately 5 minutes)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99212</td>
<td>N/A</td>
<td>Office or other outpatient visit (Approximately 10 minutes)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99213</td>
<td>N/A</td>
<td>Office or other outpatient visit (Approximately 15 minutes)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99214</td>
<td>N/A</td>
<td>Office or other outpatient visit (Approximately 25 minutes)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99215</td>
<td>N/A</td>
<td>Office or other outpatient visit (Approximately 40 minutes)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99441</td>
<td>N/A</td>
<td>Telephone evaluation/management (5-10 minutes of medical discussion)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99442</td>
<td>N/A</td>
<td>Telephone evaluation/management (11-20 minutes of medical discussion)</td>
<td>$36.07</td>
</tr>
<tr>
<td>99443</td>
<td>N/A</td>
<td>Telephone evaluation/management (21-30 minutes of medical discussion)</td>
<td>$36.07</td>
</tr>
</tbody>
</table>

NOTE: Authorizations for Health Consultation services do not identify a CPT code. The authorization simply states, “Health Consultation”. Please use the above CPT codes and bill the most appropriate code for each Health Consultation provided.
Chapter 11: Interpretation and Translation Services

Interpreter and Interpreter for the Deaf
The responsibility of the EI Interpreter and EI Interpreter for the Deaf is to interpret the words of the Service Coordinator or EI Provider to the parent/caregiver and the word of the parent/caregiver back to the Service Coordinator or EI Provider. Interpreters are always to be accompanied by a Service Coordinator or an EI Provider. Therefore, must never be alone with the parent/caregiver under any circumstance.

Services include bilingual interpreter and interpreter for the Deaf that are necessary during the rendering of other EI services in order to communicate with the child and parent/caregiver. If the interpreter is authorized to interpret services for parent/caregiver and EI Provider, the interpreter may assist that EI Provider in scheduling EI appointments with the family. This does not include bilingual interpreter services that would otherwise be provided at no charge to the family or bilingual interpreter services by the same person rendering the service. All services are to be pre-authorized.

Translator
The responsibility of the EI Translator is to provide written translation of EI documents which are completed onsite, into the native language of the parent/caregiver. Translation of non-EI documents is not a billable service. Acceptable documents for translation include the Individualized Family Service Plan (IFSP), EI evaluation/assessment reports, six-month review reports, discharge reports, and letters to the parent/caregiver from the Service Coordinator or EI Provider. All services are to be pre-authorized.

Qualified Staff
1. Non-Credentialed Provider enrolled as:
   a. Interpreter
   b. Interpreter for the Deaf
   c. Translator

NOTE: Individuals enrolling in the EI Program as an interpreter, interpreter for the deaf or translator must meet licensing requirements and document the completion of Early Intervention Systems Overview Training for Interpreters and Translators (online and face-to-face follow-up session.)

Billable Activities with Authorization
Direct service called Family Training and Support and Group Family Training and Support either onsite or offsite based on location of the service for Interpreters and Interpreters for the deaf. Translation direct service would be onsite only.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

Authorizations for interpretation and translation services should only be accepted if the family/caregiver is unable to speak or read the language of the Service Coordinator or EI provider unless, specifically requested by the family to have services performed in their native language. In the event that a service is provided, and the interpreter observes that the family speaks the language of the Service Coordinator or EI provider, the Interpreter should discontinue providing services in the future and request the Service Coordinator to end the authorization. Services billed to the EI Program for unnecessary services will be require a refund and could be considered fraud by the EI Program/Medicaid. The enrollment of the interpreter/translator for future services to the EI Program will be inactivated.
As an additional resource for billing, please see Billing Tips for Interpreters, Translators and Interpreters for the Deaf at: [https://eicbo.files.wordpress.com/2017/05/billing-tips-for-interpreters-translators-and-interpreters-for-the-deaf1.pdf](https://eicbo.files.wordpress.com/2017/05/billing-tips-for-interpreters-translators-and-interpreters-for-the-deaf1.pdf)

**NOTE:** If there is more than one EI Provider and four children in a group, there must be one Interpreter for each EI Provider.

### INTERPRETER PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier(s)</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1013</td>
<td></td>
<td>15 minutes</td>
<td>Family training and support –onsite</td>
<td>$11.03</td>
</tr>
<tr>
<td>T1013</td>
<td></td>
<td>15 minutes</td>
<td>Family training and support - offsite</td>
<td>$13.91</td>
</tr>
<tr>
<td>T1013</td>
<td>HQ</td>
<td>15 minutes</td>
<td>Group family training and support (multiple families or group with one provider and not more than four children)</td>
<td>$2.76</td>
</tr>
</tbody>
</table>

Please see alpha code table at [https://eicbo.files.wordpress.com/2017/05/discipline_description_t1013.pdf](https://eicbo.files.wordpress.com/2017/05/discipline_description_t1013.pdf) for billing purposes.

### INTERPRETER FOR THE DEAF PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier(s)</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1013</td>
<td>HT</td>
<td>15 minutes</td>
<td>Family training and support –onsite</td>
<td>$11.03</td>
</tr>
<tr>
<td>T1013</td>
<td>HT</td>
<td>15 minutes</td>
<td>Family training and support - offsite</td>
<td>$13.91</td>
</tr>
<tr>
<td>T1013</td>
<td>HQ &amp; HT</td>
<td>15 minutes</td>
<td>Group family training and support (multiple families or group with one provider and not more than four children)</td>
<td>$2.76</td>
</tr>
</tbody>
</table>

### TRANSLATOR PROCEDURE CODE

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifiers</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1013</td>
<td>TL</td>
<td>15 minutes</td>
<td>Family training and support –onsite</td>
<td>$11.03</td>
</tr>
</tbody>
</table>

Please see alpha code table at [https://eicbo.files.wordpress.com/2017/05/discipline_description_t1013_tl.pdf](https://eicbo.files.wordpress.com/2017/05/discipline_description_t1013_tl.pdf) for billing purposes.
Chapter 12: Medical Services (DIAGNOSTIC/EVALUATION/ASSESSMENT PURPOSES ONLY FOR EI)

Service Description
Medical services only for diagnostic and evaluation/assessment purposes means services provided by an enrolled licensed physician or a multidisciplinary team (if needed) under the direction of an EI enrolled licensed physician to determine a child’s developmental status and need for EI support services. Medical diagnostic services may be appropriate 1) when the child’s record documents that other evaluations have failed to determine the child’s eligibility for EI and the child is likely to be determined eligible if additional developmental diagnostic services are provided, or to establish a diagnosis which would potentially meet the eligibility parameters for services; or 2) when a child has significant developmental delays and/or lacks developmental progress, presents with unexpected regression, or demonstrates atypical development that cannot be explained based upon known medical, developmental or social etiology. Medical referrals may be required if the need for medical testing is identified. The EI Program does not pay for medical testing. The diagnostic report (see Attachment 5, Medical Diagnostic Report Format) must include a statement about the child’s developmental status and EI eligibility. The report may include medical, educational and family support recommendations not necessarily covered by EI but that may be useful to families. Service Coordinators may assist families with the recommendations not covered by EI by making referrals to other community resources.

Services must be consistent with the provider’s qualifications and licensure. If team members are needed based on the child’s individual circumstances, they are assigned by each clinic based on information received from the Service Coordinator (current IFSP, IFSP team’s reports). They must be individually enrolled to provide EI services under their respective disciplines, have an EI evaluator credential, and have an authorization under their discipline to provide and bill for the particular service. Team members should use the codes found under their respective disciplines for billing purposes. A licensed physician should always be present throughout the diagnostic visit.

If a family does not speak English, the Service Coordinator shall check if Interpreters are available at the Medical Diagnostic Clinic. If an interpreter is available, the family shall be given the choice to select between the interpreter provided by the Medical Diagnostic Clinic and an interpreter likely to be selected from a list of available EI Interpreters.

The only other medical or health-related services which are covered by EI (other than the above diagnostic medical services) are defined under the “Nursing” and “Health Consultation” chapters. Medical and health services do not include the following:

1. Services that are:
   a. Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); or
   b. Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or
   c. Relating to the implementation, optimization (i.e., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.

2. Devices necessary to control or treat a medical condition.

3. Medical-health services (such as immunizations and regular “well-baby” care) that are routinely recommended for all children.

Qualified Staff
An EI-enrolled Physician licensed by the state in which he or she provides EI services to Illinois children, with an appropriate subspecialty, including developmental-behavioral pediatrics, pediatric neurology, child and
adolescent psychiatry, physical medicine and rehabilitation pediatrics, or neonatal-perinatal medicine. Non-
medical professions, such as a Psychologists, do not qualify to perform Medical Diagnostics in the EI Program. 
Additionally, any team members utilized by the Medical Diagnostician must be EI-Credentialed Evaluators.

**Standard Referral Process**

- Service Coordinator sends referral to the Medical Diagnostician.
- Medical Diagnostic Clinician contacts the family and sets up an appointment(s) based on Service 
  Coordinator’s input and family concerns.
- Information is given to family about appointment, i.e., what to expect & how long, possibility of a 
  diagnosis that day, address & telephone numbers, answers to family’s questions, etc.
- Confirmation letter is sent out to family.
- Request is made to Service Coordinator for IFSP, most recent IFSP team’s evaluation/assessment reports, 
  existing prescriptions, and service authorizations. Authorization information for Medical Diagnostician is 
  sent in as well. (Service Coordinator must ensure that child’s information is updated two to four weeks 
  before scheduled diagnostic appointment.)
- Diagnostician meets with family to discuss findings and/or summary.
- The final report is completed no later than 14-calendar days after meeting with family and sent to 
  referring CFC and family.
- The final report is then shared with IFSP team and IFSP team is convened if changes to the IFSP are 
  needed.

**Billable Activities with Authorization**

Medical diagnostic services are used to determine the child’s developmental status and need for EI services. 
The IFSP team will define the need for medical diagnostic services, based upon the need for additional 
information about the child’s developmental status. Questions or concerns about the child’s development will 
be shared with the physician/medical diagnostic team, along with copies of the IFSP, current evaluations and 
assessments, and other IFSP team members’ reports. These evaluations should be considered prior to 
authorizing additional evaluations. When appropriate and necessary, a credentialed designee(s) from the 
medical diagnostic team will be provided with IFSP development time and encouraged to contact IFSP team 
members, including the child’s Service Coordinator and evaluators/direct service providers, to more effectively 
utilize current evaluations and acquire a more complete understanding of the child’s unique strengths and 
needs. Evaluations are authorized based upon the needs of the individual child and family.

EI will pay for one (1) Medical Diagnostic Evaluation/Assessment prior to the initial IFSP or one (1) encounter 
during the initial IFSP. EI will pay for one (1) Medical Diagnostic Evaluation/Assessment prior to each annual 
IFSP after the expiration of the initial IFSP when the first medical diagnostic evaluation/assessment is 
inconclusive, the initial diagnosis is in question, the diagnosis needs to be clarified, or the child lacks 
developmental progress, presents with unexpected regression, or demonstrates atypical development that 
cannot be explained based upon known medical, developmental or social etiology.

**Do not provide services without having an authorization in hand. Services provided without a valid, pre- 
approved authorization are not guaranteed for payment.**

**MEDICAL DIAGNOSTIC PROCEDURE CODES**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99245</td>
<td>N/A</td>
<td>Medical Diagnostic Evaluation</td>
<td>$207.50</td>
</tr>
</tbody>
</table>
Chapter 13: Nursing

Service Description
Nursing services for the purposes of:
1. Assessment to determine a child’s health status, including the identification of patterns of human response to actual or potential health problems and the identification of the need for medical referrals;
2. Provision of nursing care during the time the child is receiving other EI services that may be required to allow the child to participate in EI services such as:
   • administration of medications, treatments, and regimens prescribed by a licensed physician; and
   • clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services as required to allow the child to participate in EI services.
3. Does not include hospital or home health nursing care required due to surgical or medical intervention, or an injury, or medical-health services such as immunizations and regular well-baby care that are routinely recommended for all children.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to nursing services and enhancing the child’s development are integral to this service. For family training, education and support, the eligible child is not required to be present but may be if appropriate. Family training, education and support may include such services as support groups, individual support and other training or education for the family.

NOTE: The need for nursing services does not determine eligibility for the EI Program.

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
System enrolled Specialist credentialed as a Licensed Registered Nurse.

Billable Activities with Authorization
Assessment, IFSP development and direct service

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

NURSING PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1001</td>
<td></td>
<td>15 minutes</td>
<td>Assessment- onsite</td>
<td>$11.73</td>
</tr>
<tr>
<td>T1001</td>
<td></td>
<td>15 minutes</td>
<td>Assessment - offsite</td>
<td>$14.79</td>
</tr>
<tr>
<td>99499</td>
<td>TD</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$11.73</td>
</tr>
<tr>
<td>99499</td>
<td>TD</td>
<td>15 minutes</td>
<td>IFSP development - offsite</td>
<td>$14.79</td>
</tr>
<tr>
<td>99499</td>
<td>TD</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$14.79</td>
</tr>
<tr>
<td>T1002</td>
<td></td>
<td>15 minutes</td>
<td>Nursing services - onsite</td>
<td>$11.73</td>
</tr>
<tr>
<td>T1002</td>
<td></td>
<td>15 minutes</td>
<td>Nursing services - offsite</td>
<td>$14.79</td>
</tr>
<tr>
<td>T1002</td>
<td>HQ</td>
<td>15 minutes</td>
<td>Group Nursing services (multiple families or group not to exceed 4 children)</td>
<td>$ 2.94</td>
</tr>
</tbody>
</table>

See “Nutrition” for additional service activities and billing codes.
Chapter 14: Nutrition

Service Description
Nutrition services for the purposes of:

1. Conducting individual assessments in nutritional history and dietary intake, anthropometric, biochemical and clinical variables, feeding skills and feeding problems, and food habits and food preferences;

2. Developing and monitoring appropriate plans to address the nutritional needs of eligible children based upon individual assessment; and

3. Making referrals to appropriate community resources to achieve individual planned nutrition outcomes.

Family training, education and support provided to assist the family of a child eligible for EI services in understanding the special needs of the child as related to nutritional services and enhancing the child’s development are integral to this service. For family training, education and support, the eligible child is not required to be present but may be if appropriate. Family training, education and support may include services such as support groups, individual support and other training or education for the family.

NOTE: The need for nutrition services does not determine eligibility for the EI Program.

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
1. System enrolled Specialist credentialed as:
   a. Licensed Dietitian Nutritionist
   b. Licensed Registered Nurse

Billable Activities with Authorization
Assessment, IFSP development and direct service.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

NUTRITION PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td></td>
<td>15 minutes</td>
<td>Assessment - onsite</td>
<td>$21.93</td>
</tr>
<tr>
<td>97802</td>
<td></td>
<td>15 minutes</td>
<td>Assessment - offsite</td>
<td>$27.06</td>
</tr>
<tr>
<td>99499</td>
<td>HA</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$21.93</td>
</tr>
<tr>
<td>99499</td>
<td>HA</td>
<td>15 minutes</td>
<td>IFSP development - offsite</td>
<td>$27.06</td>
</tr>
<tr>
<td>99499</td>
<td>HA</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$27.06</td>
</tr>
<tr>
<td>97803</td>
<td></td>
<td>15 minutes</td>
<td>Nutrition services - onsite</td>
<td>$21.93</td>
</tr>
<tr>
<td>97803</td>
<td></td>
<td>15 minutes</td>
<td>Nutrition services - offsite</td>
<td>$27.06</td>
</tr>
<tr>
<td>97804</td>
<td></td>
<td>15 minutes</td>
<td>Group Nutrition services (multiple families or group not to exceed 4 children)</td>
<td>$ 5.47</td>
</tr>
</tbody>
</table>
Chapter 15: Occupational Therapy

Service Description
Occupational therapy includes services to address the functional needs of a child related to adaptive development; adaptive behavior, restoration, and play; and sensory, motor, and postural development. These services are designed to improve the child’s functional ability to perform tasks in home, child care, and community settings and include:

1. Evaluation, assessment, and intervention (global evaluation not acceptable);
2. Adaptation of the environment and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills, and
3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Activities also include IFSP development, assistive technology assessment if needed, and environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child are incorporated.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to occupational therapy services and enhancing the child’s development are integral to this service. For family training, education and support, the eligible child is not required to be present but may be if appropriate. Family training, education and support may include such services as support groups, individual support and other training or education for the family.

NOTE: The EI Program does not pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
1. System enrolled Specialist credentialed as:
   a. Licensed Occupational Therapist
2. Non-enrolled Associate-Level Provider credentialed as:
   a. Licensed Certified Occupational Therapy Assistant

   (See Chapter 3: Early Intervention Providers in Illinois, under section 3.4, Use of Associate-Level Providers and section 3.3, Provider Credentialing and Enrollment for additional information.)

Billable Activities with Authorization
Evaluation/Assessment, IFSP development, and direct service.

NOTE: Bill for time required to develop assistive technology requests using IFSP development code.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.
## OCCUPATIONAL THERAPY PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifiers</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96112</td>
<td>GO</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>96112</td>
<td>GO</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>GO</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>99499</td>
<td>GO</td>
<td>15 minutes</td>
<td>IFSP development – offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>GO</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$18.68</td>
</tr>
<tr>
<td>97530</td>
<td></td>
<td>15 minutes</td>
<td>Individual therapy – onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>97530</td>
<td></td>
<td>15 minutes</td>
<td>Individual therapy - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>97150</td>
<td></td>
<td>15 minutes</td>
<td>Group therapy (multiple families or group not to exceed 4 children)</td>
<td>$8.12</td>
</tr>
</tbody>
</table>
Chapter 16: Physical Therapy

Service Description
Physical therapy services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

1. Evaluation and assessment of infants and toddlers to identify movement dysfunction (global evaluation not acceptable);
2. Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems, and
3. Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

Activities also include IFSP development and assistive technology assessment, if needed, and environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child are incorporated.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to physical therapy services and enhancing the child’s development are integral to this service. For family training, education and support, the eligible child is not required to be present during meetings but may be if appropriate. Family training, education and support may include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider’s qualifications and licensure.

NOTE: The EI Program does not pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI. If child was eligible and receiving EI services prior to medical procedure, intervention or injury, those previously approved services must continue to be provided as long as child is medically cleared and the IFSP team confirms with the family that the outcomes still reflect the family’s priorities.

Qualified Staff
1. System enrolled Specialist, credentialed as:
   a. Licensed Physical Therapist
2. Non-enrolled Associate-Level Provider, credentialed as:
   b. Licensed Physical Therapy Assistant

(See Chapter 3: Early Intervention Providers in Illinois, under section 3.4, Use of Associate-Level Providers and section 3.3, Provider Credentialing and Enrollment for additional information.)

Billable Activities with Authorization
Evaluation/Assessment, IFSP development, and direct services.

NOTE: Bill for time required to develop assistive technology requests using IFSP development code.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.
<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96112</td>
<td>GP</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>96112</td>
<td>GP</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>GP</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>99499</td>
<td>GP</td>
<td>15 minutes</td>
<td>IFSP development – offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>97110</td>
<td>GP</td>
<td>15 minutes</td>
<td>Individual therapy - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>97110</td>
<td>GP</td>
<td>15 minutes</td>
<td>Individual therapy - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>97150</td>
<td>SE</td>
<td>15 minutes</td>
<td>Group therapy (multiple families or group not to exceed 4 children)</td>
<td>$ 8.12</td>
</tr>
</tbody>
</table>
Chapter 17: Psychological and Other Counseling Services

Service Description: Psychological and other counseling services are diagnostic or active treatments as required by the child’s IFSP provided with the intent to reasonably improve the child’s physical or mental conditions. Services include:

1. Initial evaluation/assessment, evaluation/assessment, global evaluation/assessment to determine a child’s developmental status and need for EI services (only by Evaluator-licensed, clinical level providers);
2. Administering psychological or developmental tests and other assessment procedures to determine the need for psychological or other counseling services;
3. Interpreting assessment results;
4. Obtaining, integrating and interpreting information about child behavior and child and family conditions related to learning, mental health and development;
5. Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services; and

Planning and managing a program of psychological or other counseling services, including psychological or other counseling for children and parents, family counseling required due to the developmental status of the eligible child, consultation on child development, parent training, and education programs.

NOTE: If it is identified that family members may be experiencing mental health problems that are not related to the eligible child’s special needs, it is the responsibility of the EI Provider to refer those individuals to resources other than EI for services.

6. The use of Applied Behavior Analysis (ABA) strategies may be used as long as they align with EI Philosophy and Principles. EI services do not address a diagnosis but rather the delays the child is experiencing, and the functional outcomes developed in conjunction with the family. Behavior modification may be a strategy for reaching a desired outcome, but there could be multiple disciplines that could deliver the services necessary to develop and provide strategies to the child/family. Depending on what the family has already tried and the expertise of current team members, it could be that specialized expertise in the form of Board Certified Behavior Analyst (BCBA) services are needed. These services are to be provided in alignment with our philosophy and principles and will, therefore, often look different than the 20+ hours a week of direct intervention that may be recommended in another settings. The focus in EI will be on assessment, development of strategies, and coaching of caregivers.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to the services that the EI Provider is licensed to provide and enhancing the child’s development are integral to this service. For family training, education and support, the eligible child is not required to be present but may be if appropriate. Family training, education and support may include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
1. System enrolled Specialist credentialed as:
   a. Licensed Clinical Psychologist
   b. Licensed Clinical Professional Counselor,
c. Licensed Marriage and Family Therapist,
d. Licensed Clinical Social Worker,
e. Board Certified Behavior Analyst, or

2. Non-enrolled Associate-Level Provider credentialed as:
a. Clinical Psychologist
b. Clinical Counseling Assistant (an intern graduate student in clinical psychology or clinical counseling).

**NOTE:** Assistants must be under the direction of their onsite internship supervisor, who must be an enrolled Specialist in one of the above licensed fields. (See Chapter 3: under section 3.4, Use of Associate-Level Providers and section 3.3, Provider Credentialing and Enrollment for additional information.)

c. Marriage and Family Counseling Graduate Intern

**Billable Activities with Authorization**
*Initial evaluation/assessment, *evaluation/assessment, assessment, IFSP development (see Chapter 5: Individualized Family Services Plan (IFSP)) and direct services as identified above.

**NOTE:** Does not include medical case management. (*only by Evaluator-licensed, clinical level provider)

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

**PSYCHOLOGICAL AND OTHER COUNSELING PROCEDURE CODES**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96156</td>
<td>6</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - onsite</td>
<td>$17.90</td>
</tr>
<tr>
<td>96156</td>
<td>6</td>
<td>15 minutes</td>
<td>Evaluation/Assessment - offsite</td>
<td>$22.22</td>
</tr>
<tr>
<td>99499</td>
<td>UK</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$17.90</td>
</tr>
<tr>
<td>99499</td>
<td>UK</td>
<td>15 minutes</td>
<td>IFSP development - offsite</td>
<td>$22.22</td>
</tr>
<tr>
<td>99499</td>
<td>UK</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$22.22</td>
</tr>
<tr>
<td>*96158</td>
<td>15 minutes</td>
<td>Individual treatment - onsite</td>
<td>$17.90</td>
<td></td>
</tr>
<tr>
<td>*96158</td>
<td>15 minutes</td>
<td>Individual treatment - offsite</td>
<td>$22.22</td>
<td></td>
</tr>
<tr>
<td>*96164</td>
<td>15 minutes</td>
<td>Group treatment (multiple families or group not to exceed 4 children)</td>
<td>$ 4.47</td>
<td></td>
</tr>
</tbody>
</table>

*Please use appropriate billing increments and coding for insurance billing purposes.
Chapter 18: Service Coordination

Service Description
Service coordination services are carried out by a Service Coordinator to assist an eligible child along with his or her family to receive the rights, procedural safeguards, and authorized services to be provided through the EI Program. The responsibilities of a Service Coordinator include, but are not limited to:

1. Mandatory contact (by telephone, mail or in person) with the enrolled child/family at least one time per month;
2. Coordinating the implementation of the service plan;
3. Coordinating the completion of initial and annual evaluations/assessments;
4. Facilitating and participating in the development, review and evaluation of the IFSP. This includes IFSP updates, six (6) month reviews and the annual evaluations of the IFSP;
5. Mandatory distribution of the entire initial and annual IFSP, including evaluations/assessments, to all ongoing EI Providers before the start of the services.
6. Assisting families in identifying credentialed/enrolled/available EI Providers, and Designated Service Coordinators for Hearing and Vision, when appropriate;
7. Coordinating and monitoring (through the mandatory monthly contacts) the delivery of services identified in the child’s IFSP;
8. Informing families of their rights and the availability of advocacy services;
9. Helping families to access other needed services such as WIC, housing, etc.;
10. Coordinating with medical and health providers, including requests for relevant medical records and other pertinent medical documentation from physicians, hospitals, nurses, clinics, home health agencies, etc.
11. Facilitating the development and implementation of a transition plan to preschool or other services, if appropriate; and
12. Maintenance of the child’s comprehensive permanent record at the Child and Family Connections office. Maintenance includes:
   • Evaluations/Assessments and Six-Month Report from all providers who are members of the child’s service team;
   • Notes on the progress of the child’s transition plan implementation which is to begin at age two (2) years, six (6) months.
   • IFSP updates; and
   • Any other documentation required for completion of the child’s permanent record.

Other services identified in the Child and Family Connections Procedure Manual in Chapter 3.0 Overview of Child and Family Connections.

Service Coordinators provide family assessments during the intake process, but they do not provide evaluation/assessment services to determine a child’s eligibility for services. Service Coordinators are integral members of the service team. Services must be consistent with the provider’s qualifications.
Service Coordinators are required to follow written procedures that are outlined in the *Child and Family Connections Procedure Manual* and to implement policy as set forth by the IDHS – Bureau of EI.

**NOTE:** Persons who are employed by a CFC as Service Coordinators (or Parent Liaisons) must be dedicated. “Dedicated” means that a Service Coordinator (or Parent Liaison) cannot provide any EI services other than service coordination (or parent liaison) within the CFC geographic area. However, a person can provide other EI services for children in CFC regions in which they are not employed. Providing services other than service coordination or parent liaison within your CFC geographic area is deemed a conflict of interest.

**Qualified Staff**
System enrolled individual credentialed as a Service Coordinator. Service Coordination services are provided by Service Coordinators who are employed by a Child and Family Connections office. Services are funded by contracts to the Child and Family Connection offices and are not billed fee-for-service.

**NOTE:** There is no Associate-Level Service Coordinator credential. The credentialed/enrolled Service Coordinator is responsible for personally providing services to a child/family.
Chapter 19: Social Work and Other Counseling Services

Service Descriptions
Social work and other counseling services are diagnostic or active clinical treatments provided with the intent to reasonably improve the child’s physical or mental condition or functioning. Social work and other counseling services include:

1. Initial evaluation/assessment, evaluation/assessment, Global evaluation/assessment to determine a child’s developmental status and need for EI services (*only by Evaluator-licensed, clinical-level providers);
2. Making home visits to assess a child’s living conditions and patterns of parent-child interaction to determine the need for social work or other counseling services;
3. Preparing a social or emotional developmental assessment of the child within the family context to determine the need for social work or other counseling services;
4. Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents;
   NOTE: If it is identified that family members may be experiencing mental health problems that are not related to the eligible child’s special needs, it is the responsibility of the EI Provider to refer those individuals to resources other than EI for services.
5. Working with issues in the child’s and family’s living situation (home, community, and any center where EI services are provided) that affect the child’s maximum utilization of EI services, and
6. Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services.

Family training, education, and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to the services that the EI Provider is licensed to provide and enhancing the child’s development are integral to this service. For family training, education, and support, the eligible child is not required to be present but may be if appropriate. Family training, education, and support may include services such as support groups, individual support and other training or education for the family.

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
1. System-enrolled Specialist credentialed as:
   a. Licensed Social Worker
   b. Licensed Professional Counselor
2. Non-enrolled Associate-Level Provider credentialed as:
   a. Social Work Assistant (an intern graduate student in social work).

   NOTE: Per the Clinical Social Work and Social Work Practice Act, 225 ILCS 20/10(c), a Licensed Social Worker is unable to practice in an independent, private practice. Therefore, no Licensed Social Worker may be enrolled as an independent or as an owner of a corporation with having an EI Credentialed Clinical Social Worker or equivalent on staff.

   Assistants must be under the direction of their internship supervisor, who must be an EI-enrolled Specialist in one of the above licensed fields. (See Chapter 3: Early Intervention Providers in Illinois, under
section 3.4, Use of Associate-Level Providers and section 3.3, Provider Credentialing and Enrollment for additional information.)

**Billable Activities with Authorization**

*Evaluation/assessment, assessment, IFSP development (See Chapter 5: Individualized Family Service Plan (IFSP)) and direct services as described above. (*only by Evaluator credentialed-licensed, clinical-level EI Providers)*

**NOTE:** Does not include medical case management.

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

**SOCIAL WORK AND OTHER COUNSELING PROCEDURE CODES**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite</td>
<td>$11.94</td>
</tr>
<tr>
<td>90791</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite</td>
<td>$14.37</td>
</tr>
<tr>
<td>99499</td>
<td>SE</td>
<td>15 minutes</td>
<td>IFSP development – onsite</td>
<td>$11.94</td>
</tr>
<tr>
<td>99499</td>
<td>SE</td>
<td>15 minutes</td>
<td>IFSP development – offsite</td>
<td>$14.37</td>
</tr>
<tr>
<td>99499</td>
<td>SE</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$14.37</td>
</tr>
<tr>
<td>H0004</td>
<td></td>
<td>15 minutes</td>
<td>Individual treatment – onsite</td>
<td>$11.94</td>
</tr>
<tr>
<td>H0004</td>
<td></td>
<td>15 minutes</td>
<td>Individual treatment – offsite</td>
<td>$14.37</td>
</tr>
<tr>
<td>H0004</td>
<td>HQ</td>
<td>15 minutes</td>
<td>Group treatment (multiple families or group not to exceed 4 children)</td>
<td>$ 2.98</td>
</tr>
</tbody>
</table>
Chapter 20: Speech-Language Pathology Therapy

Service Description
Speech therapy services include:

1. Completing evaluation/assessment activities to identify communication (speech/language) or swallowing (eating/drinking) disorders or delays that would impact communication or feeding; (global evaluations not acceptable);

2. Referring to medical and/or other professional services necessary for the habilitation or rehabilitation of children with medically based communicative or oropharyngeal disorders and delays;

3. Participating in IFSP development;

4. Implementing treatment programs as a result of a medical referral by a licensed physician to improve the child’s functional ability to communicate at home and in other environments. These activities for EI may include assistive technology assessments, audiological-based setups, aural rehabilitation services and environmental adaptation recommendations.

5. Providing family education, training and support in order to assist the family in understanding the special needs of the child as well as promoting family involvement in services so they can enhance their children’s learning and development.

6. Providing services for children with feeding/swallowing deficits related to sensory integration, medically stable oropharyngeal disorders, and behavioral issues. All other feeding/swallowing deficits are medically related and should be referred to the child’s primary medical physician or medical home for medical intervention.

Services must be consistent with the provider’s qualifications and licensure.

NOTE: The EI Program does not pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury is not developmentally based but is medically based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

Qualified Staff
1. System enrolled Specialist credentialed as
   a. Licensed Speech-Language Pathologist

2. Non-enrolled Associate-Level Provider credentialed as:
   a. Speech-Language Pathology Therapy Assistant
   b. Temporary Speech-Language Pathology license and is completing a clinical fellowship year (CFY).

NOTE: Assistants must be under the direction of an enrolled Speech-Language Pathologist Specialist. A Clinical Fellow is also under the supervision of a fully, licensed Speech Language Pathologist.
(See detailed requirements within Chapter 3: Early Intervention Providers in Illinois, under section 3.4, Use of Associate-Level Providers)

Billable Activities with Authorization
Evaluation/Assessment, IFSP development, (See Chapter 5 - Individualized Family Service Plan (IFSP)) and direct services.

NOTE: Bill for the time required to develop AT requests using IFSP development code.
Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

**SPEECH-LANGUAGE THERAPY PROCEDURE CODES**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92521</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite (Speech Fluency)</td>
<td>$14.97</td>
</tr>
<tr>
<td>92521</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite (Speech Fluency)</td>
<td>$18.68</td>
</tr>
<tr>
<td>92522</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite (Speech Sound Production)</td>
<td>$14.97</td>
</tr>
<tr>
<td>92522</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite (Speech Sound Production)</td>
<td>$18.68</td>
</tr>
<tr>
<td>92523</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite (Speech Sound Production with language comprehension and expression)</td>
<td>$14.97</td>
</tr>
<tr>
<td>92523</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite (Speech Sound Production with language comprehension and expression)</td>
<td>$18.68</td>
</tr>
<tr>
<td>92524</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite (Behavioral and qualitative analysis of voice and resonance)</td>
<td>$14.97</td>
</tr>
<tr>
<td>92524</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite (Behavioral and qualitative analysis of voice and resonance)</td>
<td>$18.68</td>
</tr>
<tr>
<td>92610</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – onsite (oral &amp; pharyngeal swallowing function)</td>
<td>$14.97</td>
</tr>
<tr>
<td>92610</td>
<td></td>
<td>15 minutes</td>
<td>Evaluation/Assessment – offsite (oral &amp; pharyngeal swallowing function)</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>GN</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>99499</td>
<td>GN</td>
<td>15 minutes</td>
<td>IFSP development - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>99499</td>
<td>GN</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td>$18.68</td>
</tr>
<tr>
<td>92507</td>
<td></td>
<td>15 minutes</td>
<td>Individual therapy - onsite</td>
<td>$14.97</td>
</tr>
<tr>
<td>92507</td>
<td></td>
<td>15 minutes</td>
<td>Individual therapy - offsite</td>
<td>$18.68</td>
</tr>
<tr>
<td>92508</td>
<td></td>
<td>15 minutes</td>
<td>Group therapy (multiple families or group not to exceed 4 children)</td>
<td>$8.12</td>
</tr>
</tbody>
</table>

**NOTE:** Authorizations will display 92506; however, Evaluations/Assessments must be billed using the appropriate code(s), listed above.

See “Audiology, Aural Rehabilitation and Other Related Services” for additional service activities and billing codes for EI. Provider MUST have authorization prior to billing those codes.

Examples of use of codes include:
- **92521** - Speech fluency, for example, stuttering, the most common fluency disorder, is an interruption in the flow of speaking characterized by repetitions (sounds, syllables, words, phrases), sound prolongations, blocks, interjections, and revisions, which may affect the rate and rhythm of speech
- **92522** - Speech sound production, for example, articulation, phonological process, apraxia, dysarthria
- **92523** - Speech sound production with evaluation of language comprehension and expression, for example, receptive and expressive language

Payment for evaluation(s)/assessment(s) performed will be based on the total units of time used to perform the process. The claim must identify, per code, the units to complete the process. The total units of time billed must not exceed the allowable and authorized amount listed on the authorization received prior to conducting the evaluation.
Chapter 21: Transportation

Service Description
Transportation services as defined in the IFSP that are necessary to enable an eligible child and a member of the child’s family (if accompanying the child) to travel to and from the location where another EI service is to be provided. Transportation services include transportation by taxicab, service car, or private automobile. The prior approval requirement for Medicaid-eligible children, for Transportation to and from EI services only, is satisfied by enrollment in the EI Program and by denoting the necessity of the service in the IFSP. (See Chapter 6 - Billing Guidelines and Use of Insurance for additional resources.)

Services must be consistent with the provider’s qualifications and licensure.

Qualified Staff
System-enrolled transportation provider. Providers may include parents, guardians and other responsible adults.

Billable Activities with Authorization
Transportation for child and family member to and from the location where EI services are provided. Must be by most economical means appropriate for the child. Transportation codes can only be billed for loaded mileage, meaning the child is in the vehicle and is being transported to and from an EI service.

NOTE: Transportation is considered a direct service; one authorization, one eligible child with caregiver (related children or family members may accompany the caregiver). This does NOT include transporting non-related children or multiple EI children with their caregivers to appointments at the same time.

Rate
Established individually based on *Medicaid rates, to verify rates, please go to:
https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Transportation.aspx

Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.

TRANSPORTATION PROCEDURE CODES

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0120</td>
<td>N/A</td>
<td>N/A</td>
<td>Service car, base rate</td>
</tr>
<tr>
<td>A0120</td>
<td>N/A</td>
<td>N/A</td>
<td>Service car, return</td>
</tr>
<tr>
<td>A0425</td>
<td>N/A</td>
<td>N/A</td>
<td>Service car, mileage</td>
</tr>
<tr>
<td>T2001</td>
<td>N/A</td>
<td>N/A</td>
<td>Non-employee attendant</td>
</tr>
<tr>
<td>A0100</td>
<td>N/A</td>
<td>N/A</td>
<td>Taxi, base rate</td>
</tr>
<tr>
<td>A0100</td>
<td>N/A</td>
<td>N/A</td>
<td>Taxi, return</td>
</tr>
<tr>
<td>A0425</td>
<td>N/A</td>
<td>N/A</td>
<td>Taxi, mileage</td>
</tr>
<tr>
<td>T2001</td>
<td>N/A</td>
<td>N/A</td>
<td>Non-employee attendant</td>
</tr>
<tr>
<td>A0090</td>
<td>N/A</td>
<td>*Varies</td>
<td>Private auto mileage (parents transporting their own children)</td>
</tr>
</tbody>
</table>

*Current Private auto mileage reimbursement must be confirmed by visiting:
www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Transportation.aspx
Chapter 22: Vision

Service Description
Optometric Vision services include diagnosis and appraisal of specific visual disorders, delays, and abilities, dispensing of eyeglasses, and referral for medical or other professional services necessary for the habilitation or rehabilitation of delays related to impairment in functional vision development.

Developmental habilitation/rehabilitation services for vision address delays in a child’s development that are a result of impairments in functional vision development. Such services include:

1. functional vision evaluation, assessment, IFSP development, and intervention;
2. adaptations to the environment and materials in the environment to maximize use of vision and other sensory inputs, and
3. promotion of unique skills to minimize initial or future atypical development in areas often compromised by a visual impairment (i.e., orientation and mobility, independent living, compensatory needs for acquisition of literacy and numeracy including communication modes, social interaction, self-determination, and sensory efficiency).

A Developmental Therapist-Vision (DT-V) may conduct a global evaluation required for eligibility and still be able to recommend for his/her specialized service. A DT-V can also recommend regular DT if it is determined that the child’s vision concern doesn’t require specialized services and that DT itself could assist the child in reaching his/her outcome(s).

Family training, education, and support provided to assist the family of a child eligible for services in understanding the special needs of the child related to vision services and enhancing the child’s development are integral to this service. For family training, education, and support, the eligible child is not required to be present but may be if appropriate. Family training, education, and support may include such services as support groups, individual support, and other training or education for the family.

Policy and Procedures for Authorization for Eyeglasses (separate from the AT Process) Policy
Eyeglasses for eligible children are purchased through a contracted vendor with the Department of Healthcare and Family Service (HFS). Optometric examination services and dispensing fees must be authorized prior to service provision.

Procedure
The selection of available vision providers to conduct the optometric examination is facilitated by the Service Coordinator.

If it is determined that the child needs eyeglasses, the provider submits the HFS 2803 Optical Prescription Order form that includes the prescription information to the CBO along with their claim for the optometric examination and the dispensing fee. The CBO generates the specific authorization(s) and sends it to the contracted vendor with the order form.

The contracted vendor produces the eyeglasses and sends them to the EI Provider. The EI Provider dispenses the eyeglasses to the child and family.

NOTE: A claim against the dispensing fee authorization will not be honored by the CBO unless the claim is accompanied by the HFS 2803 Optical Prescription Order form requesting eyeglasses for the child. Please review all notices from HFS pertaining to the current procedure for ordering eyeglasses, as updates have occurred regarding the process.
To determine the need for eyeglasses, the Optometrist must follow these procedures:

- The EI Optometrist is responsible for billing private insurance, as applicable.

- For eyeglasses to be purchased by the EI Program, the Optometrist must contact the IDOC at 1-800-523-1487 to request the frame kit. Once the family has chosen an eyeglasses frame, the Optometrist must:
  - Complete the HFS 2803, Optical Prescription Order Form, attach it to the claim form and submit to the EI CBO. This triggers EI to generate the authorization for the eyeglasses to send to IDOC.
  - The HFS vendor will make the eyeglasses and send directly to the Optometrist to properly fit the glasses on the child.

Services must be consistent with the provider’s qualifications and licensure.

**NOTE:** The EI Program does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury is not developmentally based but is medically based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

**Qualified Staff**

1. System Enrolled Specialist credentialed as:
   a. Developmental Therapist-Vision (DT-V)

2. Non-Enrolled Provider credentialed as:
   a. Licensed Registered Optometrist
   b. Licensed Ophthalmologist

**Billable Activities with Authorization**

Optometric examination, vision evaluation/assessment, dispensing fee, assessment, IFSP development and direct services.

*Do not provide services without having an authorization in hand. Services provided without a valid, pre-approved authorization are not guaranteed for payment.*

**VISION PROCEDURE CODES**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92015</td>
<td>n/a</td>
<td>n/a</td>
<td>Optometric examination</td>
<td>$30.15</td>
</tr>
<tr>
<td>92340</td>
<td>n/a</td>
<td>n/a</td>
<td>Dispensing fee</td>
<td>$30.99</td>
</tr>
</tbody>
</table>

**NOTE:** Practice has been to create both authorizations simultaneously, but they can be created at separate times based on the process with the Optometrist and the CFC.
**Procedure Codes** listed below are for use by Illinois Department of Corrections only.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2020</td>
<td>n/a</td>
<td>Frame</td>
<td></td>
<td>Varies</td>
</tr>
<tr>
<td>V2025</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VISION PROCEDURE CODES-cont.**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>varies</td>
<td>n/a</td>
<td></td>
<td>Pair of lenses (same Rx)</td>
<td>Varies</td>
</tr>
<tr>
<td>varies</td>
<td>n/a</td>
<td></td>
<td>Right lens (different Rx)</td>
<td>Varies</td>
</tr>
<tr>
<td>varies</td>
<td>n/a</td>
<td></td>
<td>Left lens (different Rx)</td>
<td>Varies</td>
</tr>
</tbody>
</table>

**NOTE:** Prescriptions for eyeglasses must be submitted to the CBO along with the bill for the optometric examination and the dispensing fee using “optical prescription order forms” from the Illinois Department of Corrections. The CBO will make arrangements to fill the prescription as ordered.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Modifier</th>
<th>Unit of Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99199</td>
<td>15 minutes</td>
<td>Assessment - onsite</td>
<td></td>
<td>$11.36</td>
</tr>
<tr>
<td>99199</td>
<td>15 minutes</td>
<td>Assessment - offsite</td>
<td></td>
<td>$14.33</td>
</tr>
<tr>
<td>99499</td>
<td>15 minutes</td>
<td>IFSP development - onsite</td>
<td></td>
<td>$11.36</td>
</tr>
<tr>
<td>99499</td>
<td>15 minutes</td>
<td>IFSP development - offsite</td>
<td></td>
<td>$14.33</td>
</tr>
<tr>
<td>99499</td>
<td>15 minutes</td>
<td>IFSP meeting</td>
<td></td>
<td>$14.33</td>
</tr>
<tr>
<td>V2799</td>
<td>15 minutes</td>
<td>Vision services - onsite</td>
<td></td>
<td>$11.36</td>
</tr>
<tr>
<td>V2799</td>
<td>15 minutes</td>
<td>Vision services - offsite</td>
<td></td>
<td>$14.33</td>
</tr>
<tr>
<td>V2799</td>
<td>HQ</td>
<td>15 minutes</td>
<td>Group vision services (multiple families or group not to exceed 4 children)</td>
<td>$2.84</td>
</tr>
</tbody>
</table>
### Chapter 23: Glossary and Abbreviations

| **Adjusted Age** | The Illinois EI Program defines prematurity as a birth that occurs prior to 37 weeks gestation. Full term pregnancy is 40 weeks gestation and children are considered premature if born at 36 weeks or less. When children are being evaluated/assessed in the EI Program, an adjusted age which fully corrects for prematurity should be used for calculating percent of delay up to age two.  
**Example:** A child is born at 36 weeks; this child is considered to be four weeks or one-month premature. When that child is chronologically 10 months old, the evaluators should correct the child’s age to nine months. This correction for prematurity is to provide that child time to “catch up” developmentally to their same-age peers who were born full term. This can often be confusing to parents/caregivers, so as an EI Provider, it is best to help them understand this by explaining how correcting for prematurity is calculated. |
| **Arena Evaluation/Assessments & Reports** | Please see evaluation/assessments later in this chapter. |
| **Assistive Technology** | A letter of developmental necessity provides evidence to support the need for AT devices and/or services that are identified as a strategy on a child’s IFSP. This letter also provides information on intended usage of AT, how the AT strategy will be implemented into the child’s daily routines, and any training needs required for the child’s IFSP team members. This letter must be written by the child’s AT evaluator and include information on the AT device, how the device will be implemented, accessed and supported by the child and family. Additionally, the letter must include the Evaluator-credentialed EI Provider’s name; both printed and signed, date, discipline, and telephone number. See Attachment 1 for guidelines and report format. |
| **Authorizations** | Pre-approval is required before any service can be rendered. The exception to this rule is the IFSP meeting. IFSP Meeting authorizations will be based upon actual attendance at the IFSP meeting. For direct services, authorizations are generated as either Individual or Group. |
| **Authorization - Individual** | An authorization to provide services to a single child/family based upon a defined frequency, intensity, and duration. An Individual Authorization cannot be used to provide services to a child/family during the same time frame that the child/family is receiving authorized group therapy services.  
**Example:** A Speech-Language Pathologist (SLP) provides services to a single child for a designated time, such as 60 minutes, for a designated frequency, such as one time per week, at a designated environment, such as the child’s home or at child care, to meet the child’s outcome(s). |
| **Authorization - Group** | An authorization to provide direct services to two or more children during the same period of time based upon a defined frequency, intensity, and duration. One EI Provider can serve up to four (4) children or multiple families (parent groups) during a group session. See service description “Family Training and Support” for information on groups and Interpreters. |
### Authorization - Group – Cont.

**Example:** A SLP receives a Group Authorization for four (4) different EI children and provides services to the four (4) children in her clinic between 10 am and 11 am, once time a week, to meet the individual functional outcome(s) identified on the four (4) children’s IFSP.

### Authorization - Evaluation/Assessment

An authorization to provide an evaluation or assessment to determine a child’s initial eligibility, re-determination of eligibility, identification of the individual child’s strengths and needs, and the EI services appropriate to meet those needs, the need to add new types of services to an existing IFSP, and if deemed necessary, for the annual six-month review.

### Authorization - IFSP Development

An authorization to allow EI Providers to complete the following activities directly related to the development of the IFSP, including:

- provider to provider consultation; see IFSP Development;
- completion of direct service reports required for the six-month review;
- attendance in the transition meeting;
- attendance at the child’s IEP meeting (only if prior to the child’s third birthday);

**NOTE:** The EI Program does not pay for attendance at pre-IEP meetings.

- completion of the *Illinois Early Intervention Assistive Technology Developmental Letter of Necessity* form, see [Attachment 1](#);
- completion of the *Developmental Justification to Change Frequency, Intensity, and/or Location of Authorized Services* worksheet, and
- completion of the *Discharge Report*.

Additional information may also be found for IFSP development within the Documentation definition.

### Authorization - IFSP Meeting

An authorization that is based on attendance at the IFSP meeting. This is the **only** authorization that is generated after the service has been provided. The amount of time allowed for billing on this authorization will be the amount of time that the EI Provider was actually in attendance at the IFSP meeting, in person or by telephone (only due to exceptional circumstances).

### Authorization - Offsite

A site where the child typically spends his or her day which may be the child’s home, child care, play groups, (not therapy specific) or other natural setting. The EI Provider travels to the child to provide services. This is considered a natural environment.

Offsite authorizations would also include settings where both the child and EI Provider must travel to the site of service. This type of setting would include sites such as a local library where children meet for story time, a community swimming pool, a park, or other community setting that is frequented by typically developing children.

**Example:** A SLP provides services to child for 60 minutes at home, child care or community swimming pool as outlined to meet the child’s functional outcome(s).

### Authorization – Onsite

A site where the EI Provider of services is located during a regular workday where the family must travel to in order for their child to receive services. This would include agencies, hospitals, satellite sites, and other similar settings. This type of setting may not be considered a natural environment.
Authorization –
Onsite –
Cont.

Example: A speech therapy clinic where children come to receive speech services in group or in individual sessions between 10 am and 11 am (Group Authorization/rate or Individual Authorization/rate) as outlined to meet the child’s functional outcome(s).

Co-treatment

A strategy available to team members that allows for the integration of treatment by two disciplines in order to maximize therapy benefits for one individual child/family while working towards the achievement of IFSP outcomes. This strategy allows members of the team to communicate and support one another as well as the family/child. Co-treatment could be included as a possible strategy to support the functional outcomes written in the IFSP and must be discussed with the family before utilization. Co-treatment must be based upon a child/family’s needs and not EI Provider logistics. Co-treatment is not considered Group Therapy. For more information see definition of “Group Therapy”. If the need for co-treatment is determined after the IFSP is developed, IFSP team consensus for the use of this strategy must be sought and confirmed in writing.

Example: A SLP and Developmental Therapist (DT) each receive Individual Authorizations for 60 minutes, one time a week, to provide services to the child at home or child care together from 10am to 11am.

Child Outcomes

The changes experienced as a result of the EI services and supports provided to a child. All children in the EI Program will have their skills compared to other children their age in three areas, including:

1. positive social emotional skills (including social relationships);
2. acquisition and use of knowledge and skills, and
3. taking appropriate action to meet needs.

The following three areas are believed to be important for all young children, including:

1. having relationships with family and friends;
2. being able to gain new information and skills, and
3. being able to communicate and meet needs.

As an EI Provider on a multi-disciplinary team, you will discuss a child’s status in the three child outcome areas. These child outcomes will be determined when the child enters the EI Program, at his/her annual IFSP meeting, and again before exiting the EI Program. Child outcomes compare a child’s status to expected development for other children of the same age.

Clinical Opinion

If a child is unable to be appropriately and accurately tested by the standardized measures available, informed clinical opinion of the qualified staff based upon multidisciplinary evaluation may be used to document the level of delay. The child is eligible if the clinical opinion of the level of delay meets or exceeds the Department-approved level of 30%.

Concerns

What family members identify as needs, issues, or problems they want to address as part of the IFSP process.

Confidentiality

The expectation that EI Providers will limit access to information about the children and families served in EI, the Illinois EI Program follows all guidelines and procedures in accordance with the Health Insurance Portability and Accountability Act (HIPAA)
Confidentiality – Cont. and the Family Education Rights and Privacy Act (FERPA) to ensure the families’ right to privacy and confidentiality.

Corrected Claim

A corrected claim refers to a claim that was sent previously to the CBO and has one or more of following characteristics: the CBO made either a partial payment or complete payment, and/or the claim was requested by a CBO processor to be sent in response to a mistake or inquiry. For additional information, please see: https://eicbo.files.wordpress.com/2017/05/how-to-send-resubmitted-or-corrected-claims-to-the-central-billing-office3.pdf.

Claims resubmitted due to rejection of payment because of billing errors must be submitted no more than sixty (60) calendar days from the date of the related CBO correspondence.

The resubmitted claim must be clearly marked “Resubmitted Claim” at the top of the claim form and must only include services documented on the original claim.

For previously adjudicated claims that produced payment to the Payee for incorrect information (amount, frequency, place of service, etc.) must be resubmitted no more than sixty (60) calendar days from the date of the related Provider Claim Summary.

The resubmitted claim for this purpose must be clearly marked “Corrected Claim” at the top of the claim form. Claims for rebilling are to be corrected on the original claim striking through incorrect information with correct information filled in.

Please visit www.eicbo.info for additional instruction on Resubmitted and Corrected Claims.

Direct Service

Treatment services provided directly to an eligible child or an eligible child’s family in accordance with their Individualized Family Service Plan (IFSP). All direct services must be justified by functional outcomes (see definition below) that are included in a child’s IFSP. One person cannot provide services to the same child/family as two disciplines.

Example: One person cannot provide services as a Developmental Therapist and as an Occupational Therapist.

Discharge

A child receiving EI services may be discharged from a service for various reasons including, child turns three years of age, meets all functional outcomes, changes EI Providers, moves out of a particular CFC area (original EI Provider must complete a Discharge Report). If frequency, intensity and/or location of services listed in IFSP, EI Providers must complete the Developmental Justification to Change Frequency, Intensity and/or Location of Authorized Services Worksheet. Providers are expected to complete a Discharge Report following the format provided by IDHS. Copies are to go to the Service Coordinator who will share with the team, including the family.

Documentation

1. Documentation of direct services

Documentation of direct service for each date and procedure code must include the child’s full name, actual date of service, exact time in, exact time out, location, modality (if LVV, platform used), all persons present, EI provider’s name, and signature and a concise, complete, objective account of service, and for each direct service provided.
Further details on effective documentation rules, tips, and strategies - [EI Documentation Graphic](illinois.edu).

**NOTE:** A checklist or pages from an appointment book are not considered documentation or a complete overview of the services provided. Documentation overview and the complete EI Provider’s signature (not initials) must be legible and understandable to families and to persons who will monitor or audit the EI Payee’s service billed.

2. **Documentation of supervision**

   In addition to the direct service overview from the account of the Associate-Level EI provider who is actually providing service in the child –

   Supervisory documentation should include all contact between the supervisor who is responsible for a child’s case. Documentation from the account of the supervisor attending the direct service session can include the following information:
   - review of IFSP functional outcomes identified in each child’s IFSP to determine if the IFSP requires modifications;
   - discussion with parent/caregiver about family priorities and concerns;
   - observation of interaction between the Credentialed Associate-Level Provider and the parent/caregiver;
   - observation of interaction between the Credentialed Associate-Level Provider and the child;
   - observation of direct service to the child;
   - review of child’s progress or lack thereof;

   **NOTE:** Calendar pages that identify dates of supervision are not considered supervision notes or appropriate documentation.

3. **Documentation of services provided by Interpreters, including Interpreters for the Deaf, and Translators,**

   - child’s first and last name, date of birth and EI number; date of service; discipline and rendering EI Provider name for which you have interpreted services; exact time in/exact time out, *i.e.*, start: 9:12am/end: 10:15am;
   - interpretation type: verbal, sign, or written translation;
   - translation document type (example: IFSP);
   - copy of the document to translate and copy of the final translated document, and
   - printed name and signature of Interpreter/Translator.

   **NOTE:** Billing of translation of documents is not to occur until after reports have been received by the Service Coordinator.

4. **Documentation of evaluation/assessment time:**

   - Separate from the evaluation/assessment report, documentation must include the date, time in and time out assessing the child, and time spent completing evaluation activities (ex. scoring and interpreting, writing the
assessments to be completed by a credentialed, enrolled Evaluating EI Provider. Evaluation/assessment reports are billed under the report, and the provider’s signature. EI requires all initial evaluations and evaluation/assessment procedure codes and must be completed by the credentialed, enrolled Evaluating EI Provider who actually provided that service.

5. Documentation of IFSP development time:

 IFSP development time documentation must include date, type of IFSP development activity, duration, and the provider’s signature. Types of billable IFSP development time that require documentation include:

- Attendance at a child’s IFSP meeting
- Attendance at a child’s IEP meeting if the meeting occurs prior to the child’s third birthday;

 **NOTE:** The EI Program does not pay for attendance at pre-IEP meetings

- EI Provider-to-EI provider consultation performed by the credentialed, enrolled EI Provider among members of the child’s service team who are identified on the IFSP as EI Providers of EI services, the CFC Parent Liaison, the CFC Social Emotional Consultant, the Service Coordinator and the child’s physician concerning the child’s developmental needs or the impact of special health care needs on services. Other team members may include Early Childhood Professionals, such as Home Visiting, Child Care, etc. with parental consent

  Must also include name/discipline of consulting provider, Service Coordinator, Physician, or other approved team member, and an overview of the communication. (If speaking with the Service Coordinator, verification may be documented in the Service Coordinator’s case notes.)

- Time spent developing the *Discharge report*
- Time spent developing the *Six-month summary report*
- Time spent developing the *Letter of developmental necessity for AT*
- Time spent developing the *Developmental justifications for changes to IFSP*
- Time spent developing the *Assistive technology letter of developmental necessity*

Providers are required to maintain daily documentation for all IFSP Development time based upon date of service and type of service. For IFSP development time only, an EI Provider can bundle multiple dates of service together to equal a 15-minute unit. Bill using the last date added to the bundle as the date of service. All dates of service bundled into a single date of service for payment must all fall within the 90-day billing time frame.

6. Other types of documentation that should be retained include:

- copies of all authorizations under which you have billed for services;
- a copy of the child’s current IFSP;
- copies of all claims submitted to insurance and to the CBO;
- copies of all Explanations of Benefit received from insurance and the CBO, and
• any correspondence sent or received on behalf of the child.

In the absence of proper and complete documentation from EI Providers, no payments will be made, and payments previously made will be recouped by IDHS or HFS.

Documentation of direct service or IFSP consultation time signed by multiple EI Providers and copied for all involved parties is considered unacceptable documentation for the entire group of EI Providers who signed it. Each EI Provider that provides a service to a child must maintain appropriate documentation to support the actual services provided, each date of service, and each procedure code billed to the CBO. This also includes EI Providers of group therapy services.

Domains and Sub-Domains
IDHS uses five developmental domains to determine eligibility. These five domains are: cognitive, physical, including vision and hearing, communication, social or emotional, and adaptive skills as confirmed by a multidisciplinary team. There are also subdomains in some of the domain areas, i.e., fine motor/gross motor under the physical domain and receptive/expressive communication skills in the communication domain. See Chapter 3.12.6 (b) Eligibility Criteria.

Electronic Billing
Qclaims is the EI Program’s method of allowing EI Providers to submit claims electronically to the CBO. This software is free, easy to use and completely HIPAA compliant. Additionally, it drastically cuts the time from claim submission to EI Provider payment, creates a permanent record of your billing and submission dates, and reduces your cost of doing business in EI. To get started simply visit http://spicclaims01.eicbo.info/ and view the initial sign up documentation.

Eligibility Criteria
See Eligibility Criteria in Chapter 3.12.6 b.

Equally-Qualified Providers
This means EI Providers who are equally credentialed and enrolled as the same discipline under the same provider category (i.e., physical therapy evaluator) and enrolled with the CBO under the same Payee. To provide services under an existing authorization as an “Equally-Qualified Provider”, the payee identified on the authorization must be an active, CBO-enrolled payee. The Payee entity must not allow the same EI Provider to serve a child as two or more disciplines, even under this category. Equally qualifying provider use is short term. If the replacement will be long-term, the EI Provider should notify the family and the Service Coordinator for all children on his/her caseload and work with the Service Coordinator to find a credentialed and/or enrolled substitute EI Provider for each child/family.
Evaluation and assessment services are for the purpose of determining initial eligibility, participating in the development of an initial comprehensive multi-disciplinary IFSP, annual re-determination of eligibility, adding new types of services to an existing IFSP, and if deemed necessary, to write reports for six-month reviews.

Initial evaluation and assessment services to determine eligibility, develop an initial IFSP or to add a new service to an existing IFSP must be provided by an EI Provider with a credential for Evaluation and Assessment. Evaluation and assessment services provided to complete a six-month review or for re-determination of eligibility on an annual basis should be provided by the EI Provider, even if that EI Provider is not credentialed as an evaluator.

Upon completion of an evaluation or assessment, a written report of findings is required and must be submitted in the “Early Intervention Evaluation/Assessment Report Format” to the Child and Family Connections office that is working with the child/family.

Incomplete reports are not acceptable and will be returned to the provider (See Attachment 3 for the Evaluation/Assessment Report Format and Guidance).

1. In order for a provider to receive payment for an initial evaluation to determine eligibility, the provider must also attend the initial IFSP meeting and participate in the development of the IFSP;

2. EI Providers are required to attend the entire IFSP meeting in order to receive an authorization for payment, and

3. When completing evaluations/assessments, providers are required to use Department-approved tools. This list, entitled, Early Intervention Approved Evaluation and Assessment Instruments may be found online at: www.dhs.state.il.us/page.aspx?item=86067. Please review the information toward the end of this list to learn about how to have a tool approved and added to the list. Evaluations/Assessments completed using tools not approved or with no tool listed will be returned to the EI Provider to complete the evaluation/assessment following all current rules, policies and procedures.

**NOTE:** Specific percentages of delay are to be included in each discipline’s report, ranges are not acceptable.

4. **EI Providers must accept evaluations/assessments that have been completed prior to the initial IFSP meeting when beginning direct services considering the evaluations and assessments are not more than six-months old.** The EI Program will not pay the EI Provider to duplicate initial evaluations and assessments.

**NOTE:** See Chapter 3.13 Reporting for additional information on required timelines.

Evaluations/assessment reports must be dated and billed the date the actual Evaluation/assessment was performed. The report must be signed and dated using the date it is completed. A progress note should also accompany the Evaluation/Assessment report within the child’s permanent file. Please ensure your authorization is correct for the date you perform the evaluation/assessment.
Evaluation/Assessments Reports, Arena

Arena evaluations may be conducted as long as activities are performed by the Service Coordinator including a conversation with the parent about the benefits and drawbacks of same-day versus separate day procedures have been fully explained and that a Waiver of Written Prior Notice has been signed and placed in the child’s permanent case file.

The Service Coordinator is tasked with carefully observing the family to ensure that they are adequately informed and emotionally prepared to proceed with the development of the IFSP. If the Service Coordinator feels that the parent(s) needs time to consider the evaluation findings or lack sufficient support to proceed, the Service Coordinator has been instructed to stop the meeting immediately and work with the family and providers to reconvene the team at a later date that is convenient to the family.

While arena evaluations may be conducted with prior consent from the family, individual reports must still be written by each evaluating provider and supplied to the Service Coordinator for distribution to the team, including the family. Combined reports are not acceptable and will be returned if received.

Providers should also be aware that they should only bill for the time used to evaluate the child, score and write their reports.

As with all evaluations/assessments, each provider must attend the full IFSP meeting in order to be paid for the Initial Evaluation, Evaluation, Initial Assessment and Assessment. Partial IFSP meeting authorizations will not be authorized.

Individual reports are often requested by different entities, such as the family, Bureau, HFS/PERM requests, physician’s offices, and court orders, so individual reports are necessary for all EI providers to maintain.

NOTE: The exception to this rule is Medical Diagnostic reports. These are conducted under the purview of a medical physician. The medical diagnostician is responsible to take what is necessary from the EI evaluation/assessment reports received from any additional team members to develop the Medical Diagnostic report.

Evaluation/Assessments Reports, Arena, continued

It is best practice for team members to maintain their own participation documentation in the diagnostic process to support the time spent, in the event that records were ever monitored by other covered funding entities. At the very least, a copy of the medical diagnostic report with your recommendations included, and documentation to support performing the evaluation/assessment and the scoring of the tool used. Copies of all information should be kept in the copy of the child’s file to support billing of the evaluation/assessment report authorized.

Evaluation and Assessment Instruments, Early Intervention Approved

A provider’s evaluation/assessment, including initials, annuals and six-month reviews, of the child must include the administration of a global or specific discipline’s evaluation and/or assessment tool. The purpose of using an approved, age-appropriate tool is to understand the child’s development in comparison to his/her typical peers, determine the presence/absence of developmental delays, document progress, and determine areas where intervention is needed. The approved tools help the provider quantify the child’s development in order to document age equivalents as well as the child’s individual areas of strength and need. The EI Program requires all EI providers who perform evaluations and/or
evaluation and assessment instruments, early intervention approved – cont.

assessments to use approved tools and document their results using approved templates/reports.

In order to submit a new instrument to be approved and added to the list, the provider must present proof of the criteria listed below to the IDHS-Bureau of Early Intervention (EI) for the Illinois Department of Healthcare and Family Services' (HFS) review and approval. Criteria includes the tool is:

- listed in the Mental Measurement Yearbook Series;
- nationally distributed;
- age appropriate;
- formally validated;
- individually administered; and approved previously for use by the HFS

The Mental Measurement Yearbook Series can be found at the Early Intervention Clearinghouse, many local libraries and by visiting the website at www.unl.edu/buros. There is a cost to access some of the materials found on this website. A list of approved tools entitled Early Intervention Approved Evaluation and Assessment Instruments may be viewed at: www.dhs.state.il.us/page.aspx?item=86067.

Early Intervention/Extended Services (EI/ES) Please see Chapter 3.14 for additional information about Extended Services which went into effect on January 1, 2022. This chapter includes information on eligibility, time frames, and transition to Early Childhood Special Education.

Family Educational Rights and Privacy Act (FERPA) This federal law protects the privacy of students’ “education records”. (20 U.S.C. § 1232g; 34 CFR Part 99). Part C records are covered under FERPA since they are directly related to a student/child in EI and maintained by an educational agency/lead agency or institution/CFC or by a party acting for the agency or institution/EI Provider/Service Coordinator. In Part C, any individual, agency, entity, or institution that collects, maintains, or uses personally identifiable information (PII) to implement the requirements in Part C must follow FERPA.

Family Outcomes The changes experienced by the family as a result of EI services and supports. Family outcomes examined include information concerning a child’s strengths, abilities, and special needs and how the family helps their child develop and learn. These outcomes are measured by a survey that is sent to families whose children exit EI services shortly after the child exits.

Family Participation Fees Families enrolled in the EI Program are assessed for family participation fees upon entering the EI Program. This fee is based on household size and taxable reported income. This fee helps to pay for services they receive during their family fee effective period. Not all families are required to pay family participation fees. Families with questions regarding their fees should be encouraged to contact their Service Coordinator for additional information.

Family Training, Education and Support Time spent with the parent/caregiver during direct service sessions only, to assist with their understanding of the child’s special needs in relation to the EI Providers discipline and enhancing the child’s development. The purpose of Family Training, Education and Support is to emphasize parent participation and education to maximize a child’s development. Services may consist of the following:

1. Time spent with the parent/caregiver to reflect on how the child is doing, to understand the family’s priorities and concerns (parent/caregiver report), and
to problem solve together to generate new ideas about how to best work with the child in the natural environment to maximize development;

2. Time to model exercises/activities that the parent/caregiver can incorporate into the child’s daily activities/typical routines. This would require observation of the parent/caregiver’s existing methods. Examples of daily activities may include going to the grocery store, reading books, social play, etc. Examples of typical routines may include mealtime, toileting, riding in the car, nap, etc.,

Time spent with the parent/caregiver to develop written strategies to use with the child between direct service sessions to help meet the functional outcomes identified on the IFSP. If this document includes a complete overview of the services that were provided on the date of service that it was written, includes a time in/time out, is signed by the therapist and the parent/caregiver, and a copy is left with the parent, then this document can be considered documentation of services for billing and payment purposes (see Documentation definition earlier in the Chapter).

**NOTE:** Time to complete documentation in the home that does not meet this definition is not considered “Family Training, Education and Support” time.

**Functional Outcomes**

Family-centered outcomes that are written by the IFSP team, including the family, based upon the family’s identified priorities and concerns. Family-centered functional outcomes are designed to encourage children to participate in the same types of family and community activities as other children their age. In order for this to occur the IFSP team needs to be aware of the family’s routines and the community activities that the family engages in. This will allow the team to consider daily routines and a variety of natural settings for intervention strategies to be implemented once the outcomes are developed. Family participation is the key to intervention and families are more likely to participate when the outcomes are meaningful to them and can be worked on throughout their everyday routines and activities. Functional Outcomes must be written to address areas of family concern rather than focusing on specific professional disciplines or therapies. The outcome must be related to a necessary skill and should state a process and a product.

Functional outcomes are developed and written during the child’s IFSP meeting. Family centered functional outcomes drive the decision-making process to determine what EI services a child and family will receive.

**Service delivery decisions are not based on a child’s medical diagnosis or percentage of delay, but rather on the child’s and family’s unique strengths, needs, concerns and priorities that led to must be functional and meaningful to the child and family.** Family centered functional outcomes must be written prior to the development of each individualized family centered outcome. All outcomes the determination of service delivery decisions, which would include disciplines to provide services and frequency, intensity, and duration of services identified on authorizations. All recommendations for services should be based upon the *Principles of Early Intervention* found on page one of this document.
Global Evaluation

A global evaluation is comprehensive testing that is used to determine a child’s status in each of the following developmental domains using testing instruments approved for use by the Bureau of EI in the following five (5) domain areas:

1. physical development, including vision and hearing;
2. cognitive development;
3. communication development,
4. social or emotional development; and
5. adaptive development.

Because a global evaluation is a general testing of the five domains and is not domain specific, further discipline specific evaluations/assessments must occur and the results of a domain specific evaluation always supersede the results of a global evaluation.

Group Therapy

Services provided by one or more disciplines to two or more children in a group setting. EI supports and services must be based upon family identified priorities and clearly stated IFSP functional outcomes. If the team consensus is that group therapy would best support a particular family in reaching their outcomes, then it must be identified on the IFSP outcome page.

**NOTE:** Group size not to exceed more than four (4) children with one EI Provider. See definition for “Family Training and Support” for information on the use of Interpreters for group services. Providing an individual direct service and a group service on the same day for the same child is not considered best practice.

**Example:** A SLP provides services to four (4) children in the clinic that employs her between 10 am and 11 am (Group Authorization/rate for each of the 4 children).

Health Insurance Portability and Accountability Act (HIPAA)

Congress enacted HIPAA in 1996 to, among other things, improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individually identifiable health information. A HIPAA covered entity is any organization, corporation or individual that directly handles Personal Health Information (PHI).

Healthcare Common Procedure Coding System (HCPCS)

The Healthcare Common Procedure Coding System (HCPCS, often pronounced by its acronym as "hick picks") is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

International Classification of Diseases (ICD)

The current version of the International Classification of Diseases which is a clinical cataloging system that went into effect for the US healthcare industry on 10/01/2015.

Individual Therapy

Therapy services provided to a single child/family in a natural environment based upon a frequency, intensity, and duration determined in the IFSP.

**Example:** A SLP provides services to child for 60 minutes at home or at child care (Individual Authorization/rate)
Individualized Family Service Plan (IFSP) Development Time

The following activities may be used for IFSP development time, which include:

1. Attendance at a child’s IEP meeting if the meeting occurs prior to the child’s third birthday.

   **NOTE**: The EI Program does not pay for attendance at pre-IEP meetings.

   The development of a direct service report required for the six-month review or more frequently if conditions warrant a periodic review at a time other than at six months or if a review, see IFSP Meeting, is requested by the family. This report would be a summary of an EI Provider’s record notes.

2. All IFSP Development activities must be provided by the credentialed, enrolled EI Provider who was authorized. If direct services are provided by an Associate-Level EI Provider under the supervision of a credentialed, enrolled professional, the Associate-Level EI Provider may summarize his/her record notes and develop the direct service report required for the six-month review if licensing laws that govern the supervisor’s discipline allows. However, the credentialed, enrolled EI Provider who supervises the associate must document that he/she has reviewed and agrees with the report and must sign the report as the Associate’s Supervisor.

3. EI requires all initial evaluations and assessments to be completed by a credentialed, enrolled Evaluating EI Provider. Evaluation/assessment reports are billed under the evaluation/assessment procedure codes and must be completed by the credentialed, enrolled Evaluating EI Provider who actually provided that service. The credentialed EI Provider must develop a **Discharge Report**.

4. Time for an Audiologist, Occupational Therapist, Physical Therapist, or Speech Therapist to write an **Assistive Technology Letter of Developmental Necessity** for the CFC to submit to the Bureau of EI for the AT approval process.

5. Requests for AT must include all required information. If a direct service EI Provider determines a possible need for AT devices, the EI Provider should call the child’s Service Coordinator to recommend that AT be added to the child’s IFSP. The Service Coordinator will call a meeting of the IFSP team to discuss the need to add a new service to the IFSP. If the team determines that there is a need, and the direct service EI Provider is also a credentialed/enrolled evaluator, then the evaluator will write the letter of developmental necessity to submit to the Service Coordinator for AT prior approval purposes.

   If the direct service provider is not a credentialed/enrolled evaluator, then the Service Coordinator will generate an assessment authorization to a credentialed/enrolled evaluator who will complete an assessment and develop the AT letter of developmental necessity to submit to the Service Coordinator for prior approval purposes. The evaluator will bill for this time under the assessment procedure code identified on the authorization based on EI Provider’s need to see the child as off-site (if not the direct service EI Provider on the IFSP) or using existing evaluation/assessment/direct service notes (for EI Provider currently serving child) as onsite.

   **NOTE**: The **Assistive Technology Letter of Developmental Necessity** can only be submitted through an evaluator-credentialed EI Provider. This is based on the necessary expertise of the evaluator to know and understand the functionality of the specific AT equipment/services and the ability of the AT equipment/services to help meet an outcome the family has helped develop.
IFSP Development Time – Cont.

6. Time for an EI Provider who is requesting a change to the frequency or intensity of an existing service authorization to write the required justification of need that will be attached to the form entitled *Early Intervention Provider Developmental Justification to Change Frequency, Intensity, and/or Location of Authorized Services Worksheet*. This justification must be written and signed by the EI Provider who has requested the change and the content must justify the time billed to and paid by the CBO. EI Provider-to-EI provider consultation performed by the credentialed, enrolled EI Provider among members of the child’s service team who are identified on the IFSP as EI Providers of EI services, the CFC Parent Liaison, the CFC Social Emotional Consultant, the Service Coordinator and the child’s physician concerning the child’s developmental needs or the impact of special health care needs on services. Other team members may include Early Childhood Professionals, such as Home Visiting, Child Care, etc. with parental consent.

EI Providers should always document this time accurately and should identify the names of the EI Providers (including the EI Provider submitting IFSP Development names of the EI Providers (including the EI Provider submitting IFSP development time claim), Service Coordinator or physician who was consulted in their documentation. EI Providers must sign for each communication. Each communication to any/all team members must be recorded per discussion. These consultations should occur in person or by telephone but may occur by fax, as long as the time used is documented with a date, begin/end time or exact time used in minutes per contact. If speaking with the Service Coordinator, verification may be documented in the Service Coordinator’s case notes.

After the child/family has received an assistive technology device, consultation includes conversations held with the vendor concerning the fit and/or use of the device.

The ability to perform this consultation is defined in the IFSP under *Section 7 Implementation and Distribution Authorization*.

7. IFSP Development **does not include** time to speak to a child’s parent(s) on the telephone. Time to speak to a child’s parent(s) on the telephone is not considered EI provider-to-EI provider consultation and is not billable time. Providers should speak to a child’s parent(s) during face-to-face direct service sessions. If the parent(s) cannot be present during a normally scheduled direct service session, EI Providers should schedule an occasional direct service session at a time when the parent(s) can be present.

**Note:** Phone consultation may be permitted during a Pandemic.

8. IFSP Development **does not include** staff supervisory time; routine preparatory activities such as time spent packing or washing toys, file review and/or review of record notes or development of lesson plans or activity plans prior to each incident of service; time to leave voicemail messages; the scheduling and canceling of appointments, including time to speak to the interpreter who will schedule and cancel appointments for the discipline who they are interpreting for; time to write reports other than those identified in numbers above; or family training, education, and support which is an activity identified under each service description where appropriate. The activity “Family Training, Education, and Support” is built into all services and is only billable under individual treatment
IFSP Development Time – Cont.

Providers are required to maintain daily documentation for all IFSP Development time based upon date of service and type of service. For IFSP development time only, an EI Provider can bundle multiple dates of service together to equal a 15-minute unit. Bill using the last date added to the bundle as the date of service. All dates of service bundled into a single date of service for payment must all fall within the 90-day billing time frame.

IFSP Meeting

Development of an IFSP includes the following activities that must be completed by the credentialed, enrolled EI Provider, with the exception described below.

Development of the IFSP includes attendance at the initial/annual IFSP meeting as a member of a child/family’s service team to assist in the completion of a written document on the statewide IFSP form detailing individualized functional outcomes for the child and family, services based upon the unique needs of the child and family, and transition strategies. Providers can attend the meeting in person or be present by conference call only if exceptional circumstances arise. Providers must accept responsibility for telephone charges for IFSP conference calls. Providers are required to attend the entire IFSP meeting. If necessary, periodic review of a child’s IFSP every six months or more frequently if conditions warrant, or if the family requests such a review, to determine if adjustment of the IFSP is needed. Periodic reviews must be conducted as defined in 34 CFR Parts 303.342 and 303.343.

IFSP Meetings, at a minimum, must include the child’s parent(s), other family members as requested by the child’s parent(s), an advocate or person outside of the family if requested by the parent(s) and the Service Coordinator for the child and family. Meeting arrangements and written prior notice for each IFSP Meeting must be made to the family and other participants early enough before the meeting date to ensure that the participants will be able to attend. Meetings must be held in settings and at times that are convenient to the family and in the family’s native language or other mode of communication used by the family, unless it is clearly not feasible to do so. IFSP Meetings, at a minimum, must include the child’s parent(s), other family members as requested by the child’s parent(s), an advocate or person outside of the family if requested by the parent(s) and the Service Coordinator for the child and family. Meeting arrangements and written prior notice for each IFSP Meeting must be made to the family and other participants early enough before the meeting date to ensure that the participants will be able to attend. These meetings must be held in settings and at times that are convenient to the family and in the family’s native language or other mode of communication used by the family, unless it is clearly not feasible to do so.

If combined with an IFSP Meeting, attendance at the Transition Planning Conference as required.

Insurance Billing Service

A free insurance billing service is available for EI Providers participating in the program. This Insurance Billing service is specifically designed to bill primary insurance companies on behalf of the EI Provider free of charge for new child referrals, ONLY. Additional information may be found at: https://eicbo.files.wordpress.com/2017/05/eicbo-information-for-providers.pdf

Interpretation Services

Please see Chapter 11 for additional information.
Make-Up Sessions

An EI Provider may reschedule a missed session based upon the guidelines stated below:

1. An EI Provider may make up a missed session, within seven (7) calendar days from the original scheduled date.

   If an EI Provider knows that a service will be missed prior to the regular date of service due to an upcoming leave, the EI Provider may complete the service up to seven (7) calendar days prior to the anticipated missed session date. If more than one date of service will be missed due to an extended leave and is unable to be made up, based on the guidelines above, it should be considered a missed session. **NOTE:** Do not provide multiple sessions in one week in order to make up for an extended leave (i.e., services on Monday, Wednesday and Friday of one week to make up for a three-week leave). If a weekly or monthly service session cannot be rescheduled within seven (7) calendar days from the original scheduled date, it should be considered a missed session. Given the frequency of illness in young children, family and EI Provider vacations, and other unforeseen issues, missed sessions are inevitable. However, they should not be routine occurrences. Providers should make every effort to avoid missing service sessions.

2. **Never** provide a make-up session on the same date that a regular session has been scheduled or as back-to-back sessions. Most birth to three children would be unable to tolerate an extended session.

3. If it is necessary for an EI Provider to miss several services due to a short-term illness/injury, or any other leave, an equally-qualified provider (see Equally-Qualified Provider definition) may be identified to carry out the services identified on the IFSP. The EI Provider should notify the family and the Service Coordinator for all children on his/her caseload and work with the Service Coordinator to find a credentialed and/or enrolled substitute EI Provider for each child/family. Always document in your case notes the date of the missed visit, the reason for the missed visit and if you reschedule based upon the above guidelines. When completing documentation after a make-up session, include information in the documentation that identifies the date of service as a “make-up session”.

   **Always** bill for a make-up session based upon the actual date of service, not the date that the session was missed.

**Multidisciplinary**

The involvement of two or more disciplines or professionals in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

**Natural Environment**

A setting (home or community) that is natural or typical for a child’s same age peers who have no disability.

**Example:** Child’s home, grandma’s house, child care, a library where a group meets for story time, a community swimming pool, a park, or other community setting that is frequented by typically developing children.

**Need**

A condition or situation in which something is essential, necessary or required.

**National Provider Identifier – (NPI)**

A NPI is a unique 10-digit identification number issued to health care EI Providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
| **Ongoing Professional Development** | All new/renewing EI credentialed providers must agree to participate in Ongoing Professional Development activities by using the Ongoing Professional Development Plan form found on the Provider Connections Website at https://providerconnections.org/temporary-credential-requirements/. The activities must be once a month, non-billable, meeting held either face-to-face or over the telephone with an individual specialist-level credentialed provider or group, of which at least one member is a specialist-level credentialed provider. A credentialed EI Provider, now including EI Providers with a temporary credential, must document a minimum of 75% of their Ongoing Professional Development Plan (OPDP) meetings completed. These meetings are intended to be used for professional development through discussion of child/family concerns, needs, strengths, resources, priorities, outcomes, strategies, and service plans in order to support best practices. |
| **Protected Health Information (PHI)** | Under US law, PHI is any information about health status, provision of health care, or payment for health care that is created or collected by a “Covered Entity” (or a Business Associate of a Covered Entity) and can be linked to a specific individual. |
| **Personally-identifiable Information (PII)** | Information that can be used on its own or with other information to identify, contact, or locate a single person, or to identify an individual in context. |
| **Priorities** | A family’s choices and agenda for how EI will be involved in the family life. |
| **Resources** | The strengths, abilities, and formal or informal supports that can be mobilized to meet the family’s concerns, needs, or outcomes. |
| **Reports** | All reports including, evaluations/assessments, 6-month summaries, discharge, letters of developmental necessity for AT, developmental justifications for changes to IFSP, etc., must have documentation to ensure: |
| | a. time used to develop the report is documented in case notes and |
| | b. content of the report justifies the time billed to and paid by the CBO.  |
| | **NOTE:** Individual reports are required for all evaluation/assessment reports with the exception of Medical Diagnostic reports. See Evaluation/Assessment, Arena & Reports. |
| **Secure Electronic Mail** | A server-based approach to protect PHI or PII data that provides compliance with IDHS/EI standards, including HIPAA and FERPA. The emails are encrypted to protect the content from being read by other entities with the identifying key only known to the recipient of the email. When selection of a secure email service is obtained, the EI Provider must ensure these standards are met. |
| **Signature, Digital** | Sometimes referred to as a cryptographic signature, a digital signature is considered the most “secure” type of electronic signature. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature’s author and owner). The EI Program, currently, does not accept digital signatures. |
| **Signature, Electronic** | Often referred to as an e-signature, is a person’s electronic expression of his or her agreement to the terms of a particular document. Currently, the EI Program does not accept electronic signatures. |
| **Signature, Handwritten** | Also referred to as a wet signature, is created when a person physically marks a document. Handwritten signatures are required for all EI documentation including reports. Typing a name is not a handwritten signature. If a document is scanned, the original handwritten signature must be present. |
| **Strengths** | Individual characteristics that can be used as a resource. |
| **Transition Planning Conference** | Meeting with family and required team members to support the transition of a child from EI to Special Education services. See Chapter 3- Early Intervention Providers in Illinois, under section 3.12.8 b. for additional information. |
| **Transition Steps and Services** | Please see Chapter 3 - Chapter 3: Early Intervention Providers in Illinois |
| **Transdisciplinary** | Members of a transdisciplinary team cross professional discipline boundaries to achieve service integration by consulting... with one another. They do not abandon their discipline, but blend specific skills with other team members to focus on and achieve integrated outcomes |
| **Want** | A preference or end result that is desired but not essential, necessary, or required. |
| **Written Home Activity Program** | A written home activity program is a document that is written in the home or other place of service, with the input of the parent/caregiver during a direct service session. It should identify developmental strategies to meet functional outcomes that are important to the family and that support the family in developing or refining their ability to facilitate their child’s active involvement in his or her community and family. This document should be shared with all members of the IFSP service team and the parent/caregiver and is considered to be family training, education, and support time and is billable as direct service time only. |
| **Written Developmental Justification of Need** | A written developmental justification of need must be completed and clearly state the developmental needs that drive the recommendation for services(s). Information must also include how each recommended service is required and designed to meet the functional outcomes that have been identified in the child/family’s IFSP. Each child/family’s unique strengths/developmental needs must be reflected in the written developmental justification of need. A written developmental justification of need is not a letter and must be written based upon the Guidelines/Worksheet found further in this document. EI Providers must submit the completed Developmental Justification To Change Frequency, Intensity, and/or Location Of Authorized Services Worksheet, see Attachment 6 of this handbook, to the Service Coordinator for any changes that are requested to existing authorizations for the time period between annual IFSP meetings. |
| **Under the Supervision of** | For Associate-Level EI Providers, work performed under the guidance and direction of a supervisor who is responsible for supervision of the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly review the work performed and |
Under the Supervision of – Cont.

who is accountable for the results, see Chapter 3: Early Intervention Providers in Illinois, under section 3.3 earlier in this document.

Supervisory time is non-billable time and is considered to be administrative time that is included in the rate paid to the EI Provider for direct service.
Abbreviations

The EI Program utilizes many abbreviations. This document references many abbreviations that may not be familiar to all audiences. Below are a list of abbreviations and other terms used that you may encounter as EI Provider of Early Intervention Services.

AOTA – American Occupational Therapy Association
APR – Annual Performance Report
APTA – American Physical Therapy Association
ASHA – American Speech-Language-Hearing Association
ASQ:SE – Ages and Stages Questionnaire/Social Emotional Component
AT – Assistive Technology
Auth. – Authorization
BV - Benefit Verification
CBO – Central Billing Office
CFC – Child and Family Connections
CMS – Centers for Medicare and Medicaid Services (US Agency)
CPS – Chicago Public Schools
CPT – Current Procedural Technology
DS – Direct Service
DT – Developmental Therapist
DEC – Division of Early Childhood
DSCC – Division of Specialized Care for Children
EA - Evaluation/Assessment
ECO – Early Childhood Outcomes Center
ECSE – Early Childhood Special Education
ECTA – Early Childhood Technical Assistance Center
EI – Early Intervention
EI-EC PD CoP – Early Intervention-Early Childhood Professional Development Community of Practice
EI/ES – Early Intervention/Extended services for eligible children whose third birthday falls in the summer months, May 1 – August 31
FERPA – Family Educational Rights and Privacy Act
HCPC – Healthcare Common Procedure Coding System
HIPAA – Health Insurance Portability and Accountability Act
ICD – International Classification of Diseases
IDEA – Individuals with Disabilities Education Act
IDHS – Illinois Department of Human Services
IDTA – Illinois Developmental Therapy Association
IEP – Individual Education Plan (equivalent to an IFSP but in the school)
IFSP – Individualized Family Service Plan
IICEI – Illinois Interagency Council on Early Intervention
IMPACT – Illinois Medical Program Cloud Technology (HFS Provider Enrollment System)
LIC – Local Interagency Council
LVV – Live Video Visits, aka Teletherapy
NICHCY – National Infant National Dissemination Center for Children with Disabilities
NPI – National Provider Identifier
OSEP – Office of Special Education Programs operated by the US Department of Education
OSERS – Office of Special Education and Rehabilitation Services operated by the US Department of Education
PD SIG – Professional Development Special Interest Group
PHI – Protected Health Information
PII – Personally identifiable information
PL – Parent Liaison
PT – Physical Therapist
RBI – Routine-Based Interview
SAMHSA - Substance Abuse and Mental Health Services Administration
SC – Service Coordinator
SDA Workgroup – Service Delivery Approaches Workgroup, a Workgroup of the IICEI
SE – Social Emotional Consultant
SLP or ST – Speech Language Pathologist
SMART Act – Save Medicaid Access & Resources Together
SPP – State Performance Plan
SSIP – State Systemic Improvement Plan
TA – Technical Assistance
Assistive Technology

Assistive Technology (AT) may be defined as any service or item that supports a child’s ability to participate actively in his or her home, community settings, or other natural environments. It is a broad term that includes a service or items ranging from something as “low tech” such as a foam wedge for positioning to something as “high tech” as an electronic communication device.

AT Device Definition

The Federal definition of AT, as described in Part C, CFR Part 303.13 (i), includes both devices and services. An AT device is any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. This term does not include a medical device that is surgically implanted, or the replacement of such device. (34 CFR §303.13(i))

AT Service Definition

An AT service means any service that directly assists a child with a disability in the selection, acquisition or use of an AT device (34 CFR 303.13(ii). The term includes:

- The evaluation of the needs of the child with a disability, including a functional evaluation of the child in the child’s natural environment;
- Purchasing, leasing or otherwise providing for the acquisition of AT devices by children with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing or replacing AT devices;
- Coordinating and using other therapies, interventions or services with AT devices such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for a child with a disability or, if appropriate, that child’s family; and
- Training or technical assistance for professionals who provide services to children with disabilities through the EI program.

AT services do not include any activity for a medical device that is surgically implanted, the optimization of that device’s functioning (e.g. mapping) maintenance of that device, or the replacement of that device.

There are additional documents that provide more information about the categories and types of equipment funded by the Illinois EI Program and items that are not funded (see Appendices B-E for additional information regarding general recommendations on sensory equipment, positioning equipment, communication and software.

AT Inclusion

All children with disabilities who are eligible for EI services are also eligible to receive AT services, if appropriate, as part of an IFSP. AT devices should be considered if interventions are required to aid in developmental tasks such as interaction with the environment, communication and cognition. These AT devices and services are authorized, however, only when they directly related to the developmental needs of the infants and toddlers.

Inclusion of AT in the IFSP occurs on an individual basis based on the child's needs, the family's concerns and intervention priorities and functional outcomes. AT devices/services must be included in the IFSP as agreed upon by the parent and other team members and must be developmentally and age appropriate to be considered for EI funding.

N07/2022
Prior approval is required to qualify for EI and other types of funding. It is during this prior approval process that funding sources review developmental necessity, determine covered services, pricing requests, quantity and duplication. The **Assistive Technology Letter of Developmental Necessity** provides all but the pricing information for this review. Vendors providing the equipment are to submit pricing information.

**Assistive Technology Assessments**

AT assessments differ from "typical" evaluations and assessments conducted as part of eligibility or review of a child's needs and strengths. There are virtually no standardized tests to determine what kind of technology a child needs to use. Instead, a good AT assessment looks at the results of all recent evaluations/assessments, along with the current IFSP goals and objectives. The evaluator should talk with the child's parents, interview people who work with the child, and interact directly with the child and the devices. The environment should be carefully examined, especially when the device has to work in a variety of settings.

**AT Assessment Process**

Assistive technology assessment, selection, training and maintenance should be carried out by qualified professionals, with active participation on the part of the family. The IDEA requires that all special education services be family-centered and directly related to the family's priorities and concerns for their child. Family members are in a position to provide valuable information about the child's strengths, interests and daily routines, which is critical for determining what types of AT devices and services will best meet the child and family's needs.

The assessment process also consists of considerable observation coupled with trials with a full range or continuum of possible devices from low to high technology. Data is gathered from these trials about the effectiveness of various technologies to meet the child's needs. Information is collected concerning the child's ability and accuracy when using various technologies, including the positioning and settings that work best.

Part C of IDEA states that AT must be provided in natural environments, to the maximum extent appropriate, for children from birth to age 3 (34CFR§303.13(a)(8)). As part of the assessment process, families and professionals decide where assistive technology devices and services will be provided to best meet the child's needs.

The child's and family's feelings about the actual devices tried should be considered, as even very young children can show what they like and dislike by how they interact with different devices. AT abandonment (rejection, no-use of the device) is often due to the fact that the family input played only a small role in the AT evaluation and selection process. Understanding and taking into account the values, resources, concerns and routines of the child's family help ensure a greater level of success when it comes to using AT effectively in the child's everyday activities.

**AT Assessment Specialization**

As the number of devices and the complexity of those technologies have grown exponentially in the past few years, many people who work extensively in this area have found the need to specialize in different areas of AT.

Typically, these people have expertise in areas such as assistive computer technology, augmentative communication, mobility and positioning. Other AT experts may specialize in age or disability-specific technologies, such as visual and hearing impairment devices.

**Assistive Technology Assessments and the IFSP**

AT assessments can be requested when there is reason to believe that a child may benefit from the use of AT to help achieve an IFSP outcome. The AT assessment is to be completed by a credentialed/enrolled evaluator. The need for AT devices/services may be identified:

N07/2022
• As part of the initial or annual multidisciplinary evaluation/assessment, where the credentialed evaluator identifies a potential AT strategy that can be considered after eligibility is determined and IFSP outcomes are identified;

• As part of supplemental assessments included in the child's IFSP based on an anticipated or emerging need and as agreed upon by the team;

• Through the ongoing assessment process conducted by the child's provider(s) if they are a credentialed evaluator.

Completing AT Assessments and Related Authorizations
AT assessments should be completed by the appropriate discipline, determined by the type of AT considered. Specific provider types (PT, OT, SLP, Audiologist) who are enrolled EI evaluators can complete AT assessments and author the Assistive Technology Letter of Developmental Necessity. Other provider types (Nursing, psychologists, those providers who do not hold evaluator credentials, etc.) are part of the multidisciplinary team, but should not be the primary author of the Assistive Technology Letter of Developmental Necessity. Upon review of a request, the IDHS AT Coordinator may require additional information from another discipline to complete the prior approval process.

These AT assessments might be authorized and completed in a variety of different ways, dependent on the individualized needs of the child and the AT type considered. Some variations include:

1) During the initial/annual multidisciplinary evaluation/assessment,
   a) Evaluator(s) identifies a potential AT strategy that can be considered once eligibility is determined and IFSP outcomes are identified. This device is easily identifiable, doesn't require trials, and can be added as a strategy to the IFSP at that moment. The AT is added as a strategy, along with strategies addressing implementation of the device and any training or other follow-up required. In this situation, the evaluator would utilize IFSP development time to complete the Assistive Technology Letter of Developmental Necessity. The evaluator would need to communicate with the Service Coordinator for additional IFSP development time required to accommodate the additional reporting.

   b) Evaluator(s) identifies a potential AT strategy that can be considered once eligibility is determined and IFSP outcomes are identified. The team resolves that additional information is required to further distinguish the specific AT and to determine how it would be implemented. The team would add an AT assessment as a strategy (identifying what general device type is being considered). If known, additional strategies would be added addressing implementation of the device and any training or other follow-up required.
      i) The evaluator, currently on the IFSP team, would complete the AT assessment during ongoing direct services and would utilize IFSP development time to complete the Assistive Technology Letter of Developmental Necessity. The evaluator would need to communicate with the Service Coordinator for additional IFSP development time required to accommodate the additional reporting or,
      ii) If the team must bring in an evaluator to complete the AT assessment, an AT AS authorization would be included in the IFSP. The AT AS authorization will provide the evaluator time to complete the assessment and the Assistive Technology Letter of Developmental Necessity. The EI evaluator would need to communicate with the Service Coordinator on time needed to complete the Assistive Technology Assessment, Assistive Technology Letter of Developmental Necessity.
2) During the ongoing assessment that occurs in direct services,  
   a) Interventionist identifies a potential AT strategy that might be of benefit. The interventionist, who is also an evaluator, can specify the AT device. An IFSP team meeting/discussion is called, and the outcomes are reviewed. If the team determines it is appropriate, and the device does not require trials, the recommended AT is added as a strategy to the existing outcome. The team must also include strategies addressing implementation of the device and any training or other follow-up required. In this situation, the evaluator would utilize IFSP development time to complete the Assistive Technology Letter of Developmental Necessity. The evaluator would need to communicate with the Service Coordinator for additional IFSP development time required to accommodate the additional reporting, or

   b) Interventionist identifies a potential AT strategy that can be added to an existing IFSP outcome but requires additional information to further distinguish the specific AT and to determine how it would be implemented. An IFSP team meeting/discussion is called, and the outcomes are reviewed. If the team determines an AT strategy is appropriate and additional information is still needed, the team will add an AT assessment as a strategy (identifying what general device type is being considered) to the existing outcome. If known, additional strategies would be added addressing implementation of the device and any training or other follow-up required.

   i) The evaluator, currently on the IFSP team, would complete the AT assessment during ongoing direct services and would utilize IFSP development time to complete the Assistive Technology Letter of Developmental Necessity. The evaluator would need to communicate with the Service Coordinator for additional IFSP development time required to accommodate the additional reporting, or

   ii) If the team must bring in an evaluator to complete the AT assessment, an AT AS authorization would be included in the IFSP. Situations where this may occur are when the recommending interventionist is not a credentialed evaluator (and no other member of the team can complete the AT Assessment), or a more specialized assessment is required. The AT-AS authorization will provide the evaluator time to complete the assessment and the Assistive Technology Letter of Developmental Necessity. The evaluator would need to communicate with the Service Coordinator on time needed to complete the AT Assessment/Assistive Technology Letter of Developmental Necessity.

   c) Interventionist identifies a potential AT strategy based on a new concern identified by the family. The current IFSP does not have an outcome to address this new concern. An IFSP review meeting must be held to review the current IFSP, revisit current outcomes, and add any additional outcomes. If the potential AT addresses one of the outcomes, it is added as a strategy. The AT assessment is completed in one of the ways identified above in 2b.

In all scenarios, the commonality is an IFSP meeting/discussion is held before adding any AT assessment or device as a strategy. After an AT assessment is completed to further identify the appropriate AT, a follow-up IFSP meeting/discussion is held to add the recommended AT device as a strategy, along with strategies addressing implementation of the device and any training or other follow-up required. This follow-up IFSP meeting is to ensure that the team is in agreement on the recommended device and its implementation plan.

Evaluators issued an AT AS authorization must have this authorization in hand prior to completing the assessment. To distinguish the AS authorization from discipline-specific assessments, “AT assessment” is written into the comment field.
**AT Assessments with Trials**

AT assessments requiring trials can be completed during direct service visits if the ongoing interventionist is an evaluator and is qualified to complete the trials. The individual needs of the child/family and AT type considered will determine if trials can be completed during one visit or over multiple sessions.

**Adding Additional Evaluators**

Sometimes AT assessments require bringing in an additional team member. This might be because the ongoing interventionist is not credentialed as an EI evaluator, or the team agrees a more specialized evaluation is required. Based on the individual needs of the child/family and AT devices considered, the type and number of authorizations will vary. In many situations, a single AT AS authorization will be enough. In other cases, an AT AS authorization coupled with a few direct services to accommodate trials should be considered. The Service Coordinator and evaluator should work together to determine what will work best to provide a complete AT assessment.

**Additional AT Support**

AT assessments might reveal that additional training is required for the family and/or the IFSP team after the device arrives. If the ongoing interventionist will be providing this training, adjustments to direct service authorizations might be indicated. This training might include instructions on the function of a device or associated software programs. If this training will be completed by a consulting team member, additional direct service authorizations for this consultant may be necessary to complete the training requirements. The evaluator should discuss this with the Service Coordinator and the IFSP team.

**Time Considerations**

No matter what the situation, AT AS authorizations may require more time than a typical AS authorization. The evaluator completing an AT assessment with an AT AS authorization should work with the Service Coordinator to ensure adequate time is included in the authorization.

Time for the evaluator/consultant/interventionist to make items for families is not an authorized service, unless this is done as part of the direct service time, providing education and support on how to incorporate into the child’s daily routines.

**Additional AT Supports**

The Bureau has provided IFSP teams and evaluators with additional documents to assist in understanding what items are available for Illinois EI AT funding, what items are excluded from that funding, and additional criteria/limitations for specific types of AT. Please refer to these documents, in the EI Provider Handbook before adding AT to an IFSP or completing AT assessments.

- **Appendix A – Pricing Information and Examples**
- **Appendix B – Category Listing of Eligible Assistive Technology Devices**
- **Appendix C – Guidelines for Seating and Positioning Devices**
- **Appendix D – Guidelines for Vestibular Therapy Equipment**
- **Appendix E – Guidelines for Adaptive and Assisted Toileting Systems**
- **Appendix F – Guidelines for Software and Augmentative Alternative Communication (AAC) Devices**
- **Appendix G – Assistive Technology Devices Not Eligible for EI AT Funding**
Assistive Technology Letter of Developmental Necessity

The Assistive Technology Letter of Developmental Necessity provides evidence supporting the necessity of the AT device/service identified as a strategy on the IFSP, as well as includes information required for multiple funding sources. In addition, the Assistive Technology Letter of Developmental Necessity also provides information on current usage of AT, how the AT strategy will be implemented into the child’s daily routines and any training needs required for team members.

To reduce the need to complete multiple justification reports for different funders, The Assistive Technology Letter of Developmental Necessity is designed to meet the requirements for EI as well as most insurance documentation. This information will assist the DHS AT Coordinator and any other potential payers in determining if the AT requested meets current funding criteria.

The Assistive Technology Letter of Developmental Necessity should conclude with the evaluator’s name, both printed and signed, the date, and phone number.

The Assistive Technology Letter of Developmental Necessity may be sent to the physician for review. If the physician signs the assessment, this will suffice for any prescription requirements. While the evaluator may assist in obtaining the prescription, ultimately it is the responsibility of the Service Coordinator to ensure the prescription is collected and included in the request packet and the child’s file. Please check with your CFC AT Coordinator to determine the best way to get the prescription.

Resources

Both IDEA Part C and the key principles in EI direct us to consider research findings. Specifically, IDEA Part C says that all states must ensure appropriate EI services are based on scientifically based research, to the extent practical, and are available to all infants and toddlers with disabilities and their families (34CFR§300.112). Scientifically based research provides information to support evidence-based practices which helps interventionists enhance the development of infants and toddlers with disabilities and to build the capacity of families to meet their child’s needs. There are several resources to support the use and implementation of AT. A few are identified below.

DEC Recommended Practices - There are many sources that provide evidence-based practices related to assistive technology. The Division of Early Childhood provides Recommended Practices for interventionists on a variety of topics, with assistive technology being addressed in the Environments section (http://dec-sp ed.org/recommendedpractices).

ECTA Center - The ECTA Center has several checklists that can support the inclusion of AT to promote a child’s access to and full participation in everyday routines, activities, and learning experiences (http://ectacenter.org/topics/atech/decrp_atech.asp). They include:

- Center on Technology and Disability – The CTD provides resources on AT participation, funding, the IFSP process, technology tools, and others (http://www.ctdinstitute.org/library).
**Report Format Sample**
Illinois Early Intervention Program

**ASSISTIVE TECHNOLOGY LETTER OF DEVELOPMENTAL NECESSITY**

Please note that a blank version of this form is available at: **coming soon**

<table>
<thead>
<tr>
<th>Section 1: General Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child’s Name:</strong> Full Name</td>
</tr>
<tr>
<td><strong>Date of Assessment:</strong> Actual date of assessment</td>
</tr>
<tr>
<td><strong>Chronological Age:</strong></td>
</tr>
<tr>
<td><strong>EI Evaluator’s Name:</strong></td>
</tr>
<tr>
<td><strong>Service Coordinator’s Name:</strong></td>
</tr>
<tr>
<td><strong>Physician’s First/Last Name:</strong></td>
</tr>
<tr>
<td><strong>Setting Child is being observed in:</strong> (check one)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Physician license numbers for can be found at:
- Illinois - [https://ilesonline.idfpr.illinois.gov/DPR/Lookup/LicenseLookup.aspx](https://ilesonline.idfpr.illinois.gov/DPR/Lookup/LicenseLookup.aspx) (Medical Board)
- Indiana - [https://mylicense.in.gov/everification/Search.aspx](https://mylicense.in.gov/everification/Search.aspx) (Medical Licensing Board, Physician)
- Iowa - [https://eservices.iowa.gov/PublicPortal/Iowa/IBM/licenseQuery/LicenseQuery.jsp?Profession=Physician](https://eservices.iowa.gov/PublicPortal/Iowa/IBM/licenseQuery/LicenseQuery.jsp?Profession=Physician)
- Missouri - [https://renew.pr.mo.gov/licensee-search.asp](https://renew.pr.mo.gov/licensee-search.asp) (Healing Arts, Medical Physician and Surgeon)
- Wisconsin - [https://app.wi.gov/licensesearch](https://app.wi.gov/licensesearch) (Medicine and Surgery, DO or MD)

<table>
<thead>
<tr>
<th>Section 2: Individualized Family Service Plan (IFSP) Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IFSP Begin Date:</strong> Current IFSP</td>
</tr>
<tr>
<td><strong>Medical History (including diagnosis):</strong> Summarize all reports on file including any updated information</td>
</tr>
<tr>
<td><strong>Current EI Services being provided:</strong> For example, DT–1x per wk., ST–1x per wk., OT–1x per wk., PT–1x per wk.</td>
</tr>
<tr>
<td><strong>Functional Outcome that supports current equipment request:</strong> Identify outcome(s) from current IFSP that may be met with the use of AT.</td>
</tr>
<tr>
<td><strong>Current progress toward that outcome:</strong> Describe activities taking place in therapy sessions combined with family education to meet specific outcome(s) listed above.</td>
</tr>
<tr>
<td><strong>Parent’s concerns related to outcome:</strong> Describe impediments in reaching outcome and concerns family has and why the goal has not been attainable.</td>
</tr>
</tbody>
</table>

**AT Category 1 (See example list in Appendix B in Provider Manual)**

**AT Item(s) Requested** (attach catalog photos, with pricing not included):

List item(s) requesting:
- Benik Vest
- Nuk brush
- Go Talk 9+
- Peanut ball

Attach catalog pages to show exact desired item(s). If vendor quotes are not available, include catalog pricing.

**AT Category 2 (See example list in Appendix B in Provider Manual)**

**AT Item(s) Requested** (attach catalog pages, with pricing not included):

List item(s) requesting:
- Stander, Gait Trainer
- Communication Board
- Swing
- Orthotics
- Hearing Aids and Related Accessories

Attach catalog photos to show exact desired item(s). Prices should not be included; the vendor will provide a quote.

**Provider Information:** If evaluator is not ongoing provider, describe the collaboration with the IFSP team members and the plan to implement the requested item(s).

If SLP on team is not an initial evaluator but provides ongoing services, gather previous reports, collaborate via telephone prior to evaluation and arrange evaluation to occur during provider’s therapy session to gain input, ideas, etc.

**Ongoing Provider Name/Discipline:** Jane Doe, SLP; Johnny Appleseed, PT

**Current Functional Status:** Discuss vision, hearing, motor, communication, sensory, mode of access-level/method of assistance needed to use AT, etc.

**Assessment and Findings:** Include trials of various equipment/devices, height/weight, and/or other pertinent measurements, etc.

**Recommendations:** Include any additional components/accessories needed for device

---

### Section 3: Justification

1. **Describe AT currently being utilized; consider all adaptive supports.**
   
   Explain trials that have occurred in the home.
   
   **Example:** The use of tight pajamas, spandex shirt, electric toothbrush...

2. **Will the requested AT supplement or replace current AT or adaptations? If yes, please describe.**
   
   Explain how it will assist child with current AT available or how it may replace items that aren’t effective.
   
   **Example:** Yes. The Benik Vest will supplement the use of other in-home items and will provide additional support.

3. **Describe how the physical environment supports the use of requested AT.**
   
   Include information on how the size and layout of the home would support specific equipment and that the family is aware of space requirements.
   
   **Example:** Family was shown a picture of the item(s) being requested, its dimensions and expectations for physical space needed.

4. **Describe how you will educate/collaborate with the entire IFSP team regarding the instruction, fit and use of the AT?**
   
   Describe who will set up the equipment, demonstrate, elicit trials during therapy and develop a plan for use and carryover of the equipment. Include examples of how you will collaborate and work with all team members.
   
   **Example:** A telephone call with each provider will be made to inform of device arrival and how each team member can assist in its use, a co-treat session may be arranged as indicated in IFSP, or a team meeting may be arranged.

5. **Describe how the family’s home activity program will be developed. List specific strategies for the use of AT in the home and how the activities are related to the outcome(s).**
   
   List specific strategies related to outcome(s) on how AT will be integrated into family home and daily routine.
   
   **Example:**
   - Nuk brush will be used 2-3 times a day prior at family mealtimes to prepare child for introduction of textured food
   - Go Talk 9+ will be used throughout day with family to assist child in making requests during dressing, eating and making choices, etc.
6. Explain how the AT will help facilitate the child’s participation in the family’s daily routines and community activities, including specific time frames when the family will use the device. Describe specifically how the item(s) will assist the child and how the family will participate in daily use.

*Example*: Use of AAC device (Go Talk) will allow the child and family to communicate throughout the day.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Full Name – In case pages are separated.</th>
<th>EI#:</th>
<th>CFC #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>List of All Items Requested:</th>
<th>Relist all items here requested by EI Provider regardless of Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benik Vest</td>
<td>Communication Board</td>
</tr>
<tr>
<td>Nuk brush</td>
<td>Swing</td>
</tr>
<tr>
<td>Go Talk 9+</td>
<td>Orthotics</td>
</tr>
<tr>
<td>Peanut Ball</td>
<td>Hearing Aids and Related Accessories, i.e., ear molds, batteries, etc.</td>
</tr>
<tr>
<td>Stander</td>
<td></td>
</tr>
<tr>
<td>Gait Trainer</td>
<td></td>
</tr>
</tbody>
</table>

---

**For Physician’s use only:**

By signing this document, the physician agrees with information presented. The signature serves as a prescription for recommended item(s).

---

**Physician’s Signature**  
**Date**

**Physician’s Full Name**  
**Physician’s Printed First/Last Name**  
**Physician’s Address**  
**Physician’s License #**

**Physician’s Printed Name**  
**Phone Number**

---

**EI Provider’s Signature**  
**Date**

**EI Provider’s Full Name**  
**EI Provider’s Printed Name**  
**Phone Number**
### Illinois Early Intervention Program

**ASSISTIVE TECHNOLOGY LETTER OF DEVELOPMENTAL NECESSITY**

#### Section 1: General Information

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>EI#:</th>
<th>CFC #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Assessment:</td>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Chronological Age:</td>
<td>Adjusted Age:</td>
<td></td>
</tr>
<tr>
<td>EI Evaluator’s Name:</td>
<td>Discipline:</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator’s Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s First/Last Name:</td>
<td>Physician’s License #:</td>
<td></td>
</tr>
<tr>
<td>Setting Child is being observed in: (check one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Home</td>
<td>☐ Childcare</td>
<td>☐ Clinic</td>
</tr>
</tbody>
</table>

#### Section 2: Individualized Family Service Plan (IFSP) Information

<table>
<thead>
<tr>
<th>IFSP Begin Date:</th>
<th>IFSP End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History (including diagnosis):</td>
<td></td>
</tr>
<tr>
<td>Current EI Services being provided:</td>
<td></td>
</tr>
<tr>
<td>Functional Outcome that supports current equipment request:</td>
<td></td>
</tr>
<tr>
<td>Current progress toward that outcome:</td>
<td></td>
</tr>
<tr>
<td>Parent’s concerns related to outcome:</td>
<td></td>
</tr>
</tbody>
</table>

**AT Category 1**

**AT Item(s) Requested** (attach catalog photos, with pricing not included):

**AT Category 2**

**AT Item(s) Requested** (attach catalog pages, with pricing not included):

**Provider Information:** If evaluator is not ongoing provider, describe the collaboration with the IFSP team members and the plan to implement the requested item(s).

**Ongoing Provider Name/Discipline:**

**Current Functional Status:**

**Assessment and Findings:**

**Recommendations:**
## Section 3: Justification

1. Describe AT currently being utilized; consider all adaptive supports.

2. Will the requested AT supplement or replace current AT or adaptations? If yes, please describe.

3. Describe how the physical environment supports the use of requested AT.

4. Describe how you will educate/collaborate with the entire IFSP team regarding the instruction, fit and use of the AT?

5. Describe how the family’s home activity program will be developed. List specific strategies for the use of AT in the home and how the activities are related to the outcome(s).

6. Explain how the AT will help facilitate the child’s participation in the family’s daily routines and community activities, including specific time frames when the family will use the device.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>EI#:</th>
<th>CFC #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of All Items Requested:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

El Provider’s Signature

Date

El Provider’s Printed Name

Phone Number

For Physician’s use only:

By signing this document, the physician agrees with information presented. The signature serves as a prescription for recommended item(s).

Physician’s Signature

Date

Physician’s Printed First/Last Name

Phone Number

Physician’s Address

Physician’s License #
Pricing Information and Examples

The following are several Equipment Price Examples to use as a guide when completing calculations according to the SMART Act requirements. Please note that the example prices are just “examples” as the approval amount may vary. Each vendor may negotiate with specific manufacturers and submit their own price quote.

Determine if manufacturer pricing is:

**Acquisition price** shows a retail price and a discounted price. This discounted price may be referred to as dealer price, discounted price or educator price. Sale price is usually short term and is not considered acquisition pricing as it may end at any time Allow 50% mark-up.

**Retail price** is a catalog page with no discounted pricing. Vendor must provide three catalog prices, not copy pricing (could be changed) onto other pages (i.e., *Assistive Technology Letter of Developmental Necessity*). Allow 25% mark-up.

**Note:** For Dynavox Systems, LLC or Prentke Romich Company (vendors) for all SDG communication devices and accessories, HFS negotiates a 30% discount (regardless of Medicaid status) to be approved as the manufacturer is also the vendor. Requests for these devices should be forwarded to the Bureau, as there are specific prices outlined by HFS that are subject to change due to the negotiated time frame.

**Note:** Foot orthotics, leg rotation straps, elbow immobilizers, knee immobilizers, hand/wrist/thumb/finger splints, Benik vests, cervical collars, hip helper shorts, abdominal binders, BAHA sound processors, hearing aid ear molds, hearing aid batteries, etc. are Medicaid pre-priced on the DME list.

**Note:** For any other brand (usually splashy bath chair) the *Assistive Technology Letter of Developmental Necessity* must include a side-by-side comparison of the

<table>
<thead>
<tr>
<th>Example Price</th>
<th>Description</th>
<th>Retail Price Example</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPIO shirt</td>
<td>Example: Three retail prices: $165.95, $219.93, $259.95</td>
<td>Take lowest</td>
<td>$165.95 x 1.25 = $207.44</td>
</tr>
<tr>
<td>Weighted compression vest</td>
<td>Example: Acquisition price: $103.50 x 1.5 = $155.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted or pressure vest</td>
<td>Example: Acquisition price: $161.50 x 1.5 = $242.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewy tube</td>
<td>Example: Acquisition price: $12.72 x 1.5 = $19.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doorway support bar</td>
<td>Example: Three retail prices: $139.95, $155.55, $159.84</td>
<td>Take lowest</td>
<td>$139.95 x 1.25 = $174.94</td>
</tr>
<tr>
<td>Rotary platform swing</td>
<td>Example: Three retail prices: $279.92, $337.65, $363.49</td>
<td>Take lowest</td>
<td>$279.92 x 1.25 = $349.90</td>
</tr>
<tr>
<td>Cuddle swing</td>
<td>Example: Acquisition price: $233.10 x 1.5 = 349.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big red switch</td>
<td>Example: three retail prices: $65.00, $65.00, $66.00</td>
<td>Take lowest</td>
<td>$65.00 x 1.2 = $81.25</td>
</tr>
<tr>
<td>Switch toy</td>
<td>Example: Acquisition price: $89.99 x 1.5 = $134.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switch toy</td>
<td>Example: Three retail prices: $99.95, $101.54, $120.00</td>
<td>Take lowest</td>
<td>$99.95 x 1.25 = $124.94</td>
</tr>
<tr>
<td>Otter bath chair</td>
<td>(preferred brand by HFS) – For any other brand (usually splashy bath chair)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N04/2022
Appendix A

otter bath chair with any other brand with justification of why the otter bath chair does not meet the child’s needs and the requested bath chair brand will better meet the child’s needs.

Example: Acquisition price: $286.19 x 1.5 = $429.29

Tub stand or shower stand for bath chair – EI will fund one. This item can be purchased separately and is a separate authorization. Example: Acquisition price: $131.97 x 1.5 = $197.96

Standers and accessories: Ensure category two trial information is completed in the Assistive Technology Letter of Developmental Necessity. Match components on the vendor quote to manufacturer price list.

Example: Acquisition price: $4,797.10 x 1.5 = $7,195.10

Make sure the list of components on the vendor quote match the acquisition price page. Take total acquisition price times 1.5 for approved total.

Zing stander – vendor quote $4,048.00. Acquisition pricing from Ultimate Medical is $2,833.60 x 1.5 = $4,250.40. Approve the lesser amount quoted by the vendor.

Specific for the Squiggles stander and accessories – HFS does not fund the pivot base, must be authorized separately to not be sent for Medicaid match.

Example: Stander components w/o pivot base $2,723.80 x 1.5 = $4,085.70
Pivot base component $1,003.10 x 1.5 = $1,504.65

Positioning chair – Ensure category two trial information is completed in the developmental necessity. Match components on the vendor’s quote to the manufacturer’s price list.

Example: Acquisition price: $4,912.60 x 1.5 = $6,918.90

Hearing aids – Monaural aid (1), binaural aids, for 2 hearing aids, enter auth quantity of one. Dispensing fee, ear molds, batteries have Medicaid pricing. Pediatric care kit is not more than $50.00. BAHA sound processor price includes the Softband at the Medicaid price. Manufacturer pricing will be acquisition although the manufacturer does not state this.

Example: Binaural hearing aids net price $311.00 each x 2 = $622.00 x 1.5 = $933.00

Gait trainer – Ensure category two trial information is completed in the Assistive Technology Letter of Developmental Necessity. HFS requires and prefers the moxie gait trainer but will approve Kidwalk and crocodile gait trainers based on Assistive Technology Letter of Developmental Necessity category two trial results. Rifton pacer gait trainer not funded by HFS. HFS considers the Rifton pacer a high end model of the moxie gait trainer meeting the same needs and is not cost effective. However, the Rifton mini gait trainer can be approved if necessary, as no other company makes a gait trainer this small.

Moxie Gait Trainer – Example: Acquisition price: $779.82 x 1.5 = $1,169.73

Z-vibe travel kit – Example: Acquisition price: $49.99 x 1.5 = $74.99. EI approves Z-vibe travel kit or Z-vibe personal kit with five tips (most common) OR single Z-vibe and two tip sets

Reverse walker – Example: Acquisition price: $213.50 x 1.5 = $320.25
# Category Listing of Eligible Assistive Technology Devices

**Category Listing of Eligible Assistive Technology Devices**

**Definition of Assistive Technology (AT) devices:**

- Devices, items, pieces of equipment, or product systems acquired commercially off the shelf; (an item that is readily available at stores or online) modified or customized. Used to increase, maintain, or improve the functional capabilities of people developmental delays or disabilities.

- Range from low-tech to high-tech, are directly relevant to child’s developmental needs, and are developmentally and age appropriate.

- Families and EI Providers are to first utilize items within the family/child’s natural environment or that are readily available to meet the developmental needs of the child.

## Category 1 – Items that may be recommended by ongoing EI Providers with consultation and consensus of IFSP team. *Assistive Technology Developmental Letter of Necessity* must be completed. Items that are size-dependent must have height/weight documented.

<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Adapted Tables, Adjustable Benches, Crawlers, Walkers, Bath Chairs, Positioning - Bolster Chairs, Corner Chairs, Feeder Seats</td>
</tr>
<tr>
<td><strong>Orthotics</strong></td>
<td>Items recommended by an Orthotist or Physical Therapist that supports or corrects the function of a limb or the torso</td>
</tr>
<tr>
<td><strong>Weighted Items</strong></td>
<td>Vests, Belts, Weighted Accessories</td>
</tr>
<tr>
<td><strong>Oral-Motor Items</strong></td>
<td>Bite/Chew items, Grabber, Oral Vibrators/Massagers, Speech Praxis Kits</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>Adapted Utensils, Battery Adapters/Interrupters, Massagers, Therapy Balls, Tactile Air Cushions – <em>See Appendix D</em>, Visual Timers, Orthotics – Hip Abduction Orthosis, Foot Orthotics, Hand Splints, Knee/Elbow Immobilizers - (needs orthotist review)</td>
</tr>
</tbody>
</table>
### Appendix B

- **Hearing Aids and Accessories** - Requires the evaluation and recommendation of an EI-Enrolled Audiologist
  - BAHA Bone Conduction Aids
  - Binaural/Monaural aids
    - Batteries, Ear Molds, Dispensing Fees, Pediatric Care Kits
- **Developmental Play** -
  - Light Boxes
  - Multiple Control Units, Switch Latches, Switch Timers
  - Software or Applications - *See Appendix F*
  - Switches, Switch toys, Switch Mounts
- **Adapted Swings/Scooter Boards** –
  - Communication Boards, Picture Communication, Non-electronic Devices
  - Compartment Communicators

### Category 2 – Items that require trial and more specific evaluation of need. Additional justification must be provided on the *Assistive Technology Developmental Letter of Necessity* form.

- **Durable Medical Equipment** -
  - Communication – *See Appendix F*
    - Software or Applications for Augmentative or Alternative Communication supports
    - Speech Generating Devices requiring message formulation by spelling or other methods of message formulation and physical or multiple methods of device access
    - Speech Generating Devices using recorded or digitized Speech - Single Message Devices, Multistep Message Devices, Multiple Message Communicators, Multi-level Communicators
    - Speech-Generating Software Programs
  - Positioning Chairs – *See Appendix C*
  - Standers, Gait Trainers
Guidelines for Seating and Positioning Devices

Only a licensed provider who has training in evaluation and fitting shall fit seating and positioning equipment for the child. Parents, caregivers and direct service providers shall be instructed in the therapeutic purpose and correct use of the equipment. Written instructions shall be provided, and any training and support delivered documented in the provider’s notes.

Acceptable types: Seating and positioning devices, bolsters, benches, and adapted tables, slant boards, and standers. Devices must address current needs of the child, birth to three-years old and not anticipated needs of a school-aged child. These requests must also consider the growth needs of a birth to three-years old.

Caps/Limits and other requirements: The child’s height and weight must be documented for all devices except bolsters. Evaluations for both categories of equipment must address purpose and type of any additional supports or accessories required. Multi-positioning standing devices must include justification for benefit of multiple positions specific to each child.

Category 1:
• Positioning/seating devices less than $1,000.00 - examples include corner chair, tumble form feeder chair, positioning seat/system with trunk supports (includes Kaye Posture system and benches). Also includes Tripp Trapp Chair.
• Adapted tables/slant boards
• Adjustable benches

Category 2:
• Positioning/seating devices over $1000.00 - documentation of a trial with over-the-counter seating systems must be completed before a request for custom seat inserts will be accepted.
• All standers

* See Appendices A and F for additional information.
Guidelines for Vestibular Therapy Equipment

**Therapy Balls**

**Definition:** Therapy balls and dynamic surfaces are therapeutic equipment that is utilized to provide sensory input, correct posture, promote strengthening and weight shift. These balls do not include balls used for throwing, kicking, and catching.

**Acceptable types:** Therapy balls that are acceptable for use in early intervention include 24- or 36-inch balls, BOSU and peanut balls.

**Not acceptable:** 8-inch or 12-inch balls, as these are items typically used by all children and balance disc sit cushions.

**Caps/Limits or other requirements:** Child’s height/length must be documented. Category 1 item.

**Swings**

**Definition:** A therapeutic swing is a piece of equipment utilized to provide vestibular, proprioceptive, visual, auditory, and tactile sensory input by providing suspended angular and linear movement in all planes and directions. This movement requires a neuromuscular response to the sensory input, thus creating sensorimotor stimulation and integration of the sensory system. This sensory input improves all areas of development including attention/focus, behavior/coping skills, speech and language skills, balance, movement, and motor planning skills.

**Acceptable types:** Swings that are designed for use inside the home, such as the door jam type swing with the net and platform swing or the Wing Bo type swing designed for prone swinging.

**Not acceptable:** Swings and associated equipment that require outdoor frames, large indoor suspension frames, permanent installation, or modification to a home. Commercially available infant/toddler swing seats, gliders, strap swings, trapeze bars, and slide type swings.

**Caps/Limits or other requirements:** Swings are limited to two requests while in the EI Program. Category 2 item.

**Trampoline**

**Definition:** A therapeutic trampoline is a piece of therapy equipment utilized to provide vestibular, proprioceptive, visual, auditory and tactile sensory input in a controlled and safe manner with the close supervision of a skilled OT or parent trained on the apparatus. This sensory input improves all areas of development including attention/focus, behavior/coping skills, speech and language skills, balance, movement, and motor planning skills.

**Acceptable types:** Nursery or child sized trampolines should have appropriate safety rails or handles and be able to support the child’s weight. Trampolines should be the appropriate size for a 2-2.5 year-old child and designed for use by one child only.

**Not acceptable:** Larger outdoor or indoor trampolines, trampolines that do not have the appropriate safety rails or handles, or trampolines that a designed for two children.
Appendix D

**Caps/Limits or other requirements:** Trampolines will be capped at $400. Child’s weight must be documented. Category 1 item.

**Scooter Board**

**Definition:** A therapeutic scooter is a square board with wheels. A child can sit or lie on their stomach on the scooter board and scoot. Scooter boards provide proprioceptive, vestibular, and tactile sensory input as well as improve strength, coordination, and endurance.

**Acceptable types:** Per definition.

**Not acceptable***: See caps.

**Caps/Limits or other requirements:** Scooter board will be capped at $200. Exception to caps may be allowed with appropriate justification. Category 2 item.

Caution and skilled clinical expertise must be applied when ordering sensory equipment, specifically, vestibular stimulation devices. Evidence shows that the effects of vestibular overstimulation on the autonomic nervous system can cause adverse effects on the child. Therapists MUST be observant of child experiencing input from swings, scooter boards, and trampolines and must be aware of the potential adverse effects and contraindications that may be applicable. These items are NOT intended for a “one size” fits all and require the recommendation and or evaluation of a skilled, licensed therapist.

*See Appendices A and F for additional information.
Guidelines for Adaptive and Assisted Toileting Systems

**Definition:** Adapted and assisted toileting systems help provide independence while being designed to be practical, versatile and comfortable, as well as, easy to clean. These adjustable toilets and commodes can be used as a freestanding commode chair, over the toilet, on the toilet, or as a shower chair. They are designed for children that require assistance to sit upright in a chair. Additionally, the child should exhibit the cognitive ability and skills required for toilet training.

**Acceptable types:** Must address current needs of child, birth to three-years old and not anticipated needs of a school-aged child. Requests must consider the growth needs of a birth to three-year old.

**Not acceptable:** Chairs that are utilized by typically developing children.

**CAPs/Limits and other requirements:** Documentation that demonstrates the child exhibits the cognitive ability and skills required for toilet training. For size-dependent devices, child’s height and weight must be documented. Evaluation must address purpose and type of any additional supports or accessories required. Category 2 item.
Guidelines for Software and Augmentative and Alternative Communication (AAC) Devices

General Guidelines:

1. Requests must address current needs of a child, aged birth to three-years old and not anticipated needs of a school-aged child.

2. Requests must consider the growth, needs, and development of a child aged birth to three-years old. Some communication devices may be short or long-term, thus an evaluation must be conducted.

3. A trial period must be implemented: of up to six (6) weeks. Loaner resources may be accessed. Loaner devices/trial equipment is available at the Illinois Assistive Technology Project (IATP).

4. Requests should match the child’s cognitive ability with appropriate AT.

5. The child must have participated in a speech and language evaluation prior to the AAC evaluation.

6. Category 1: AAC that does not require evaluation

   A fully, credentialed EI Provider may request Category 1 items. However, a request will not be granted until the EI Provider has accessed the resources available, and a trial period has been initiated and documented.

7. Category 2: AAC that does require evaluation.

   In addition to the general guidelines:

   a. Any Category 2 item requires an evaluation by an EI credentialed-Evaluator Provider.

   b. Documentation of a trial AAC device(s) must be completed before a request will be accepted.
Assistive Technology Devices Not Eligible for EI AT Funding

Definition of ineligible Assistive Technology (AT) devices:

- Devices, items, pieces of equipment, or product systems acquired commercially off the shelf; (an item that is readily available at stores or online) modified or customized. Used to increase, maintain, or improve the functional capabilities of people developmental delays or disabilities.
- Range from low-tech to high-tech and directly relevant to child’s needs, that are both age and developmentally appropriate.
- Any device or service:
  - necessary to treat or control a medical condition
  - requiring home installation or home modification
  - used to assist a primary caregiver with their own disability
- Families and EI Providers are to utilize items within the family/child’s natural environment or that are readily available to meet the developmental needs of the child.

<table>
<thead>
<tr>
<th>Items Not Covered</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Bowls/Plates</td>
<td>Suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Adaptive Scissors</td>
<td>Therapy Tool</td>
</tr>
<tr>
<td>Baby Scale</td>
<td>Commercially available for use by parent</td>
</tr>
<tr>
<td>Balance Board, Balance Disk, balance-disc sit cushion, mov-n-sit cushion</td>
<td>Therapy Tool</td>
</tr>
<tr>
<td>Barrel Roll</td>
<td>Use smaller pieces to achieve same outcome</td>
</tr>
<tr>
<td>Beds, including accessories, i.e., sheets, pillows, etc.</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Boardmaker Software, add-on libraries</td>
<td>EI funds basic Boardmaker software program, no longer funds additional library addendums</td>
</tr>
<tr>
<td>Car Chargers for any Device</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Car Seats (Any kind)</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Chair, Bumbo Seat</td>
<td>Anatomically Incorrect/Improper Positioning</td>
</tr>
<tr>
<td>Chair, Cube Chairs &amp; Trays</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Chair, Nada Chair, Kiddy-Up</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Chair, Play</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Chair, Seat to Go, Firefly Chair</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Chair, Straddle Sitter</td>
<td>Use smaller pieces to achieve outcome; bolster, corner chair</td>
</tr>
<tr>
<td>Climbing System</td>
<td>Suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Cups, Trainer, Flexi/Cut Out, Infa-Trainer, Sippy, Straw</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to birth to three-years old</td>
</tr>
<tr>
<td>Items Not Covered</td>
<td>Rationale</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Developmental Tree</td>
<td>Non-therapeutic item</td>
</tr>
<tr>
<td>Dycem Mat</td>
<td>Commercially available; suitable for all ages</td>
</tr>
<tr>
<td>FM Transmitter for Hearing Loss</td>
<td>Therapy tool for classroom school setting above age three</td>
</tr>
<tr>
<td>Foam Weights</td>
<td>Therapy Tool</td>
</tr>
<tr>
<td>Gym mat, tumbling mat, protective mat, etc.</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Hand-Held Rotation Board</td>
<td>Therapy Tool; similar to balance board</td>
</tr>
<tr>
<td>Helmet</td>
<td>Medical, non-therapeutic</td>
</tr>
<tr>
<td>Ipad, Tablets, Computers</td>
<td>HFS requires dedicated communication devices, only</td>
</tr>
<tr>
<td>Knobbed Puzzle</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Laryngeal Mirror; any Mirror</td>
<td>Therapy tool; not for home use</td>
</tr>
<tr>
<td>Mother’s Third Arm</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Neuromuscular Stimulation Unit</td>
<td>For use with physician supervision, not developmentally appropriate</td>
</tr>
<tr>
<td>Noise Reduction Headphones</td>
<td>Commercially available, non-therapeutic; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Oral Motor Parent Kit</td>
<td>Order components separately, therapist provide a home program and instruction</td>
</tr>
<tr>
<td>Oral Probes</td>
<td>Therapy Tool</td>
</tr>
<tr>
<td>Peapod Jr.- Sensory</td>
<td>No clinical research to support item</td>
</tr>
<tr>
<td>Pop Tubes</td>
<td>Non-adaptive; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Positioner, Sidelyer</td>
<td>Use smaller pieces to achieve same outcome</td>
</tr>
<tr>
<td>Positioner, Tadpole</td>
<td>Use smaller pieces to achieve same outcome</td>
</tr>
<tr>
<td>River Stones or Similar Items</td>
<td>Commercially Available; suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Rocking Boat/Stair Climber</td>
<td>Use actual stairs to learn this skill</td>
</tr>
<tr>
<td>Rocking Rody</td>
<td>Riding Toy; not adapted</td>
</tr>
<tr>
<td>Safety/Elopement Alarm</td>
<td>Commercially available for use by parent</td>
</tr>
<tr>
<td>Sensory Brush</td>
<td>No clinical research to support Item</td>
</tr>
<tr>
<td>Shower Head</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Sign Language Book</td>
<td>Therapist should use family training/home activity program</td>
</tr>
<tr>
<td>Spinning Board</td>
<td>Commercially available; not adapted</td>
</tr>
<tr>
<td>Spoons/Forks, Textured, Flexible, Weighted, etc.</td>
<td>Suitable for all children birth to three-years old</td>
</tr>
<tr>
<td>Steamroller</td>
<td>Lacks Clinical Research</td>
</tr>
<tr>
<td>Swing-Height Adjustment, Beam Installation</td>
<td>Home conversion/adaption required</td>
</tr>
<tr>
<td>Table, Standard Play (only legs adjust)</td>
<td>Commercially available; non-therapeutic-suitable for all children, birth to three-years old</td>
</tr>
<tr>
<td>Items Not Covered</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Therapeutic Listening Device</td>
<td>Lacks clinical research</td>
</tr>
<tr>
<td>Therapeutic Manipulated Center</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Therapy Ball Pump</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Therapy Ball with Shaggy Doo Cover</td>
<td>Therapy tool; May use household items to replicate cover</td>
</tr>
<tr>
<td>Therapy Mirror</td>
<td>Therapy tool</td>
</tr>
<tr>
<td>Therapy Putty</td>
<td>Therapy tool</td>
</tr>
<tr>
<td>Theratubing</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Toy Bars for seating devices</td>
<td>Not an acceptable accessory</td>
</tr>
<tr>
<td>Toy, Activity Center, Cause/Effect</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, Chime Garden Reward Toy</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, Combo Board</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, Curious George In the Box or similar</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, Go Go Bus</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, High Striker Reward Toy</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Toy, Pegs &amp; Pegboard</td>
<td>Toy; Commercially available</td>
</tr>
<tr>
<td>Tray Overlay, Transparent Tray, only basic trays funded</td>
<td>Not an acceptable accessory</td>
</tr>
<tr>
<td>Treadmill, Pediatric</td>
<td>Therapy tool; Commercially available</td>
</tr>
<tr>
<td>Trays for Gait Trainers</td>
<td>Not an acceptable accessory, not funded by HFS</td>
</tr>
<tr>
<td>Tunnels, any type</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Twist Pillow</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Vibe Mitt</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Vibrating Bolster, Pillow or Snake</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Vibrating Body Massager</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Vibrator Tubular</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Weighted Blankets</td>
<td>Hazard to children under three-years old</td>
</tr>
<tr>
<td>Weighed Hats, Collars</td>
<td>Not appropriate for children birth to three-years old</td>
</tr>
<tr>
<td>Weights, Ankle/Leg, Arm, Sleeve</td>
<td>Commercially available</td>
</tr>
<tr>
<td>Wiggle Writer</td>
<td>Toy; Commercially available</td>
</tr>
</tbody>
</table>

**Natural Environment:** Families and therapists are encouraged to utilize items within their natural environment or that are readily available to meet the developmental needs of the child.

**Definition of commercially available:** an item that is readily available at stores or online stores.
ILLINOIS EARLY INTERVENTION
GUIDANCE FOR DISCHARGE REPORT

A discharge report from the provider is required for a child who is changing providers, turns three years of age, moves out of a particular CFC’s geographic boundaries (unless no provider change occurs), when child meets outcomes or is no longer responding to communication from the Service Coordinator. EI Providers are required to submit a report to each individual child’s Service Coordinator in a timely fashion. The Discharge report is due 14-calendar days from the date of discharge, but before the child turns three years of age. A child who changes EI Providers within the same Payee is not required to have a Discharge report with the assumption the Payee shares the case record within their agency. For a family who chooses to change EI providers or for families receiving limited services over a limited time, EI providers should follow best practice to support the new provider or the family with the status of the progress during the short tenure with the child. Any progress status can assist the new provider or family. Those families who never see the EI provider before changing or leaving the EI Program will not receive a Discharge report.

EI Providers must be given an authorization for IFSP Development time to write the Discharge report. These summary reports of a EI provider’s record notes should include:

SECTION 1: Demographic information about the child;
SECTION 2: EI Provider’s information, including signature;
1. Updates/changes in the child’s developmental/social/medical history and a summary of the family’s ongoing concerns including information about the child’s/family’s participation in services, i.e. expected frequency/intensity of service, attendance, child/family engagement, family carryover of recommended strategies
2. The degree to which progress toward achieving the outcomes identified in the IFSP is being made and whether modification or revision of the outcomes or EI services identified in the IFSP is necessary; and
3. Recommendations for additional EI services or community resources that should be discussed at the IFSP meeting.

NOTE: This report may be combined with a Six Month or Annual if it is in close proximity to the child’s third birthday.
**SECTION 1: Demographic Information**

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>EI #:</th>
<th>CFC #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date of Report:</td>
<td></td>
</tr>
<tr>
<td>Chronological Age:</td>
<td>Adjusted Age:</td>
<td></td>
</tr>
<tr>
<td>Parent’s Name:</td>
<td>Language Spoken in Home:</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator’s Name:</td>
<td>Physician’s Name:</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 2: Provider Information**

<table>
<thead>
<tr>
<th>Reason for Discharge:</th>
<th>☐ Change of Providers</th>
<th>☐ Exiting the Early Intervention Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Name:</td>
<td>Provider’s Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Provider’s Discipline:</td>
<td>☐ OT</td>
<td>☐ PT</td>
</tr>
</tbody>
</table>

**SECTION 3: Concerns and Updates**

A. Summarize any changes to the child’s medical history, including evaluations/assessments completed, since the last report and summarize parents’ continuing concerns. Include information from other sources such as family members, other caregivers, social workers, and educators, if necessary, to understand the full scope of the child’s unique strengths and needs.

**SECTION 4: Progress Towards Outcomes**

A. Please list the outcomes on the IFSP the provider has been addressing and the progress the child has made towards reaching those outcomes since the last progress/assessment report.

**SECTION 5: Further Recommendations**

B. If applicable, recommendations for additional Early Intervention or other resources outside of Early Intervention that may help the child/family.

---

Provider’s Printed Name

Provider’s Signature | Date

---

R07/2022
Illinois Early Intervention
GUIDANCE FOR EVALUATION/ASSESSMENT REPORT

Evaluation of a Child:
Early Intervention (EI) definitions:
• **Initial Evaluation** - the procedures used by qualified personnel to determine the child’s initial eligibility.
• **Evaluation** - the procedures used by qualified personnel to determine a child’s continuing eligibility.

Initial Evaluations to determine eligibility shall be completed by EI credentialed/enrolled **Evaluators** only. Evaluations to determine on-going eligibility will be completed by EI credentialed/enrolled providers. A minimum of two or more separate disciplines are required to complete both Initial Evaluations and Evaluations. Unless clearly not feasible to do so, all evaluations/assessments or assessments must be conducted in the language normally used by the child.

Evaluations of the child shall include:
1. administration of the evaluation tool;
2. collection of the child’s history (including interviewing the parent);
3. identification of the child’s level of functioning in each of the five developmental areas: cognitive, physical, communication, social or emotional, and adaptive;
4. gathering information from other sources such as family members, other caregivers, medical providers, social workers and educators, if necessary, to understand the full scope of the child’s unique strengths and needs; and
5. reviewing medical, educational, and other records.

Assessment of a Child:
EI definitions:
• **Initial Assessment** – the assessment of the child conducted prior to the child’s first IFSP meeting.
• **Assessment** - the ongoing procedures used by qualified personnel to identify the child’s unique strengths and needs and the EI services appropriate to meet those needs throughout the child’s eligibility under EI, which includes the assessment of the child and the child’s family.

Initial Assessments of the child shall be completed by EI credentialed/enrolled **Evaluators** only. Assessments of the child and family to determine on-going service needs shall be completed by EI credentialed/enrolled providers. A minimum of two or more separate disciplines are required to complete both Initial Assessments and Assessments.

Assessments of the child shall include:
1. a review of the results of any evaluations;
2. personal observations of the child;
3. identification of the child’s needs in each of the developmental areas (cognitive development, physical development, communication development, social or emotional development and adaptive development).
4. If medical records determined eligibility, the assessment of the child shall also include the review of those records.
Note: When an EI Provider accepts an individual authorization for an evaluation or assessment, an individual report is required. If a provider participates in an Arena evaluation, an individual report is still required. This is not a new practice. Any combined reports will be returned to the provider to complete an individual report for submission to the Service Coordinator, IFSP team and family.

Eligibility Determination:
When determining initial eligibility, a child will be determined eligible based upon one of the following reasons as stated in 89 Illinois Administrative Code 500.50(a):

Subsection(a)
An Illinois child under the age of 36 months of age and his or her family are eligible for the program as set forth in this Part if the child:

1. is experiencing a IDHS determined eligible level of developmental delay; or
2. is experiencing a medically diagnosed physical or mental condition that typically results in developmental delay; or
3. is, according to informed clinical opinion of qualified staff based upon a multidisciplinary evaluation and assessment, at risk of substantial developmental delay. As defined in 89 Illinois Administrative Code 500.20, “At risk of substantial developmental delay, according to informed clinical opinion,” means that there is consensus of qualified staff based upon multidisciplinary evaluation and assessment that development of a Department determined eligible level of delay is probable if EI services are not provided, because a child is experiencing either:
   - a parent who has been medically diagnosed as having a mental illness or serious emotional disorder defined in the Diagnostic and Statistical Manual V (DSM V) (American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901) that has resulted in a significant impairment in the parent’s level of functioning in at least one major life functional area or a developmental disability; or
   - three or more of the following risk factors:
     - current alcohol or substance abuse by the primary caregiver;
     - primary caregiver who is currently less than 15 years of age;
     - current homelessness of the child;
     - chronic illness of the primary caregiver;
     - alcohol or substance abuse by the mother during pregnancy with the child;
     - primary caregiver with a level of education equal to or less than the 10th grade, unless that level is appropriate to the primary caregiver’s age;
     - an indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

Adjusted Age
The Illinois EI Program defines prematurity as a birth that occurs prior to 37 weeks gestation. When children are being evaluated/assessed in EI, an adjusted age which fully corrects for prematurity should be used for calculating percent of delay up to age two. Additional information may be found in the Glossary of the Illinois Early Intervention Provider Handbook.

On an annual basis a re-determination of eligibility must occur. If the child is not found eligible based upon the reasons outlined in Subsection (a) above, the child must meet the criteria as set forth in 89 Illinois Administrative Code 500.50(g) below in order to continue to receive services:
A child will continue to be eligible if he/she:
R07/2022
1. has entered the program under any of the eligibility criteria in Subsection (a) but no longer meet the current eligibility criteria under this Subsection; and

2. either:
   A. continues to have any measurable delay; or
   B. has not attained a level of development in each area, including cognitive, physical (including vision and hearing), communication, social or emotional or adaptive skills, that is at least at the mean of the child’s age equivalent peers; and

3. has been determined by the multidisciplinary team to require the continuation of EI services in order to support continuing developmental progress, pursuant to the child’s needs, and provided in an appropriate developmental manner. The type, frequency, and intensity of services will likely differ from the initial IFSP because of the child’s developmental progress, and may consist of only service coordination, evaluations and assessments.

Evaluation/Assessment and Assessment Report:
Upon completion of either an Evaluation/Assessment or an Assessment, a written report of findings is required and must be submitted using the Illinois Early Intervention Evaluation/Assessment Report format to the Child and Family Connections office within 14-calendar days, see Chapter 3: Early Intervention Providers in Illinois, under section 3.13 Reporting for additional information. Complete all appropriate sections outlined in these instructions. Incomplete reports are not acceptable and will be returned to the provider for the revisions required to bring the report into compliance.

For initial and annual eligibility, a provider may receive an EA authorization if eligibility has not been determined or an AS authorization if eligibility has already been determined. If a child enters EI already eligible based on any of the factors listed above under Eligibility Determination, no Evaluation is necessary. Only an Assessment (AS), to determine the needs of the child/family, must be performed. If a child needs to be determined eligible for EI, then both Evaluation and Assessment (EA) must be performed.

Evaluation/Assessment:
EI Providers performing evaluations and assessments for the purpose of determining initial and annual eligibility for EI must have an EA authorization in hand prior to service provision. The provider is expected to perform the Evaluation and Assessment and record the results on the Illinois Early Intervention Evaluation/Assessment Report format. Section 5E will only be completed for annual evaluation/assessment as it does not apply to initial eligibility.

EA authorizations:
• Initial eligibility determination:
  o Completed by a credentialed Evaluator to perform the initial Evaluation/Assessment of the child for eligibility determination, completing all sections except 5E.

• Redetermination of eligibility:
  o Completed by the ongoing direct service provider to perform the ongoing Evaluation/Assessment of the child for redetermination of eligibility, completing all sections including 5E, if applicable.
Assessment:
Providers performing initial and annual assessments for the purpose of identifying the unique strengths and needs and appropriate EI services to meet those needs must have an AS authorization in hand prior to service provision. The provider is expected to perform the Assessment using Department-approved tools and record the results on the Illinois Early Intervention Evaluation/Assessment Report format. For assessments, complete all sections except 5E.

AS authorizations:
- Initial assessment:
  - Completed by a credentialed Evaluator to perform the Assessment of a child/family prior to initial IFSP for a child whose eligibility for EI has already been established.
- Ongoing assessments:
  - Completed by ongoing direct service provider to perform the Assessment of a child/family at necessary intervals including, but not limited to, six-month and annual reviews.

Report Format:
Section 1: Complete all demographic information for the child including the child’s Service Coordinator and physician.

Section 2: Indicate whether this report reflects information for evaluation and assessment (if eligibility needs to be determined) or assessment only (if eligibility has already been determined). Include the date of testing as well as provider name, telephone number, and discipline. Indicate where testing occurred by checking appropriate box, identify where testing took place if not in the home.

Section 3: Summarize referral information including who made the referral and the reason for referral as well as any developmental concerns the parents have if they are not the source of referral.

Section 4: Indicate the name(s) of any tool(s) used for evaluation and/or assessment. Include which of the five developmental domains are being addressed through testing, provide age equivalents and percentages of delay for each domain evaluated. If assessment only, provide age equivalents and percentages of delay, if available.

Section 5:
A. Summarize the child’s social and developmental history and parents’ concerns based on referral and intake information as well as information received from other sources, if applicable. Consider who is involved in the child’s caregiving environment and include information from them, if applicable. Information from parent interview should be summarized here as well. Information about childcare, available family support, and family involvement in community activities may also be included here, if applicable.

B. Summarize the child’s medical history as it pertains to the child’s developmental functioning. Include information about prenatal care and complications, delivery information, child’s health status, history of intervention, and/or use of assistive technology (if applicable) as well as available hearing and vision information.

C. Provide behavioral observations of the child. This section should include information about the child’s attention span and ability to complete tasks. It should also include who was present for testing and how the child responded to the evaluator/assessor(s). Information about the child’s communication strategies and persistence with tasks should also be included. Finally, a statement about how the observed behavior
is or is not typical compared to how the child normally behaves based on feedback from the child’s caregiver should also be provided.

D. Provide information about the child’s level of functioning in each developmental domain tested. This should include information about the child’s strengths and needs in each domain. This section should include not only information about response to testing tasks but also information about functional skills and how these relate to the child’s ability to participate in family routines. At the annual review, this section should also include information about the child’s progress towards IFSP outcomes. Each provider should include an update about the skills the child has acquired relative to the IFSP outcomes that the provider has been addressing with the family. If the child’s age equivalents do not accurately portray the child’s developmental status and Clinical Opinion will be used to determine initial or ongoing eligibility, explain:
   1. The reason(s) the child was unable to be appropriately and accurately tested using a formal evaluation tool, and
   2. The observed atypical development that may be causing the child to experience an IDHS determined eligible level of delay or greater.

E. This section is only used for annual redetermination of eligibility when a child no longer meets the current eligibility criteria. If the provider feels there is a need to continue services to support developmental progress, the provider must complete this section and address:
   1. Any measurable delay or not attaining a level of development that is at least the mean of the child’s same age equivalent peers; and
   2. The specific needs of the child that require continued EI services for developmental progress.

Section 6:
A. Briefly summarize the child’s strengths and needs including how this impacts the child’s ability to participate in family routines and activities. Include a statement about the accuracy of the tool’s portrayal of the child’s development.

B. List recommendations for EI and/or other community resources which may benefit the child and family, if applicable.

IFSP outcomes as well as strategies and recommendations for services, with frequency, intensity, duration and location will be determined at the IFSP meeting in collaboration with the child’s family based on their identified priorities and concerns and the Principles of Early Intervention.

NOTE: Providers must accept Evaluations/Assessments and Assessments that have been completed prior to the initial IFSP meeting or that have been completed to determine the need to add a new service to an existing IFSP when beginning direct services unless the evaluations/assessments are more than six (6) months old. EI will not pay for the direct service provider to duplicate existing Evaluations/Assessments and Assessments.

Annual Review:
On an annual basis, redetermination of eligibility must be completed. Direct Service Providers must use the Illinois Early Intervention Evaluation/Assessment Report format following the instructions in this document for ongoing eligibility redetermination. Providers should receive either an EA or AS authorization based on the information required to determine eligibility. In addition to the information included in the initial evaluation/assessment report, an annual review report should include information about services received and a summary of the child’s progress towards IFSP outcomes.
Recommendation of further assessments:
When any team member feels a new service may be needed, the team member must notify the Service Coordinator to communicate the need for an assessment. No service can be added to an IFSP or services begun, unless the assessment process is completed, the team has met and agreed on the need for the service, the service addresses a Functional Outcome outlined on the child’s IFSP, and consent is received by the parent for the service.

Reminders for billing:
- Bill for evaluation/assessment report writing time using the evaluation and/or assessment code identified under your credentialed/enrolled profession.
- Claims for evaluation/assessment or assessment and corresponding IFSP meeting attendance must be submitted together. If child is not eligible and no IFSP meeting is held, no IFSP authorization will be provided, so claim can be submitted when the evaluator is notified of the decision of ineligibility.
- Bill for the time to write direct service or discharge reports which require no testing procedures using the IFSP Development code identified under your credentialed / enrolled profession. See definition of IFSP development found in the Glossary section of the Provider Handbook document to determine the types of service that are considered billable under IFSP development procedure codes.
- The EI Program does not pay a provider to write reports other than those required by EI for the initial evaluation/assessment, annual IFSP review, the six-month review, or discharge.
- Only bill for the actual time used to complete the evaluation/assessment or assessment process and the time spent writing the report. Documentation must justify the time billed or refunds may be required during monitoring, as outlined in this document.
- Documentation of evaluation/assessment should include a record note that identifies:
  - The date of service that the evaluation and assessment, assessment, or summary report was completed.
  - Time used to complete the evaluation and assessment or assessment.
  - Time used to write the report based upon the results of the evaluation and assessment or assessment.
- Evaluations/assessment reports should be dated and billed the date the actual Evaluation/assessment was performed with the report signed and dated when it is complete. A progress note should also accompany the evaluation/assessment report within the child’s permanent file. Please ensure your authorization is correct for the date you perform the evaluation/assessment.
# Illinois Early Intervention Evaluation/Assessment Report Format

Fillable Version Available at: [www.XXXX](http://www.XXXX)

## Section 1: Demographic Information

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>EI #:</th>
<th>CFC #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date of Evaluation/Assessment or Assessment:</td>
<td></td>
</tr>
<tr>
<td>Chronological Age:</td>
<td>Adjusted Age:</td>
<td></td>
</tr>
<tr>
<td>Parent’s Name:</td>
<td>Language Spoken in Home:</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator’s Name:</td>
<td>Physician’s Name:</td>
<td></td>
</tr>
</tbody>
</table>

## Section 2: Type of Report

Check One:  
- [ ] Evaluation/Assessment *(for Eligibility Determination)*  
- [ ] Assessment *(if child already eligible)*

**Provider’s Name:**  
**Provider’s Phone Number:**

**Provider’s Discipline:**  
- [ ] OT  
- [ ] PT  
- [ ] DT  
- [ ] SLP  
- [ ] SW  
- [ ] Other:

**Location of Evaluation/Assessment:** *(check one)*  
- [ ] Home  
- [ ] Other Setting *(identify where):*

## Section 3: Referral Information

Please list reason for referral, who referred to Child & Family Connections, and Parent/Guardian Concerns:

## Section 4: Instrument(s) Administered during Evaluation and/or Assessment

<table>
<thead>
<tr>
<th>Title of Instrument Used</th>
<th>Developmental Domain Addressed</th>
<th>Age Equivalent*</th>
<th>Percent of delay*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Required for Evaluation/Assessment. If completing Assessment only, provide if known.

## Section 5: Evaluation and/or Assessment

A. Child’s developmental history and summary of parents’ concerns. Include information from other sources such as family members, other caregivers, social workers, and educators, as necessary to understand the full scope of the child’s unique strengths and needs.
B. Summary of medical history, including pregnancy, delivery, child’s health since birth, hearing and vision.

C. Behavioral Observations of the child (also include if observed behavior was viewed as typical or atypical as compared to child’s usual behavior).

D. Child’s level of functioning (identifying strengths and needs) in each of the developmental areas tested. As appropriate, include explanation of use of Clinical Opinion in determining eligibility. For annual reviews, also include information about the child’s progress towards IFSP outcomes.

E. Provide justification for annual re-determination for children not meeting original eligibility criteria:

SECTION 6: Summary and Interpretation

A. Brief summation of the child’s unique strengths and needs, ability to perform functional skills and how the child is able to participate in family routines. Include a statement about tool’s accuracy in portraying child’s development.

B. If applicable, recommendations for referrals for additional EI assessments and/or other resources outside of Early Intervention to be discussed at the IFSP meeting.

Evaluator’s Printed Name

Evaluator’s Signature                     Date

R07/2022
ILLINOIS EARLY INTERVENTION
GUIDANCE FOR SIX-MONTH REVIEW REPORT

A periodic review of each child’s IFSP must occur every six months or more frequently if conditions warrant, or if the family requests such a review, to determine if adjustment of the IFSP is needed.

Providers must be given an authorization for IFSP Development time to write the summary report. Providers are required to submit a report to each individual child’s Service Coordinator prior to the six-month review. These summary reports of a provider’s record notes should include:

• Demographic information about the child;
• Provider information;
• Updates/changes in the child’s developmental/social/medical history and a summary of the family’s ongoing concerns including information about the child’s/family’s participation in services, i.e. expected frequency/intensity of service, attendance, child/family engagement, family carryover of recommended strategies;
• The degree to which progress toward achieving the outcomes identified in the IFSP is being made and whether modification or revision of the outcomes or EI services identified in the IFSP is necessary; this is not just a listing of IFSP outcomes, providers should include the outcomes that they have been addressing and the child’s progress they have observed towards meeting those outcomes; and
• Recommendations for additional EI or community resources that should be discussed at the IFSP meeting.
### SECTION 1: Demographic Information

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>EI #:</th>
<th>CFC #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date of Report:</td>
<td></td>
</tr>
<tr>
<td>Chronological Age:</td>
<td>Adjusted Age:</td>
<td></td>
</tr>
<tr>
<td>Parent’s Name:</td>
<td>Language Spoken in home:</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator’s Name:</td>
<td>Physician’s Name:</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION 2: Provider Information

<table>
<thead>
<tr>
<th>Provider’s Name:</th>
<th>Provider’s Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Discipline:</td>
<td>☐ OT ☐ PT ☐ DT ☐ SLP ☐ SW ☐ Other:</td>
</tr>
</tbody>
</table>

### SECTION 3: Concerns and Updates

**A.** Child’s developmental history and summary of parents’ concerns. Include information from other sources such as family members, other caregivers, social workers, and educators, if necessary to understand the full scope of the child’s unique strengths and needs.

**B.** Summary of medical history, including pregnancy, delivery, child’s health since birth, hearing and vision.

**C.** Child/family participation in services.

### SECTION 4: Progress Towards Outcomes

**A.** Please list each outcome on the IFSP and the progress the child has made towards reaching that outcome:

### SECTION 5: Further Recommendations

**B.** If applicable, recommendations for additional EI Assessments and/or other resources outside of Early Intervention to be discussed at the IFSP meeting.

---

Provider’s Printed Name

Provider’s Signature

Date
ILLINOIS EARLY INTERVENTION
GUIDANCE FOR MEDICAL DIAGNOSTIC REPORT

Medical Diagnostic Services:
Medical services only for diagnostic and evaluation/assessment purposes means services provided by an enrolled licensed physician and may utilize a multidisciplinary team (if needed) under the direction of an EI-enrolled licensed physician to determine a child’s developmental status and need for EI support services.

Medical diagnostic services may be appropriate:
1. when the child’s record documents that other evaluations have failed to determine the child’s eligibility for EI and the child is likely to be determined eligible if additional developmental diagnostic services are provided, or to establish a diagnosis which would potentially meet the eligibility parameters for services, or
2. when a child has significant developmental delays and/or lacks developmental progress, presents with unexpected regression, or demonstrates atypical development that cannot be explained based upon known medical, developmental or social etiology. Medical referrals may be required if the need for medical testing is identified. The EI Program does not pay for medical testing. The diagnostic report below (Attachment 5, Medical Diagnostic Report Format) must include a statement about the child’s developmental status and EI eligibility. The report may include medical, educational, and family support recommendations not necessarily covered by EI but that may be useful to families. Service Coordinators may assist families with the recommendations not covered by EI by making referrals to other community resources.

Services must be consistent with the provider’s qualifications and licensure. If team members are needed based on the child’s individual circumstances, they are assigned by each clinic based on information received from the Service Coordinator (current IFSP, IFSP team’s reports). They must be individually enrolled to provide EI services under their respective disciplines, have an EI evaluator credential, and have an authorization under their discipline to provide and bill for the particular service. Team members should use the codes found under their respective disciplines for billing purposes. A licensed physician should always be present throughout the diagnostic visit.

Medical Diagnostic Report:
Upon completion of Medical Diagnostic visit, a written report of findings is required and must be submitted using the Illinois Early Intervention Medical Diagnostic Report format to the CFC office within 14 calendar days of receipt of the request to perform the visit. Complete all appropriate sections outlined in these instructions. Incomplete reports are not acceptable and will be returned to the provider for the revisions required to bring the report into compliance.

Section 1: Complete all demographic information for the child including the child’s Service Coordinator and physician.

Section 2: Include information about the date of the visit, including the date and telephone number of the physician and the names and disciplines of any other providers involved in the evaluation/assessment process. Also include the name, address, and telephone number of the diagnostic clinic and the name of the clinic coordinator.

N07/2022
Section 3: Summarize the reason provided for the referral, including who made the referral, as well as any additional family concerns.

Section 4: Indicate the name(s) of any tool(s) used for evaluation and/or assessment. Include which of the five developmental domains are being addressed through testing. Provide age equivalents and percentages of delay for each domain, if available. At least one evaluation/assessment tool must be on the approved list of Early Intervention Approved Evaluation and Assessment Instruments, available at [www.dhs.state.il.us/page.aspx?item=86067](http://www.dhs.state.il.us/page.aspx?item=86067).

Section 5:
A. Summarize the child’s social and developmental history and parents’ concerns based on referral and intake information as well as information received from other sources, such as other caregivers and the child’s IFSP team. Information from intake, the IFSP, prior evaluation/assessment reports, and IFSP progress reports should be considered to form a thorough understanding of the child’s developmental history. Information about childcare, available family support, and family involvement in community activities may also be included here, if applicable.

B. Summarize the child’s medical history as it pertains to the child’s developmental functioning. Summarize information about prenatal care and complications, delivery information, child’s health status, history of intervention, and/or use of assistive technology (if applicable) as well as available hearing and vision information.

C. Summarize the results of the physician’s physical and neuro-developmental exams. This should include a general review of systems in addition to the general physical and neurodevelopmental exams.

D. Provide behavioral observations of the child. This section should include information about the child’s attention span and ability to complete tasks. It should also include who was present for testing and how the child responded to the evaluator/assessor(s). Information about the child’s communication strategies and persistence with tasks should also be included. Finally, a statement about how the observed behavior is or is not typical compared to how the child normally behaves based on feedback from the child’s caregiver should also be provided.

E. Provide information about the child’s level of functioning in each developmental domain tested. This should include information about the child’s strengths and needs in each domain. This section should include not only information about response to testing tasks but also information about functional skills and how these relate to the child’s ability to participate in family routines.

Section 6:
A. Briefly summarize the team’s impressions of the child including any diagnostic information. This summary should include the child’s strengths and needs and how the diagnosis might impact the child’s ability to participate in family routines and activities. Also include information about whether the child is already eligible for early intervention or if this diagnostic visit is providing the information needed to establish eligibility.

B. If applicable, list any recommendations the evaluators/assessors might have for the IFSP, any developmental/educational/family support services that may be useful for the child/family to consider, and any medical recommendations for outside of EI that might be necessary to better understand the child’s development.

N07/2022
ILLINOIS EARLY INTERVENTION
MEDICAL DIAGNOSTIC REPORT FORMAT
FILLABLE VERSION AVAILABLE AT: COMING SOON

SECTION 1: Demographic Information

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>EI #</th>
<th>CFC #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Date of Medical Diagnostic Evaluation/Assessment</td>
<td></td>
</tr>
<tr>
<td>Chronological Age</td>
<td>Adjusted Age</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian’s Name</td>
<td>Language Spoken in Home</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator’s Name</td>
<td>Primary Physician’s Name</td>
<td></td>
</tr>
</tbody>
</table>

SECTION 2: Visit Information

<table>
<thead>
<tr>
<th>Physician’s Name</th>
<th>Physician’s Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Providers’ Names and Disciplines (if any):</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>Medical Diagnostic Clinic’s Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Clinic Coordinator’s Name</td>
<td>Phone #</td>
</tr>
</tbody>
</table>

SECTION 3: Referral Information

Please list reason for referral to medical diagnostic, and Parent/Guardian concerns:

SECTION 4: Instrument(s) Administered during Evaluation/Assessment (or complete 5.E)

<table>
<thead>
<tr>
<th>Title of Instrument Used</th>
<th>Developmental Domain Addressed</th>
<th>Age Equivalency</th>
<th>Percentage of Delay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 5: Evaluation and/or Assessment

A. Child’s developmental history and summary of parents’ concerns. (include information from other sources such as family members, other caregivers, social workers, educators, and IFSP team members, as necessary, to understand the full scope of the child’s unique strengths and needs This information is found in child’s IFSP, current evaluations and assessments, most recent IFSP teams’ reports, existing scripts and authorizations.)

R07/2022
B. Summary of relevant medical family history, including pregnancy, delivery, child’s health since birth, hearing and vision

C. Results from physical and neuro-developmental exams

D. Behavioral Observations of the Child
(Also include if observed behavior was viewed as typical or atypical as compared to child’s usual behavior)

E. Child’s level of functioning (identifying strengths and needs) in each of the developmental areas observed/examined. List instruments used, developmental domains addressed, age equivalency and percent of delay (if not completed in 4)

SECTION 6: Summary and Interpretation
A. Diagnostic impression and descriptive summary of developmental status (impact on typical functioning in all domains). Include a statement about child’s eligibility.

B. If applicable, identify:

IFSP Recommendations:

Developmental/Educational/Family Support Recommendations:

Medical Recommendations:

SECTION 7: Signatures

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Discipline</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R07/2022
GUIDANCE AND CONSENT FOR OBSERVATION AND STUDENT PLACEMENT IN EARLY INTERVENTION (EI)

Students in Early Intervention

The Early Intervention (EI) Program values college students and future providers engaging, learning and observing while EI services are being performed with EI families and their children with developmental delays and disabilities.

The EI Program supports the use of students which have been broken down into two categories – Student Observers and Student Interns.

To begin the conversation, the family's ongoing EI-Credentialed/Enrolled Provider or EI-Credentialed Service Coordinator will discuss the possibility and intent of a student observer or a student intern participating in EI services, including the number of weeks/sessions/ or time the student will be involved with the family/child’s services and answer any of the family’s questions.

Student Observers

Student observation may be conducted by an individual that is not yet admitted/registered in a specific Occupational Therapy (OT), Physical Therapy (PT), Speech-Language Pathology Therapy (ST), or Developmental Therapy (DT) program, as well as professionals, such as degrees related to becoming a Service Coordinator, who are considering a career in EI. These individuals are unable to actively participate in EI sessions, but rather may observe EI sessions or IFSP Meetings as they are taking place.

Families who are interested in allowing student observation must:
- sign a written consent prior to any observation, using the suggested consent below,
- be informed that the student observer is not yet admitted/registered in a specific field with the college he or her is enrolled with,
- be ensured that the student observing has signed a confidentiality statement clarifying that the individual will not disclose any Personally Identifiable Information (PII) about the family or the child with the college they are enrolled with, and
- be informed that observation may not occur at any time without the Supervising EI-Credentialed/Provider or the EI-Credentialed Service Coordinator present.

Student observations are limited to one student per session or IFSP Meeting.

The written consent is to be obtained by the Supervising EI-Credentialed/Enrolled Provider and copies provided to the family and the EI-Credentialed Service Coordinator to be placed in the child’s permanent EI record at the CFC office.

Student Interns

Student interns who are currently completing their clinical internship, practicum or field experience (usually in their last year of college) are allowed to actively participate in the delivery of EI services, with written parental consent, as long as a supervisor who is either an EI-Credentialed/Enrolled Provider or EI-Credentialed Service Coordinator is present for all sessions. Additionally, explanation of the intent of the student intern will be explained to the family that their role will be to take on increased responsibilities for leading the EI session with the EI-Credentialed/Enrolled Provider’s or EI-Credentialed Service Coordinator’s supervision.

Prior to the student intern’s involvement, the following activities must occur.

The family will be fully informed by the EI-Credentialed/Enrolled Provider that selected student intern:
- is currently completing his or her clinical internship, practicum or field experience and in which discipline,
• has a signed confidentiality statement on file with his or her enrolled college,
• has proof of liability insurance,
• will be supervised, by the EI-Credentialed/Enrolled Provider or EI-Credentialed Service Coordinator,
• is never to be alone with the family or child,
• has results from a criminal background check on file with his or her college, and
• that a signed written consent is necessary, using the suggested consent below.

The college or university the student intern is enrolled with is responsible for securing contracts with payees/organizations/entities/agencies that serve EI families and ensures student interns are in compliance with signed confidentiality statements, liability insurance, and criminal background checks; a fingerprint-based Illinois criminal history records information check of the student’s criminal history.

All notes and reports of sessions that the student intern participates in must be signed by the student intern and co-signed by the Supervising EI-Credentialed/Enrolled Provider and kept in the child’s file.
PARENTAL CONSENT TO ALLOW STUDENTS TO ATTEND EARLY INTERVENTION (EI) SESSIONS

I understand and agree to a student being assigned to my ongoing EI-Credentialed and Enrolled Provider or EI-Credentialed Service Coordinator to observe sessions and IFSP meetings or actively participate if the student is completing his or her clinical internship, practicum and/or field experience.

I understand that I may consent or decline this request. I also understand that I can revoke this consent, even after first accepting it, without jeopardizing or compromising the EI services being received except to the extent it has already been acted upon.

The assigned student is a: ☐ Student Observer -or - ☐ Student Intern. I understand the responsibilities of the student assigned.

☐ I give my consent to allow the student, ___________________________ to attend Student’s Name
sessions where my child, ___________________________ receives them.
Child’s Name

☐ I do not give my consent.

The student will (list specific responsibilities):
1. 
2. 
3. 
4. 
5. 

Parent’s/Guardian’s Name: ___________________________

Parent’s/Guardian’s Signature ___________________________ Date ___________________________

Student Observer’s Name: ___________________________

Student Observer’s Signature ___________________________ Date ___________________________

Student Intern’s Name: ___________________________

Student Intern’s Signature ___________________________ Date ___________________________

*EI Supervisor’s Name: ___________________________

EI Supervisor’s Signature ___________________________ Date ___________________________

*May be the student’s supervising EI-credentialed and Enrolled Provider or EI-Credentialed Service Coordinator.
CONSENTIMIENTO DE PADRES PARA PERMITIR PARTICIPACIÓN DE ESTUDIANTES EN SESIONES DE INTERVENCION TEMPRANA (EI POR SUS SIGLAS EN INGLÉS)

Entiendo que un estudiante ha sido asignado a mi terapeuta de EI para observar sesiones y/o para completar un pasantía clínica, práctica o experiencia de campo.

Entiendo que puedo dar consentimiento o declinar este pedido. También entiendo que puedo declinar el consentimiento aun después de aceptarlo, sin poner en peligro o comprometer la intervención que estoy recibiendo.

El estudiante asignado es un: ☐ Observador estudiantil -o- ☐ Pasante estudiantil. Entiendo las responsabilidades del estudiante asignado.

☐ Doy mi consentimiento para permitir al estudiante, __________________________ asistir a __________________________ los recibe.

☐ No doy mi consentimiento.

El estudiante lo hará (enumerar responsabilidades específicas):
1. 
2. 
3. 
4. 
5. 

Nombre de los padres/tutores: __________________________

Firma de los padres/tutores Fecha

Nombre del observador estudiantil: __________________________

Firma del observador estudiantil Fecha

Nombre del pasante estudiantil: __________________________

Firma del pasante estudiantil Fecha

*EI Supervisor’s Name: __________________________

Firma del supervisor de EI Fecha

* Puede ser el proveedor supervisado por EI y Enrolled del estudiante o coordinador de servicio con credenciales rojas de EI-C

N07/2022
DEVELOPMENTAL JUSTIFICATION TO CHANGE FREQUENCY, INTENSITY AND/OR LOCATION OF AUTHORIZED SERVICES WORKSHEET AND GUIDANCE

In order to ensure that all Early Intervention (EI) Providers and Service Coordinators are in compliance with 303.421 of Part C of Individuals with Disabilities Education Act (IDEA), are addressing the Principles of Early Intervention and other important policies, rules, regulations and guidelines required, all EI Providers must submit a written Developmental Justification of Need and the EI Provider Developmental Justification to Change Frequency, Intensity and/or Location of Authorized Services Worksheet to the Service Coordinator for any changes that are requested to existing authorizations for the time period between annual Individualized Family Service Plan (IFSP) meetings and changes that are made at the six-month review.

EI Providers who wish to request an increase or decrease, including discontinuation of services, in the frequency, intensity and/or change the location to an existing authorization must submit a written Developmental Justification of Need to the child’s Service Coordinator. As mentioned above, this includes changes that are made at six-month reviews. Upon receipt of a written Developmental Justification of Need that contains all required information found in the following Worksheet, the Service Coordinator will convene an IFSP review meeting. If changes are requested within the first three (3) months after the development of an IFSP, the original multidisciplinary IFSP team must reconvene. The EI Provider who is recommending the change(s) must be in attendance. The team must agree that a change from the original recommendation(s) is needed and is in the best interest of the child/family.

If changes are requested more than three (3) months after the development of an IFSP, the child’s current multidisciplinary IFSP team must participate in the IFSP review meeting. The team must agree that a change from the team’s original recommendation(s) is needed and is in the best interest of the child/family.

The written Developmental Justification of Need must be based upon the Principles of Early Intervention and the policies identified in numbers one (1) through four (4) below. The EI Provider must address all information requested in the following Worksheet. Service Coordinators will return all requests to increase or decrease the frequency, intensity and/or change the location of an existing authorization to EI Providers who fail to include all required information requested in the Worksheet.

Please keep the following policies in mind when developing a written Developmental Justification of Need:

1. EI is covered under Part C of IDEA and is a developmental program. Services are authorized based upon the development of functional outcomes that focus on child development and family training, education, and support and must address a child’s developmental needs rather than a child’s medical needs;

2. At the IFSP team meeting, family-centered functional outcomes must be written prior to the determination of service delivery decisions, which would include frequency, intensity, and duration of authorizations (see definition of functional outcomes within the Illinois Early Intervention Provider Handbook);

3. Functional outcomes must be based upon the Principles of Early Intervention which may be found in Chapter 1: Welcome to Early Intervention of the – Early Intervention Provider Handbook;

4. Part C requires states to provide services in “Natural Environments”. Under Section 303.26 of Part C, Natural Environments is defined as “settings that are natural or typical for a same-aged infant or toddler without a disability.” The Office of Special Education Programs (OSEP) has had a longstanding interpretation of IDEA that EI services must be provided in a natural environment, unless a
written justification exists for providing these services in other settings. Effective July 1, 2005, all Service Coordinators and EI Providers were required to use the Natural Environment Worksheet at the IFSP meeting to justify all services that would not be provided in a child’s most natural learning environment. (See Natural Environments Requirements/Worksheet as defined in the definition section under Natural Environments in the Illinois Early Intervention Provider Handbook). Service Coordinators will not authorize services in a non-natural environment without completing the Natural Environment Worksheet at the IFSP meeting.

At the end of the IFSP review meeting, if the IFSP multidisciplinary team has agreed that a change in the originally recommended frequency, intensity and/or location of the existing authorization(s) is in the best interest of the child/family, the Service Coordinator will complete the following steps:

- Require that all members of the IFSP multidisciplinary team who attended the meeting sign the Developmental Justification to Change Frequency, Intensity and/or Location for Authorized Services form. By signing this form, the EI Provider is acknowledging that he/she participated in the IFSP review meeting and agrees that a change from the originally recommended frequency, intensity and/or location is needed and that the change is in the best interest of the child/family.

- If an EI Provider attends the IFSP review meeting telephonically, the Service Coordinator will print and initial their name by the EI Provider’s name on the form. This will verify that the EI Provider attended the meeting telephonically.

- If a change in location from the natural environment was made, attach the Natural Environment Worksheet that was completed at the IFSP review meeting to the EI Provider Developmental Justification to Change Frequency, Intensity and/or Location for Authorized Services Worksheet at the completion of the meeting.

- Attach the written Developmental Justification of Need that was submitted by the EI Provider who requested the change to the EI Provider Developmental Justification to Change Frequency, Intensity and/or Location for Authorized Services Worksheet at the completion of the IFSP review meeting.

- Discontinue the existing authorization(s) and generate a new authorization(s) that reflects the recommended change(s).
### Section 1: General Information (Required for All Changes)

<table>
<thead>
<tr>
<th>Name and Discipline of Provider Requesting Change</th>
<th>Date of Request</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Child’s Service Coordinator</th>
<th>CFC #</th>
<th>Child’s Name</th>
<th>EI #</th>
</tr>
</thead>
</table>

### Section 2: Current IFSP/Authorization Information (Required for All Changes)

<table>
<thead>
<tr>
<th>IFSP Begin Date</th>
<th>Authorized Frequency</th>
<th>Authorized Intensity</th>
<th>Authorized Location</th>
<th># of Service Sessions Completed by Provider</th>
</tr>
</thead>
</table>

**Functional Outcome That Supports Current Authorization:**

**Current Progress Toward That Outcome:**

### Section 3: Change Requested (Required for All Changes)

<table>
<thead>
<tr>
<th>Increase in Frequency or Intensity</th>
<th>Decrease in Frequency or Intensity</th>
<th>Change in Location</th>
<th>Discharge</th>
</tr>
</thead>
</table>
SECTION 4: WRITTEN DEVELOPMENTAL JUSTIFICATION OF NEED TO CHANGE EXISTING AUTHORIZATION

Providers who are requesting an increase in frequency or intensity or a change of location must address all questions and provide all explanations/documentation requested in this Section. Providers who are requesting a decrease in services or who have found the child age appropriate and are recommending that the child be discharged from services are only required to address the last statement found under Principle #4 in the “Information Required to Justify This Principle” column.

<table>
<thead>
<tr>
<th>Principles of Early Intervention &amp; Definition of Functional Outcomes &amp; Written Home Activity Program</th>
<th>Information Required to Justify This Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Principle #1</strong> - The primary goal of EI is to support families in promoting their child’s optimal development and facilitate the child’s participation in family and community activities.</td>
<td>Explain how the proposed change will increase this family’s knowledge of child development and help to facilitate the child’s participation in this family’s daily routines and community activities.</td>
</tr>
<tr>
<td><strong>Principle #1 Written Justification:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2) Principle #2</strong> - The focus of EI is to encourage the active participation of families in the therapeutic process by imbedding intervention strategies into family routines. It is the parents who provide the real Early Intervention by creatively adapting their child care methods to facilitate the development of their child, while balancing the needs of the rest of their family.</td>
<td>What types of family training, education, and support have you provided to this family to encourage their active participation in their child’s services? What types of developmental strategies have been imbedded into this family’s daily routines?</td>
</tr>
<tr>
<td><strong>Principle #2 Written Justification:</strong></td>
<td></td>
</tr>
<tr>
<td>Principles of Early Intervention &amp; Definition of Functional Outcomes &amp; Written Home Activity Program</td>
<td>Information Required to Justify This Principle</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>3) Principle #3</strong> - EI requires a collaborative relationship between families and providers, with equal participation by all those involved in the process. An on-going parent-professional dialogue is needed to develop, implement, monitor and modify therapeutic activities.</td>
<td>Does this family (parent/caregiver) routinely participate in the therapeutic activities as an equal participant? If so, do they participate hands-on, observation, or both?</td>
</tr>
<tr>
<td></td>
<td>If the family does not actively participate, document the strategies that you have used to encourage active participation. If you have not encouraged active participation in the past, document how you will proceed to work with this family (parent/caregiver) to facilitate participation in all future therapeutic activities.</td>
</tr>
<tr>
<td></td>
<td>Document the type of existing on-going parent/professional dialogue that you have with this family to determine when therapeutic activities/developmental strategies that have been incorporated into this family's daily routines need to be modified.</td>
</tr>
<tr>
<td></td>
<td>If you do not currently have on-going parent/professional dialogue with the family, document how you will proceed to work with this family (parent/caregiver) to develop therapeutic activities/developmental strategies to incorporate into this family's daily routines.</td>
</tr>
</tbody>
</table>

**Principle #3 Written Justification:**
<table>
<thead>
<tr>
<th>Principles of Early Intervention &amp; Definition of Functional Outcomes &amp; Written Home Activity Program</th>
<th>Information Required to Justify This Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4) Principle #4</strong> - Intervention must be linked to specific outcomes that are family-centered, functional and measurable. Intervention strategies should focus on facilitating social interaction, exploration and autonomy. <strong>Definition of Functional Outcomes</strong> – Family centered outcomes that are written by the IFSP team and the family based upon the family’s identified priorities and concerns. Family centered functional outcomes are designed to encourage children to participate in the same types of family and community activities as other children their age. In order for this to occur the IFSP team needs to be aware of the family’s routines and the community activities that the family engages in. This will allow the team to consider daily routines and a variety of natural settings for intervention strategies to be implemented once the outcomes are developed. Family participation is the key to intervention and families are more likely to participate when the outcomes are meaningful to them and can be worked on throughout their everyday routines and activities. Functional Outcomes should be written to address areas of family concern rather than focusing on specific professional disciplines or therapies. The outcome must be related to a necessary skill and should state a process and a product. Functional outcomes are developed at the child’s IFSP meeting. <strong>Family centered functional outcomes drive the decision-making process to determine what EI services a child and family will receive. Service delivery decisions are not based on a child’s medical diagnosis or percentage of delay, but rather on the child and family’s unique strengths, needs, concerns and priorities that led to the development of each individualized family centered outcome. All outcomes must be functional and meaningful to the child and family. Family centered functional outcomes must be written prior to the determination of service delivery decisions, which would include disciplines to provide services and frequency, intensity, and duration of services identified on authorizations. All recommendations for services must be based upon the Principles of Early Intervention.</strong></td>
<td></td>
</tr>
<tr>
<td>Based upon the Principles of Early Intervention and the definition of Functional Outcomes, are the current functional outcome/intervention services considered to be family-centered and do they focus on facilitating social interaction, exploration and autonomy for the child/family? If so, has the current outcome been met? If the current outcome has been met, or is not in compliance with the definition of “Functional Outcomes,” would it be more appropriate to develop a new functional outcome rather than to increase the frequency/intensity of services or to change the location of services? If it is determined that a new functional outcome would not be more appropriate, please explain why an increase in frequency or intensity or a change in location of services would be more appropriate. If this request is to decrease services or discharge the child, please document the progress that this child has made and why intervention services should be decreased or why services are no longer required.</td>
<td></td>
</tr>
<tr>
<td>Principles of Early Intervention &amp; Definition of Functional Outcomes &amp; Written Home Activity Program</td>
<td>Information Required to Justify This Principle</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Principle #4 Written Justification:</td>
<td></td>
</tr>
</tbody>
</table>

5) **Principle #5** - Intervention shall be integrated into a comprehensive plan that encourages transdisciplinary activities and avoids unnecessary duplication of services. The plan shall be built around family routines, with written home activity programs to encourage family participation in therapeutic activities on a daily basis.

**Definition of Written Home Activity Program** - A written home activity program is a document that is written in the home or other place of service, with the input of the parent/caregiver during a direct service session. It should identify developmental strategies to meet functional outcomes that are important to the family and that support the family in developing or refining their ability to facilitate their child’s active involvement in his or her community and family. This document should be shared with all members of the IFSP service team and the parent/caregiver. Time to create a written home activity program with the parent/caregiver is considered to be family training, education, and support time that is billable as direct service time only.

| | Will the proposed increase in frequency or intensity or change in location be a duplication of services that the child is currently receiving? |
| | Is there an existing home activity program in place that you developed with the parent/caregiver? |
| | If so, was the existing program built around family routines and does it encourage family participation in therapeutic activities on a daily basis? |
| | Have the family and other members of the child’s IFSP team implemented that program? |
| | Would a change to the existing home activity program be more appropriate rather than an increase in frequency/intensity or change in location? |
| | If an increase in frequency/intensity or a change in location is still required, explain how the recommended increase or change will impact/change the existing home activity program that is currently in place. |

| Principle #5 Written Justification: | 

6) **Principle #6** - Intervention should be monitored periodically to assure that the strategies implemented are successful in achieving outcomes.

| | Explain how you will work with this family/caregiver to monitor and make changes to the “written home activity program” when needed. |
| **NOTE:** | Please refer back to Principle #3. |

| Principle #6 Written Justification: |
Sample Individualized Family Service Plan (IFSP)
*In English and Spanish

STATE OF ILLINOIS
CORNERSTONE
EARLY INTERVENTION SERVICE PLAN

Child's Name: ____________________________ Date of Birth: ________ EI #: ________ Part I.D. #: ________

Street: ________________________________ City, State, Zip: __________________________ Phone #: __________________________

Primary Contact: _______________________ Relationship: __________ Primary Language Spoken: ________________________

Service Coordinator: ____________________ Telephone #: __________________________ FAX #: __________________________

CFC: _________________________________ CFC Phone #: __________________________ IFSP Begin: ________ IFSP End: ________

EI Cover Page

Date Prepared:

PROVIDER INFORMATION AND OTHER HELPFUL RESOURCES (EI providers, doctors, family/friends, daycare providers, L/C contacts, etc.)

ROLE ________________________ NAME ________________________ ADDRESS ________________________ PHONE/FAX ________________________

School District/LEA Rep.: 

Primary Care Physician: 

Parent Liaison: 

Local Interagency Council Coor.: 

DCFS Caseworker (If applicable) 

IFSP TABLE OF CONTENTS

Required Sections: Attach if Completed:

[ ] Present Levels of Development [ ] Family Considerations for the IFSP
[ ] Child and Family Outcomes [ ] Transition Planning Worksheet(s)

Notice to Receiving Agency/Person: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the No Child Left Behind Act of 2001, information collected hereunder cannot be disclosed unless the person who promoted to this disclosure specifically consents to such disclosure or the...
STATE OF ILLINOIS
CORNERSTONE
EARLY INTERVENTION SERVICE PLAN

Child's Name: ___________________________ Date of Birth: _______ EI #: _____ Part I.D.#: ____

EI Cover Page Date Prepared:

[ ] Part C EI Service Authorizations [ ] Other ____________________________
[ ] Transition Plan [ ] Other ____________________________
[ ] IFSP Implementation and Distribution Authorization

ELIGIBILITY DETERMINED:
PRIMARY DIAGNOSIS:

CONFIDENTIAL MATERIAL
CURRENT STATUS OF FUNCTIONING/LEVELS OF DEVELOPMENT

Visit date: 

Document the child's percent of delay and/or age equivalent in months and provide a narrative description of the child's level of functioning, including the child and family's strengths, resources, priorities and concerns.

1. What are the family's strengths, resources, priorities and concerns related to enhancing the overall development of their child? (Review the ASQ-SE and the routines and daily activities discussed during the intake interview)

2. Overall Health and Medical Information (Including a statement regarding Hearing and Vision Status)

3. Adaptive Development

4. Cognitive Development

5. Communication Development (Total)
   - Expressive Communication
   - Receptive Communication

6. Motor Development (Total)
   - Fine Motor
   - Gross Motor

7. Social/Emotional Development
**SECTION 1: FAMILY CONSIDERATIONS**

1. **How would you describe your child?**
   - The following would be helpful in the weeks or months ahead:
     - Meeting other families whose child has similar needs
     - Finding or working with doctors or other specialists
     - Coordinating your child's medical care
     - Finding out more about the services your family is receiving or could be receiving
     - Finding new places to go in my community
     - Planning for the future
     - Transportation
     - Child Care
     - Finding someone to help out in my home (respite)
     - Housing, clothing, jobs, food, telephone
     - Safety
     - Finding a support group
     - Support/information for brothers, sisters, friends, relatives and/or others
     - Information about my child's needs
     - Help with insurance, SSI, Medicaid, Kid Care and/or DSCC
     - Recreation - fun things to do as a family
     - Other:

2. **What are some great things about your family?**

3. **What are some things you find challenging or difficult?**

4. **Is there anything else you think would be helpful for others to know about your child or your family?**

---

**Describe a typical day for your child and/or family:**

- **Morning:**
- **Lunchtime:**
- **Afternoon:**
- **Dinnertime:**
- **Evening:**
- **Bedtime:**

**I'm concerned about and/or interested in my child's:**
- Moving, crawling and/or walking
- Communicating
- Learning
- Feeding, nutrition
- Having fun with other kids
- Challenging behaviors or emotions
- Sleep patterns
- Equipment or supplies
- Health or dental care
- Pain or discomfort
- Vision or discomfort
- Other:

---

I understand that provision of this information on this page is voluntary and if I provide this information, it will be shared with the service plan team members and others indicated in this plan.

- [ ] I agree to provide this information
- [ ] I do not agree to provide this information

Signature: ___________________________ Date: ____________
CHILD OUTCOMES SUMMARY

The overall goal of Early Intervention supports and services is for children to be able to successfully participate in their family and their community. To that end, progress toward the following child outcomes is being measured.

8. Positive Socio-Emotional Skills (Including Social Relationships)
   Children who achieve this outcome show a variety of behaviors related to making and maintaining positive social relationships in age-appropriate ways. For example, they:
   * Demonstrate attachment with the significant caregivers in their lives.
   * Initiate and maintain social relationships with children and adults.
   * Behave in a way that allows them to participate in a variety of settings and situations.
   * Demonstrate trust in others.
   * Regulate sensory and emotional experiences.
   * Understand and follow rules.
   * Solve social problems.

A. To what extent does this child show behavior and skills related to this outcome appropriate for his or her age across a variety of settings and situations?

<table>
<thead>
<tr>
<th>COMPLETELY</th>
<th>Between SOMETHING and COMPLETELY</th>
<th>SOMETHAT</th>
<th>Between EMERGING and SOMETHAT</th>
<th>EMERGING</th>
<th>Between NOT YET and EMERGING</th>
<th>NOT YET</th>
<th>RATING</th>
</tr>
</thead>
</table>

B. Has the child shown any new skills or behaviors related to this outcome since the last outcome summary?

9. Acquiring and Using Knowledge and Skills
   Children who achieve this outcome show a variety of behaviors related to acquiring and using knowledge and skills across a variety of everyday routines and activities. For example, they:
   * Explore their environment.
   * Engage in daily learning opportunities through manipulating toys and other objects in an appropriate manner.
   * Use vocabulary through speaking, sign language or augmentative communication devices to communicate in an increasingly complex form.
   * Show imagination and creativity in play.
   * Obtain and maintain attention.
Child's Name: __________________________  Date of Birth: ___________  EI #: ___________  Part I.D. #: ___________

**CURRENT STATUS OF FUNCTIONING/LEVELS OF DEVELOPMENT**  
Visit date: ___________

A. To what extent does this child show behavior and skills related to this outcome appropriate for his or her age across a variety of settings and situations?

<table>
<thead>
<tr>
<th>COMPLETELY</th>
<th>Between SOMEWHAT and COMPLETELY</th>
<th>SOMEWHAT</th>
<th>Between EMERGING and SOMEWHAT</th>
<th>EMERGING</th>
<th>Between NOT YET and EMERGING</th>
<th>NOT YET</th>
<th>RATING</th>
</tr>
</thead>
</table>

B. Has the child shown any new skills or behaviors related to this outcome since the last outcome summary?

10. **Taking Appropriate Action to Meet Needs**

Children who take appropriate action to meet their needs show a variety of behaviors related to this outcome. For example, they:

* Use gestures, sounds, words, signs or other means to communicate wants and needs.
* Meet their self care needs (feeding, dressing, etc.) so they can participate in everyday routines and activities.
* Use objects as tools in appropriate ways (for example, forks, sticks, pencils, crayons, switches).
* Move from place to place to participate in everyday activities, play and routines.
* Seek help when necessary to move from place to place or to assist with basic care or other needs.
* Follow rules related to health and safety.

A. To what extent does this child show behavior and skills related to this outcome appropriate for his or her age across a variety of settings and situations?

<table>
<thead>
<tr>
<th>COMPLETELY</th>
<th>Between SOMEWHAT and COMPLETELY</th>
<th>SOMEWHAT</th>
<th>Between EMERGING and SOMEWHAT</th>
<th>EMERGING</th>
<th>Between NOT YET and EMERGING</th>
<th>NOT YET</th>
<th>RATING</th>
</tr>
</thead>
</table>

B. Has the child shown any new skills or behaviors related to this outcome since the last outcome summary?

**SOURCE OF INFORMATION**

**ASSESSMENT INSTRUMENT, IF APPLICABLE**

DATE

FORMAL ASSESSMENT INSTRUMENT

OBSERVATION
### Child's Name: [ ]
### EI #: [ ]
### Date: [ ]

#### SECTION 3: IFSP FUNCTIONAL OUTCOME #: [ ]
(May be used as an Annual goal statement for Part B Preschool Services.)

Develop one outcome per page. Assign outcome # to identify each page individually. Each outcome may have several services, strategies and/or activities designed to facilitate the achievement of the outcome.

#### *** Family Priorities (Concerns):***

What do we want for [___________] and our family? (What does the family want and why?)

<table>
<thead>
<tr>
<th>How will we achieve this outcome? (List strategies and/or activities designed to facilitate the achievement of this outcome and/or steps to be taken to link us to services and/or secure funding for services if not required to be provided by the Part C Early Intervention System)</th>
<th>What Early Intervention and/or other services and supports would help us with this?</th>
<th>Fund Source</th>
<th>Upon review, how are we doing? Has our outcome been achieved? Should our outcome, strategies, activities and/or services change? If so, how? Written parental consent required to change any services.</th>
</tr>
</thead>
</table>

#### FOR EARLY INTERVENTION PARTICIPANTS ONLY:

The primary setting for young children is within the context of the family, their home, their community, lifestyle and daily activities, routines, and obligations. To the extent appropriate, services must be provided in the types of settings in which young children without and their families would participate. Are all Part C EI services needed to achieve this outcome being provided in natural environments? ☐ Yes ☐ No

If no, justify the extent to which any services will not be provided in natural environments:

Outcomes include strategies with an educational component that facilitate school readiness and incorporates pre-literacy, language, and numeracy skills where appropriate: ☐ Yes ☐ No

**Note regarding Fund Source:** All Part C Early Intervention Services must be pre-authorized. For all other services identified as needed but not required to be provided by the Part C Early Intervention System, indicate the fund Source (i.e. Medicaid, DSCC, private insurance) which is either responsible for payment or from which payment is being sought.

R04/2022
**SECTION 6: TRANSITION OUTCOME:** Individualized Family Service Plan (IFSP) Team meetings must be held not fewer than 90 days and, at the discretion of all parties, not more than nine (9) months before the child's third birthday to develop/update a transition outcome. No later than six (6) months prior to the child's third birthday, the CFC Service Coordinator will begin communication with the child's family about transition.

What do we want for ______________________ and our family?

**Family Considerations:**

- Do you have questions on transition?
- Would you like to tour a preschool classroom?
- Do you understand parental rights and responsibilities regarding transition?
- Do you have concerns or questions about leaving Early Intervention?

- Would you like to talk to other parents about transition?
- Is there anything else that would make transition easier for you?
- What additional knowledge and skills does your child need to prepare them to be active participants in their home, school, and community?

If your child is not or may not be eligible under Part B Early Childhood Special Education, where will your child be, and do you want other options for community programs?

<table>
<thead>
<tr>
<th>Family Needs/Priorities for Transition</th>
<th>Comments/Strategies</th>
<th>Who will help you?</th>
<th>Date Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TRANSITION ACTIVITIES REQUIRED PRIOR TO THIRD BIRTHDAY**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explored Local Education Agency (LEA) and/or community program options with family</td>
<td></td>
</tr>
<tr>
<td>2. Discussed options for referral to the Part B system with family, if applicable</td>
<td></td>
</tr>
<tr>
<td>3. Discussed parental rights and responsibilities under Part B with family</td>
<td></td>
</tr>
<tr>
<td>4. Family Consented to Referral to LEA: ☐ Yes ☐ No If no, why no:</td>
<td></td>
</tr>
<tr>
<td>5. Identified and implemented steps to assist the family in evaluating eligible programs and services</td>
<td></td>
</tr>
<tr>
<td>6. Sent specific information, including evaluation and assessment information and copy of the current IFSP, to the LEA and/or other community programs with informed, written parental consent</td>
<td></td>
</tr>
<tr>
<td>7. Family Accepted TPC: ☐ Yes ☐ No If no, why not:</td>
<td></td>
</tr>
<tr>
<td>8. Revisited TPC option with family, reviewed important deadlines, family accepted ☐ Yes ☐ No If no, why not:</td>
<td></td>
</tr>
<tr>
<td>9. Convened a Transition Planning Conference with, at a minimum, the CFC Service Coordinator, a representative(s) from the LEA, and the family not fewer than 90 days and, at the discretion of all parties, not more than nine (9) months before the child's third birthday to discuss any services the toddler may receive under the Part B system</td>
<td></td>
</tr>
<tr>
<td>10. Child is eligible for EI/ES option: ☐ Yes ☐ No If eligible, Functional Outcomes regarding School Readiness identified: ☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

**Comments regarding Transition Activities/Progress:**
**SECTION 7. IMPLEMENTATION AND DISTRIBUTION AUTHORIZATION**

The purpose of the required "Implementation and Distribution Authorization" signature page is: 1) to certify that the family consents to the Early Intervention (EI) services outlined in the IFSP implementation and 2) to indicate who may view or receive copies of the IFSP and who the family consents may exchange verbal/written information about the eligible child.

### FOR EARLY INTERVENTION (EI) PARTICIPANTS ONLY

- The contents of the IFSP have been fully explained to me and if I agree to the services, I understand they must be provided.
- I understand that I may refuse any or all of the services offered by the Part C EI Program but that if I do, my child may not receive those services through the Part C EI Program.
- I also understand that I may request dispute resolution regarding the services offered and receive the undisputed services while the dispute is being resolved, or if I already have an IFSP, continue to receive the services currently being provided, while the dispute is being resolved.
- I understand and agree that individual EI Provider changes may occur during the course of services, which do not require additional written consent on this page if the service type, frequency, duration, and location are maintained.
- I understand that a new signed *Child and Family Connections Consent for Release of Information* will be required for any EI providers not listed below by name/discipline, prior to services beginning and in order to receive a copy of the IFSP.
- In order to implement delivery of EI services, I understand that this IFSP will be distributed to EI Providers listed below.
- I consent to the verbal and written exchange of information between members of my child’s IFSP Team.
- I understand that this IFSP must be reviewed every six (6) months, or more often if necessary.
- Finally, I understand that the Illinois Department of Human Services, as lead agency for the Part C EI Program, may refuse reimbursement for services not required to be funded by the Part C EI Program and is payor of last resort for all services required to be funded by the Part C EI Program. I hereby waive further notice regarding the EI services agreed to.

☐ I hereby consent to all EI services herein.
☐ I hereby consent to all EI services herein, except:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Address</th>
<th>Phone #</th>
</tr>
</thead>
</table>

☐ I hereby refuse all EI services offered herein.

I consent to the following individuals/agencies to receive a copy of this IFSP, and any revisions made to it.

Parent or Caregiver Parent Signature: ___________________________ Date: __________

Other Signature: ___________________________ Relationship: ___________________________ Date: __________
### SECTION 8. MEETING PARTICIPANT/CONTRIBUTOR LIST

<table>
<thead>
<tr>
<th>Initial Service Plan Meeting</th>
<th>Service Plan Review Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Role</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service Plan Review Meeting**
- 6 Month
- Annual
- Other

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Participated/Contributed</th>
<th>Name</th>
<th>Role</th>
<th>Participated/Contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service Plan Review Meeting**
- 6 Month
- Annual
- Other

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Participated/Contributed</th>
<th>Name</th>
<th>Role</th>
<th>Participated/Contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**ESTADO DE ILLINOIS**  
CORNERSTONE  
PLAN DE SERVICIO DE INTERVENCIÓN TEMPRANA

<table>
<thead>
<tr>
<th>RESIDENCIA:</th>
<th>CONTACTO:</th>
<th>PARENTESCO:</th>
<th>TELÉFONO:</th>
</tr>
</thead>
</table>

**Fecha de inicio de autorización:**  
**Fecha final:**  
**Tipo de autorización:**  
**Método:**  
**Procedimiento:**  
**Frecuencia:**  
**Nº de autorización:**  
**Fecha:**  
**Fecha de estado:**  
**Seguro privado:**  
**Comentarios:**

<table>
<thead>
<tr>
<th>FECHA DE INICIO DE AUTORIZACIÓN:</th>
<th>Fecha final:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFICIARIO AUTORIZADO:</td>
<td>TELÉFONO:</td>
</tr>
<tr>
<td>TIPO DE AUTORIZACIÓN:</td>
<td>SERVICIO:</td>
</tr>
<tr>
<td>MÉTODO:</td>
<td>LUGAR DEL SERVICIO:</td>
</tr>
<tr>
<td>PROCEDIMIENTO:</td>
<td></td>
</tr>
<tr>
<td>FRECUENCIA:</td>
<td>POR MES: PARA:</td>
</tr>
<tr>
<td>Nº DE AUTORIZACIÓN:</td>
<td>FECHA: FECHA DE ESTADO:</td>
</tr>
<tr>
<td>SEGURO PRIVADO:</td>
<td></td>
</tr>
<tr>
<td>COMENTARIOS:</td>
<td></td>
</tr>
</tbody>
</table>

R04/2022
Nombre del niño(a):          Fecha de nacimiento:          Nº de EI:          Fecha de preparación:
Domicilio:          Ciudad, estado, código postal:          Nº de teléfono:          Inicio del IFSP:
Contacto primario:          Parentesco:          Idioma primario:          Fin del IFSP:
Coordinador(a) de servicio:          Nº de teléfono:          Nº de fax:
CFC:          Nº de teléfono del CFC:          Inicio del IFSP:

INFORMACIÓN SOBRE EL PROVEEDOR Y OTROS RECURSOS ÚTILES (proveedores de EI, doctores, familia/amigos, guarderías, contactos de LIC, etc.)

PAPEL QUE DESEMPEÑA---NOMBRE---DOMICILIO---

Distrito escolar/Rep. de LEA:
Médico principal:
Padre enlace:
Coordinador(a) de LIC:
Trabajador de DCFS (si pertinente):
Terapeutas:

Notificación para agencia/persona receptora: Bajo provisiones de la ley de Confidencialidad de Salud Mental y Discapacidades del Desarrollo de Illinois, la ley de Derechos Educacionales de la Familia y Privacidad, 20 USC 1232g y la ley de Portabilidad y Responsabilidad de 1996, la información recogida a continuación no puede ser re-divulgada a menos que la persona que dio el consentimiento original, vuelva a dar consentimiento un específico para su re-divulgación.
**DETERMINACIÓN DE ELEGIBILIDAD:**
**DIAGNÓSTICO PRIMARIO:**

<table>
<thead>
<tr>
<th>Secciones obligatorias</th>
<th>Adjunte si fueron completadas</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Niveles actuales de desarrollo</td>
<td>□ Consideraciones familiares para el IFSP</td>
</tr>
<tr>
<td>□ Resultados infantiles y familiares</td>
<td>□ Hojas de planeamiento para transición</td>
</tr>
<tr>
<td>□ Autorizaciones de servicio de Part C</td>
<td>□ Otro</td>
</tr>
<tr>
<td>□ Plan de transición</td>
<td>□ Otro</td>
</tr>
<tr>
<td>□ Implementación del IFSP y autorización para su distribución</td>
<td></td>
</tr>
</tbody>
</table>

**MATERIAL CONFIDENCIAL**
CORNERSTONE
PLAN DE SERVICIO DE INTERVENCIÓN TEMPRANA

Nombre del niño(a):              Fecha de nacimiento:           Nº de EI:

ESTADO DEL FUNCIONAMIENTO/NIVELES DE DESARROLLO ACTUALES
Fecha de la visita:

Documente el porcentaje de retraso y/o la edad equivalente del niño en meses, y ofrezca una descripción de los niveles de funcionamiento del niño, incluyendo las fortalezas, recursos, prioridades y preocupaciones del niño y familia.

1. ¿Cuáles son las fortalezas, recursos, prioridades y preocupaciones de la familia relacionadas a mejorar el desarrollo del niño? (Revise el ASQ-SE y las rutinas y actividades diarias discutidas durante la entrevista de admisión)

2. Información global de salud y médica (incluyendo una declaración sobre el estado de la visión y la audición)

3. Desarrollo de adaptabilidad
   Retraso               Edad equivalente

4. Desarrollo cognitivo
   Retraso               Edad equivalente

5. Desarrollo de la comunicación (total)
   a. Comunicación expresiva
      Retraso               Edad equivalente
   b. Comunicación receptiva
      Retraso               Edad equivalente

6. Desarrollo motriz (total)
   a. Motricidad fina
      Retraso               Edad equivalente
   b. Motricidad gruesa
      Retraso               Edad equivalente

7. Desarrollo social/emocional
   Retraso               Edad equivalente
EVALUACIÓN DE RESULTADOS INFANTILES

El objetivo global de los apoyos y servicios de Intervención Temprana es que los niños puedan exitosamente participar en su familia y en su comunidad. A tal fin, se mide el progreso hacia los siguientes resultados infantiles:

8. Habilidades socio emocionales positivas (incluyen relaciones sociales)

Los niños que logran este resultado muestran una variedad de conductas relacionadas a hacer y mantener relaciones sociales positivas de maneras apropiadas para la edad. Por ejemplo, ellos:

- Demuestran apego con cuidadores importantes en su vida
- Inician y mantienen relaciones sociales con niños y adultos
- Se comportan de maneras que les permiten participar en una variedad de lugares y situaciones
- Demuestran confianza en otros
- Regulan experiencias sensoriales y emocionales
- Comprenden y siguen reglas
- Resuelven problemas sociales

A. ¿Hasta qué punto muestra el niño un comportamiento y habilidades relacionadas a este resultado apropiado para su edad en una variedad de lugares y situaciones?

<table>
<thead>
<tr>
<th>COMPLETAMENTE</th>
<th>Entre UN POCO y COMPLETAMENTE</th>
<th>UN POCO</th>
<th>Entre EMERGENTE y UN POCO</th>
<th>EMERGENTE</th>
<th>Entre NO AUN y EMERGENTE</th>
<th>NO AUN</th>
<th>CLASIFICACIÓN</th>
</tr>
</thead>
</table>

B. ¿Ha mostrado el niño nuevas habilidades o conductas relacionadas a este resultado desde el último resumen de resultados?

9. Adquisición y uso de conocimiento y habilidades

Los niños que logran este resultado muestran una variedad de conductas relacionadas a la adquisición y uso de conocimiento y habilidades en una variedad de rutinas y actividades cotidianas. Por ejemplo, ellos:

- Exploran su ambiente
- Se involucran en oportunidades de aprendizaje diarias a través de la manipulación de juguetes y otros objetos de manera apropiada
- Usan vocabulario por medio de habla, lenguaje de signos o aparatos de comunicación aumentativa para comunicarse en formas cada vez más complejas
- Muestran imaginación y creatividad en el juego
- Obtienen y mantienen la atención

A. ¿Hasta qué punto muestra el niño un comportamiento y habilidades relacionadas a este resultado apropiado para su edad en una variedad de lugares y situaciones?
### Uso de acción apropiada para satisfacer necesidades

Los niños que usan acciones apropiadas para satisfacer necesidades muestran una variedad de conductas relacionadas a este resultado. Por ejemplo, ellos:

- Usan gestos, sonidos, palabras, signos u otros medios para comunicar sus deseos y necesidades
- Satisfacen sus necesidades de cuidado personal (comer, vestirse, etc.) para poder participar en rutinas y actividades cotidianas
- Usan objetos como herramientas en formas apropiadas (por ej., tenedores, palitos, lápices, crayones, interruptores)
- Se mueven de un lugar a otro para participar en actividades, juego y rutinas cotidianas
- Buscan ayuda cuando es necesario para moverse de un lugar a otro o con necesidades de cuidado básico u otras necesidades
- Cumplen con las reglas relacionadas a la salud y seguridad

### A. ¿Hasta qué punto muestra el niño un comportamiento y habilidades relacionadas a este resultado apropiado para su edad en una variedad de lugares y situaciones?

<table>
<thead>
<tr>
<th>COMPLETAMENTE</th>
<th>Entre UN POCO y COMPLETAMENTE</th>
<th>UN POCO</th>
<th>Entre EMERGENTE y UN POCO</th>
<th>EMERGENTE</th>
<th>Entre NO AUN y EMERGENTE</th>
<th>NO AUN</th>
<th>CLASIFICACIÓN</th>
</tr>
</thead>
</table>

### B. ¿Ha mostrado el niño nuevas habilidades o conductas relacionadas a este resultado desde el último resumen de resultados?

**Nombre del niño(a):**

**Nº de EI:**

**Fecha:**

**R04/2022**
### SECCIÓN 1: CONSIDERACIONES FAMILIARES (Opcional)

1. **¿Cómo describiría a su hijo(a)?**
   - Lo siguiente, sería útil en las semanas o meses venideros:
     - Conocer a otras familias de niños(as) con necesidades similares
     - Encontrar o trabajar con doctores u otros especialistas
     - Coordinar el cuidado médico de su niño(a)
     - Averiguar más sobre servicios que su familia recibe o podría recibir
     - Encontrar nuevos lugares para ir/visitar en la comunidad
     - Planear para el futuro
     - Transporte
     - Cuidado infantil (guardería)
     - Encontrar a alguien que ayude en su casa (**“respite”** en inglés)
     - Vivienda, ropa, trabajo, alimentos, teléfono
     - Seguridad
     - Encontrar un grupo de apoyo
     - Apoyo/información para hermanos(as), amigos, parientes y/u otros
     - Información acerca de las necesidades de su hijo(a)
     - Ayuda con el seguro, SSI, Medicaid, Kidcare y/o DSCC
     - Recreación – cosas divertidas para hacer en familia
   - Otros:

2. **¿Cuáles son algunas de las cosas estupendas sobre su familia?**

3. **¿Cuáles son algunas de las cosas que encuentra desafiantes o difíciles?**

4. **¿Hay algo más que Ud. cree deberían otros saber sobre su niño(a) o familia?**

 Describa un día típico para su niño(a) y/o familia:

**Mañana:**

**Almuerzo (lonche):**

**Tarde:**

**Cena:**

**Noche:**

**Hora de irse a la cama:**

Entiendo que el suministro de la información de esta página es voluntario y que si la doy, será compartida con miembros del equipo del plan de servicios y otros indicados en este plan.

- [ ] Doy mi consentimiento para suministrar esta información
- [ ] No doy mi consentimiento para suministrar esta información

Firma: ______________________ Fecha: ____________

---

**Estoy preocupado(a) y/o interesado(a) en que mi hijo(a):**

- [ ] Se mueve, gatee o camine
- [ ] Se comunique
- [ ] Aprenda
- [ ] Se alimente, nutrición
- [ ] Se divierta con otros niños(as)
- [ ] Comportamientos desafiantes o emociones
- [ ] Patrones de dormir
- [ ] Equipos o materiales
- [ ] Cuidado de salud o dental
- [ ] Dolor o incomodidad
- [ ] Visión o audición
- [ ] Otros:
**SECCIÓN 3: RESULTADO FUNCIONAL Nº:** ________________
(Puede usarse como declaración del objetivo anual para servicios preescolares de Part B)

Desarrolle un resultado por página. Asigne el Nº de resultado para identificar cada página individualmente. Cada resultado puede tener varios servicios, estrategias y/o actividades designadas para facilitar el logro del resultado.

*** Prioridades familiares (Preocupaciones) ______

¿Qué queremos para _____ y nuestra familia? (¿Qué desea la familia y por qué?)

¿Cómo lograremos este resultado? (Liste las estrategias y/o actividades diseñadas para facilitar el logro de este resultado y/o los pasos a tomar para conectar a servicios y/o para asegurar fondos para los servicios que no requieren ser financiados por el Sistema de Intervención Temprana Part C)

¿Qué ayuda podría ofrecer Intervención Temprana y/u otros servicios y respaldos?

Fuente de financiamiento

Analizando ahora, ¿cómo nos está yendo? ¿Logramos el resultado? ¿Deberemos cambiar el resultado, estrategias, actividades y/o servicios? Si creemos que sí, ¿cómo? Es necesario el consentimiento escrito de los padres para el cambio de servicios.

SOLO PARA PARTICIPANTES DE INTERVENCIÓN TEMPRANA: El ambiente principal para niños(as) pequeños(as) es dentro del contexto familiar, hogar, comunidad, estilo de vida y actividades, rutinas y obligaciones diarias. En la medida posible, los servicios deben ofrecerse en ambientes donde otros niños(as) pequeños(as) sin discapacidades y sus familias podrían participar. ¿Son todos los servicios de Part C necesarios para lograr este resultado, ofrecidos en ambientes naturales?  ☐ Si  ☐ No
Si la respuesta es negativa, justifique el grado en que alguno de los servicios no será ofrecido en ambientes naturales:

Los resultados incluyen estrategias con un componente educativo que facilitan la preparación escolar e incorporan habilidades de prealfabetización, lenguaje y aritmética cuando sea apropiado:  ☐ Si  ☐ No

Nota sobre la fuente de financiamiento: Todos los servicios de intervención temprana Part C deben estar pre-autorizados. Indique la fuente de financiamiento (por ej., Medicaid, DSCC, seguro privado) responsable por el pago o de quien se solicita pago para los otros servicios identificados como necesarios pero que no requieren ser financiados por el Sistema de Intervención Temprana Part C.
Nombre del niño(a):  
Nº de EI:  
Fecha:  

**SECCIÓN 7. AUTORIZACIÓN PARA IMPLEMENTACIÓN Y DISTRIBUCIÓN**  
Necesario para la implementación de servicios

*El propósito de esta página de firmas obligatoria, “Autorización para Implementación y Distribución”, es para: 1) certificar que la familia da consentimiento para los servicios de Intervención Temprana listados en el plan de implementación IFSP y 2) indicar quien puede ver o recibir copias del plan IFSP, y quien tiene consentimiento familiar para intercambiar información verbal/escrita acerca del niño elegible.*

**SOLO PARA PARTICIPANTES DE INTERVENCIÓN TEMPRANA (EI)**

- El contenido de este IFSP me ha sido explicado en su totalidad y si doy consentimiento para los servicios, entiendo que deben ser provistos.
- Entiendo que puedo rehusar alguno o todos los servicios ofrecidos por el Programa Parte C pero si lo hago, mi hijo puede no recibir estos servicios del programa de intervención temprana.
- También entiendo que puedo solicitar la resolución de disputas para los servicios ofrecidos y recibir los servicios que no están siendo cuestionados mientras se resuelve la disputa o, si ya tengo un IFSP, continuar recibiendo los servicios ofrecidos mientras se resuelve la disputa.
- Entiendo y estoy de acuerdo que puede haber cambios con el EI Proveedor individual de servicios de EI durante el curso de los servicios y que no se requiere mi consentimiento escrito siempre que el tipo, frecuencia, duración y lugar de los servicios si se mantengan igual.
- Entiendo que un nuevo firmado Niño y Conexiones Familiares Consentimiento Para La Divulgación De Información será necesario para cualquier proveedor de EI no enumerado a continuación por su nombre / área de especialización antes del inicio de los servicios y con el fin de recibir una copia del IFSP.
- Para implementar la entrega de servicios de EI, entiendo que este IFSP sea distribuido a proveedores de servicios de EI enumerados a continuación.
- Doy consentimiento para el intercambio escrito y verbal de información entre miembros del equipo IFSP de mi hijo.
- Entiendo que este IFSP debe ser revisado cada seis (6) meses o más seguido si es necesario.
- Finalmente, entiendo que el Departamento de Servicios Humanos de Illinois, la agencia que lidera el Programa de la Parte C, puede rehusar el reembolso de servicios no requeridos por el programa EI, y es el pagador de última instancia de servicios requeridos a ser pagados por La Parte C. Por la presente, renuncio a futuros avisos referidos a los servicios de EI acordados.

☐ Doy mi consentimiento para todos los servicios de EI descriptos en este documento.
☐ Doy mi consentimiento para todos los servicios de EI descriptos en este documento, excepto:

________________________________________________________________________

☐ Rehúso los servicios de intervención temprana ofrecidos en este documento.

Doy mi consentimiento para que las siguientes personas/agencias reciban una copia de este plan de servicios y correcciones hechas al mismo.

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Papel</th>
<th>Domicilio</th>
<th>Nº de teléfono</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Firma del padre, madre o padre sustituto: ____________________________ Fecha: ____________________________
Otra Firma: ____________________________ Parentesco: ____________________________ Fecha: ____________________________
<table>
<thead>
<tr>
<th>Nombre</th>
<th>Papel</th>
<th>Participó/Contribuyó</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reunión para revisar plan de servicios inicial:
- 6 meses
- Anual
- Otro

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Papel</th>
<th>Participó/Contribuyó</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reunión para revisar plan:
- 6 meses
- Anual
- Otro

<table>
<thead>
<tr>
<th>Nombre</th>
<th>Papel</th>
<th>Participó/Contribuyó</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**NATURAL ENVIRONMENTS REQUIREMENT**

Part C of the Individuals with Disabilities Education Act (IDEA) requires that EI services be provided in “Natural Environments”. Section 303.26 of Part C defines Natural Environments as “settings that are natural or typical for a same aged infant or toddler without a disability”. Therefore, the provision of EI in natural environments is not just a guiding principle but is also required by Federal law.

In 2004 IDEA was amended to include changes to the following statement: “The provision of early intervention services for any infant or toddler with a disability occurs in a setting other than a natural environment that is most appropriate, as determined by the parent and the individualized family service plan team, only when EI cannot be achieved satisfactorily for the infant or toddler in a natural environment”. In addition, the federal Office for Special Education Programs (OSEP) has had a longstanding interpretation of the IDEA that EI services must be provided in a natural environment, unless a written justification exists for providing these services in other settings.

Based upon the above federal regulations, all Service Coordinators and providers were required to use the “Natural Environment Justification Worksheet” at the IFSP meeting to justify all services that would not be provided in a child’s most natural learning environments. Family centered functional outcomes must be written prior to the determination of service delivery decisions (see definition section for functional outcomes, within the *Illinois Early Intervention Provider Handbook*). Once the functional outcomes have been written, if it is determined that the outcomes cannot be met in the child’s natural learning environment, the IFSP team must complete the Worksheet.

The Worksheet requires the IFSP team to explain why it was determined that it was not appropriate to provide the service(s) in the natural learning environment. Justification must be based on the needs of the child and the *Principles of Early Intervention* and not on any of the following, which are considered unacceptable justification reasons:

- Administrative convenience; and/or
- Fiscal reasons; and/or
- Personnel limitations; and/or
- Parent/therapist preferences; and/or
- Medical needs rather than developmental needs.

In addition, justification must indicate why the recommended setting is necessary to achieve the identified outcome, as well as why no other natural learning environment is appropriate. An IFSP team should always maximize their efforts to support the family within the child’s natural learning environments before contemplating the need for any justification process. Justification for each outcome must include a plan to transition interventions into the natural setting.
<table>
<thead>
<tr>
<th>Outcome #:</th>
<th>Service(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Environment in which service(s) will be provided:

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

<table>
<thead>
<tr>
<th>Outcome #:</th>
<th>Service(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Environment in which service(s) will be provided:

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

<table>
<thead>
<tr>
<th>Outcome #:</th>
<th>Service(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Environment in which service(s) will be provided:

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:
## Natural Environments Justification Worksheet

<table>
<thead>
<tr>
<th>Review area</th>
<th>1 (unacceptable)</th>
<th>3 (acceptable)</th>
<th>5 (best practice)</th>
</tr>
</thead>
</table>
| A. Adequate information and evidence are provided to support the rationale that a child’s needs and outcomes cannot be achieved in natural settings. | The IFSP identifies one or more services that are not in a natural environment for the child and family. **AND** There is no justification, or the justification is not based on the needs of the child but appears to be for:  
  - administrative convenience, *and/or*  
  - fiscal reasons, *and/or*  
  - personnel limitations, *and/or*  
  - parent/therapist preferences. | The child is receiving **most** services in natural environments. **AND** When a service is provided in a setting that is not a natural environment, a justification is included in the IFSP that is based on the needs of the child, justifying that the setting is necessary to achieve the outcome. **AND** For each service justified there is a plan to transition interventions into natural settings. | All services are provided in natural environments. **OR** The child is receiving **most** services in natural environments. **AND** When a service is provided in a setting that is not a natural environment, a justification is included in the IFSP that is based on the needs of the child, justifying that the setting is necessary to achieve the outcome. **AND** For each service justified there is a plan to transition interventions into natural settings. |
OVERVIEW OF EARLY INTERVENTION REFERRAL TO TRANSITION ACTIVITIES

Referral to CFC Office

Initial Intake with Families
The SC has a face-to-face meeting to discuss the family's priorities and an explanation of EI. With parental consent, the SC administers the appropriate family-directed assessment, a screening for Medicaid and DSSC eligibility, family fees and use of insurance.

Parent Refuses EI Evaluations
Parent is informed of how to reconnect if services are desired in the future.

Location of Credentialed Evaluation/Assessment Providers
Parent's choices of providers are contacted. Materials are sent to providers prior to visit.

Parent Declines
Explain how to access services if desired in the future.

NOTE: See list of required documents that are listed earlier in this document.

Perform Initial Evaluations & Assessments
Determine eligibility and/or EI services.

Child Found INELIGIBLE for EI Program
Parent is provided with additional community and public resources and recommendations from evaluating providers.

Development of IFSP
IFSP (with child outcomes ratings) developed for the child and family (within 45 days of referral) and implemented timely.

Parent Declines
Explain how to access services if desired in the future.

Parent Choice and Connection to Appropriate EI Providers

Review of IFSP
IFSP reviewed every 6 months or more frequently, if necessary. Eligibility and child outcomes ratings re-determined annually.

Transition/Discharge Meeting
Review of IFSP outcomes, completion of final child outcomes ratings, discussion of future service needs.

Transition Planning
Family & child preparation at age 30 months (or earlier) and referral to 3-5 early childhood programs, at-risk programs, preschools, day care, home or other services in the community.
Early Intervention/Extended Services (EI/ES)

Does the child meet these criteria?
- Child currently has an active Individualized Family Service Plan (IFSP) in Early Intervention (EI) and
- Child has a date of birth between May 1 and August 31, and
- Child has been determined eligible for Early Childhood Special Education

**No**
- IFSP will end no later than the day before the child’s third birthday.

**Yes**
- The child is eligible for EI/ES.

An Individualized Education Program (IEP) is developed by IEP Team for parent(s) to consider services with the IFSP vs the IEP

Does family consent to EI/ES over three as noted on the current IFSP?

**Yes**
- IFSP will end no later than the day before the first day of school following the child’s third birthday.

**No**
- IFSP ends no later than the day before the child’s third birthday

Please note that a child cannot re-enter EI once they exit, following their third birthday.
**Sample Cornerstone Authorization with Descriptions**

**REPORT:** HSPR0771  
**STATE OF ILLINOIS**  
**CORNERSTONE**  
**EARLY INTERVENTION PROGRAM – AUTHORIZED PROVIDER SERVICES**  
**TIME:** 10:45  
**RUN DATE:** 04/12/2021  
**PAGE:** 1

| CFC SITE: | 999999 #30 CFC - SUBURBIA | TELEPHONE: (217) 555-1234 |
| SERVICE COORDINATOR: | 999999001 DECKER, CHLOE |

| CHILD EI NUMBER: | 123456 | PARTICIPANT ID: | S111-9901-9901-00 |
| NAME: | GREEN, EMMA | DATE OF BIRTH: | 11/25/2013 |
| CATEGORY: | EI EARLY INTERVENTION |

| RESIDENCE | 123 HAPPY LANE  
SPRINGFIELD, IL  62777 | TELEPHONE: (217) 555-1235  
CELL: (217) 555-1236 |
| CONTACT: | RACHEL GREEN  
RELATIONSHIP: MOTHER |

**AUTHORIZATION START DATE:** 02/01/2021  
**END:** 10/31/2021

| AUTHORIZED PAYEE: | CENTRAL PERK THERAPY  
123 MAIN STREET  
SPRINGFIELD, IL 67777-7777 | TELEPHONE: (217) 555-0001 |

| AUTHORIZED PROVIDER: | LINDA MARTIN, SLP |
| AUTH TYPE: | IFSP-DIRECT SERVICE |
| SERVICE: | SPEECH LANGUAGE THERAPY |
| METHOD: | INDIVIDUAL |
| PLACE OF SERVICE: | 12 / HOME (OFFSITE) |
| PROCEDURE: | 92507 / SPEECH THERAPY SERVICES |
| FREQUENCY: | 2 PER WEEK  
FOR: 60 MINUTE(S) |
| AUTH NUM: | 123456-791-001-00  
PRINT DATE: 01/30/2021 |
| COMMENTS: | MIKE SMITH, SLP-A |

| PRIVATE INSURANCE: | 02/PRIVATE INSURANCE BILL |

**Notes:**

A – Child’s information, including, child’s name, home address, C’Stone identification #, EI #, DOB, contact name, relationship, & contact telephone #
B – Payee or Agency the authorization has been assigned to
C – Date range for when the specified service is authorized to be performed
D – Name of rendering and enrolled provider
E – Type of authorization, see Glossary for definitions
F – Service type, i.e., OT, PT, SLP, etc.
G – Method in which the service must be provided, i.e., individual, group, purchase, repair, etc. See Glossary for additional information
H – Type of location the service will be provided, i.e., offsite, onsite, other, etc.
I – Procedure code authorized, and brief description of the procedure code listed in H, see Chapters 7-22 for your provider type for additional information
J – Number of times and length of service is to be provided, i.e. number of times, per week or month, number of minutes, miles, etc.
K – Authorization number to use when billing
L – Date the authorization was printed by the Service Coordinator
M – Date the authorization was created or last updated
N – Comment Field Associate-Level Providers and Rendering Providers should be noted here. Correct name must be listed here if the provider is with an agency. If not, the Service Coordinator must be notified to make the necessary corrections.
O – Insurance requirements, i.e., private insurance bill, insurance billing not required, etc. See CBO Billing Handbook for additional information

*Please note, any and all errors must be corrected prior to providing the service to ensure payment.*