

Program Policy Manual



Babies Can't Wait
dph.georgia.gov/bcw

POLICY MANUAL

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**Maternal and Child Health Section
Early Intervention**

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PREFACE

This manual contains basic information and State and Federal guidance for the provision of services for eligible children, birth through 2 years of age, enrolled in the Babies Can't Wait (BCW) program and their families.

The manual is intended for use by participating service providers, Early Intervention partners and stakeholders and should be used in conjunction with applicable agreements, which outlines the Statement of Participation and terms and conditions for receipt of reimbursement and payments; as well as relevant Child Health programs' policy and procedure manuals, i.e., Children First (C1st), Children Medical Services (CMS), etc.

We urge all BCW personnel and providers to become familiar with the contents of this manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning the coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in Federal and State Local Educational Agency (LEA) and Department of Public Health (DPH), Maternal and Child Health policies. When such amendments are made, they will be posted on the DPH website at: <https://dph.georgia.gov/babies-cant-wait/bcw-services>, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

This policy is updated in accordance with current applicable federal regulations and supersedes any prior action bulletins and prior policies.

Public Law 94-142, the Education for All Handicapped Children Act (EHA), was passed by Congress and signed into law by President Ford in 1975. This law is well-known; it required states to fully educate all children with disabilities. It has been amended several times. In 1986, the EHA was amended through P.L. 99-457 to, among other things, lower the age at which children can receive special services to 3 years old. It also established the Handicapped Infants and Toddlers Program (formally Part H, renamed Part C in 1997), which is for children who need additional support from birth to their third birthday. The amendments of 1990 and 1991 brought about more changes, among which was a change in the name from EHA to the IDEA, the Individuals with Disabilities Education Act. Public Law 108-446, the Individuals with Disabilities Education Act of 2004 was signed into law December 3, 2004. The rules or guidelines for special education in the United States and its territories are outlined in the IDEA. Each state or territory develops its own policies for carrying out this Act. The final Federal Regulations 2011 "implement changes in the regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities necessitated by the reauthorization of the IDEA" and are utilized to guide the implementation of this mandate in Georgia.

INTRODUCTION

About Part C/Babies Can't Wait Program

Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEIA) says that to the maximum extent appropriate, early intervention services must be provided in natural environments, including home and community settings in which children without disabilities participate.

The mission for Part C/Babies Can't Wait early intervention is to build upon and provide supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

Babies Can't Wait (BCW) is Georgia's comprehensive, coordinated, statewide, interagency service delivery system for infants and toddlers, birth through 2 years of age, who have or are at risk for developmental delays, and their families. The program is established under Part C of the Individuals with Disabilities Education Act (IDEA), as amended. Family-centered care and family empowerment are important concepts in IDEA. Through participation in Babies Can't Wait, families are assisted in identifying and accessing resources that may be available to them. Equipped with information, families become more effective advocates for themselves and their children.

Services for children 3 years old and up are provided by the state Department of Education. However, programs for children under age 3 are provided by different agencies in different states. Sometimes the Department of Education will handle all these programs; in other states it may be another lead agency. In Georgia, the Department of Public Health administers the Part C/Babies Can't Wait program. The term "infants and toddlers with disabilities" in the law refers to children (ages birth through two years) who, with their families, may benefit from early intervention supports and services designed to promote development in the following areas:

- Physical,
- Cognitive,
- Communication,
- Social or emotional, and/or
- Adaptive development.

Early intervention supports and services must be provided by individuals who are qualified to work with infants and toddlers who have disabilities or who are at risk of developing disabilities. Any services provided must be documented on the Individual Family Service Plan (IFSP) that is reviewed at a minimum every six months.

The guiding principles for early intervention for infants and toddlers with special needs and their families include:

- All children are unique, with individual strengths and talents. The presence of a disability or special need is not the defining characteristic of any child.
- Children grow and develop in the context of relationships with their families and other caregivers.
- All children have the right to belong, to be welcomed, and to participate fully in the typical places and activities of their communities.
- Children with and without special needs learn important things from one another.
- Everyday routines, activities, and places offer countless opportunities for children to learn and develop.

- The lives of families are enhanced when they are successful in maintaining their everyday lives and relationships.

The philosophy of family empowerment drives the service coordination that all eligible children and families receive. Babies Can't Wait early intervention services are to be family-centered, provided in natural environments and culturally competent. Family members have an integral and equal role in identifying outcomes for the Individualized Family Service Plan (IFSP), determining services and supports necessary to achieve those outcomes, and promoting the child's development through participation in family activities and routines. Early intervention services are provided based upon the identification of child/ family strengths, interests, and desired skills to be acquired by each eligible child in order to promote maximum inclusion and participation in home and community settings. Intervention is integrated throughout activity settings and learning opportunities within locations where children and families typically spend time. Intervention focuses on working with and coaching families and caregivers to support each child to achieve optimal participation and inclusion in home and community activities and settings.

100.1 – Administration and Organization

GUIDING FEDERAL POLICY 34 CFR §303.120 Lead agency role in supervision, monitoring, funding, interagency coordination, and other responsibilities.

BABIES CAN'T WAIT PROGRAM STANDARD

The Georgia Department of Public Health (DPH) serves as the designated Lead Agency for the provision of Part C early intervention services. Each local program assumes responsibility as the “local lead agency” in fulfilling the federal requirements for the provision of a comprehensive early intervention system of services in their local communities. The state Babies Can’t Wait (BCW) office under the auspices of DPH, operates in partnership with each local program’s BCW staff and administration to monitor, support and provide guidance to ensure services are rendered in accordance with federally mandated Part C components. The state BCW office is responsible for determining and reporting annually to the Office of Special Education Programs (OSEP) if local programs meet compliance according to federally targeted indicators. OSEP, in turn, makes a determination if the State meets requirements for the purposes of Part C. It is imperative that local programs, in good faith, facilitate an organized, structured system that addresses the needs of children with disabilities and their families.

IMPLEMENTATION

Local programs are responsible for implementing practices and procedures that are in compliance with Federal and State policies that support a local system of early intervention services. The administrative and organizational structure of the local program must provide for the:

- Inclusion of public and private agencies/ resources in the planning, development and provision of services to infants and toddlers’ birth through 2 years of age;
- Establishment of a Local Interagency Coordinating Council (LICC);
- Early identification and referral of infants and toddlers;
- Provision of information to primary referrals sources about the local early intervention system;
- Implementation of screening, evaluation and assessment activities according to federally established procedural safeguards;
- Implementation of planning and the provision of services to families in a timely manner;
- Utilization of best practices in the implementation of the Individual Family Service Plan (IFSP) by way of a primary service provider model of service delivery;
- Maintenance of early intervention records in compliance with Part C Regulations;
- Compliance with the State’s System of Payment for eligible children and families;
- Participation of families in the IFSP process;
- Timely transition from Part C to preschool services (Part B) or other appropriate services;
- Timely review, response and resolution of parent complaints;
- Gathering, maintenance and reporting of information required of the State to support data.

100.2 – Public Participation and Notice of Policy

GUIDING FEDERAL POLICY 34 CFR §303.208 [Public participation policies and procedures](#)

BABIES CAN'T WAIT PROGRAM STANDARD

In accordance with Part C §303.208(a), Georgia's Babies Can't Wait Program must place the Part C grant application on the Georgia Department of Public Health/ Babies Can't Wait website and throughout the state for at least 60 days with an opportunity for public comment on the application for at least 30 days during the period before the application is submitted to the Office of Special Education Programs.

Section 303.208(b) clarifies that the State application must include a description of the policies and procedures used by the State to ensure that, before adopting any new policy or procedure (including any revision to an existing policy or procedure) needed to comply with part C of the IDEA and the regulations.

Where feasible and appropriate, local programs (upon request from the state BCW office) should provide assistance and support in facilitating public notification and participation in their communities as described below:

- At minimum, place notification of the Part C grant and request for comments on local program's and/or Babies Can't Wait website where they exist (and other appropriate media sources) in each of the 18 local programs throughout the state;
- Hold public hearings on any new State policy or procedure needed to comply with Part C (including any revision to an existing policy or procedure), after providing notice for the public hearing at least 30 days before the hearing is held to enable public participation;
- Provide an opportunity for the general public including individuals with disabilities, parents of infants and toddlers with disabilities, early intervention service providers, and the members of the Local Interagency Coordinating Council (LICC), to comment for at least 30 days on the new policy or procedure.

100.3 – Interagency Coordinating Council

GUIDING FEDERAL POLICY 34 CFR §303.600 [Establishment of Council](#)

BABIES CAN'T WAIT PROGRAM STANDARD

To further the intent of the federal policy and to expand opportunities for local collaboration, Georgia has elected to establish local interagency councils in conjunction with the State Interagency Coordinating Council (SICC). As with the State ICC, each local program is responsible for ensuring that there is a Local Interagency Coordinating Council (LICC) in place and operating to advise and assist the local program in the planning and implementation of a local early intervention (EI) service delivery system for the Babies Can't Wait (BCW) Program (Part C of the Individuals with Disabilities Education Act [IDEA]).

IMPLEMENTATION

A. Responsibilities of the State and Local ICC

1. The purpose of the Local ICC under this program is to advise the local program on all components related to the EI service delivery system for infants and toddlers with disabilities birth through 2 years of age and their families.
2. Responsibilities of the State and Local ICC may include but are not limited to:
 - a. Identifying existing EI services and resources;
 - b. Identifying gaps in the service delivery system;
 - c. Identifying strategies to address gaps;
 - d. Assisting in the identification of alternative funding sources;
 - e. Assisting in the development of interagency agreements for supporting service coalitions;
 - f. Assisting in the implementation of policies and procedures to promote interagency collaboration;
 - g. Assisting in the development of local procedures and determining mechanisms for implementing procedures in accordance with federal and state regulations and policies;
 - h. Assisting with the collection of data;
 - i. Assisting in surveying consumer satisfaction;
 - j. Ensuring adequate and appropriate parent/legal guardian involvement at all levels of the local system; and
 - k. Ensuring that all State and Local ICC members have an understanding of the intent of the law relative to EI through appropriate training and technical assistance.
3. Councils may identify other relevant activities or short-term projects for the Council in addition to the above. All activities should be consistent with Part C policies and philosophy and should protect the confidentiality of the families and children at all times.

B. Membership

The Local ICCs shall adhere to the same philosophical guidelines for membership which are stated in the federal law for the State ICC and shall endeavor to:

1. be inclusive of all partners in EI, both public and private;
2. reflect the cultural and economic diversity of the community; and have at least 20 percent of the membership be parents/legal guardians of a child who is receiving or has received EI services and at least 20 percent comprised of public and private providers of Part C services.

Any member of the Council who is a representative of the lead agency may not serve as the chairperson of the Council. **§303.600**

C. By-Laws

The State and Local ICC shall develop by-laws that:

1. Outline their organizational structure;
2. Address council size and membership;
3. Specify term length for members;
4. Provide for the election of officers;
5. Define voting rights; and
6. Define standing committees.

D. Accountability

1. The State and Local ICC shall ensure that all confidentiality rights of families receiving services in the EI system are protected during all ICC activities.
2. State and Local ICCs will assist the local BCW Program in the development of a program plan, describing the local program's outcomes and activities throughout all of the required areas of performance. State and Local ICCs and local BCW Programs

will utilize a self- assessment process to assist in the identification of strengths and need areas. External input will be obtained from family satisfaction surveys, data review, and demographic analysis.

E. Integration with Other Collaborative Initiatives

State and Local ICCs should seek to integrate their efforts with other community collaboratives to avoid duplication and maximize efforts. Many communities have expanded community collaborative efforts across other focus areas and age ranges since the inception of the ICC under Part C. It is important that the ICC carefully and thoughtfully examine how interagency collaboration fits into other collaborative efforts that reach out to a broader population in the community.

F. Use of BCW Funds for ICC

1. BCW funds for State and Local ICC activities shall be used only to support activities sanctioned by the BCW Program.
2. Activities that are considered sanctioned by the BCW Program are those that strive to improve the availability of services or quality of services in the community by addressing systemic issues or service gaps. Staffing and addressing individual family service needs are not sanctioned activities. Service needs are better addressed through the multidisciplinary IFSP process.
3. If BCW funds are used to support parent participation on the Local ICC, they may only be used for those families being served by BCW. Funding from other agencies or community groups should be identified to supplement the Part C funds.
4. **LICC Expenditure Report must be submitted to the state office by the 10th of the month following the end of each quarter.**

100.4 – Personnel Management

Guiding Federal Policy 34CFR §303.119 Personnel standards

BABIES CAN'T WAIT PROGRAM STANDARD

Each district must include policies and procedures relating to the establishment and maintenance of qualification standards to ensure the personnel necessary to carry out the purposes of this part are appropriately and adequately prepared and trained.

Any individual providing specialized services to infants and toddlers with disabilities shall possess valid licenses as governed by professional licensure and/or certification, according to professional boards and regulations determined by the lead agency. All providers, including translators/interpreters, must pass the BCW Criminal History Check through Cogent and the Office of Inspector General (OIG). Non-Licensed Providers (Service Coordinators & Special Instructors) are required to have a one-time educational check.

Qualified Personnel

The following are the types of qualified personnel who provide early intervention services:

- (1) Audiologist
- (2) Board Certified Behavior Analyst (BCBA)
- (3) Board Certified Behavior Analyst – Doctoral (BCBA-D)
- (4) Counselor (Licensed)
- (5) Dietitian (Licensed)
- (6) Early Intervention Coordinator
- (7) Early Intervention Specialist

- (8) Early Interventionist
- (9) Early Intervention Assistant
- (10) Family Therapist (Licensed)
- (11) Interpreter for the Deaf
- (12) Nurse (Licensed Registered/Practical/Practitioner)
- (13) Occupational Therapist (Licensed)
- (14) Physician for diagnostic and evaluation purposes
- (15) Physician Assistant for diagnostic and evaluation purposes
- (16) Physical Therapist (Licensed)
- (17) Psychologist
- (18) Service Coordinator
- (19) Social Worker (Licensed)
- (20) Speech and Language Pathologist (Licensed)
- (21) Speech and Language Pathologist (Licensed) —Clinical Fellow
- (22) Translator/Interpreter
- (23) Vision Teacher/Specialist (Ophthalmologist and Optometrist (see 34 CFR [§303.13](#) (c)), Orientation and Mobility Specialist, certified vision teacher, GA PINES trainer in vision)

A. Personnel Qualifications

Profession/Discipline	Certification/ License Requirement	Educational Background	Professional Examination
Audiologist	X	Master's Degree	X
Board Certified Behavior Analyst (BCBA)	x	Master's Degree	x
Board Certified Behavior Analyst – Doctoral (BCBA-D)	x	Doctorate Degree	
Counselor (Licensed)	X	Master's Degree	X
Dietitian (Licensed)	X	Bachelor's Degree – Refer to Practice Act	X
Early Intervention Coordinator		Master's Degree or Equivalent* + experience	
Early Intervention Specialist		Master's Degree + 2 yrs. experience	
Early Interventionist		Bachelor's Degree + 2 yrs. experience	
Early Intervention Assistant		Child Development Associates Degree, Technical Certificate of Credit in Early Childhood Exceptionalities or Associate Degree in a related field	
Family Therapist (Licensed)	X	Master's Degree	X
Interpreter for the Deaf	Certification		X
Nurse – Licensed/Registered	X	BSN or 2-year assoc. degree program	X
Nurse – Licensed/Practical	X	1-year approved course of study	X
Nurse Practitioner (Licensed)	X	Master's Degree	X
Occupational Therapist	X	Meets licensure requirements	X
Physician	X	Medical Degree	X
Physician Assistant	X	Licensed and under supervision of MD	X

Physical Therapist (Licensed)	X	Meets licensure requirements	X
Psychologist (Licensed)	X	Doctorate Degree	X
Service Coordinator	BCW Orientation Certificate	Bachelor's Degree	
Social Worker (Licensed/ Licensed Clinical)	X	Master's Degree	X
Speech-Language Pathologist (Licensed)	X	Master's Degree	X
Speech-Language Pathologist (Licensed) - Clinical Fellow	X	Master's Degree	X
Translator/Interpreter		Proficiency in foreign language	
Vision Teacher/Specialist	X	Bachelor's Degree. Certified vision teacher, GA PINES trainer in Vision, Orientation and Mobility Specialist, Optometrist, Ophthalmologist	

**Babies Can't Wait requires that district early intervention program directors/coordinators must meet the following qualifications: (1) master's degree in education (early childhood or special education), pediatric nursing, psychology, social work, or other directly related field, and (2) two years of professional experience providing services to or teaching infants/toddlers and families and/or in the administration of a service delivery program for infants/toddlers and families or children's health. Or (1) bachelor's degree in education (early childhood or special education), pediatric nursing, psychology, social work, or other directly related field, and (2) five years of professional experience providing services to or teaching infants/toddlers and families and/or in the administration of a service delivery program for infants/toddlers and families or children's health.*

B. Service Coordinator Qualifications – Public and Private

A copy of each candidate's resume and contract interest form must be submitted to the district EIC. If a candidate has a current Georgia professional license in one of the below fields, they may submit a copy of their license in lieu of a transcript.

1. **The potential candidate may have a bachelor or master's degree in one of the following fields.** (Resume must include date degree was awarded):

- | | | |
|---------------------------|-----------------------------|---------------------------|
| Audiology | Education | Physical Therapy |
| Child Development | Elementary Education | Psychology |
| Child Psychology | Family/Community Counseling | School Psychology |
| Clinical Psychology | Human Services | Social Work |
| Developmental Psychology | Nutrition | Sociology |
| Dietetics | Nursing | Speech-Language Pathology |
| Early Childhood Education | Occupational Therapy | Special Education |

- OR -

2. **The potential candidate may have a related bachelor or master's degree** (Resume must include date degree was awarded). Related is defined as **“at least 20 percent of the credit hours of the transcript must address child development, disabilities, or family systems.”** A copy of the candidate's full transcript(s) must be submitted with the resume.

- OR -

3. **The potential candidate may be a licensed Registered Nurse.** A copy of the candidate's Georgia nursing license must be forwarded with the resume.

All Service Coordinators must:

- Complete and pass the online BCW Service Coordinator Orientation before contracting or providing services.
- Obtain a Medicaid number prior to contracting with BCW. (**NOTE: Service Coordinators only providing intake service coordination are not required to have a Medicaid number.**)
- Complete the Skilled Credentialed Early Interventionists (SCEIs) training modules within six months of their initial date of hire or contract with BCW or successfully pass the PRAXIS II test.

C. Personnel Requirements for Special Instruction

A copy of each candidate's full transcript(s), resume and contract interest form must be submitted to the district EIC. If a candidate has a current Georgia professional license in one of the below fields, they may submit a copy of their license in lieu of a transcript.

1. **The potential candidate may have a bachelor or master's degree in one of the following fields.** (Resume must include date degree was awarded):

Audiology	Education	Physical Therapy
Child Development	Elementary Education	Psychology
Child Psychology	Family/Community Counseling	School Psychology
Clinical Psychology	Human Services	Social Work
Developmental Psychology	Nutrition	Sociology
Dietetics	Nursing	Speech-Language Pathology
Early Childhood Education	Occupational Therapy	Special Education

- **OR -**

2. **The potential candidate may have a related bachelor or master's degree** (Resume must include date degree was awarded). Related is defined as ***"at least 20 percent of the credit hours of the transcript must address child development, disabilities, or family systems."*** A copy of the candidate's full transcript(s) must be submitted with the resume.

- **OR -**

3. **The potential candidate may be a licensed Registered Nurse.** A copy of the candidate's Georgia nursing license must be forwarded with the resume.

Personnel who are responsible for Special Instruction may be employed or contracted in accordance with a three-tier model.

The **Early Intervention Specialist** position requires:

1. A Master's degree in child development, early childhood education, early childhood special education, special education or other closely related field.
2. A minimum of two years of professional experience providing service to children and families or in the administration of a service delivery program for children and families or children's health.
3. Completion of the Level II SCEIs training modules developed by the Lead Agency or successfully passing the PRAXIS II test* **within six months of employment or contracting with the Babies Can't Wait System.** (NOTE: Providers who were hired or had a contract start date prior to this policy are still under the old requirement of two years.)

The Early Intervention Specialist will provide specialized instruction, supervise Early Intervention Assistants in performing their duties and consult with Early Interventionists based on review of Special Instruction program planning and implementation*.

The **Early Interventionist** position requires:

1. A bachelor's degree in education, child development, pediatric nursing, psychology, social work or another directly related field.
2. A minimum of two years of professional experience providing service to children and families or in the administration of a service delivery program for children and families or children's health.
3. Completion of the Level II training modules developed by the Lead Agency or successfully passing the PRAXIS II test* **within six months of employment or contracting with the Babies Can't Wait System.**

The Early Interventionist will provide specialized instruction with consultation by the Early Intervention Specialist.

The **Early Intervention Assistant** position requires:

1. An associate degree in child development or a related field, or a technical certificate of credit in early childhood exceptionalities. (NOTE: Prior to September 2012, EIA qualifications were possession of a high school diploma or G.E.D. EIAs under an existing contract at that time not meeting the new qualifications were "grandfathered in.")
2. Completion of the Level I SCEIS training modules **within six months from date of hire/contract.**

The *Early Intervention Assistant* will provide specialized instruction under the clinical supervision of the Early Intervention Specialist.

** Level II personnel may be exempt from SCEIs training based on passage of the PRAXIS II Special Education: Preschool/Early Childhood examination (test code 5691) with a minimum score of 159.*

D. Service Coordinator & Special Instructor Continuing Education Requirements

The following are the continuing education requirements for Service Coordinators, early intervention specialists, early interventionists, and early intervention assistants, regardless of licensure/certification:

- **Level I Personnel:** Level I refers to personnel who do not have at least a bachelor's degree in an early intervention discipline. Level I personnel are required to have ten (10) contact hours of continuing education specific to young children (birth to eight) and their families every year; five (5) of these hours must be specific to young children with disabilities and/ or their families. All continuing education offerings must be documented with Project SCEIs within 45 calendar days of completion.
- **Level II Personnel:** Level II refers to personnel who have at least a bachelor's degree in an early intervention discipline. Level II personnel are required to have twenty (20) contact hours of continuing education specific to young children (birth to eight) and their families every TWO years; ten (10) of these hours must be specific to young children with disabilities and/ or their families. All continuing education offerings must be documented with Project SCEIs within 45 calendar days of completion.

- These continuing education requirements go into effect for an individual July 1 after he/she has completed all SCEIs modules (or has successfully passed the PRAXIS II Test). For example, if a Level I person completes all required SCEIs modules in October 2015, the first year of continuing education requirement would begin July 1, 2016, and he/she would need to complete the ten required hours by June 30, 2017.
- For a Level II person, after completing all required SCEIs modules (or passing the PRAXIS) in October 2015, he/she would have until June 30, 2018, to complete the 20 hours of approved continuing education. The second time period for continuing education requirement would begin July 1, 2017 (Level I) and July 1, 2018 (Level II).

100.5 – Procedural Safeguards (Child Records, Confidentially, Consent & Due Process)

Guiding Federal Policy 34 CFR Subpart E. Procedural Safeguards

BABIES CAN'T WAIT PROGRAM STANDARD

The Georgia Department of Public Health (hereafter referred to as State Lead Agency) is responsible for ensuring effective implementation of the procedural safeguards by each participating agency in the state who is involved in the provision of early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA).

The purpose of this section is to set forth standards for procedural safeguards established by the State Lead Agency (in accordance with 34 CFR Subpart E, Procedural Safeguards) to protect the rights of eligible infants/toddlers with disabilities and their families in Babies Can't Wait (BCW).

The State Lead Agency has established the procedural safeguards that:

- Meet the requirements of this subpart, including the provisions on confidentiality of personally identifiable information and early intervention records contained in §§303.401 through 303.417, parental consent and notice in §§ 303.420 and 303.421, surrogate parents in §303.422 and dispute resolution procedures in §303.430;
- Ensure the effective implementation of the safeguards by each participating agency (including the state lead agency and EIS providers) in the statewide system that is involved in the provision of early intervention services under this part.

Definitions as defined in the Congressional Federal Register

- [§303.7 Consent](#)
- [§303.25 Native language](#)
- [34 CFR 303.27 and 34 CFR §303.422 Parent](#)
- [34 CFR §303.29 Personally Identifiable information](#)
- [§303.37 Ward of the State](#)
- [34 CFR §303.401 Confidentiality and opportunity to examine records Confidentiality and opportunity to examine records](#)
- [§§303.401 through 303.417 Confidentiality procedures](#)
- [20 U.S.C. 1232g and Part 99 Family Educational Rights and Privacy Act \(FERPA\)](#)
- [§303.211 Services available under Part B](#)
- [§§303.401 Confidentiality](#)
- [§303.405 Access Rights](#)
- [34 CFR §303.406 Record Access](#)
- [34 CFR §303.407 Records on more than one child](#)
- [34 CFR §303.408 List of types and locations of information](#)

- [34 CFR §303.409](#) Fees for records
- [34 CFR §303.410](#) Amendment of records at a parent's request
- [34 CFR §303.411](#) Opportunity for a hearing
- [34 CFR §303.412](#) Results of a hearing
- [34 CFR §303.413](#) Hearing Procedures
- [34 CFR §303.414](#) Consent prior to disclosure or use
- [34 CFR §303.415](#) Safeguards
- [34 CFR §303.416](#) Destruction of Information
- [34 CFR §303.417](#) Enforcement
- [34 CFR §303.420](#) Parental Consent
- [34 CFR §303.421](#) Prior Written Notice and Procedural Safeguards Notice

100.6 – Data and Child Records

GUIDING FEDERAL POLICY 34 CFR [§303.124](#), [§303.403\(b\)](#), [§303.720- §303.724](#)

Data collection, early intervention records and reporting.

Babies Can't Wait Program Standard

The collection and maintenance of reliable data is essential for program management and evaluation. Reliable programmatic data can reveal the efficacy of state and local early intervention (EI) policies as well as identify areas in need of additional resources. Section 618 of the Individuals with Disabilities Education Act (IDEA) requires states to collect, maintain and report data for children receiving Part C services. The State Lead Agency (LA) is responsible for the collection, maintenance and reporting of Georgia EI services implemented through the BCW program. All local EI programs shall utilize Babies Information and Billing System (BIBS) web-based data and billing system; establish data collection procedures that ensure the efficient and effective operation of its BCW program; and submit periodic reports of BCW activities as requested by the State LEA.

IMPLEMENTATION

- The child record consists of all information relevant to his/her participation in BCW that is maintained at the local program office and the electronic information maintained in BIBS. Each child receiving EI services through BCW must have only one active record. The creation and maintenance of the record must comply with each of the procedural requirements of this policy.
- All BCW employees, contractors and other persons providing services or carrying out administrative activities on behalf of BCW are aware of the importance of data collection, timely data entry and protecting the privacy of children and families receiving BCW services. All aforementioned persons shall comply with each of the procedural requirements of this policy.
- Local EI programs shall collect and enter data into BIBS within 10 calendar days for the completion of evaluation and assessment, and 7 calendar days for the development or revision of the Individualized Family Service Plan (IFSP) and implementation of transition planning activities and conference.

A. Child Record

1. Each child receiving EI services through BCW must have only one active record created and maintained in BIBS.

2. The local EI programs shall keep a file for each child that will include the following:
 - a. Referral documentation for services and/or supports (including but not limited to the Children First (C1st) Referral)
 - b. Signed consents to receive BCW services, screenings and assessments
 - c. Signed consents to collect and release information
 - d. Signed Personable Identifiable Information (PII) consent
 - e. copies of all records and correspondence received from the family, service providers, other agencies and medical providers
 - f. Documentation of eligibility summary
 - g. Medical documentation of any Category 1 diagnosis
 - h. IFSP meeting information, to include all reviews and revisions, minutes, and signature pages
 - i. All screenings
 - j. The results of all evaluation and assessment reports
 - k. Copies of all prior written notice forms
 - l. Child Outcome Summary (COS)
 - m. Family Outcome Survey Consent Form
 - n. Family Cost Participation analysis, signed by parent
 - o. Access Log to child record
 - p. LEA notification form (a.k.a.: Notice of Intent to Transmit Notification Information to Local School System(s))
 - q. Surrogate parent forms
3. If the required document(s) are completed in paper form, that information must be entered or uploaded into BIBS.
4. All children referred to or receiving services through BCW that change residence between two local programs within the state must have their records transferred from the prior local program of residence to the new local program of residence at the request of the family or appropriate district staff. The child's file shall be transferred to the receiving local program and the completed Transfer-Between Districts Checklist must be provided (See APPENDIX K). **Electronic file transfer will take place within 3 calendar days; any paper records must be provided within 7 calendar days.** Since the BCW program is statewide, the original release and consent to participate obtained in one local program applies to these functions provided by the program in another local program. If a child exits but then returns to BCW, their previous record shall continue.
5. Parents/ guardians must have access and the opportunity to examine all information in their child's paper and electronic record including documents received from a third party, i.e., from a physician's office. Data stored only in BIBS must be printed upon parental request. This includes any and all results from evaluation, assessment, screenings, Individualized Family Service Plans (IFSPs), Family Cost Participation (FCP), provider notes, Service Coordinator notes, referrals made or received and program evaluation measures.
6. Parents/ guardians must submit a request in writing to view their child's BCW record. Each request must be accommodated within 10 calendar days.
7. All records pertaining to the provision of EI services, shall be maintained (archived) at the local lead agency for a **period of five years** after the child exits BCW. Notification of the record destruction policy will be given to families when a child is referred to the program during intake and when a child exits the program during the exit meeting. The Service Coordinator will provide a copy of, and review with the family, a notice explaining record retention and destruction (See APPENDIX J). The family will sign the notification form,

at entry and exit, acknowledging that they are aware of the record policy and their applicable rights. If the family chooses not to obtain their child's record during the five years, the record will then be destroyed at its conclusion.

8. If there is a complaint or litigation pending, or an unresolved financial audit activity, related to an individual record, this record must not be destroyed and must be retained until the pending matter is resolved.
9. BCW local program offices are responsible for ensuring that local data is collected in a comprehensive, accurate and timely manner so that the lead agency is able to complete and submit federal data reports. Data will be reported regularly as required to the lead agency.

B. Early Intervention Coordinator Responsibilities

Early Intervention Coordinator (EIC) shall:

1. Ensure that data collected and submitted is valid and accurate and matches information in the child's record.
2. Develop and implement procedures to ensure the appropriate, timely, accurate and complete collection of BCW data including but not limited to adherence to the following programmatic timelines:
 - a. Initial attempt to contact the family occurs within 3 business days of receipt of the C1st referral.
 - b. The secondary referral source must receive confirmation within 3 business days of receipt of the referral.
 - c. The initial IFSP (including evaluation and assessment, clinical opinion, vision, hearing and family assessments for a Part C eligible infant or toddler who does not have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay) must be completed within **45 calendar days** from the date of the referral.
 - d. The initial IFSP (including vision, hearing and family assessments for a Part C eligible infant or toddler who has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay) must be completed within **45 days from** the date of the referral.
 - e. Services, as documented on the IFSP, must be initiated within **45 calendar days** from the date the parent(s) consents and signs the IFSP.
 - f. The transition planning conference must be completed by **90 days prior** to the child's third birthday.
3. Designate a person(s) responsible for the local program's data quality assurance process. This individual(s) shall:
 - a. Oversee the accuracy and timeliness of data entered into BIBS for the entire local program.
 - b. Assign access rights to individuals using the electronic system.
 - c. Run and analyze data reports in BIBS in order to monitor local program compliance with state and federally mandated indicators.
 - d. Ensure data collection, data management and reporting activities carried out by contractual agencies shall be subject to provisions of this policy.

C. Service Coordinator (SC) Responsibilities

Service Coordinator shall:

1. Ensure the timely and accurate entry of child record data, including but not limited to regular case notes reports.

2. Document all contacts made, and all activities completed with or on behalf of the child and family. This includes, but is not limited to, phone calls (including 'no answer' or a 'voice message left'), face-to-face contacts, and written correspondence. **If the contact or activity is not documented, it will be assumed that the contact or activity did not occur.**

The job of service coordination does not change based on the preferred method of contact. For that reason, contact notes must substantiate that the communication between the Service Coordinator and the family is substantive and does constitute actual service coordination. **Asking a family how things are going and a getting a reply of "Fine" is not service coordination. See Service Coordination Policy in this manual for what constitutes billable ancillary contacts.**

3. Collect and enter data into BIBS within 10 calendar days for the completion of evaluation and assessment, and 7 calendar days for the development or revision of the Individualized Family Service Plan (IFSP) and implementation of transition planning activities and conference.
4. Use contact notes to provide essential information that is not contained in meeting record forms such as the IFSP.
5. Ensure the timely scheduling and notification of all meetings.
6. Comply with all EI timelines; review and respond when necessary to all message board notifications and emails.
7. Ensure the timely (**within 7 calendar days**) and accurate data collection and entry of all documentation related to the initial, annual, inter-periodic and six-month reviews of the IFSP.

D. Service Provider Responsibilities

Service Provider shall:

1. Ensure the timely and accurate entry of child record data, including but not limited to regular progress notes for each service rendered.
2. Shall collect and enter data into BIBS within **14 calendar days** of the date of service.
3. Shall upload in BIBS or submit to district program requested eligibility evaluations and assessments within 10 calendar days of completion of service.
4. Comply with all EI timelines; review all and respond when necessary to message board notifications and emails.

E. Confidentiality and Privacy

1. All obligations and requirements of the Family Educational Rights and Privacy Act (FERPA) [20 U.S.C. 1232g](#) and Health Insurance Portability and Accountability Act (HIPAA) [110 Stat. 1936](#) shall be applied to all records including those individually maintained in the clinical provider records.
2. Parents should be assured that information collected and stored in BIBS and paper files stored in filing cabinets are subject to confidentiality safeguards. The use of passwords and selective user privileges within BIBS ensures that only those who are authorized have access to a child's record.

3. All paper files are stored in locked cabinets. EICs shall ensure only authorized personnel have access to child records. In accordance with FERPA, an access list must be posted on the outside of all filing cabinets where child records are maintained, indicating those persons by title, who may access individual child records. This listing should include the EIC, his/her supervisor, the local program Health Director, support staff, BCW SCs etc. The cabinets must have locks. If an individual who is not an employee of BCW wants access to BCW EI records, there must be a signed release by the parent(s)/ guardian authorizing such access.

In these instances, the BCW employee with authorized access will obtain the record from the cabinet and reposition it once the authorized individual has completed their inquiry. An access log will be maintained in each child's record indicating, by signature, date, and purpose, any and all access to the BCW early intervention record made by persons who are not employees of the BCW Program.

4. All BCW employees and contracted staff shall comply with all FERPA [20 U.S.C. 1232g](#) and HIPAA [110 Stat. 1936](#) regulations when utilizing BIBS. These regulations shall also be enforced when staff are working in the field. BCW personnel must access BIBS always utilizing a secured LAN or wireless internet connection. All staff shall logout of BIBS or lock their workstation if he/she should have to leave the data system to complete another task on the computer or if he/she must leave their desk. While providing services in the natural environment, therapists and SCs are responsible for locking their computers when they are not entering data into BIBS and are interacting directly with the child or family.

F. Data Sharing and Notification – Within DPH

Consent to exchange information among agencies

For children who may be served by both Babies Can't Wait and Children's Medical Services, Babies Can't Wait and First Care or Children's Medical Services and First Care, or by all three programs/services, program staff should obtain informed parental consent for services, written parental consent to request, receive, and release information, and other relevant authorizations from the parent/legal guardian for both programs at the time of the initial visit/intake.

For example, a child referred to Babies Can't Wait due to severe bilateral hearing loss is also referred to Children's Medical Services for services. A Babies Can't Wait Intake Coordinator meets with the family to obtain consent for services and necessary releases as well as intake information. During the intake visit, the Babies Can't Wait Intake Coordinator may also obtain necessary consent and release signatures as required for the Children's Medical Services program enrollment. As a result, the family is able to access services through both programs without having to participate in an additional intake visit/meeting. In addition, access to services is streamlined, and the child is able to receive services in a timelier manner because an additional visit is not needed in order to access the Children's Medical Services system.

For example, a premature infant with a Grade III intraventricular hemorrhage is referred to Babies Can't Wait and First Care. A First Care nurse meets with the family to obtain consent for services and necessary releases as well as intake information. During the intake visit, the First Care nurse should also obtain necessary consent and release signatures as required for the Babies Can't Wait program enrollment. As a result, the family is able to access services through both programs without having to participate in an additional intake visit/meeting.

In addition, access to services is streamlined, and the child is able to receive services in a timelier manner because an additional visit is not needed in order to access the Babies Can't Wait system.

** The implementation of this activity will require local program-level staff to share general information across Maternal & Child Health programs and to engage in dialogue about how to best accomplish these tasks. Cross-training of staff will be critical to the successful implementation of these activities.

Sharing of Information between programs

- a. For children receiving services by multiple child health services, program staff requesting information such as medical records should complete the Release of Information form to reflect that the request is for use by each program (Babies Can't Wait, First Care, and Children's Medical Services). This enables staff from each of the Maternal & Child Health programs to access and review such records as needed to assist in program planning within each program.

For example, a child enrolled in Children's Medical Services with a diagnosis of spina bifida is also receiving services through Babies Can't Wait and First Care. When Children's Medical Services staff receives permission from the child's family to request medical records from her neurosurgeon, the request should be written to reflect those records are also intended for use by Babies Can't Wait staff and First Care. As a result, the physician's office does not have to respond to two or three requests for records and duplicates of records are not unnecessarily stored in child records within the same local program.

- b. When completing the DPH Release of Information form, only Children's Medical Services, Children 1st or Babies Can't Wait should be listed as the agencies to which information is being released and from whom information is being shared.
- c. In situations where medical records or other relevant information has already been received by one program and would be beneficial to another Maternal & Child Health program, programs must seek parent/guardian consent to share records between Maternal & Child Health programs and then may release information, including third-party records, to other Maternal & Child Health programs. As stated above, this is possible when local programs are functioning as integrated Maternal & Child Health units as well as when local programs view themselves as a unit and share some common functions.

For example, a child with a diagnosis of a seizure disorder has been receiving Babies Can't Wait and First Care services for several months and is now being enrolled in Children's Medical Services. The child's Babies Can't Wait record contains medical records that document his diagnosis as well as the results of previous medical testing and intervention efforts. With written parental consent using the DPH/ BCW Release of Information form, Babies Can't Wait can share the child's medical records with First Care and Children's Medical Services in order to expedite services for him.

****It is important to note that these guidelines apply to Maternal & Child Health programs within a local program but do not apply to other public health programs that are not included in the Maternal & Child Health system of programs and services.**

G. Data Sharing and Notification – BCW & LEA

1. Interagency agreements may be developed by the State LEA and local EI programs with other state agencies and/or organizations which specify methods and procedures that will be used to ethically share BCW information. Data should be shared by agencies for specific purposes and for the mutual benefit of each agency.
2. Local EI programs are responsible for notifying local school systems (LSS) of children who will potentially be referred for eligibility to the LSS for preschool services under Part B. The Service Coordinator should schedule an IFSP meeting closest to the child's second birthday and explain the relationship between BCW and the Department of Education (DOE). Parents should understand that BCW is required to provide transition information and data to the LSS unless the parent opts out. The "Babies Can't Wait Notice of Intent to Transmit Notification Information to Local School System(s)" is signed by the parent, if they choose to opt-out of the notification and **all** families should complete the signature line on the notification form indicating that the transmission process has been explained and that they understand it. This does not indicate permission to transmit information. Unless the parent opts out, information has to be transmitted to the LSS the month following an enrolled BCW child turns 27 months of age or if a child enters the program past 27 months of age, the month after the initial IFSP is completed.

Submission of the notification to the LSS can be conducted manually utilizing report information in BIBS. Notification information should only include child's name, parent name, address, phone number, and date of birth.

H. Data Monitoring and Reporting

Local EI program staff shall review BIBS data reports quarterly to validate the accuracy and reliability of all data stored in BIBS and the child's record.

State EI Regional Coordinators shall:

1. Review BIBS data and documentation at least quarterly.
2. Assess the local EI program's progress toward meeting the State Performance Plan (SPP) targets for each programmatic and compliance indicator.

State Data Manager shall:

1. Run the Department of Education Report on the 15th of every month and upload it to the Department of Education data portal.
2. Utilize BIBS data to complete all federal and state reporting requirements.
3. Utilize BIBS data to complete EI data requests as necessary.
4. Analyze BIBS data to assess program efficacy.

Local EI program staff shall:

1. Review BIBS data reports monthly for program monitoring.
2. Review BIBS reports monthly to ensure compliance with EI timelines and all policies.

CHAPTER 200 – ELIGIBILITY

200.1 – Comprehensive Child Find

GUIDING FEDERAL POLICY 34CFR Subpart D §303.301 – 303.303 pre-referral policies, public awareness program, comprehensive child find system, and referral policies.

BABIES CAN'T WAIT PROGRAM STANDARD

The Department of Public Health is responsible for ensuring that pre-referral policies, a public awareness program, comprehensive child find system, and referral policies are in place. This ensures that all infants and toddlers with disabilities in the State who are eligible for early intervention services under Part C are identified, located and evaluated, and an effective method is developed and implemented to identify children who are in need of early intervention (EI) services. Infants and toddlers with disabilities include Native American infants and toddlers with disabilities residing on a reservation geographically located in the State based in part on the information provided by the tribe, tribal organization, or consortium to the State lead agency under §303.731 (e) (1); infants and toddlers with disabilities who are homeless, in foster care, and wards of the State; and specific-at-risk infants and toddlers with disabilities (is the subject of a substantiated case of child abuse or neglect or is identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure).

IMPLEMENTATION

A. Public Awareness Program

1. Public awareness activities must focus on both internal and external audiences to involve and communicate with major organizations throughout the State that have a direct interest in Part C, public agencies providing early intervention services as well as other services or sources of funding for early intervention services.
 - a. Internal Audiences include all appropriate state agencies and their local offices, including but not limited to the Department of Public Health including the State Early Hearing Detection and Intervention System (EHDI), Department of Human Services, Division of Family and Children Services (both child protection and child welfare), Department of Behavioral Health and Developmental Disabilities, Department of Community Health including the Children's Health Insurance Program, Department of Education, Department of Early Care and Learning, the Governor's Office for Children and Families and the local program personnel who work with infants and children and Early Intervention (e.g., Women, Infant, and Children Nutrition, 1st Care, Children's Medical Services, Early Hearing Detection and Intervention, Newborn Metabolic/Genetic Screening, Children 1st, and others).
 - b. External Audiences include the medical community (physicians, hospitals, including all birthing facilities and regional perinatal centers), advocates, public and private service providers, parents/legal guardians, civic, business and professional organizations, faith-based organizations, homeless family and domestic violence shelters, childcare and early learning programs, tribes, tribal organizations and consortia, Early Head Start, educators, and teachers. Particular emphasis will be given to hospital neonatal intensive care units and regional perinatal centers specializing in the care of infants who were born premature and/or with complications.

2. Public awareness activities must provide detailed information on the availability of early intervention services, a description of how the child find system works, how to refer a child under age 3 for evaluation or for early intervention services, and a central directory of information on available early intervention services, supports, and projects within the state that is easily accessible to the general public.
3. Public Awareness reports are submitted to the state office by the **10th of the month following the end of each quarter.**
4. Implementation of a comprehensive well planned targeted outreach and public awareness activities at the state, local program and county levels to include:
 - a. Use of population and program data to inform outreach;
 - b. Use of family and child risk factors to predict and identify children who are most likely to have significant developmental delays;
 - c. Identification of suspected developmental delays using a developmental screener which would trigger a referral to BCW;
 - d. Provision of information about BCW to other Public Health programs and childcare providers that may serve potentially eligible children;
 - e. Education and awareness activities with physicians, hospitals, community agencies and the general public to ensure that they understand BCW and the functions of Children 1st as the Maternal and Child Health (MCH) system's Single Point of Entry (SPOE) or front door to these programs including BCW and how this referral process benefits children, families and providers;
 - f. BCW's 18 local programs shall actively participate in community events minimally once per quarter in an effort to increase community awareness of early intervention services; and
 - g. Public awareness activities include informing all parents served under Part C about preschool programs under Part B. This information must be provided no fewer than 90 days before the toddler's third birthday.
5. Early Intervention (EI) public awareness activities shall be continuous and coordinated with other Child Find efforts in the State (e.g., the Georgia Learning Resource System, United Way 211, Healthy Mothers Healthy Babies, Early Head Start and Head Start Programs, Part B/Special Education, Family Connections, Governor's Office for Children and Families including the Home Visiting Program, Prevent Child Abuse Georgia, etc.).
6. Materials including printed materials such as brochures shall be available in a variety of media, utilize a variety of settings, and reflect the diversity of individuals by using appropriate prevalent languages that are relevant to communities, and ensure the materials are user-friendly and sensitive to cultural diversity.
7. Community-based providers (e.g., family shelters, faith-based organizations, and recreation organizations) will be engaged through outreach efforts.

B. Central Directory

1. The State Lead Agency shall ensure the establishment and maintenance of the State's Central Directory, which shall include information about the following:
 - a. Public and private EI services, resources, and experts available in the State;
 - b. Public and private EI services, resources, and experts available at the local program, county and community levels;
 - c. Scientifically based research and demonstration projects being conducted in the

- State;
- d. Professional and other groups that provide assistance to children eligible under Part C and their families; and
 - e. Training opportunities (e.g., continuing education courses, in-service training, and professional meetings).
2. The State Lead Agency shall ensure that a toll-free Central Directory number is available to the general public and staffed by trained personnel. Parent to Parent Phone Number: (800) 229-2038.
 3. The State Lead Agency shall ensure that the Central Directory is updated annually. Each local program is responsible for assisting with keeping the Central Directory information up to date for their local catchment area.
 4. Each local program is responsible for disseminating information about the Central Directory throughout their local area.
 5. The State Lead Agency shall ensure the Directory is available to all persons through the toll-free statewide number; a telecommunications device (TDD) is available for persons who are speech and hearing impaired; and upon request printed information is available in large print face or Braille for those who are visually impaired.

C. Comprehensive Child Find System

1. Local programs are expected to collaborate with other agencies who serve children birth through 2 years of age to coordinate local Child Find efforts. These include but are not limited to: Early Head Start/Head Start; maternal child health programs such as Children's Medical Services, Health Check, Early Hearing Detection and Intervention (EHDI) systems, Healthy Mothers' Healthy Babies, DFCS (Department of Family and Children Services), family homeless shelters, childcare centers, NICUs, perinatal centers, tribal organizations and organizations working with military families.
2. Participation by BCW in local interagency coordinating councils (LICCs) is required to foster collaboration with other agencies serving children birth to five. LICCs will be composed of community stakeholders who will make recommendations for activities to promote child find in their local programs.
3. Local BCW programs will identify and participate in local community events (i.e., health fairs, parent support groups) where families with infants and toddlers with disabilities may attend.
4. Local BCW program staff may attend conferences, or meetings attended by physicians and other health providers to provide information on the BCW program and referral process.

D. Referrals and Screening

1. Referrals of children birth to 5 years of age to public health services including EI services provided through BCW, will come through Children 1st. Children 1st is Georgia's Maternal and Child Health program Single Point of Entry. Referral sources, such as childcare or physician communities, are informed through a variety of methods about referral procedures and the benefits of referring children birth to 5 years of age through Children 1st.

2. Referrals may come directly to BCW from families, other agencies or the public. Family information will be gathered on the Children 1st Screening and Referral form and sent to Children 1st in order to be presented at the weekly staffing meeting to be reviewed by the Birth to Five Review Team, to ensure the most appropriate referral(s) are made on behalf of the child and family.

E. Timelines to Act on Referrals

Once the local agency or C1st receives a referral, the district has 45 days to complete the referral process, which includes:

1. Intake
2. Evaluation and /or Assessment
3. IFSP development
4. If a child is referred less than 45 days from the child's third birthday, the local lead agency is not required to complete an evaluation or assessment or to hold an IFSP meeting, however, if that child may be eligible for preschool services or other services under Part B, the lead agency with the parental consent must refer the toddler to the State Educational Agency (SEA) and the appropriate Local Educational Agency (LEA).

200.2 – Child Abuse Prevention and Treatment Act (CAPTA) Policy

Children 1st is a single point of entry to Georgia's statewide collaborative birth-to-five system of public health and other prevention- based programs and services.

A. Babies Can't Wait

1. Accepts referrals from DFCS to BCW via Children 1st for children under the age of three who are:
 - a. The subject of a substantiated case of child abuse or neglect; or
 - b. Directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure; or
 - c. Have a diagnosed disability, developmental delay, or physical impairment included on the BCW Category 1 conditions list
2. Release the Individual Family Service Plan (IFSP) to DFCS provided BCW has a FERPA complaint consent form signed by the parent as defined in IDEA under 20 U.S.C. §1401(23)A parent is defined as:
 - a. A biological, adoptive, or foster parent of a child (unless a foster parent is prohibited by State LEA from serving as a parent*).
 - b. A guardian (but not the state if the child is a ward of the state);
 - c. An individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or a person who is legally responsible for the child's welfare;
 - d. An individual assigned to be a surrogate parent, in accordance with BCW policies.
3. Ensure that a DFCS representative is invited to participate in IFSP meetings and Transition Conference (via conference all or face-to-face) held for children who are in DFCS legal custody (foster care) and have been found eligible for the BCW program.

4. Ensure that local BCW personnel provide service coordination and intervention for eligible children referred to BCW.

B. Department of Family and Children Services (DFCS)

Referrals:

1. DFCS will use the Children 1st Referral Form and complete it in its entirety including caseworker's name, phone, and fax number, child's county of custody, and the guardian/foster parent's name and phone number.
2. DFCS shall include with their referral:
 - a. Signed Authorization for Release of Information (ROI) form
 - b. Most current court order associated with the child referred that states who has legal custody of the child in question.

If any changes in placement or status occur for a child, DFCS will notify appropriate public health representatives in Child Health (Children 1st or BCW) within 15 calendar days of any change.

DFCS will make contact with the applicable Children 1st or BCW Coordinator in the district that serves the children in the care of DFCS, monthly to share information about children referred and ensure that systems and linkages are working appropriately.

C. Children 1st

Referral Process:

Day 1 of the 45-day time period begins on the day that the Children 1st SPOE receives a referral indicating that it is a BCW referral. Examples of BCW referrals include:

- A physician-initiated referral due to a suspected developmental delay or Category 1 diagnosis;
- A CAPTA referral made by a DFCS caseworker for a child (birth to three) with substantiated abuse or neglect;

A referral received (from a parent, hospital or licensed professional) with a Category 1 diagnosis for eligibility; or a referral received from a parent, family member or childcare provider who is concerned about the child's development.

Districts must work together to develop a process that maximizes the amount of time available for scheduling an evaluation and developing an Individualized Family Service Plan (IFSP) within the 45 days.

Category 1 Referral Process:

A referral from any source with a Category 1 diagnosis.

1. Category 1 referrals are sent by Children 1st directly to BCW within 2 business days of identification. BCW receives the referral, completes the BCW intake process and enrolls the child, if appropriate.
2. The referral is sent to the next staffing of the Birth of Five Review Team (BCW, Children 1st, 1st Care, EHDI, Children's Medical Services [CMS], Child Health Coordinators or some combination thereof) to determine most appropriate Public Health program referral(s).

Category 2 Referral Process:

1. The Developmental Specialist (or other trained DPH staff) will initiate contact with the family within three business days. Staff will use at least two unique forms of contact which may include a telephone call, letter or home visit.
2. Once contact has been made with the family, a screening may be scheduled using the Ages and Stages Questionnaire (ASQ-3). The Developmental Specialist (or other ASQ trained DPH staff) will complete the Ages and Stages Questionnaire Social and Emotional (ASQ-SE) if:
 - a. The Children 1st Screening and Referral Form indicates mental health or socio-emotional concerns and the child is at least six months of age;
 - b. After the review of the OVERALL QUESTIONS section of the ASQ- 3 and there is an indication that a social-emotional concern warrants an ASQ-SE screening;
 - c. A score in the black/gray area of the ASQ-3 Personal-Social areas.
3. If the screening indicates possible developmental delays, then C1st will send the referral along with the ASQ-3 (and ASQ-SE if completed) to BCW within two business days. If the referral to C1st did not mention a delay or BCW, then the 45-day clock starts with the day that the screener was completed.
4. If the screening indicates that the child is age appropriate or in the monitoring zone, the Children 1st Developmental Specialist will offer to enroll the child in Children 1st.

Birth to Five Review Team:

A representative from each child health program to include Babies Can't Wait, Children 1st, Early Hearing Detection and Intervention, and Children's Medical Services **shall meet at a minimum of once per week to review referrals**. All referrals that enter Children 1st as the SPOE shall be reviewed to determine the most appropriate referrals are made on behalf of the child's family. Each local Children 1st Coordinator will be responsible for documenting the frequency, attendance, and outcome of the Birth to Five Review Meeting. Each child health program shall be responsible for reporting the disposition of their referrals at a minimum, once per month, to the Birth to Five Review Team. Documentation of these meetings shall be available upon request of State Office staff.

202.3 – Evaluation and Assessment: Determination of Eligibility

Guiding FEDERAL POLICY 34 CFR §303.321*Evaluation of the child and assessment of the child and family.*

BABIES CAN'T WAIT PROGRAM STANDARD

A timely, comprehensive, multidisciplinary developmental evaluation will be conducted for each child, birth through age two, referred for evaluation, including assessment activities related to the child and, with family consent, the child's family. Nondiscriminatory evaluation and assessment procedures shall be used in all evaluation and assessment activities of children and families.

Evaluation and Assessment Section 303.321(a)(3)

1. A child's medical and other records may be used to establish eligibility (without conducting an evaluation of the child) under this part if those records indicate that the child's level of functioning in one or more of the developmental areas identified in §303.21 (a)(1) constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a disability under §303.21. If the child's Part C eligibility is established under this paragraph, the lead agency or Early Intervention Service (EIS) provider must conduct

- assessments of the child and family in accordance with the following section.
2. Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of the child.
 3. In addition, the lead agency must ensure that informed clinical opinion may be used as an independent method to establish a child's eligibility as Category 2 under this part even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility.

Section § 303.321

Evaluation and assessment of the child: All evaluations of the child and family must be conducted by qualified personnel, in a nondiscriminatory manner, and selected and administered so as not to be racially or culturally discriminatory.

Unless clearly not feasible to do so, all evaluations and assessments of a child or family must be conducted in the native language of the child, in accordance with the definition of native language in § 303.25.

Procedures for evaluation of the child. In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility under this part. Procedures must include-

1. Administering an evaluation instrument;
2. Taking the child's history (including interviewing the parent);
3. Identifying the child's level of functioning in each of the developmental areas in §303.21 (a)(1);
4. Gathering information from other sources such as family members, other care-givers, 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, or other records
6. Procedures for assessment of the child and family.
7. An assessment of each infant or toddler with a disability must be conducted by qualified personnel in order to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. The assessment of the child must include the following--
 - a. A review of the results of the evaluation;
 - b. Personal observations of the child; and
 - c. The identification of the child's needs in each of the developmental areas in §303.21 (a)(1).
8. A family-directed assessment must be conducted by qualified personnel in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability. The family-directed assessment must--
 - a. Be voluntary on the part of each family member participating in the assessment;
 - b. Be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and
 - c. Include the family's description of its resources, priorities, and concerns related to enhancing the child's development.

Section 303.310

Post-Referral Timeline 45 days

- A. Except as described in the following paragraph, any screening (if the State has adopted a

policy and elects and the parent consents to conduct a screening of the child), the initial evaluation and initial assessments of the child and family must be completed within 45-days from the date the lead agency receives the referral of the child.

- B. The 45-day timeline does not apply for any period when—
 - 1. The child or parent is unable to complete the screening (if applicable), the initial evaluation, the initial assessments of the child and family, or the initial IFSP meeting due to exceptional family circumstances that are documented in the child’s early intervention records; or
 - 2. The parent has not provided consent for the screening (if applicable), the initial evaluation, or the initial assessment of the child, despite documented, repeated attempts by the lead agency or EIS provider to obtain parental consent.
- C. The lead agency must develop procedures to ensure that in the event that the child or family is unable to complete, or the parent has not given consent for the screening (if applicable), the initial evaluation, the initial assessment, or the initial IFSP, the lead agency or EIS provider must—
 - 1. Document in the child’s early intervention records the exceptional family circumstances or repeated attempts by the lead agency or EIS provider to obtain parental consent;
 - 2. Complete the screening (if applicable), the initial evaluation, the initial assessments (of the child and family), and the initial IFSP meeting as soon as possible after the documented exceptional family circumstances described above no longer exist or parental consent is obtained for the screening (if applicable), the initial evaluation, and the initial assessment of the child; and
 - 3. Develop and implement an interim IFSP, to the extent appropriate and consistent with §303.345.
- D. The initial family assessment must be conducted within the 45-day timeline that begins with the date that the lead agency or EIS provider receives the referral of the child if the parent concurs and even if other family members are unavailable.

IMPLEMENTATION

A referral to the local lead agency (BCW) begins the Individual Family Service Plan (IFSP) process which ensures:

- 1. Completion of a developmental evaluation and assessment by a Multidisciplinary Team (MDT);
- 2. Eligibility determination through a review of developmental evaluation and assessment results and other information;
- 3. An IFSP meeting is held; and,
- 4. An initial IFSP is developed within 45 calendar days of receipt of referral by the local lead agency (BCW).

The evaluation and assessment of the developmental skills and functional levels of infants and toddlers cannot rely solely on standardized scores and/or measures (quantitative information). Professionals must also integrate qualitative information with traditional evaluation and assessment procedures (e.g., systematic observations, interviews, neonatal medical histories, etc.) through the use of informed clinical opinion. The following procedures relate to this process.

A. Eligibility

Children are eligible for Babies Can’t Wait (BCW) in Georgia if they are:

- 1. Between the ages of 0 and 36 months;
- 2. Reside in the State of Georgia; AND

3. Meet eligibility criteria of Category 1 or Category 2 as follows:

B. Category 1 - Infants & Toddlers with Established Risk for Developmental Delay

Children who have an established risk of developmental delay due to a diagnosed physical or mental condition of known etiology and significant developmental consequences are considered to have a Category 1 condition, regardless of whether a delay is manifested at the time of identification. A child's medical and other records may be used to establish eligibility without an evaluation. Please refer to the Category 1 Conditions List in the Appendix for a complete list of eligible diagnoses.

Referrals of children with a diagnosed Category 1 condition from a physician must include a medical diagnosis with the ICD-10 code confirming the Category 1 condition and all other medical diagnoses and accompanying code(s) available in the medical record. This statement will be retained in the early intervention record.

For Category 1 children, the local program must:

Obtain a medical report which confirms a diagnosed mental or physical condition with ICD-10. This documentation must be received and obtained from a physician.

Assess the child in all five developmental domains by at least one qualified individual for the purposes of initial assessment for program planning using a curriculum-based assessment, such as:

1. The "Assessment, Evaluation, and Programming System for Infants and Children" (AEPS)
2. The "Hawaii Early Learning Profile" (HELP)
3. The Carolina Curriculum for Infants and Toddlers with Special Needs

C. Category 2 - Infants & Toddlers with a Significant Developmental Delay Children eligible under Category 2 are those children who are determined by the MDT to have a significant developmental delay in one or more areas of development. A delay is considered significant when standardized measures yield a score of 2 standard deviations below the mean in one or more of the five developmental domains or at least 1.5 standard deviations (moderate delay) below the mean in two or more of the five developmental domains and/or the child's developmental issues interfere with their functional ability when compared with peers.

An initial evaluation tool must be completed for the purposes of eligibility determination by using the latest edition of one of the below tools:

- Bayley Scales of Infant Development
- Battelle Developmental Inventory
- Developmental Assessment of Young Children (DAYC)
- Developmental Profile

At least two qualified individuals must participate in the evaluation with one person having expertise in the area of suspected delay. Personnel and training requirements for administration of each of the tools as outlined in the tool's administration guide must be used in determination of a qualified evaluator. All evaluators must have a background in child development and testing. Qualified personnel, under §303.31, are individuals who meet State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the developmental area in which the individuals are conducting an evaluation or assessments or providing early intervention services.

The second professional on the Multidisciplinary Team may use additional tools such as, but not limited to, those listed below to assist in identifying the unique strengths, needs,

supports and services appropriate to meet the needs of the child:

1. Pre-school Language Scale (PLS) latest edition
2. Peabody Developmental Motor Scale latest edition
3. The Receptive-Expressive Emergent Language Test (REEL) latest edition
4. Alberta Infant Motor Scales (AIMS)
5. Rossetti Infant Toddler Language Scale
6. Sensory Profile - 2
7. The "Assessment, Evaluation, and Programming System for Infants and Children" (AEPS)
8. The "Hawaii Early Learning Profile" (HELP)
9. The Carolina Curriculum for Infants and Toddlers with Special Needs

If the results of the above tools/procedures do not meet the criteria for a significant delay, the MDT may use informed clinical opinion to reach a determination. In addition, a child's medical or other records may be used to establish eligibility (without conducting an evaluation of the child) if those records indicate a significant developmental delay or meets the criteria of a disability. The medical records must meet the criteria for Georgia's BCW eligibility. i.e., appropriate tool, significant delay. 303.321 (a)(3)(i) If a child's eligibility is established under these criteria, an assessment of the child must still be performed for IFSP planning.

D. Required Components of Initial Evaluation or Assessment

1. The choice of MDT/PSP members and developmental evaluation tools/procedures for any child should be based on the presenting developmental needs of the individual child and the priorities of the family.
2. If a parent has not provided consent to the initial screening, evaluation, or assessment of a child, despite documented, repeated attempts to obtain parental consent, the local lead agency must complete the initial evaluation, assessments, and IFSP meeting as soon as possible after parental consent is obtained.
3. An assessment is required once a child is determined eligible, regardless of how the child is determined to be eligible. A 5-domain evaluation tool used for eligibility determination may also be utilized for assessment.
4. All initial evaluations or assessments must include the collection and review of the following information:
 - a. Reason for referral/statement of concern and referral source;
 - b. Parent(s) information which may include an interview, questionnaire or developmental checklist, and other information collected during intake;
 - c. Review of pertinent records related to the child's current health status and medical history, which may include a written statement from the primary health care provider; and other diagnostic codes available in the medical record;
 - d. Vision and hearing screening;
 - e. A completed evaluation or assessment instrument covering five developmental domains: cognitive, communication, adaptive, physical, and social-emotional development.

For children with Category I conditions, this will include:

- A curriculum-based assessment
- A physician's completion of the Physician Health Review with confirmation of the diagnosis, including diagnostic codes.

For children with Category 2 conditions, this will include:

- Appropriate standardized and norm-referenced diagnostic tools (at least one), and;
- Standardized behavior checklists or curriculum-based measures; or Systematic observation of functional abilities in the child's daily routine or natural setting.

If a child shows signs of or is diagnosed with a condition in which the effects on development are unknown, the Physician Health Summary should be completed.

- f. Adjusted or corrected age of the child must be used when evaluating infants and toddlers under age 2 born before 37 weeks gestation, except in situations in which the publisher of the evaluation tool recommends using chronological age as the basis for scoring the instrument.

- 4 The eligibility decision is confirmed through the consensus of the MDT.
- 5 If a consensus on eligibility is not initially reached, additional developmental evaluation/assessment information is gathered, and the decision is achieved with the assistance of the Early Intervention Coordinator or designee.
- 6 If the parent does not agree with the determination of eligibility based on the developmental evaluation procedures as described above, the parent can initiate a due process hearing in accordance with the Procedural Safeguards Section.
- 7 The above-collected information must be documented in the child's BCW early intervention record prior to IFSP development and before initiation of any services. For children with Category 2 conditions, this documentation must delineate how the MDT/PSP team reached an informed clinical opinion substantiating a significant developmental delay.
- 8 Any completed test protocols or question booklets that contain information about a specific child being evaluated or assessed by/for BCW must be retained for five years after the child exits the program and be made available for parent review as part of the child's early intervention record under Federal Educational Rights and Privacy Act (FERPA).
- 9 If a child is found not eligible, the parent will be provided with prior written notice and information about the parent's right to dispute the eligibility determination through dispute resolution mechanisms under §303.430, such as requesting a due process hearing or mediation or filing a State complaint.

C. Informed Clinical Opinion

Under section § 303.300 and § 303.322(c)(2), States are required to ensure that informed clinical opinion is used in determining a child's eligibility. Informed clinical opinion is especially important if there are no standardized measures or if the standardized procedures are not appropriate for a given age or developmental area. Informed clinical opinion will be used to determine the existence of a condition that has a high probability of resulting in developmental delay under § 303.16(a)(2).

If the team cannot identify appropriate instruments to accurately capture a child's developmental status because of health status, age, or characteristics of the disability,

then Informed Clinical Opinion (ICO) can be used to determine eligibility. The early intervention professional or team uses both qualitative and quantitative information to shape an informed clinical opinion in determining a child's difficult-to-measure aspects of current developmental status and potential need for early intervention services. To do so, the professional must have knowledge of the multiple domains of development characteristic of infants and toddlers; the expected sequence of development; and the broad range of individual variations that may be seen in appropriately developing infants and toddlers.

In addition to meeting IDEA requirements, ICO provides a basis for planning appropriate services for children and families, for individual professionals and also at the team level. ICO is used throughout the process of evaluating and assessing an infant or toddler to yield a comprehensive and accurate description of the functional skills and behaviors a child uses to participate in routines and activities within his/her natural environments.

ICO is a process, not a definition of eligibility, and its use to determine eligibility does not replace or modify a state's definition of eligibility. In no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility (34CFR§ 303.321(a)3(ii)).

The rationale for ICO is a discussion of the "whole child" that goes beyond a reporting of just test scores. Therefore, the functional impact of documented developmental delays can be discussed and considered in determining eligibility.

In writing the ICO when documenting eligibility, the multidisciplinary team MUST document the following:

1. Who was involved in the team and in gathering information
2. Description of the procedures used and in which settings
3. Summary of the information and description of the functioning of the child in each developmental area.
4. That the informed clinical opinion was a consensus of the multidisciplinary team (not the judgment of only one member). Statement of the decision of the team and rationale for concluding that the child is eligible.

Methods and Procedures

Methods and procedures are to include the following:

1. Answers to the following questions regarding child's development:
 - How does the child's behavior/atypical development or delay adversely affect the child's day-to-day functioning, daily routines, or activities? What are the child's abilities and needs within his/her natural environment?
 - Has the child lost skills and/or stopped making progress in this developmental area?
 - Has more than one person expressed concern with atypical or delayed development?
2. Objective data is used to conclude that the child has a developmental delay and is in need of early intervention services. Any or all of the following can be used:
 - Clinical interviews with parents and family members;
 - Evaluation of the child in his/her daily routine;
 - Observation of parent-child interaction;
 - Information from teachers or childcare providers;
 - Medical records;

- Neurodevelopmental or other physical examinations;
- Test scores (from additional testing performed that indicate significant delay)
- Other developmental data, including health status and medical history
- Systematic observation tools, which may include state-developed tools and/or selected parts of domain tools.

Information obtained from these methods is synthesized to form the informed clinical opinion of the child's development and family resources, priorities, and concerns and suggest areas that may need further assessment.

D. Review of Prior Developmental Evaluation/Assessment Data

With written, informed parental consent, MDT/PSP must consider any *standardized or curriculum-based developmental evaluation/assessment that meets Georgia requirements* that is less than six (6) months old. If the evaluation/assessment does not include a five-domain instrument that meets Georgia requirements, the MDT/PSP must complete a five-domain tool or procedure to ensure that all five domains are addressed. In this case, only one professional is required.

The MDT/PSP must prevent children and families from undergoing unnecessary assessments and avoid duplicating already existing evaluation/assessment information. In addition, a child's medical or other records may be used to establish eligibility (without conducting an evaluation of the child) if those records indicate a significant developmental delay that meets the Georgia BCW criteria of a disability.

E. Nondiscriminatory Procedures

Nondiscriminatory procedures must be used in all developmental evaluations and assessments. These nondiscriminatory procedures require that:

1. All tools/procedures are conducted and interpreted in the native language when used with respect to an individual who is limited English proficiency. The language normally used by the individual, or in the case of a child, the language generally used by the parents of the child for evaluations and assessments conducted, and the language normally used by the child if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment. Native language, when used with respect to an individual who is deaf or hard of hearing, blind, or visually impaired, or for an individual with no written language, means the mode of communication that is normally used by the individual (such as sign language, braille, or oral communication).
2. Any developmental evaluation/assessment(s) tools/procedures that are used are selected and administered in a racially or culturally sensitive and effective manner so as not to discriminate against but respect and recognize the culture of the family and child. In addition, tools/procedures must be adaptable to accommodate the physical and sensory needs of the child.
3. Developmental evaluations and assessments are conducted by qualified personnel.
4. Interpretation services must be offered and made available to families to ensure that families are full and active participants in the IFSP process.

F. Family Assessment

1. Family assessment refers to a process designed to assist families in identifying their resources, priorities, and concerns related to enhancing the development of the

child. This process is family-directed and based on the family's determination of which aspects of the child's developmental delays are of high priority, relevance, and importance.

2. Family assessment is strictly voluntary on the part of each family member, and a family member's decision not to participate in this process will not affect the child's eligibility for BCW services.
3. Requirements Related to Assessment of the Family. If an assessment of the family is carried out, the assessment must:
 - a. Be conducted by qualified personnel;
 - b. Be based on information provided by the family through a personal interview;
 - c. Incorporate the family's description of its resources, priorities, and concerns and the identification of supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.
4. Native Language in accordance with the definition in Evaluation and Assessment Policy.

G. Timeline for Initial Developmental Evaluations and Assessments

If a child with a Category 1 condition requires immediate services, an Interim IFSP (see IFSP Policy) may be developed prior to completing the initial assessment. Developmental assessments must be completed within the required timelines.

H. Maintaining MDT/PSP Members for Developmental Assessments

1. Selection of a developmental evaluation/assessment provider is the decision of the local program. Local programs must have policies that indicate how and by whom this function will be implemented.
2. Each local program is responsible for establishing and maintaining a list of service providers who meet the highest entry-level requirements for their respective disciplines as specified by the Georgia Licensing Board, the BCW Program State Plan Application and Part C Personnel Policy for early intervention professionals and: 1) are employed by the local lead agency; or 2) have a current contract with the state lead agency.
3. The local lead agency must provide a copy of each evaluation/assessment to the parent within 21 calendar days, at no cost to the family.

I. State Approved Tools/Procedures

To make the eligibility determination for children with Category 2 conditions, evaluators must use at least one standardized, norm-referenced instrument appropriate for the child's age. In addition, a child's medical or other records may be used to establish eligibility (without conducting an evaluation of the child) if those records indicate a significant developmental delay or meets the Georgia BCW criteria of a disability.

One of the tools listed below **must** be utilized to establish eligibility:

1. Bayley Scales of Infant Development
2. Battelle Developmental Inventory (BDI)
3. Developmental Assessment of Young Children (DAYC)
4. Developmental Profile 4 (DP-4)

For assessment for IFSP Planning, one of the following tools **must** be utilized:

1. The Carolina Curriculum for Infants and Toddlers with Special Needs
2. Hawaii Early Learning Profile (HELP)
3. Assessment, Evaluation and Programming System (AEPS)
4. The Trans-Disciplinary Play-based Assessment
5. Battelle Developmental Inventory (BDI)

6. Developmental Assessment of Young Children (DAYC)
7. Developmental Profile 4 (DP-4)
8. Bayley Scales of Infant Development

These tools can track the child's ongoing developmental progress in the context of everyday routines and activities and obtain federally required information about child outcomes.

A formal evaluation/assessment is not required for determining COS exit ratings. Additional information from crosswalks of evaluation/assessment tools developed by the ECO Center, other approved evaluation/assessment tools, observation and informed clinical opinion can be considered in determining COS exit ratings.

CHAPTER 300 – INDIVIDUALIZED FAMILY SERVICE PLAN

GUIDING FEDERAL POLICY 34 CFR §303.340 – §303.346 IFSP

BABIES CAN'T WAIT (BCW) PROGRAM STANDARD

An Individualized Family Service Plan (IFSP) document shall be developed for each eligible child and family in accordance with Part C of the Individuals with Disabilities Education Act (IDEA). The IFSP shall be a documented plan for providing early intervention services to an eligible child and the child's family and shall be based upon information compiled through multidisciplinary developmental evaluation and/or assessment processes.

Lead Agency responsibility:

The lead agency shall ensure that an IFSP is developed and implemented for each eligible child, in accordance with the requirements of Part C. If there is a dispute between local BCW programs as to who has responsibility for developing or implementing an IFSP, the lead agency shall resolve the dispute or assign responsibility.

Each local program must implement policies & procedures regarding IFSPs that meet the requirements.

IMPLEMENTATION

A. Orientation:

1. The Service Coordinator shall provide the parent(s) of eligible children an orientation to the IFSP process.
2. This orientation must be conducted:
 - in the native language or mode of communication most commonly used by the parents, unless it is clearly not feasible to do so and;
 - according to all federal and state procedural safeguards
 - at a time and place that is convenient for the parent(s)
3. The Service Coordinator shall exchange information with the child's primary care physician (PCP) on:
 - the importance of their involvement in the development of the IFSP;
 - options available to them to allow their participation in the IFSP development process;
 - the best way to keep them informed and maintain contact with his or her office;
 - how to engage the PCP's office in the IFSP reviews and updates

B. Timelines:

Meeting to develop initial IFSP – timelines:

For a child referred to the Part C program and determined to be eligible, a meeting to develop the initial IFSP must be conducted within the 45-day time period that begins with the receipt of the referral when BCW is mentioned. (C1st or BCW).

EXCEPTIONS:

IFSPs may be delayed when there are family-initiated reasons for delays.

- The first exception to the 45-day timeline is for situations when the child or parent is unavailable to complete the screening, if applicable; the initial evaluation; the initial assessment of the child; the initial assessment of the family; or the initial IFSP meeting due to exceptional family circumstances that are documented in the child's early intervention records.
- The second exception is if the parent has not provided consent for screening (if applicable), or the child's evaluation and assessment despite documented, repeated attempts by the local agency (LA) to obtain consent from the parent. Acceptable family-initiated reasons for delay in this timeline

include child illness/hospitalization, delayed family response time, and family requested delay. Family initiated reasons for delays must be well documented.

If a family moves from one local program to another in Georgia, the IFSP moves with them and continues to be valid and in place for a period not to exceed the six-month review. The receiving local program and IFSP Team will review the current IFSP and revise as needed based on the current identified needs of the eligible child and family. (See Child Record Procedures)

If a family moves to Georgia with an active IFSP from a Part C program in another state, the receiving local program and IFSP Team will treat the child as a new referral to the Part C system in Georgia, completing intake, evaluation (as needed), assessment, determination of eligibility, and IFSP development within the 45-day timeline.

C. **Participants:**

Participants in IFSP meetings (initial, annual, 6 Month Review and periodic reviews):

Initial IFSP meetings:

Each initial 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 who has been assigned to the family since the initial referral of the child for evaluation, or who has been designated by the public agency to be responsible for implementation of the IFSP.
5. A person or persons directly involved in conducting the evaluations & assessments.
6. As appropriate, persons who will be providing services to the child or family.
7. If the initial IFSP meeting will require a transition meeting in order to have the transition plan and conference completed by 33 months, the LEA representative should be invited unless the parent requests otherwise.

If a person listed under 5, 6 or 7 above is unable to attend a meeting and the parent(s) agree, arrangements must be made for the person's involvement through other means, including one of the following:

1. Participating in a telephone conference call;
2. Having a knowledgeable authorized representative attend the meeting.
3. Making pertinent records (evaluation/recommendations) available as soon as possible prior to the initial IFSP meeting to allow sufficient time for review. Prior to the annual IFSP, the pertinent records (evaluation/progress notes or summary) are due five days prior to the meeting.

Annual IFSP meetings:

Each Annual 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 who has been working with the family or who has been designated by the public agency to be responsible for implementation of the IFSP.
5. A person or persons directly involved in conducting the evaluations & assessments (this may be the ongoing provider if they conduct assessments).
6. As appropriate, persons who have been providing services to the child or family.

If a person listed under 5 & 6 above is unable to attend a meeting and the parent(s) agree, arrangements must be made for the person's involvement through other means, including one of the following:

1. Participating in a telephone conference call;
2. Having a knowledgeable authorized representative attend the meeting; or
3. Making pertinent records (evaluation/recommendations) available as soon as possible prior to the initial IFSP meeting to allow sufficient time for review. Prior to the annual IFSP, the pertinent records (evaluation/progress notes or summary) are due five days prior to the meeting.

Six Month Review Participants:

1. The parent or parents of the child. (Required)
2. The Service Coordinator. (Required)
3. Other family members, as requested by the parent, if feasible to do so. (Optional)
4. An advocate or person outside of the family, if the parent requests that the person participate. (Optional)
5. If the 6 Month Review IFSP meeting falls within the last six months prior to a child turning three, this meeting should also be the transition meeting. The school system representative must then also be invited unless the parent requests otherwise.
6. Participation by an evaluator or ongoing service provider will depend upon warranted conditions such as:
 - a) The individual conducted a re-evaluation of an infant or toddler with a disability, and the results of that evaluation will be discussed at the periodic review.
 - b) Discussion of a particular developmental area may require the participation of the EIS provider(s) in those areas. In such instances, the lead agency must ensure the participation of those individuals.

D. Meeting arrangements:

1. Parents must be given at least 5 calendar days prior written notice of any local program initiated IFSP meeting. Other IFSP Team members will be notified reasonably in advance to allow for participation. Team members can participate in IFSP meetings in person, via speakerphone, video conferencing, internet connections, or other means that allow them to interact in real time with other team members. If a BCW team member is unable to participate face to face or other real-time method in the IFSP meeting, documentation must be submitted prior to the IFSP meeting as outlined in the Participants section of this policy.
2. At least one IFSP Team member/discipline must participate in the IFSP development meeting.
3. Because the family is an integral part of the multidisciplinary team, the IFSP meeting must be held in settings and at times that are convenient to families. Such settings may include, but are not limited to, home, childcare, Early

Intervention office, primary care physician's office, or other settings as requested by the family.

4. IFSP meetings must be held in the native language or other mode of communication of the parent(s), unless clearly not feasible to do so (see Procedural Safeguards Section).
5. All attempts to schedule the IFSP meeting must be documented in the child's file
6. Documentation of efforts to locate interpreter services for the parent(s) must be maintained in the child's BCW early intervention record.

E. IFSP Team Members

Role and Responsibilities of a Service Coordinator are:

1. Inform families about who will participate in the IFSP development;
2. Assist families in identifying additional persons who will participate in development of the initial IFSP (e.g., a family friend, advocate, and/or potential service provider(s));
3. Facilitate and participate in the development, review, and evaluation of IFSPs along with the entire IFSP Team;
4. Promote along with the entire IFSP Team, family-centered services that respect families' decisions, values, beliefs and norms;
5. Coordinate along with the entire IFSP Team, the provision of the identified early intervention services and other services identified on the IFSP, including:
 - Ensuring timeliness in initiation of service delivery;
 - Documenting methods to monitor delivery and effectiveness of services identified in the IFSP, and reviewing the need for new, additional or modified supports/services
 - Ensuring that information from the "Identification of Natural Environments" and "All About Our Child and Family" sections of the IFSP document are reflected in the development, review and evaluation of the IFSP.
6. The IFSP Team members are selected based on competencies that match the needs of the child, and includes the parent(s), individuals involved in evaluation/assessment activities (in the case of initial IFSPs), and others who have information and input helpful in the design, development, and implementation of the IFSP for the child and family. The IFSP Team must include the parent, and at least two individuals from separate disciplines or professions and one of these Individuals must be the Service Coordinator.
 - The primary care physician may be invited to participate in the development of the IFSP, and may provide input by attendance in person, via a knowledgeable designated person, or in writing.
 - For children receiving service coordination only, the person(s) that was directly involved in conducting the initial evaluation and assessment or another member of the IFSP Team will be invited to participate in the IFSP meeting.

Upon completion of the IFSP document, the Service Coordinator must:

1. Ensure that the parent(s) has all of the necessary and relevant information to access services identified in the IFSP;
2. Determine with the parent's agreement, the specific nature of assistance the Service Coordinator shall provide to support parent(s) in gaining access to services identified in the IFSP;
3. Determine with the parent's agreement, the specific services identified in the IFSP that the Service Coordinator shall access on behalf of the child/family; and
4. Inform the family of advocacy services and groups that provide assistance to

families in accessing or relating to BCW service providers and provide information on the complaint and fair hearing process to families who experience dissatisfaction with BCW service providers.

5. The Service Coordinator must have the parent sign the IFSP signature page and then provide the parent with a copy of the entire IFSP within 10 business days. This is also true for periodic review and transition planning IFSP meetings.

F. Content of the Individualized Family Service Plan:

The IFSP document must directly address the child's developmental conditions, be linked to the child's level of need, address the medical cause and/or contributing factors to the developmental delays, and establish clear measures of outcomes and improvements with timelines. The child's delay, and the medical cause and/or contributing factors, if known, should be considered in determining the selection of primary service provider, the appropriate intervention methods and results/outcomes measures in both developmental and functional areas.

1. With the consent of the family, the IFSP document shall contain an assessment of the family's resources, priorities, and concerns and the identification of supports and services necessary to enhance the family's capacity to meet the identified developmental needs of the child.
2. The IFSP must include a statement of the infant/toddler's present level of development and be based on information gathered from intake and the comprehensive developmental evaluation and/or assessment. The statement must address at least the following areas:
 - Physical development (including vision, hearing, and health status);
 - Cognitive development;
 - Communication development;
 - Social or emotional development; and
 - Adaptive development.
3. The IFSP must document and include diagnoses related to the child's developmental delay and conditions with appropriate codes. The IFSP must contain measurable developmental goals and measurable functional outcomes expected to be achieved by the child based on the presenting conditions of delay and developmental needs. Functional outcomes enhance learning through child participation in everyday activities; are important and meaningful to the family; expand activity settings so the child can be competent and are based on the child's interests.
4. The IFSP must include specific early intervention service(s) based on:
 - peer-reviewed research to the extent practicable,
 - what is necessary to meet the unique developmental needs of the child,
 - the child's ability to function in his/her natural environment,
 - the capacity of the family to meet the child's developmental needs in order to achieve IFSP outcomes

NOTE: Early Intervention services should not be selected based on the ability of the local program to provide the services.

5. The IFSP must include a statement of the early intervention services identified by the IFSP Team as necessary and appropriate to address the developmental needs of an infant or toddler with a disability. Those early intervention services may include the following:
 - Assistive technology devices and services;
 - Audiology services;

- Family training, counseling, and home visits;
 - Health services;
 - Medical services only for diagnostic or evaluation purposes;
 - Occupational therapy;
 - Physical therapy;
 - Psychological services;
 - Service coordination services;
 - Social work services;
 - Special Instruction;
 - Speech-language pathology;
 - Transportation and related costs;
 - Vision services;
 - Other Required Services
6. The IFSP must include the frequency, intensity, location, duration, and method of delivering services, projected dates for initiation of services and the anticipated length and duration of such services.
7. Early intervention services must, to the maximum extent appropriate to the needs of the child, be provided in natural environments, including home and community settings that are natural and typical for the child's same age peers who do not have any developmental delays.
- Natural environments may include, but are not limited to: childcare settings, home, Early Head Start, the park or the playground, Mother's Morning Out or other community preschool programs, restaurants or shopping centers, or other places where families spend time.
 - The provision of early intervention services for any infant or toddler can occur in a setting other than a natural environment only when early intervention outcomes cannot be achieved satisfactorily for the infant or toddler in a natural environment. Identification of the early intervention service needed, as well as the appropriate setting for providing each service to an infant or toddler with a disability, is a decision made by the IFSP Team based on that child's unique needs, family routines, and developmental outcomes. If a determination is made by the IFSP Team that, based on a review of all relevant information regarding the unique needs of the child, the child cannot satisfactorily achieve the identified early intervention outcomes in natural environments, then services could be provided in another environment (e.g., clinic, hospital, service provider's office).
 - If the IFSP Team is considering service provision in a location other than the child's natural environment, the IFSP Team must show sufficient documentation to support the team's decision that the child's outcomes/strategies cannot be achieved by providing the service in the child's natural environment, even with supports/accommodations. The justification must be reconsidered at least every six months, and documented in the IFSP document to include:
 - A detailed explanation of why the IFSP Team determined that the child's outcomes/strategies cannot be met if the services are provided in the child's natural environment with supports/accommodations provided by BCW;
 - How interventions provided in the non-natural environment will be transferred into activities to support the child's ability to function in his/her natural environment; and
 - A plan that describes the review process to monitor the child's development relating to the possibility of moving service provision, to the extent appropriate to the natural environment.

8. The IFSP must include the name of the individual who will serve as the Service Coordinator. All early intervention services must be provided by personnel who have met state-approved or recognized certification, licensing, registration, or other comparable requirements for the discipline as recognized by BCW.
9. All funding sources for early intervention services must be listed in the IFSP document, including any family costs and third-party billing.
10. To the extent appropriate, the IFSP may include other services that a child or family needs but are neither required nor covered under Part C (BCW is not responsible to provide or covers financially). Examples include respite care, routine pediatric medical care or other family support services. If a family chooses to receive a service in a location other than the child's natural environment (without justification from the IFSP Team), these services will be outside the BCW system; therefore, these services will not be eligible for coverage by BCW.
11. The IFSP must include steps and services to be taken to support the transition of the child to preschool services, early education, Early Head Start, childcare or other appropriate services. Transition steps must include:
 - Discussions with parents, beginning with the initial IFSP meeting, regarding transition goals and future placements;
 - Procedures to prepare the child for changes in service delivery and settings;
 - Transmission of information, with parental consent, to the local educational agency (LEA) to ensure continuity of services.

G. Availability of Services:

BCW services shall be made available throughout the calendar year, in accordance with the IFSP, for each eligible child and his/her family. Individual calendars should be mutually negotiated between the IFSP Team and the family that take into account state and national holidays, vacations, as well as acts of nature that might interfere with delivery of services.

H. Responsibility and Accountability:

1. Each BCW service provider who has a direct role in the provision of early intervention services is required to adhere to the highest standards of their profession.
2. Each BCW service provider who has a direct role in the provision of early intervention services is responsible for making a good faith effort to assist each eligible child in achieving IFSP results or outcomes.
3. BCW service providers shall be held accountable for monitoring the degree to which each child is making progress toward achieving the outcomes contained in an IFSP.
4. BCW service providers shall not be held accountable if an individual child does not achieve the expected outcomes in the IFSP where the service provider has provided services in accordance with the IFSP.
5. BCW Service Coordinators shall coordinate IFSP meetings and input all IFSP information for each assigned child into the Babies Information and Billing System (BIBS).
6. BCW service providers shall input into BIBS all eligibility, service provider notes, progress notes and required information for billing BCW.
7. BCW service providers and Service Coordinators are responsible for checking and responding to all alerts and emails from BIBS.

I. IFSP Implementation:

1. Each child and family shall have only one IFSP document in place at any one time.
2. Parent(s) signature on the IFSP allows for sharing of information among all BCW team members who are listed on the services page. The Authorization of Release

of Information form must be completed and signed by the parent to allow sharing of information with others not listed on the IFSP services page.

3. All BCW team members contributing to the development of the IFSP will be listed on the IFSP.
4. The child's PCP shall be encouraged to be an active participant in the IFSP process as indicated previously.
5. Parent(s) signature on the IFSP document shall serve as consent for implementation of the services and activities listed in the IFSP. No additional consent is required for services to begin. Early Intervention Services must be provided as soon as possible and no later than 45 days after parental consent is obtained.
6. If the parent(s) does not provide consent for a particular early intervention service, or withdraws consent after first providing it, that early intervention service cannot be provided. The other early intervention service(s) to which consent is given must be provided.

If at any time the parent(s) declines consent for early intervention services recommended by the IFSP Team, the parent must sign the "Declining Early Intervention Services" form.

If a provider session is missed, makeup sessions may be requested by the rendering provider to add additional authorization(s) for the missed session(s). The Service Coordinator must create an inter-periodic meeting in BIBS to create a new authorization for the additional visit(s) needed. The authorization must be "one per authorization" (one episode of approved units) and can be for as many sessions needed. The Service Coordinator must enter the authorization as compensatory (makeup session) and must enter a start and end date up to a 30-day period. This authorization will not affect the original authorizations on the child's IFSP. This does not mandate a face-to-face meeting with the family and Service Coordinator. Missed sessions must also be documented in the provider progress notes and in the Service Coordinator case notes.

J. Six-month Review and Annual Review:

The purpose of the review is to determine the degree to which progress toward achieving the results or outcomes identified in the IFSP is being made and whether modification or revision of the outcomes or services identified in the IFSP is necessary. It must be conducted at these junctures:

1. A review of the IFSP must be conducted at least once every six months and annually before the development of the new IFSP. It can be reviewed more frequently based on the child's conditions and/or when the family requests such a review. (Inter-periodic) The Service Coordinator must ensure that parents are informed of and understand their right to ask for more frequent reviews.
2. These reviews must be documented in writing in the IFSP and IFSP meeting minutes and maintained in the child's BCW early intervention record. The Service Coordinator must input the meeting and all changes to the IFSP in BIBS within seven (7) calendar days of the change.
3. The review must address the child's ability to function in settings identified as natural or typical for the family, and the need for assistive technology services and devices which support the child's ability to function in his/her natural environment.
4. IFSPs expiring within 45 days of the child's third birthday may be extended until the third birthday.

K. Inter-Periodic Reviews:

1. Any of the following requests to revise the IFSP need an inter-periodic review:
 - Frequency
 - Intensity

- Duration of a service
 - Addition or termination of a service
2. Requirements for an inter-periodic review:
- A change to the IFSP proposed by the local program requires written notice to the parent(s) five calendar days prior to the proposed change.
 - Adequate notice must be given to other team members to facilitate their participation.
 - Parents may call for a review of the IFSP at any time, and they may request the participation of other family members, team members, and/or additional persons.
 - The Service Coordinator must ensure that parents are informed of and understand their right to ask for this review.
 - The Service Coordinator must ensure that all team members and parent/guardian are in agreement with any revision.
 - The meeting does not have to be face to face.
 - **The parent/guardian must give signed consent for any changes listed in #1 above.**
 - The Service Coordinator must document agreed upon changes on the IFSP. The family must receive a copy of the modified IFSP within 10 business days of the change.

L. Interim IFSP for Children Known to Be Eligible Before Evaluation and Assessment is Completed:

An interim IFSP may be developed to immediately begin identified services prior to the completion of the multidisciplinary assessment (required for IFSP development) when a Category 1 condition is verified, and exceptional circumstances (e.g., the child is ill) make it impossible to complete the assessment within 45 days of the referral. Details of the exceptional circumstances must be documented.

The following conditions must be met in order to implement an interim IFSP:

- Parental consent is obtained
- The Service Coordinator who will be responsible for implementation of the interim IFSP and coordination with other agencies and persons is identified
- Services that are determined to be needed immediately by the child and the child's family are identified (e.g., Family Training and Counseling)

When Children 1st receives a referral from the hospital for a child with a Category 1 diagnosis, the referral should be sent immediately to BCW. BCW will attempt to contact the family within three business days. If it is reported by the family that the child is still in the hospital and the parent wants to move forward with the process, the local program should proceed to complete the interim IFSP.

If the child's hospital stay exceeds the 45-day timeline, the Service Coordinator must have clear documentation of the reasons why the IFSP is delayed.

If a child with an interim IFSP is released prior to 45 days from referral, the local program must make every attempt to complete the assessment and initial IFSP prior to the end of the 45-day timeline.

The local program in which the child/family has legal residence is the local program responsible for completion of the interim IFSP.

M. Transition Planning:

1. Transition planning with BCW shall be discussed and documented at each IFSP meeting beginning at the time the initial IFSP is developed. Transition planning is

required to assist children and families as they move from the Part C program to:

- a. The Part B preschool special education program;
 - b. Other community programs, such as Head Start;
 - c. Another local program or state.
2. The IFSP must include steps and services needed to support the smooth transition of a child who is exiting the Part C program and a review of program options with the family. With prior written notice and consent, the Transition Plan is developed not fewer than 90 days and at the discretion of all parties, up to nine months prior to the child's third birthday. The family holds an integral part in the development of the Transition Plan. The plan must include any appropriate steps for the toddler to exit, any identified transition services deemed necessary by the IFSP Team for the child and his or her family (§§303.209(d) (3)) and confirmation that the LEA notification has occurred unless the parent has opted out of notification. Participants must include the family, Service Coordinator, and person involved in evaluations/assessments (usually the ongoing provider and does not have to be face to face participation).
 3. With informed prior written notice and parent consent, the Service Coordinator will convene a transition conference with the appropriate parties to discuss any services the toddler may receive under Part B §303.209(c) (1). Participants must include the family, Service Coordinator, person involved in evaluations/assessments (usually ongoing provider), a Part B representative (unless parent refuses), and other community representatives as appropriate. The evaluator may participate by other means than a face to face. The LEA representative may participate by other real-time methods than face to face. The IFSP Transition Plan meeting and the Transition Conference may be combined into one meeting. The Lead Agency and the Department of Education (DOE) strongly recommends that the transition plan and the transition meeting be completed by the time the child is 30 months of age. They must be completed no later than 90 days prior to the child's third birthday (unless late referral) and may be completed up to nine months prior to the child's third birthday.
 4. Children transitioning from Babies Can't Wait at any time must be referred back to Children 1st with informed, signed parental/legal guardian consent, if the child is not enrolled in another Maternal & Child Health program (Children's Medical Services or First Care).

CHAPTER 400 – HEALTH and SAFETY

BABIES CAN'T WAIT STANDARD

Healthy, safe conditions are required to promote the growth and development of each child and the productive functioning of each employee.

- A. Each service provider shall ensure that they and their staff and sub-contractors are free from communicable and contagious disease.
- B. Each service provider shall act as a mandated reporter for suspected child abuse and/or neglect according to the DPH policy/regulations.
- C. Each service provider should be aware of the local procedures for reporting suspected child abuse and neglect. Each agency should consider an annual in-service training program by a local child protection worker or supervisor. Signs and symptoms of child abuse and reporting procedures for suspected child abuse and neglect should be reviewed at this time.

CHAPTER 500 – SERVICE DELIVERY

Service delivery will address the developmental needs of the child and enhance family/caregiver capacity to support the child's development. Service delivery will include the appropriate clinical and/or developmental professional(s) who are most competent to support the child and family/caregiver. Service delivery will be team-based, using designated teams composed of necessary disciplines in early intervention services. Service teams can be formed to enhance child development in many ways. Service team members can be chosen based on types of developmental delays and/or specialty required to meet the needs of children and families with identified delays/needs. Service teams can be formed based on the geographic coverage areas of both the providers and the children and families on the team. The designated team of providers which includes the family, selects a primary service provider (PSP), based on the competencies needed to support the needs of the child and family, and serves as the lead interventionist to provide direct service and support to the child/family. Other team members may also provide services, as needed, to support the child, family, and PSP.

A. Primary Service Provider Model

MISSION

Part C early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

KEY PRINCIPLES

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
2. All families, with the necessary supports and resources, can enhance their children's learning and development.
3. The primary role of a service provider in early intervention is to work with and support family members and caregivers in children's lives.
4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect family members' learning styles and cultural beliefs and practices.
5. IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
6. The family's priorities, needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

B. Establishment of IFSP/PSP Teams

Where appropriate and feasible, each eligible infant/toddler and their family shall have access to services/supports from a designated service delivery team of providers responsible for providing direct services in the district. The team of providers assigned to each family must have the needed skills and competencies to support the family's needs and be flexible to serve the family as their needs change.

1. Each service provider shall meet the highest entry-level certification, licensing, or registration requirements that apply to that profession or discipline, in the state.
2. Each service provider shall demonstrate skills, values and key competencies needed to address child developmental delays and levels of identified needs as well as to enhance family capacity to support child development.
3. Each service provider shall meet any BCW mandated training requirements in order to ensure key competencies. Adequate safety training shall be made available to individuals including, but not limited to, safety, health and environmental health management issues.
4. Districts may use clinical fellows (CFs) in speech-language pathology (defined by the American Speech-Language-Hearing Association). It is the responsibility of the CF to ensure that criteria for the fellowship and supervision requirements are met.

C. Selection of the Primary Service Provider (PSP) and Additional Team Members

1. The Primary Service Provider (PSP) Approach to Teaming' is the method of service delivery for BCW.
2. The Primary Service Provider shall be chosen:
 - By the entire IFSP/PSP team (including families);
 - Based on identified developmental delays and levels of presenting needs of each child, child's specific interest and natural environment, as well as the capacity needs of the family/caregiver to enhance the development of their child;
 - Based upon family dynamics and characteristics which can include language and culture; knowledge and experience; as well as family priorities;
 - Based primarily on provider competencies needed to address the causal and/or contributing factors to the developmental delays in order to support child's progress toward achieving the IFSP outcomes; and
 - From any discipline, as appropriate.
3. The Primary Service Provider may change at a family's request, as the family's situation changes, or as the causal and/or contributing factors change, including family's related capacity to enhance their child's development, or if different skills or competencies of providers are needed to promote progress toward IFSP outcomes.
4. Based on other competencies needed to support IFSP outcomes, additional service providers or team members may also be designated to support the child, family and/or the PSP team, as needed.
5. The early intervention coordinator provides administrative oversight of the provider and Service Coordinator selection process to ensure that it is equitable and representative of the child's and family's needs.

D. Roles and Responsibilities of IFSP/PSP Team

1. The PSP and any additional team members will be responsible for:
 - a. Addressing each child's identified developmental need(s);
 - b. Improving child's functioning through increased participation in daily activities and routines within natural environments, including home and community settings in which children without disabilities participate;
 - c. Increasing each family/caregiver's capacity to support their child's development and functioning;
 - d. Providing necessary services and monitoring child's progress and achievement of set goals and outcomes as specified in the IFSP;
 - e. Ensuring coordination of services and supports across all settings.
2. As a child's developmental delay and level of needs change due to changes in the causal and/or contributing factors, including family's related capacity to enhance their child's development, the PSP shall initiate or modify the intervention approach to adapt and meet the child and family needs by: changing existing service delivery methods, requesting support, information, or other assistance from other providers or team members, as appropriate, through team meetings, IFSP reviews or modifications, supplemental visits or other forms of communication and necessary adjustments.

E. Primary Service Provider (PSP) as Service Coordinator

The Primary Service Provider may also serve as the Service Coordinator. The designated Primary Service Provider on the team, if acting as the Service Coordinator, shall fulfill all service coordination responsibilities for each family for whom he or she is the Primary Service Provider (See Service Coordination policy).

F. Team Communication

Providers on designated teams shall communicate routinely with other team members about outcomes and services/supports being provided to infants and toddlers and their families. Various means of communication may be used including team meetings, telephone calls, email, written input, etc. The child's primary care physician may utilize a designated representative, knowledgeable about the child's health and medical status (e.g., a nurse). Families must be active members of their PSP team.

Team members, including families, shall:

- Be invited/involved in team meetings;
- As appropriate, be offered various ways to participate including face-to-face meetings, telephone conference calls, video conference calls, written input, use of designated physician representatives as described above, etc.
- Meet regularly/routinely to support one another and ensure appropriate needs of children and families are met on at least a quarterly basis;
- Review the child's IFSP and status and provide feedback to enhance child development appropriately;
- Provide input by other means if unable to attend;
- Be provided updates if unable to attend.

G. Training and Continuing Education

1. All personnel providing service coordination, Special Instruction and the Early Intervention Specialist (EIS) must begin Skilled Credentialed Early Interventionists (SCEIs) training

requirements upon hire or contract with BCW. The last module must be completed within six (6) months. The 6-month period for successful completion of the required SCEIs begins on:

- a. The effective date of a contract with the BCW program through the state lead agency in any role requiring SCEIs, or
 - b. The effective date of contract, subcontract, or employment with any agency or organization which contracts with the BCW program through the state lead agency in any role requiring SCEIs, or
 - c. The beginning date of employment with the local BCW program in any role requiring SCEIs.
2. All personnel providing service coordination, Special Instruction, and the Early Intervention Specialist (Level I: Paraprofessionals and Level 2: Bachelor level/Professional) regardless of licensure/certification, are required to complete Continuing Education hours after completion of the SCEIs Module requirements.
- a. All persons providing service coordination and Level 2 Special Instruction and the EIS are required to have twenty (20) contact hours of continuing education every two years. Content of continuing education must clearly focus on:
 - Young children, birth to age eight;
 - Families of young children, birth to age eight; and/or
 - A particular disability covered under Babies Can't Wait
 - Ten (10) of these hours must be specific to young children with disabilities and/or their families
 - b. Level I Paraprofessional/EIA are required to have ten (10) contact hours of continuing education every year. Content of continuing education must clearly focus on:
 - Young children, birth to age eight;
 - Families of young children, birth to age eight; and/or
 - A particular disability covered under Babies Can't Wait
 - Five (5) of these hours must be specific to young children with disabilities and/or their families
 - c. Personnel who do not comply with this policy in the timelines stated above will not be able to provide services for families and/or children through the Babies Can't Wait program until requirements are completed.
3. Continuing education requirements go into effect for an individual July 1 after he/she has received a certificate of completion for the Project SCEIs modules.

H. Service Delivery Settings

1. "Natural environment" means settings that are typical for the child's age peers who have no disabilities. Natural environments may include, but are not limited to, childcare, home, Early Head Start, the park or the playground, restaurants or shopping centers, and other places where families with typically developing children spend time.
2. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including home and community settings in which children without disabilities participate.
3. The provision of early intervention services for any infant or toddler may occur in a setting other than a natural environment only when early intervention outcomes

cannot be achieved satisfactorily for the infant or toddler in a natural environment.
(See IFSP policy, section F)

4. The needs of each infant/toddler, the family's preferences and team input shall determine specific service delivery settings chosen.
5. All team members must build upon family strengths, understand family resources and challenges, and work together to select meaningful locations for service delivery.
6. Regardless of setting, services should focus on enhancing the child's development by inclusion of the following applicable approaches in the implementation of the IFSP:
 - a. Supporting family/caregivers in their role as the first and most important facilitator of their child's development;
 - b. Building upon existing family/caregiver priorities, strengths and interests; partnering with parents/caregivers directly in facilitating their child's development;
 - c. Partnering with parents/caregivers directly in facilitating their child's development;
 - d. Assisting family/caregivers to identify routines and activities appropriate and optimal for parent/child interaction and intervention; and
 - e. Utilizing materials and toys found in or around the natural setting and supplementing with appropriate developmental materials, only as needed to meet IFSP outcomes.
7. Services must be delivered with parent(s) or the primary care giver present and participating in the activities.

CHAPTER 600 – EARLY INTERVENTION SERVICES

600.1 – Definitions of Early Intervention Services

The purpose of this section is to provide a definition of those federally required early intervention services that may be supported in whole or in part through the use of Babies Can't Wait (BCW) funds for eligible children and their families through the IFSP process.

Children and families receive individualized services in accordance with the functional outcomes identified in the IFSP. Intervention is designed to include the child, parent or person acting in the place of the parent and provider(s). Parent participation in service delivery is necessary in meeting the developmental needs of the child.

Early intervention services must be provided in a **natural environment** unless there is justification that "early intervention cannot be achieved satisfactorily for the infant/toddler in a natural environment." (Title 34 CFR [§303.126](#)). **Natural environments** may include the child's home, childcare centers, family childcare homes, playgrounds and other community settings where typically developing children live, learn and play.

The standard of "enhancing the child's development" must be applied to early intervention services provided through Babies Can't Wait (either directly or through linkages). All early intervention services must be tied to strategies needed to achieve developmental outcomes contained in the IFSP while the child is enrolled in Babies Can't Wait.

Early intervention services may include:

- Applied Behavior Analysis
- Assistive technology devices and services
- Audiology services
- Family training, counseling, and home visits
- Health services
- Medical services for diagnostic or evaluation purposes
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Service Coordination
- Social work services
- Special Instruction
- Speech-language pathology
- Transportation and related services
- Vision services
- Interpretation/Translation Services

Early Intervention Services include, but are not limited to, the following definitions:

A. Assistive Technology Devices and Services

1. **ASSISTIVE TECHNOLOGY DEVICE**

Assistive Technology Device means 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 an infant or toddler with a disability. The term does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device. (34 CFR §303.13 (b) (1) (i)).

Generally, assistive technology (AT) devices supplement the existing skills of the individual with disabilities. These devices are tools that are used to increase a child's functioning in one or more developmental areas (e.g., communication, fine motor, etc.).

PROCEDURES FOR IMPLEMENTATION

- A. The IDEA definition of assistive technology devices is broad and covers a wide range of technology devices. Assistive Technology for children with disabilities may include any of the following:
1. **Augmentative communication devices** (i.e., Single or multiple message devices with speech or picture output);
 2. **Vision and hearing devices** (i.e., Magnifying glasses, backlit surfaces, amplification systems, and tape recorders). This does **not** include eyeglasses, contact lenses or a medical device that is surgically implanted, or the replacement of such device (34cfr§ 303.13 (b) (1) (i));
 3. **Mobility and positioning equipment** (i.e., Supports for seating, adapted tricycles/scooters, etc.);
 4. **Appliance control devices** (i.e., Electrical control units for switch activation. **Note:** In catalogs these devices are also referenced as “environmental control units”);
 5. **Learning tools** (i.e., Built-up writing instruments, knobbed puzzles);
 6. **Adaptive daily living tools** (i.e., Built-up spoons, bath supports); and
 7. **Adaptive toys** (i.e., switch activation, built-up handles, amplified sounds or actions).
- B. Assistive technology devices, when determined necessary by the PSP team, must be provided as a tool to support the child in meeting IFSP developmental outcomes. AT needs may vary greatly from child to child. The appropriate technology device for a child with a disability must be determined on an individual basis by the IFSP Team. Successful use of AT is attainable only when:
- a. Care providers are willing to learn about and use the technology recommended;
 - b. Adequate funding resources are in place; and
 - c. Training for both the child and care providers are available.
- C. The need for Assistive Technology must be documented including information regarding the necessity and appropriateness for using AT and supported through IFSP activities and strategies. The provision of AT must be documented on the IFSP. To help with identification of effective AT for implementing strategies to achieve IFSP outcomes, an assessment may be needed to determine:
- a. A plan for using AT systems and choice of possible tools by the child's PSP team to accomplish strategies to meet IFSP outcomes; why current AT systems are not working;
 - b. Better utilization of AT currently used;
 - c. The use of AT for additional developmental areas; and
 - d. AT systems that may need to be purchased and possible funding options explored.

2. **ASSISTIVE TECHNOLOGY SERVICES:**

Assistive Technology Service means any service that directly assists an infant or toddler with a disability in the selection, acquisition, or use of an assistive technology device.

The term includes:

- a) The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;
- b) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
- c) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- d) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- e) Training or technical assistance for a child with a disability or, if appropriate, that child's family;
- f) Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that child.

(Note: The final regulations on IDEA also state that "related services "**do not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance, or the replacement of that device**" (34CFR§ 303.13 (b) (1) (i)).

PROCEDURES FOR IMPLEMENTATION

IDEA specifically delineates several service areas. Procedures for providing services in these areas are addressed in the following subsections:

1. AT needs must be assessed functionally within the context of the child's activities and routine. BCW expects service providers who perform evaluation/assessment activities to incorporate an examination of possible AT adaptations into their developmental evaluation/assessment report. All available information must be considered by the PSP team in order to determine whether recommended AT is necessary in order for the child to achieve developmental outcomes and must be included in the child's IFSP.

Results from PSP team and parent discussion must be used to develop or revise the IFSP, plan activities and strategies for using recommended AT, and to secure appropriate AT services and resources.

There may be situations in which a more in-depth AT assessment is necessary to assist the child's PSP team in determining essential and appropriate assistive technology such as:

- a. When the PSP team determines that specific expertise is needed regarding special technology with which they are not familiar;
- b. When the PSP team does not feel qualified to assess the assistive technology needs of a child;
- c. When the disabilities of the child are such that multiple and/or customized technology systems may be required.

BCW requires that a need for assistive technology is documented on the IFSP as a strategy to support the child's outcome.

2. Acquisition of AT: IDEA requires that AT devices must be made available for children with disabilities. The child's PSP team is responsible for making the decision of how to best provide access to AT. BCW requires that whenever possible, appropriate assistive technology must be loaned to the child as needed until the child turns three years of age.
- a. Loaned equipment is recommended by BCW as appropriate in most situations because:
- (i) A piece of technology is not for life and is constantly changing;
 - (ii) Technology in different hands and different situations brings different results; and
 - (iii) Children from birth to three are changing developmentally and need to be challenged.
- b. Loan access may be provided by:
- (i) BCW Lending Libraries: Lending Libraries may be available within each Local Lead Agency to offer loan programs to support BCW-eligible children with AT needs. A basic inventory of AT equipment is available for check out at each of these centers.
 - If a specific piece of equipment is needed for a child that is not available in the Lending Library inventory, it may be purchased by the Lending Library for use by that child. However, the equipment remains the property of BCW.
 - Devices may be loaned to a child/family until the eligible child's third birthday, the beginning of the school year, or the implementation date of the IEP. If a child turns three during summer months, the loan may extend to the beginning of the school year or the implementation date of the IEP, whichever occurs first. However, this last provision shall not extend beyond six months after the eligible child's third birthday and justification of need must be documented in the transition plan and IFSP exit documentation.
 - It is recommended that local lead agencies insure devices against theft or loss.
 - (ii) Service Providers: A service provider such as a physical therapist may loan AT to assist the child in meeting IFSP outcomes. Service providers shall report child progress to the PSP team.
 - (iii) Community Technology Centers (i.e., Tools for Life Resource Centers, Lekotek centers): These centers may offer loan programs to support children with AT needs.
- c. Equipment Purchase/Rental:
- (i) BCW will purchase or lease AT devices for an individual child when it is determined that:
 - The disabilities of the child are such that multiple or customized technology systems are required, and alternate devices have been explored and found not to be adequate through available lending options;
 - AT equipment must be highly customized to meet the needs of a specific child;
 - The child needs the item to reach developmental outcomes while enrolled in BCW and the child/family requires necessary on-going access and should, therefore, be the owner of this equipment; and
 - The item is not easily recyclable.

- (ii) Funding may be provided for an individual child under the following guidelines:
 - Alternative sources (payor of last resort policy) for payment must be explored, documented, and eliminated prior to requesting BCW funding. Each local BCW program should refer to the Tools for Life (Tools for Life Central Office can be reached via email at info@gatfl.org or by phone at 1-800-497-8665) funding guide in order to help parents identify other sources of funding.
 - If the local lead agency can document that no other fiscal resources are available, funding assistance from BCW may be requested. Family cost participation as determined by the Babies Can't Wait Financial Analysis form (see Appendix B) applies.
- (iii) Administrative Approval Requirements:
 - **Requests for items and devices must be submitted to the state office for approval if the cost of an individual piece of equipment is in excess of \$5,000.**

d. Training and Technical Assistance:

AT training is necessary to ensure that children are able to benefit from technology intervention. **Provisions for training the child and the family must be documented in the IFSP.** Parent training opportunities should also include training with the service provider during therapy or educational sessions (i.e., the speech therapist would provide assistance and training on the use of a communication aid). Training for service providers may also be necessary. This training is available from a variety of resources throughout the state (i.e., vendors, private organizations, public agencies, and conferences).

B. Audiology Services

Audiology Services include:

1. Identification of children with auditory impairments, using at-risk criteria and appropriate audiologic screening techniques;
2. Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;
3. Referral for medical and other services necessary for the habilitation or rehabilitation of an infant or toddler with a disability who has an auditory impairment;
4. Provision of auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services;
5. Provision of services for prevention of hearing loss; and
6. Determination of the child's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices." (Title 34 CFR §303.13 (b)(2))

All children with diagnosed hearing loss must be referred with parent consent to an Early Hearing Orientation Specialist through Georgia PINES (if available) for an orientation to hearing loss, resources, and intervention approaches with parental consent.

PROCEDURES FOR IMPLEMENTATION

1. Examples of Covered Services -
 - a. The evaluation of the need for devices and treatment as well as auditory training.
 - b. Evaluation to determine the range, nature, and degree of hearing loss and communication functions (using the system of payments which includes payor of last resort). Referral to medical services to manage or monitor the rehabilitation of the child's auditory loss.
 - c. Training for the child and/or family related to the child's auditory functions, use of

- devices, and the maintenance of auditory devices.
 - d. The assessment of audiological needs including the fitting, dispensing, and monitoring of hearing devices.
2. Non-covered Services - Myringotomy tubes (ear tubes) and cochlear implants are not covered services under Part C and are not eligible for BCW funding under any approved service category.
 - a. Requests for digital and programmable hearing aids must be forwarded to the State Babies Can't Wait Office if all other payment sources, including Early Hearing Detection and Intervention program resources, have been exhausted and BCW funding is being requested to support this service.
 - b. These requests will be reviewed according to protocol.

C. Family Training, Counseling and Home Visits

Family Training, Counseling, and Home Visits means services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an infant or toddler with a disability in understanding the special needs of the child and enhancing the child's development. (34 CFR §303.13 (b) (3))

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services -

1. Training (educating) families to carry out activities on the IFSP, such as carrying out developmentally appropriate activities within the child's home, when not otherwise covered as a service within a specific discipline. Examples include positioning, communication activities, nutritional training, and home care strategies that are not covered or addressed by another specific discipline on the IFSP.
2. Training must be provided and/or supervised by licensed/certified personnel. Supervision of non-licensed/non-certified personnel occurs in a variety of ways and must include at least a quarterly observation of the provider and family as a minimum standard.
3. Counseling must be provided by licensed personnel and must be specifically related to the child's disability. For example, the family is not coping well with the child's diagnosis, and their grief results in an inability to function as a family unit. The outcome might address improved family functioning through management of feelings about having a child with a disability. The strategy might be counseling sessions related to coping with grief.
4. Family training and home visits are incorporated in the "discipline" categories, and must be paid for under the respective discipline, i.e., physical therapy, occupational therapy. This section covers family training that is not otherwise covered within the context of therapy.

D. Health Services

Health Services mean services necessary to enable an otherwise eligible child to benefit from the other early intervention services.

The term includes:

1. Such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and
2. Consultation by physicians with other service providers concerning the special health care needs of infants and toddlers with disabilities that will need to be addressed in the course of providing other early intervention services.

The term does not include:

1. Services that are:
 - a. Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus);
 - 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. Related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.
 - (i) Nothing in this part limits the right of an infant or toddler with a disability with a surgically implanted device (e.g., cochlear implant) to receive the early intervention services that are identified in the child's IFSP as being needed to meet the child's developmental outcomes.
 - (ii) Nothing in this part prevents the EIS provider from routinely checking that either the hearing aid or the external components of a surgically implanted device (e.g., cochlear implant) of an infant or toddler with a disability are functioning properly;
2. Devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; and
3. Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children." (34 CFR §303.16)

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services:

1. Services provided to enable the child to benefit from other IFSP services during the time that those early intervention services are being provided OR that are necessary to prepare a child to receive other early intervention services. This includes:
 - a. Consultation by a physician with other IFSP providers concerning the special health care needs of the child that will be addressed in the course of providing other EI services.
 - b. Services such as clean intermittent catheterization, tracheotomy care, tube feeding, etc., which are necessary during the time that early intervention services are being provided.

Examples of Non-covered Services:

1. Medical monitoring, other primary health care, immunizations, or diapers.
2. Devices that are used to control or maintain a medical condition, such as an apnea monitor, infant scales, etc.

E. Medical Services

Medical services are for diagnostic or evaluation purposes to determine a child's developmental status and need for early intervention only.

F. Nursing Services

Nursing Services include:

1. The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;
2. The provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and
3. The administration of medications, treatments, and regimens prescribed by a licensed physician." (34 CFR §303.13 (b)(6))

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services:

Services provided to enable the child to benefit from other IFSP services during the time that those early intervention services are being provided. This includes:

- a. When the nurse provides evaluation and assessment services to establish initial or continuing eligibility for the program or the need for services.
- b. When the nurse provides Family Training/Counseling services.
- c. The provision of nursing care to prevent health problems, restore or improve functioning, and promote health and development (within the context of the IFSP).
- d. The administration of medications, treatments, and regimens prescribed by a licensed health care provider, i.e., Physician and nurse practitioners in the context of implementation of the IFSP.

Non-covered Services:

On-going nursing services related to sustaining life and services provided by a nurse during an inpatient hospitalization since these are not early intervention services.

Local Practice Guidance or Clarification

Nursing services are not early intervention services when they are constant rather than intermittent in nature, and when they are intensive or involve life-threatening situations that require constant vigilance. Extensive nursing care or a nursing service related to sustaining life is considered outside the intent and definition of early intervention services.

The fact that on-going nursing services do not meet the criteria for a Part C nursing service, and therefore are not covered by BCW, does not necessarily mean that a child doesn't need routine nursing services. These should be listed on the IFSP under "other" services and appropriate non BCW funding should be identified to cover these nursing/medical needs.

G. Nutrition Services

Nutrition Services include:

Conducting individual assessments in:

1. Nutritional history and dietary intake;
2. Anthropometric, biochemical, and clinical variables;
3. Feeding skills and feeding problems;
4. Food habits and food preferences;
5. Developing and monitoring appropriate plans to address the nutritional needs of children eligible under this part, based on the findings in paragraph (b)(7)(i) of this section;
6. Making referrals to appropriate community resources to carry out nutrition goals.”
(34 CFR §303.13 (b)(7))

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services:

1. An individual assessment, including the child's nutritional history and dietary intake, various anthropometric, biochemical and clinical variables.
2. An individual assessment of feeding skills, feeding problems, including food habits and preferences.
3. The development and monitoring of an appropriate plan to address the nutritional needs of the eligible child.
4. Referrals to appropriate agencies to access community resources necessary to carry out the nutritional goals.

Examples of Non-covered Services:

1. Purchase of formula, commercially prepared infant foods or dietary supplements, including specialized infant formulas.
2. Devices, such as infant scales, that are used to control or monitor nutritional status are not Part C covered services.

H. Occupational Therapy

Occupational Therapy includes services to address the functional needs of an infant or toddler with a disability related to adaptive development, adaptive behavior, and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings where the child spends a portion or all of his/her day. These services include:

1. Identification, assessment, and intervention
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
3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability. (34 CFR §303.13 (b)(8))
4. Collaboration with the family to identify locations, activity settings and learning opportunities based on the unique strengths and priorities of the child and family
5. Training and support to family members and other primary care providers in the implementation of the IFSP
6. Environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child have been incorporated as set forth in the IFSP.

The identification and incorporation of materials, equipment, and supplies related to the provision of Occupational Therapy services should follow the procedures and guidelines set forth in the Assistive Technology section of this document.

I. Physical Therapy

Physical Therapy services are designed to improve the child's functional ability to perform tasks at home, and in other environments including community programs where the child spends a portion or all of his/her day.

Physical Therapy services address 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. Screening, evaluation, and assessment of children to identify movement dysfunction;
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." (Title 34 CFR §303.13 (b)(9))
4. Collaborating with the family to identify locations, activity settings and learning opportunities based on the unique strengths and priorities of the child and family.
5. Training and support to family members and other primary care providers in the implementation of the IFSP
6. Environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child have been incorporated as set forth in the IFSP.

J. Psychological Services

Psychological services include:

1. Administering psychological and developmental tests and other assessment procedures;
2. Interpreting assessment results;
3. Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development; and
4. Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.” (34 CFR §303.13 (b)(10))

K. Service Coordination

1. **Service Coordination Services** mean services provided by a Service Coordinator to assist and enable an infant or toddler with a disability and the child's family to receive the services and rights, including procedural safeguards.
 - a. Each infant or toddler with a disability and the child's family must be provided with one Service Coordinator who is responsible for:
 - (i) Coordinating all services required under this part across agency lines; and
 - (ii) Serving as the single point of contact for carrying out the activities
 - b. Service coordination is an active, ongoing process that involves:
 - (i) Assisting parents of infants and toddlers with disabilities in gaining access to, and coordinating the provision of, the early intervention services required under this part;
 - (ii) Coordinating the other services identified in the IFSP under §303.344(e) that are needed by, or are being provided to, the infant or toddler with a disability and that child's family.
2. **Specific Service Coordination Services** include:
 - a. Assisting parents of infants and toddlers with disabilities in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families;
 - b. Coordinating the provision of early intervention services and other services (such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes) that the child needs or is being provided;
 - c. Coordinating evaluations and assessments;
 - d. Facilitating and participating in the development, review, and evaluation of IFSPs;
 - e. Conducting referral and other activities to assist families in identifying available EIS providers;
 - f. Coordinating, facilitating, and monitoring the delivery of services required under this part to ensure that the services are provided in a timely manner;
 - g. Conducting follow-up activities to determine that appropriate Part C services are being provided;
 - h. Informing families of their rights and procedural safeguards, as set forth in subpart E of this part and related resources;
 - i. Coordinating the funding sources for services required under this part; and
 - j. Facilitating the development of a transition plan to preschool, school, or, if appropriate, to other services.

PROCEDURES FOR IMPLEMENTATION

See the Service Coordination chapter in this document for detailed procedures for implementation.

L. Social Work Services

Social Work Services include:

1. Making home visits to evaluate a child's living conditions and patterns of parent-child interaction;
2. Preparing a social or emotional developmental assessment of the infant or toddler within the family context;
3. Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the infant or toddler and parents;
4. Working with those problems in the living situation (home, community, and any center where early intervention services are provided) of an infant or toddler with a
5. disability and the family of that child that affect the child's maximum utilization of early intervention services; and
6. Identifying, mobilizing, and coordinating community resources and services to enable the infant or toddler with a disability and the family to receive maximum benefit from early intervention services. (34 CFR §303.13 (b)(13))

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services -

1. Family assessment, training, and services related to the child's ability to utilize early intervention services.
2. Parent counseling (individual or in small groups) focused on skill building and assisting a family to meet the developmental needs of their child.
3. Identification, mobilization, and coordination of community resources and services to enable the child and family to receive maximum benefit from early intervention services.

Note: This is usually covered under Service Coordination.

M. Special Instruction

Special Instruction includes—

1. The design of learning environments and activities that promote the infant's or toddler's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;
2. Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the IFSP for the infant or toddler with a disability;
3. Providing families with information, skills, and support related to enhancing the skill development of the child; and
4. Working with the infant or toddler with a disability to enhance the child's development. (Title 34 CFR §303.13 (b) (14))

PROCEDURES FOR IMPLEMENTATION

Special Instruction is the “Special Education” component of Part C. It is above and beyond educational efforts aimed at typically developing children and thus must be developed and managed by professionals with specialized education and experience. (See Special Instruction more details regarding Special Instruction implementation.)

Special Instruction includes:

1. The systematic planning and coordination of people, materials, and places to assist in identifying learning environments that offer learning opportunities in which thinking, moving, communicating, playing, and living appropriately with family and friends might be encouraged and promoted;
2. Collaboration with the family to identify locations, activity settings, and learning opportunities built upon the unique strengths and priorities of the child and family. Curriculum planning materials are used for the ongoing assessment of each child's progress toward meeting stated outcomes strategies must be developmentally

appropriate, culturally relevant, child and family directed, care provider responsive, play-based, and delivered in natural settings. The goals and objectives are determined through the use of functional, developmentally appropriate assessments and curriculum, systematic observation, and data collection that led to achieving the outcomes and measuring successes as identified in the IFSP;

3. Activities with the family and caregivers to support the child through approaches described above to enhance the child's development and meet outcomes; and
4. Activities with the family in order to strengthen and reinforce the family's knowledge and ability to enhance their child's skill development within home and community. This is achieved through a systematic process that is responsive to cultural uniqueness, providing families with skills, support, resources, and unbiased information.

N. Speech-Language Pathology

Speech-Language Pathology Services include:

1. Identification of children with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and
3. Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills. (34 CFR §303.12 (b)(15))

Sign Language and Cued Language Services include:

1. Teaching sign language, cued language, and auditory/oral language,
2. Providing oral transliteration services (such as amplification), and
3. Providing sign and cued language interpretation. (34 CFR §303.13 (b) (12)).

Local Practice Guidance or Clarification

Speech-Language Pathology services are designed to identify or diagnose communicative or oropharyngeal disorders and delays in the development of communication skills. This includes collaboration with the family to identify locations, activity settings, and learning opportunities based on the unique strengths and priorities of the child and family. These services are designed to improve the child's functional ability to communicate at home and in other environments, including community programs where the child spends a portion or all of his/her day.

Communication approaches and methods used by individual children will vary significantly and will mean different forms of communication for individual children. These services include assessment, plan development, monitoring, training, and support to family members and other primary care providers in the implementation of the IFSP. The identification and incorporation of materials, equipment, and supplies related to the provision of Speech-Language Pathology services should follow the procedures and guidelines set forth in the Assistive Technology section of this document.

O. Transportation and Related Costs

Transportation and related costs include the cost of travel and other related costs that are necessary to enable an infant or toddler with a disability and the child's family to receive early intervention services. (34 CFR [§303.13 \(b\) \(16\)](#))

PROCEDURES FOR IMPLEMENTATION

Examples of Covered Services:

1. Travel and related costs to and from appointments for early intervention services included in the IFSP (such as audiology, family counseling, etc.). This includes mileage, bus fare, cab fare, and related costs, such as tolls and parking expenses.
2. Payment shall be for one round trip per authorized early intervention service. For example, mileage from the family's home and return to the home.

Examples of Non-Covered Services:

1. Transportation for Medicaid eligible children unless the IFSP documents that there is no Medicaid provider of transportation.
2. Equipment, such as car seats.
3. Transportation to services listed under "Other Services" on the IFSP, such as well-child clinics or the hospital (for admission).
4. Transportation to an inclusive, community-based childcare program, such as day care, preschool, or Parents Morning Out program, or other community activity (parks, playground, McDonalds, YMCA, library, etc.), where a child may receive early intervention services during some part of the day or during participation in activities at that site.

Local Practice Guidance or Clarification

Local lead agencies are encouraged to ensure safe transportation arrangements for eligible children, including assurances that state seat belt and license requirements are met in each instance. Specific training for transportation providers may be a covered service, if such training is necessary to ensure safe and reliable transportation of the child to enable the child to receive early intervention services. BCW funds may not be used to support "other" transportation costs, such as transportation to appointments or services listed in the "Other" section of the IFSP. In the instance where there is no Medicaid provider of transportation documented in the IFSP, the local lead agency may use BCW funds to support transportation costs for up to 12 weeks and should work with the transportation broker to resolve the issue. Local lead agencies also are encouraged to recruit new transportation providers. If after twelve (12) weeks, no Medicaid providers are recruited or their schedules are not consistent with scheduled IFSP appointments, the Early Intervention record must include documentation for use of BCW funds to continue. In the event that a Medicaid transportation issue is unresolved after 12 weeks, the local lead agency must thoroughly document the situation and all steps taken and forward this information to the State Babies Can't Wait Office.

Family Reimbursement

1. Through a Special Situation Payment Request (SSPR).
2. Family must be in BIBS and an EFT completed.

P. Vision Services

Vision Services include:

1. Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both;
3. Communication skills training, orientation and mobility training for all environments (including independent living skills)
4. Visual training and additional training necessary to activate visual motor abilities. (34 CFR §303.13 (b)(17))

Q. Interpretation/Translation Services

1. **Native Language**, when used with respect to an individual with limited English means:
 - a. The language normally used by child or the parents of the child;
 - b. For evaluations and assessments conducted pursuant to §303.321(a) (5) and (a) (6), the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.
2. **Native Language**, when used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, means the mode of communication that is normally used by the individual (such as sign language, Braille, or oral communication). (34 CFR §303.25).

PROCEDURES FOR IMPLEMENTATION

Unless clearly not feasible to do so, all evaluations and assessments of a child must be conducted in the native language, in accordance with the definition of native language in Title 34 CFR §303.25. Unless clearly not feasible to do so, family assessments must be conducted in the native language of the family members being assessed, in accordance with the definition of native language in Title 34 CFR §303.25.

Funds may be used for interpreting or translation services for evaluation and assessment purposes, and when necessary for IFSP development, administering procedural safeguards, direct services (when necessary) and family training (when necessary, within the context of the IFSP services).

Local Practice Guidance or Clarification

Local lead agencies may also choose to use a provider with an executed state term contract or a state level contract with the Department/District.

600.2 – Provider 60 Day Approval Rule to Provide Services

Pursuant to providers not being able to become credentialed by Medicaid CMOs in a timely manner and in order to allow Babies Can't Wait to meet Federal Regulations, the State Office allows 60 calendar days from the effective date of the provider master agreement for a provider to enroll with at least 2 CMOs.

NOTE: Providers **cannot** see Care Managed Organization (CMO) children until they have their number.

CHAPTER 700 – SERVICE COORDINATION PROCEDURES

FEDERAL POLICY 34 CFR §303.34 Service Coordination

BABIES CAN'T WAIT PROGRAM STANDARD

Every child receiving early intervention services in Babies Can't Wait (BCW) and their family will be assigned one Service Coordinator (SC) who is responsible for coordinating all services across providers, settings and agency lines. This SC will serve as a single point of contact in helping parents to obtain the services and assistance they require to address their child's needs. Service coordination takes place within a collaborative relationship between a family and a SC. Local program may choose to provide service coordination using a blended or dedicated model of service coordination. Each child and family will receive a minimum of four face to face service coordination visits per Individualized Family Service Plan (IFSP) year with additional visits based upon child and family needs, strengths and resources as outlined in each child's IFSP. Service coordination is an ongoing process, responsive to the needs of each child and family. Service coordination is offered at no cost to families. State Policies and Procedures are applicable to the assigned SC without regard to service provider or profession from which the assignment is made.

A. Assignment of Intake Service Coordinator

When children and their families are referred to BCW, the Early Intervention (EI) Coordinator or his/her designee shall assign an Intake SC to:

1. Complete intake activities with the family, and
2. Coordinate child developmental evaluation and assessment, as well as facilitate the eligibility determination processes.

If the child is determined eligible for BCW, a SC will be assigned as the Ongoing SC. In some cases, the Intake and Ongoing SC will be the same person. ***

***** Please note Districts are subject to be audited in regard to equitable distribution of Service Coordination cases.**

B. Intake Activities

1. When an ongoing relationship has previously been established between a child and family and the personnel working in any Public Health program serving children birth to five, (i.e., Children 1st, 1st Care, or Children's Medical Services) intake activities may be completed by Public Health staff with whom the relationship exists and who have received training in performing intake activities.
2. When no ongoing relationship or involvement with another Public Health program has been previously established, the BCW Intake SC shall complete intake activities.
3. Intake activities must include the following:
 - a. Providing information about Georgia's Birth to Five system of services and asking the parent if they would like to proceed further;
 - b. Informing families of the voluntary nature of the program and their right to refuse involvement in the program;
 - c. Asking the parent(s) if they would like to proceed further in the system processes;
 - d. Discussing with the parent(s) or guardian the need for a developmental screening if the child has not been determined to have a Category 1 condition or if the child has not had a prior up-to-date screening that has been provided to BCW by their pediatrician or other referral source (i.e., health department, C1st, Early Head Start, etc.);

Obtaining signed informed parental consent using the Babies Can't Wait *Notice and Consent for Screening/Evaluation/ development if applicable*. (for screening if needed);

- e. Providing all information regarding the BCW Program, including family rights and procedural safeguards under the law as well as a copy of the "Notice of Infant/Toddler and Family Rights under Babies Can't Wait" to each family. Discussing as well as reviewing each document with them if the screening or developmental information of the child indicates further testing or if the family indicates they want further testing (and the screening does not indicate a need);
- f. Obtaining written parental consent (using current DPH/BCW Authorization for Release of Information Form) to obtain and share necessary information with the child's primary care physician (PCP), other appropriate medical specialists, health service providers, childcare providers and other parties/providers, as necessary or indicated by the family;
- g. Requesting from the PCP a completed Physician's Health Summary Form;
- h. Completing with the family the initial intake information to be discussed and used for assessment purposes;
- i. Reviewing and completion of Family Assessment and Routines and Activities Section of the IFSP based on gathered information about the family's everyday routines and activities as well as the child's behavior and interactions within those contexts during family interview and initial intake activities;
- j. Discussing topics the family is interested in learning more about;
- k. Gathering information about the family concerns, priorities and resources;
- l. Discussing the formal and informal supports the family uses or would like to use; completed with family consent;
- m. Obtaining a summary of child's medical status;
- n. Exploring and identifying roles that the family may want to play in the evaluation and assessment process;
- o. Entering into BIBS any needed screening and intake authorizations, including interpretation.

NOTE: These sections must be completed with the family during intake, shared with individuals involved in the evaluation/assessment process and the IFSP Team.

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

1. The Intake SC is responsible for:
 - a. Requesting a surrogate parent for any child that needs one;
 - b. Coordinating and ensuring the completion of the initial developmental evaluations and assessments in order to develop the initial IFSP within 45 days of the receipt of the referral;
 - c. Explaining to the family the roles and functions of the early intervention team members, including that of the individual who will provide service coordination;
 - d. Explaining to the family of an eligible child the IFSP process and what they can expect in each step of the process;
 - e. Informing the family, and other participants of scheduled evaluation, assessment and IFSP meetings, no less than five calendar days in advance, followed by written confirmation;
 - f. Explaining the Primary Service Provider model of care to families and answering questions they may have regarding this;
 - g. Ensuring that each child referred to BCW has been linked to routine health care services, and that informed signed parental consent, using the DPH/ BCW Authorization for Release of Information form has been signed, to allow the child's

- primary care provider to participate throughout the evaluation, assessment, eligibility determination and IFSP development processes, if the primary care provider chooses to do so;
- h. Obtaining from parent PII Consent to bill public and private insurance if applicable and once signed consent is given, obtaining needed health plan information and entering into BIBS for any billable evaluation activities;
 - i. Entering into BIBS any needed intake and evaluation authorizations including interpretation;
 - j. Referring and/or linking parent(s)/legal guardian(s) of children who are ineligible for BCW to other agencies or relevant community resources as appropriate, and to refer child back to Children 1st with parental consent for appropriate monitoring and follow-up.
2. The SC is responsible for on-going services which include facilitating and participating in the development and implementation of the initial IFSP for each eligible child. The SC:
- a. Ensures that the initial evaluation/assessment is reviewed with the family so that the information/results accurately reflect their child and family;
 - b. Acts as a support on behalf of the family when no other identified advocate is in attendance;
 - c. Ensure procedural safeguards are observed (especially parent/legal guardian right to participate fully) throughout the process;
 - d. Ensures that the parent/guardian and other meeting participants have been given prior written notice within 5 calendar days of the IFSP Meeting;
 - e. Ensures that the IFSP meeting is conducted according to procedures and the IFSP document is appropriately completed;
 - f. Is responsible for obtaining parental consent for EI services by obtaining signature on the IFSP document and reviewing their rights, opportunities, and responsibilities under federal law;
 - g. Ensures timely referral and delivery of services according to the IFSP;
 - h. Is responsible for sending the information that the Primary Care Physician has requested concerning the child's Individualized Family Service Plan (IFSP) within 10 business days of the initial and annual IFSP;
 - i. Is responsible for on-going review and discussion with the family of parental rights, using the "Notice of Infant/Toddler and Family Rights Under Babies Can't Wait" booklet;
 - j. Is responsible for entering all IFSP information in Babies Information and Billing System (BIBS) within seven calendar days of completion of all initial, annual, and periodic reviews as well as all transition activities;
 - k. Ensures consent/decline forms to bill public insurance and/or private insurance are signed as applicable and entered into BIBS;
 - l. Ensures that the Babies Can't Wait Financial Analysis Form is completed and signed by the parent/guardian.

D. Service Implementation

When a child is determined eligible for BCW and an IFSP is developed, based on the evaluation and assessment results, with established intervention objectives and outcomes, a Service Coordinator links families to the Babies Can't Wait team and other community resources for the provision of all needed services, monitors outcomes and ensures that the IFSP is reviewed and revised as necessary. The Service Coordinator will authorize four (4) face to face service coordination visits per Initial/Annual IFSP for each family. Additional visits may be requested from the local BCW administrative office as recommended by the MDT to meet the specific needs of the child and family.

The authorization of a number of face-to-face visits will in no way limit the availability of the Service Coordinator to the family for any needed activities.

1. The SC must:
 - a. Assist parents/legal guardians of eligible children in gaining timely access to the EI services and other services identified in the IFSP. This includes ensuring that initial services start within 45 days of consent unless documented parent delay and entering start date in BIBS;
 - b. Coordinate the provision of the identified EI services and other services documented on the IFSP;
 - c. Actively seek and link children and their families to appropriate providers, medical services, social and other support services as needed;
 - d. In collaboration with the IFSP/PSP team, monitor delivery and effectiveness of services identified in the IFSP, and review the outcomes and need for new, additional, reduced or modified services;
 - e. Inform the family of advocacy services and groups that assist families in accessing or relating to providers, and help them resolve their complaints including providing them information on available fair hearing or complaints resolution process as needed or requested;
 - f. Promote family centered services that respect family's decisions, values, beliefs and norms;
 - g. Collaborate with the IFSP/PSP team to provide continuity and coordination of care required across agency, providers and settings that are necessary to benefit the child development and outcomes;
 - h. Assist the family in completing the Financial Analysis for Cost Participation Form to determine the assignment of family fees for some or all of their child's EI services at initial and annual IFSP and whenever family's circumstances change;
 - i. Ensure that the family understands their rights, opportunities and responsibilities as they relate to the implementation of the child's IFSP;
 - j. Ensure that the parent has all of the necessary and relevant information to access the services identified in the plan that they will access independently.
 - k. Validate Medicaid eligibility on a monthly basis for each child with Medicaid, inactive Medicaid, applied for Medicaid and check third-party payer status for each child with no health plan;
 - l. Document in BIBS all interactions with family and providers.
2. SC for families may request assistance and additional support from others when family/child needs are significantly increased in intensity or complexity.
3. Caseloads should be examined and weighted using the following variables:
 - a. The extent and intensity of the family supports, and services provided;
 - b. The extent and intensity of the child's and family's needs;
 - c. Location of services and supports including travel time to and from the home and service settings;
 - d. Number of children in BCW in the family;
 - e. The involvement and assistance of related services and other agencies;
 - f. The service options available within the community; and
 - g. The SC's ability to manage caseload in order to guarantee that all mandated service coordination responsibilities are provided and that the diverse needs of families receiving ongoing services are being met.
 - h. The number referrals assigned (if Service Coordinator is an intake and on-going Service Coordinator)

4. The EIC in each local program will be required to evaluate their referral levels to determine if all Service Coordinators will be required to perform both intake and ongoing activities.

E. Annual Evaluation of the IFSP

The purpose of the annual evaluation is to evaluate the IFSP for a child and the child's family and as appropriate, to review its provisions and determine what services are needed. The SC is responsible for coordinating the process to ensure appropriate continuous assessment of the child and IFSP review to meet the child and family needs related to the child's development. This process includes the annual evaluation of the IFSP.

The SC will (also see Individualized Family Service Plan policy):

1. Provide written notice to the family and inform participants, including the child's primary care physician if applicable, prior to the scheduled IFSP meetings. For all CAPTA children, the DFCS caseworker must be invited to the meeting;
2. Facilitate and participate in the monitoring, review, and evaluation of the IFSP and the development of the annual IFSP;
3. Ensure that current ongoing assessment information is available to the IFSP/PSP team to support annual and periodic review of the IFSP.
4. Act as a support on behalf of the family when no other identified advocate is in place;
5. Routinely review and update information in the IFSP, Family Assessment and Routines and Activities Section;
6. Continue ongoing discussion regarding the family's everyday routines and activities and child's behavior and interactions within those contexts;
7. Update the information about family concerns, priorities and resources. (completed with family consent);
8. Update the formal and informal supports the family uses or would like to use;
9. Ensure procedural safeguards are observed (especially parent/legal guardian's right to participate fully) throughout the process;
10. Ensure that the IFSP meeting is conducted according to procedures and the IFSP document is appropriately completed;
11. Be responsible for obtaining signed parental/legal guardian consent for EI services on the IFSP document and reviewing their rights, opportunities, and responsibilities under federal law;
12. Is responsible for entering all IFSP information in Babies Information and Billing System (BIBS) within seven calendar days of completion of all initial, annual and periodic reviews as well as all transition activities;
13. Complete a new Financial Analysis form with the family annually and as needed;
14. Obtaining a new PII and/or public and/or private insurance consent(s) annually as applicable and entering into BIBS.

F. Transition Planning

The SC shall:

1. Ensure that every IFSP includes documented steps toward transition.
2. Ensure that initiation of transition activities, with parental consent, shall begin as early as 27 months (nine months before age three). It is strongly recommended that the transition plan and transition conference be completed by 30 months but no later than 90 days (three months before age 3) prior to the child's third birthday. In Georgia, the Transition Plan is completed at the Transition Conference.
3. Ensure that any revisions to the transition plan are documented as part of the IFSP. Discussion at the transition conference may require changes to the transition plan.
4. Ensure that the family has all needed information about potential service options in order to make an informed choice.

5. Assist the family in understanding the differences between Part C and Part B eligibility criteria and programs as their child approaches age three.
6. Ensure that the family understands all of their rights related to the transition process.
7. Invite the Local Education Agency (LEA) to the transition conference unless family declines.
For children transitioning to non-Part B services, other community agencies such as Head Start, should be invited to the transition conference as appropriate.
8. Obtain by child's 27th month of age (unless late referral) parent signature on Notification to LEA form and signature on form if family opts out of notification.
9. Provide family with Steps for Success Transition booklet and tri-fold brochure.

Service Coordination after age 3:

During the transition planning process for **children whose third birthdays fall during; June, July, or August**, the need for service coordination as a transition activity must be discussed with the family. If service coordination is needed in order to assist the family with medical/health or other needs which might be met by the community, it must be documented on the IFSP and provided by BCW during the period from the third birthday until Aug. 31 or until the day before the Individualized Education Plan (IEP) begins, whichever comes first. This need and expected outcome must be documented in the transition plan. Service Coordination is the only service that may be funded with BCW funds for a child after the child's third birthday during the months of June, July or August.

G. Service Coordination Qualifications, Training and Continuing Education

1. All individuals providing service coordination must have at least a bachelor's degree in a related field (see Personnel Management section).
2. All individuals providing service coordination (including the blended model of service coordination) must successfully complete a state online service coordination orientation and a local program conducted orientation and training prior to providing service coordination.
3. Skilled Credentialed Early Interventionists (SCEIs) training must be completed within six months of initial date of hire or contract with BCW. Also, the Praxis II test is available for Level II professionals as an alternate to completing the SCEIs modules.
4. The six-month SCEIs period begins on:
 - a. The effective date of a contract with the BCW program or the effective date of contract, subcontract, or employment with any agency or organization which contracts with the BCW program or
 - b. The beginning date of employment with the BCW program through a local lead agency.
5. All individuals providing service coordination regardless of licensure/certification are required to complete Continuing Education hours upon completion of the SCEIs Modules requirements, which is twenty (20) contact hours of continuing education every two years that clearly focuses on:
 - a. Young children, birth to age eight
 - b. Families of young children, birth to age eight and/or
 - c. Particular disabilities covered under babies can't wait;
 - d. Ten (10) of these hours must be specific to young children with disabilities and/or their families.
6. Personnel who fail to comply with this policy in the timelines stated above will not be able to provide services for families and/or children through the Babies Can't Wait program until requirements are completed.
7. Continuing education requirements go into effect for an individual July 1 after s/he has received a certificate of completion for the Project SCEIs modules.

H. Service Coordinator Billing

In order to bill for service coordination services for an individual child, the BCW Service Coordinator must have in the **SAME** calendar month a minimum of one face-to-face child **and** family contact and at least three ancillary contacts. All contacts and activities must be documented in the child's active clinical record. All contacts must be related to the child's IFSP and the documentation must reflect effort. Refer to Data and Child Record Policy for required documentation details.

Below are what can be counted as billable ancillary contacts:

Telephone calls that result in a progress note:

- To family = 1 ancillary contact
- To medical staff = 1 ancillary contact
- To other agencies = 1 ancillary contact
- To schedule a meeting = 1 ancillary contact per meeting regardless of the number of persons called
- To coordinate meetings resulting in scheduling = 1 ancillary contact per
- To transition or arrange to transition child = 1 ancillary contact
- To therapist = 1 ancillary contact

Visits

- To family after 1 minimum face-to-face contact = 1 ancillary contact
- To day care or other community agency = 1 ancillary contact
- To therapist = 1 ancillary contact
- Meeting to transition child = 1 ancillary contact
- Attendance at other meetings on behalf of child = 1 ancillary contact

Non-covered contacts include emails, letters, faxes, and texts.

I. Service Coordinator 30 Days to Enroll in Medicaid

Pursuant to **Service Coordinators** not being able to become credentialed by Medicaid in a timely manner and in order to allow Babies Can't Wait to meet Federal Regulations, Service Coordinators are allowed 30 calendar days from the effective date of the provider master agreement to enroll in the Medicaid Early Intervention Case Management Program (EIS). In the meantime, they can only see children that have either no health plan, private insurance or CMO insurance only while they are waiting on their pending Medicaid number.

CHAPTER 800 – SPECIAL INSTRUCTION PROCEDURES

POLICY 34 CFR §303.13 Early Intervention Services

BABIES CAN'T WAIT STANDARD

Through the evaluation and assessment process, the Multidisciplinary Team (MDT) will identify children for whom Special Instruction is a service necessary to meet the outcomes identified on the IFSP.

Special Instruction shall:

1. Include the systematic planning and coordinating of people, materials, and places to assist in designing learning environments to create opportunities that help the child learn through a series of activities that encourage thinking, moving, communicating, playing, and living with family and friends;
2. Include the coordination of people, materials, times, and places based on the unique needs of the child and family. Strategies and ideas should be developmentally appropriate, culturally relevant; child and family guided, care giver responsive, play-based, and delivered in natural settings.
3. Be based on goals and objectives determined through the use of functional, developmentally appropriate assessment and curriculum, systematic observation, and data collection that led to achieving the outcomes and measuring successes as identified in the IFSP;
4. Focus on positive interactions with the child through approaches described above to enhance the child's development.
5. Strengthen and reinforce the family's knowledge and ability to enhance their child's skill development within home and community through a systematic process which is responsive to cultural uniqueness families should be provided with skills, support, resources, and complete and unbiased information related to their child through Special Instruction.

IMPLEMENTATION

Evidence from research indicates that children learn best through everyday experiences and interactions with familiar people in familiar contexts. Special Instruction is designed to support the family in identifying high-interest activities and learning opportunities for the child during the course of the family's typical daily routine, along with enhancing the caregiver's ability to respond in a supportive manner to the child's actions. Program planning should be based on the priorities, needs, and routines identified by the family and should include the suggestions of the Primary Service Provider (PSP) Team.

Each Special Instruction session should include a review of the previous week's Joint Plan that was developed by the family and the PSP, and the activities that the family tried during the time between sessions. Sessions should also include opportunities for feedback, modeling, and coaching as determined by the family's needs. Sessions end with development of a Joint Plan that includes the activities the family will try before the next session and what the focus of the next visit will be.

A formal curriculum is not required nor recommended by the State Lead Agency (State LEA); however, curriculum-based assessment tools can be used to monitor the child's progress toward achieving the IFSP outcomes and overall development. The State LEA advocates the use of natural learning environment practices that include the identification and support of everyday learning opportunities, child interests and activities, and parent responsiveness.

Personnel qualified to provide Special Instruction include (See Personnel Policy **for Qualifications for Special Instructors**).

1. Early Intervention Specialist (EIS)
2. Early Interventionist (EI)
3. Early Intervention Assistant (EIA)

A. Early Intervention Specialist (EIS)

The **Early Intervention Specialist** is responsible for the implementation and/or supervision of the local program's Special Instruction program under the supervision of the EI Coordinator. This is a position(s) that may be utilized to provide Special Instruction via contract, salary, or fee for service depending upon availability of personnel and resources in the local program. **If the EI Specialist is responsible for supervision of staff, this position cannot be contracted.**

The EI Specialist is able to assist local programs with direct service, supervision, quality assurance, training, and program development issues. The EI Specialist is knowledgeable in consultation methods and meets the following competencies:

1. Knowledge and experience participating in family-guided evaluation and assessment using a variety of methods, including multi-domain, standardized developmental instruments, curriculum-based assessments, and systematic observation tools.
2. The EI Specialist should be able to select and administer appropriate instruments, summarize results in writing, and interpret the results to parents, caregivers, and other professionals involved with the child.
3. Knowledge and experience participating in the development of IFSPs, including writing outcomes for Special Instruction and implementation of services within a team model.
4. Experience and skill in functioning as a team member within a multidisciplinary/PSP team responsible for identifying children who need Special Instruction.
5. Experience and skill in consultative methods with team members to facilitate integration of each child's individual program.
6. Experience and skill in participation and identification of appropriate service delivery options within natural environments, including home-based, community-based, consultative, and integrative therapy services.
7. Experience and skill in designing and modifying the physical and social environment, including use of adaptive materials and incorporating family-guided activity-based intervention approaches within natural environments.
8. Experience and skill in developing appropriate instructional sequences linked to programmatic assessment and the identified IFSP outcomes.
9. Experience and skill in the development of procedures for evaluating the impact of Special Instruction intervention, including child outcomes and family satisfaction.
10. Experience in supervision of Special Instructors (Early Interventionists) and Special Instructor Assistants (EI Assistants).
11. Experience collaborating with professionals from a variety of disciplines to deliver family and child-focused services.

The Early Interventionist provides Special Instruction according to the IFSP, with The EI Specialist performs and/or monitors ongoing child evaluation/assessment activities which include participation in the evaluation/assessment process and development of the IFSP, as well as periodic reviews.

Activities for the EI Specialist to meet this job responsibility include participation in pre-assessment planning, i.e., the identification of developmental areas to assess, appropriate measures to use, and other disciplines to include in the evaluation for eligibility and/or programmatic assessments for IFSP development with the Service Coordinator and the MDT. The EI Specialist should also perform and interpret the programmatic assessments for IFSP development with the MDT. The EI Specialist should be fully aware of appropriate assessments and curriculum which meet the needs of the child and family. The EI Specialist should participate in identifying children appropriate for Special Instruction based on MDT evaluation/assessment results and in writing the IFSPs (identification of outcomes, strategies, and services) for children receiving Special Instruction. The team (always remembering the family is an active participant of the team) should review the assessments and IFSP outcomes to determine the most appropriate service delivery options.

Once the child begins to receive Special Instruction, the EI Specialist should establish a system of on-going progress monitoring of each child's outcomes related to Special Instruction and review the progress to ensure consistency of service delivery across all team members. The EI Specialist should also participate in annual re-evaluations of the child's IFSP, as appropriate.

The EI Specialist collaborates with and provides consultation to direct providers in the child's environments to insure functional, integrative intervention plans. (Direct providers include Early Interventionists, EI Assistants, OT, PT, SLP, Audiologists, Child Care Providers and other personnel designated within federally mandated EI services.)

Providing consultation as necessary regarding Special Instruction outcomes to other members of the MDT may also be appropriate for the EI Specialist. Activities to support other direct service providers might include identifying and monitoring plans and activities including the identification of locations, activity settings, and learning opportunities within the child's daily routine. EI Specialists should be capable of coaching other team members, including the family, in the use of instructional and behavioral strategies. The identification of adaptations and modifications needed for successful implementation of the IFSP, including environmental arrangements and need for assistive technology, is an important role for the EI Specialist in collaboration with the PSP team.

The EI Specialist may also observe parent/ provider interaction and provide feedback when appropriate to the accomplishment of the Special Instruction outcomes. Collaboration with the Service Coordinator to ensure child and family needs are met in the areas of family training and linkages to other resources may also be appropriate.

The EI Specialist provides supervision of EI Assistants and consults with Early Interventionists. If EI Specialist is responsible for supervision, they must be hired as public health staff.

The level of supervision provided by the EI Specialist to the EI Assistant will be dependent on the level of training, experience and competence of the EI Assistant. Until the EI Assistant completes the SCEIs training modules and demonstrates the training competencies, close supervision must be maintained.

The EI Assistant will be supervised in two ways. First, the EI Assistant will be supervised at a minimal level of one face-to-face meeting per month. This requirement may be met in many different ways: joint observation of child participating in a therapy session, IFSP development meeting, PSP Team meeting, or staff training. The second requirement is for a quarterly

observation of the EI Assistant interacting with the child and teacher/caregiver if served in a community-based program, or child and family if served in a home-based program. A review of Special Instruction outcomes occurs quarterly. The frequency and type of supervisory contacts should be based on the direct observations of the EI Assistant's performance with the child and the outcome review. For some children and families, supervision may need to occur more than one time a month in order to ensure that child progress occurs according to the child's outcomes.

The monthly face-to-face meeting is in addition to other forms of supervision, such as telephone conversations, written correspondence, and review of meeting and/or service notes. Training for the EI Assistant is provided as needed. Monthly supervision might also occur in group settings (e.g., PSP Team meetings, staff meetings, consultations with therapists).

Supervision is an ongoing process and is dependent on the level of independence and competency demonstrated by the EI Assistant. Special Instruction includes many activities, such as program development, progress monitoring, coaching family and team members, and implementing recommendations from team members. Each of these activities may require a different type and frequency of supervision, depending on the competency of the EI Assistant. As these personnel develop within the discipline and field, supervision may be less frequent.

The EI Specialist provides consultation to Early Interventionists to ensure both administrative and programmatic quality assurance. Quarterly meetings are scheduled and held to

- Provide updates on State and local Special Instruction requirements and procedures;
- Share content;
- Discuss developmentally appropriate strategies and approaches for children receiving Special Instruction.

The following two standards relate to the provision of Special Instruction by Early Interventionists and Early Intervention Assistants.

B. Early Interventionist

The Early Interventionist:

1. Provides Special Instruction according to the IFSP, with consultation from the EI Specialist. This is a position(s) that may be utilized to provide Special Instruction via contract, salary, or fee for service, depending upon availability of personnel and resources in the local program.
2. Provides Special Instruction to children and families, in collaboration with the Service Coordinator, and with consultation from the EI Specialist, family, and other MDT members.
3. Shall not supervise EI Assistants.
4. Is knowledgeable in consultation methods.
5. The role of this early childhood professional includes three of the four job responsibilities of the EI Specialist (see above standards):
 - performs and/or monitors ongoing child assessment activities which include participation in the assessment process and development of the IFSP, as well as periodic reviews;
 - provides consultation and coaching to the family/caregiver and other team members (team members include OT, PT, SLP, Audiologists, Child Care Providers

- and other personnel designated within the 16 federally mandated services);
 - synthesizes recommendations from the PSP team.
6. The Early Interventionist is responsible for attending quarterly meetings with the EI Specialist to ensure administrative and programmatic quality assurance.

C. EI Assistant

The EI Assistant:

1. Provides Special Instruction services to children and families under the supervision of an EI Specialist and in collaboration with the Service Coordinator. The EI Assistant must complete the Level I SCEIS training modules within six months from date of hire or contracting. The following activities clarify the role of this provider.
2. Provides Special Instruction to children and families in the child's environments, accomplished via fee for service or contract arrangements. Activities for the EI Assistant should include implementation of the child's individualized program based on the family's goals for their child, implementation of learning opportunities and activities which have been identified by the family, monitoring progress on each visit to share with the family, PSP team, and EI Specialist; and maintaining appropriate documentation for child's EI record.
3. Should be knowledgeable of how instructional activities enhance individual child outcomes. This knowledge can be gained by meeting with the EI Specialist for the purpose of understanding desired outcomes and their relationship to the program plan; by participating in writing IFSPs (identification of outcomes, strategies, and services for Special Instruction); by providing on-going monitoring of child progress related to Special Instruction, and by being a liaison between family members and other team members or community program staff.
4. Will receive face-to-face supervision from the EI Specialist.
5. Are responsible for attending quarterly meetings with EI Specialists to ensure administrative and programmatic quality assurance.

D. Special Instruction

Special Instruction shall be provided to the maximum extent possible within natural environments. Natural environments are defined to include the child's home and community programs where children without disabilities participate. Examples of natural environments would include childcare, early education programs, and community programs such as Early Head Start.

Special Instruction shall be provided that links assessment information to program development. Ongoing assessment procedures should be used to determine the unique strengths and needs of the child and family in order to help the family meet those needs. Instruments such as the Asset-Based Context Matrix, the Routines-Based Interview, and Interest-Based Checklists can be used to help identify activity settings and learning opportunities.

E. Assessment Tools

In order to track the child's ongoing developmental progress in the context of everyday routines and activities and obtain federally required information about child outcomes, the most recent edition of one of the following assessment tools may be utilized:

1. The Carolina Curriculum for Infants and Toddlers with Special Needs
2. Hawaii Early Learning Profile (HELP)
3. Assessment, Evaluation and Programming System (AEPS)
4. The Trans-Disciplinary Play-based Assessment
5. Battelle Developmental Inventory
6. Developmental Assessment of Young Children (DAYC)
7. Developmental Profile 4 (DP-4)

F. Special Instruction, Family Training and Counseling

An Early Interventionist/ Early Intervention Specialist must have specialized training, such as Applied Behavior Analysis, DIR/ Floor time, etc. in order to provide Family Training and Counseling. If the provider has specialized training, the area of specialty must be approved by the State BCW office in order to enroll the Early Interventionist/ Early Intervention Specialist as a Family Trainer.

An Early Interventionist or Early Intervention Specialist under Family Training must complete the SCEIS Modules and adhere to the 20 hours of Continuing Education Units (CEUs) every two years.

CHAPTER 900 – TRANSITION PROCEDURES

GUIDING FEDERAL POLICY 34 CFR §303.209 *Transition to preschool and other programs.*

BABIES CAN'T WAIT (BCW) PROGRAM STANDARD

As local program programs and provider agencies plan and implement services for children with developmental delays and disabilities, transition and interagency collaboration are major components of the service delivery system. In particular, Public Law 108-446 contains requirements designed to promote more seamless systems for children birth through 5 years of age. A seamless transition system requires interagency planning and collaboration within and among community agencies and partners. Community collaboration for transition systems development is based on a philosophy of team building among community members, parents, agencies, and service providers. Having an effective transition system in place is not only a matter of legality, but also reality.

Increasingly, policy makers no longer view individual agencies or programs in isolation but rather from a holistic view of the overall community system of services for children and families. If the overall system is to produce positive and successful outcomes for children, then the various components of the system must work in harmony as children and families move throughout the system, transitioning at various points from one agency or program to another. Planning in response to the various issues associated with transition both increases the likelihood of a seamless and successful transition process and helps minimize stress for all concerned. Such planning requires development of effective practices for transition preparation, implementation, and follow-up for all involved in the process. This includes not only the children and families, but also the agencies and staff who serve them.

Upon entry into the program, the Service Coordinator should introduce the family to the concept of transition planning. The Service Coordinator should explain the relationship between BCW and the Department of Education (DOE). Transition planning helps prepare the child and family as they move from Babies Can't Wait (BCW) to Part B preschool special education and/or other community programs when the child turns three, or anytime the family chooses to end involvement with BCW. Under IDEA, transition from Part C should be planned and supported, regardless of the services or settings where a child plans to move upon transitioning out of BCW.

The transition plan is part of the individualized family service plan (IFSP) that is developed as early as 27 months of age and no later than 90 days before the child's third birthday and it includes the appropriate transition steps and services required under IDEA. BCW must hold an IFSP meeting to develop the transition plan in the IFSP (to identify appropriate steps and services). In most instances, for children potentially eligible under Part B, the transition plan is developed with the IFSP Team (including the parent) and the LEA representative as part of the transition conference. BCW and the Department of Education (DOE) strongly recommend that the transition plan be completed by the time the child is 30 months of age but no later than 90 days (three months before age 3) or earlier than nine months prior to the child's third birthday.

A. Additional Transition Requirements

Prior written parental consent is required to send personally identifiable information about a child to the LEA, including a child's eligibility criteria for Part C/areas of concern and/or other

personally identifiable information (e.g., diagnosis, evaluation or assessment reports, IFSPs, etc.). No personally identifiable information about a child, including the child's eligibility criteria for Part C/areas of concern and/or other personally identifiable information (e.g., diagnosis, evaluation, or assessment reports, IFSPs, etc.) can be sent to the LEA until a child's parent has consented in writing to the release of that information.

1. Referral to the Local School System (LSS)

- a. The Service Coordinator should discuss transition with the family at every IFSP meeting in detail upon the child's second birthday. Discussions at each IFSP meeting provide families an opportunity to hear repeated explanations about the transition process and timelines and to have an opportunity to ask questions. Discussion of the transition process at IFSP meetings prior to a child's second birthday should include an explanation of the transition process and the rationale for timely transition planning (to ensure seamless transition for each child and family). Documentation and/or discussion of the transition process should never be "deferred" until the child is 24-30 months of age.
- b. **LEA Notification:** Limited contact information that includes the child's name, birth date and parent(s) contact information (including parents' names, addresses, and telephone numbers) is sent to the local educational agency where a child resides in the month immediately following a child's second birthday, but not fewer than 90 days prior to the child's third birthday unless the parent opts Out. If a child is referred and determined eligible for services under Part C between 90 and 45 days before the child's third birthday, LEA notification must occur as soon as possible after the child is determined eligible under Part C §303.209(b)(1)(ii). If a child is referred to the lead agency fewer than 45 days before that child's third birthday, the lead agency must refer to the SEA and the LEA if the child may be eligible for Part B services; the lead agency is not required to conduct an evaluation, assessment or an initial IFSP meeting.
- c. **Parent Consent for Preschool Special Education Services:**
This step must occur at the IFSP meeting closest to the child turning 27 months of age or at the transition conference IFSP meeting. Children who may be eligible for public preschool special education services under Part B must, with signed parental consent, be referred to the local school system for eligibility determination as early as nine months prior to the child's third birthday. If consent for referral is granted by the parent, the date that the consent was granted must be documented in BIBS under the Transition Section of the IFSP.

2. The Transition conference and completion of the Transition Plan document:

The Service Coordinator must convene a transition conference (Indicator 8c) to complete the transition plan documentation (Indicator 8a). When this occurs, participants must include the family, the Service Coordinator, with signed parental consent a Part B representative(s), person conducting evaluations and assessments (usually ongoing provider who does not have to attend meeting face to face) and other community representatives as appropriate.

Other community representatives may include, but are not limited to, childcare, private preschool, childcare Inclusion Coordinators, Even Start, Head Start, and private services. Other attendees might also include current service providers, Georgia PINES, Georgia Sensory Assistance Project, etc. With parental consent, the transition plan and transition conference can occur as early as nine months, but no later than 90 days prior to the child's third

birthday. The LEA/LSS must receive timely notice of the transition conference and must participate in the transition conference unless parent requests otherwise. In Georgia, all children enrolled in BCW are considered potentially eligible for Part B services at age 3.

- a. The transition planning conference is the cornerstone of the transition process. It is an opportunity for the family, BCW personnel, and local school system personnel and/or other community program staff to come together to make plans regarding the transition process. When a child may also be eligible for programs other than preschool special education, such as Head Start services, staff from those programs should be asked to attend the conference. The BCW Service Coordinator shall make every effort to schedule the meeting for all parties' attendance. If the LSS representative cannot attend the conference in person, they may participate through other real time methods such as conference call or virtually. The BCW SC shall convene the transition conference and explain eligibility requirements if the LSS does not participate.
- b. Transition documentation must be completed by the Service Coordinator at IFSP reviews when revisions and modifications are necessary to update information on the IFSP and at the final (exit) review prior to the child's exit from BCW. The status, results, and final outcomes of each step must be included in the transition plan.
- c. The transition plan referred to in this section is actually a part of an IFSP and not a separate document. The Transition Plan section opens and becomes available to complete when "transition" is selected as IFSP meeting type. It is different from transition steps that are an ongoing part of the IFSP. The IFSP must include the steps to be taken to support the transition of the child to preschool services under Part B of the Act, to the extent that those services are appropriate; and the identification of transition services and other activities that the IFSP Team determines are necessary to support the transition of the child. Required steps include:
 - i. Documenting on the IFSP that there were discussions with and training of parents regarding future placements and other matters related to the child's transition;
 - ii. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting;
 - iii. With parental consent, the transmission of information about the child to the local educational agency, to ensure continuity of services, including evaluation and assessment information and copies of IFSPs that have been developed and implemented.
- d. As part of the IFSP conference to develop the transition plan, the IFSP Team (which includes the parent) must review the program options for the toddler with a disability for the period from that child's third birthday through the remainder of the school year.
- e. The transition conference to develop the transition plan is combined in Georgia into one meeting and must meet the IFSP transition conference participant requirements.

3. Reason for Delay in Transition conference (Meeting held less than 90 days before child's third birthday): The Service Coordinator must record the reason for the delay in meeting the requirement to convene a transition conference at least 90 days prior to the child's third birthday. The reason for delay should be documented during the transition conference. Only parent related reasons for delay or act of nature reasons are acceptable. It is strongly recommended that the transition plan and conference be completed/held by 30 months with parental consent.
4. Late referral to the BCW program:
 - a. A child referred to BCW 46-90 days before the third birthday shall be assigned a Service Coordinator, receive an evaluation for Part C eligibility, and begin transition planning.

BCW is not required to conduct a transition conference or develop a transition plan within the 90-day timeline prior to the third birthday, but transition must be discussed during the child's initial IFSP meeting. § 303.209(b)(1)(ii)
 - b. Any child referred to BCW 45 days or fewer before his/her third birthday shall be referred directly to the LSS if suspected of having a disability as defined by Part B, and/or other community programs, with parent consent. The child shall be entered into the Children's 1st program with parental consent to ensure appropriate linkages, reduce service duplication and prevent children from being lost to follow up.

B. Service Coordination after Age 3

During the transition planning process for a child whose third birthday falls during June, July, or August, the need for service coordination as a transition activity must be discussed with the family. If service coordination is needed in order to assist the family with medical/health or other needs which might be met by the community, it must be documented on the IFSP and provided by BCW during the period from the third birthday until Aug. 31 or until the day before the Individualized Education Program (IEP) begins, whichever comes first. This need and expected outcome must be documented in the transition plan. Service coordination is the only service that may be funded with BCW funds for a child after the child's third birthday during the months of June, July or August.

900.1 – SEA and LEA Notification – Opt-Out Policy

Guiding Federal Policy 34 CFR §303.401 (d) and (e)

Babies Can't Wait Program Standard

The Individuals with Disabilities Education Act (IDEA) section 637(a)(9)(A)(ii) and Part C regulations in 34 CFR §303.209 require States to have policies and procedures that ensure a smooth transition for children receiving Part C early intervention services to Part B preschool or other appropriate services, including how the Part C lead agency will notify the local educational agency (LEA) for the area in which each child resides that the child will shortly reach the age of eligibility for preschool services under Part B, as determined by State LEA.

IMPLEMENTATION

Information about transition to Part B preschool or other appropriate services is shared with the family and explained at the initial IFSP meeting and at every annual IFSP meeting and six-month review thereafter. For a child participating in early intervention prior to age two (2), specific transition information is shared and transition planning including steps to be taken at age 27 months.

A. Transition Timeline

1. At the IFSP meeting, six-month review or service coordination visit closest to a child's 27th month of age, parents are informed of their options regarding sending notification information about their child to the LEA using the 'Notice of Intent to Transmit Notification Information to Local School System(s).'

2. The Babies Can't Wait (BCW) transition conference with Part B representatives from the local educational agency must occur no later than 90 days from a child's third birthday for parents who have consented to a referral to the LEA as a part of the transition steps for their child who is at least age 27 months.

B. Notice of Intent to Transmit Notification Information to the Local School System(s)

At the IFSP meeting, six-month review or service coordination visit closest to a child's 27th month of age:

1. The Service Coordinator informs parents of their options regarding sending notification information about their child to the LEA using the 'Notice of Intent to Transmit Notification Information to Local School System(s)' (LEA Notification form). (Refer to table below that explains the options.)
2. The Service Coordinator explains to parents that BCW is required to provide directory information that includes child's name, birth date, and parent(s) contact information (including the parents' names, addresses, and telephone numbers) to the State Educational Agency (SEA) and the Local Educational Agency (LEA) unless the parent Opts Out.
3. The parent acknowledges that he/she understands the explanation and purpose of the LEA Notification form.
4. The parent signs the LEA Notification form.
5. If the family does not want the limited contact information (including parent's names, addresses, and telephone numbers) sent to the LEA, a parent must also sign the Opt-Out section of the LEA Notification form.
6. If the parent Opted Out, the Service Coordinator enters that the parent chose to Opt-Out of school notification on the child detail page in BIBS.
7. The Service Coordinator must return the LEA Notification form to the local Babies Can't Wait office within 5 calendar days and no less than one month prior to the child turning 27 months of age. If the child is already 27 months at the time of the initial IFSP meeting, the notice is signed at the IFSP meeting and turned in to the local BCW office with the IFSP documents within 7 calendar days.

C. Sending Notification Information to the LEA

1. In the month immediately following the child reaching 27 months of age, the child's name, date of birth and parent contact information (including parents' names, addresses, and telephone numbers) will be sent by the local BCW program to the Special Education Director in the school system where the child resides unless the parent has Opted Out. If the child initially enters BCW after 27 months of age, this information will be transmitted in the month immediately following the development of his or her initial IFSP. Local BCW programs will document in BIBS the date of each child's notification for Indicator 8b APR data collection purposes.
2. Prior written notice and consent must be obtained before personally identifiable information other than notification information about the child can be sent to the LEA, including the child's eligibility criteria for Part C/areas of concern and other personally identifiable information (e.g., diagnosis, evaluation or assessment reports, IFSPs, etc.).

D. Information Babies Can't Wait is required to share with the LEA

1. Child's name,
2. Birth date, and
3. Parent(s) contact information including the parents' names, addresses, and telephone numbers. (See grid below for timeline requirements.)

Option #	Option	Guidance	Actions
1	Directory information that includes child's name, birth date, gender, and parent(s) contact information (including the parents' names, addresses, and telephone numbers) is provided to LEA.	Parent signs form "Babies Can't Wait Notice of Intent to Transmit Notification Information to Local School System" indicating requirements for notification to the LEA have been explained to them.	Service Coordinator obtains parent signature in appropriate section of form that it has been explained. BCW program sends BIBS report of directory information to the appropriate LEA the month after child turns 27 months or if already 27 months when enters program, the month after the initial IFSP is completed. Information includes child's name, birth date, and parent(s) contact information (including the parents' names, addresses, and telephone numbers). The local BCW program shall keep a record of the notification.
2	No directory information is sent to LEA.	A parent must sign the "opt out" section of the form "Babies Can't Wait Notice of Intent to Transmit Notification Information to Local School System" and return form to the local Babies Can't Wait office within 7 calendar days.	Service Coordinator obtains parents signature on "opt-out" statement and provides parent with DOE Part B services information. Completes Opt-Out section on BIBS Child Detail page.
3	If prior signed parental consent is obtained, the child's eligibility criteria for BCW, areas of concern and other personally identifiable information is sent to the LEA.	Signed parental consent must be obtained to share child's eligibility criteria, or other diagnostic information for BCW, areas of concern and other personally identifiable information with the LEA.	Service Coordinator (or BCW office) provides the appropriate LEA with the information for which written parental consent has been obtained.

CHAPTER 1000 – CHILD OUTCOMES SUMMARY RATINGS POLICY

A. Child Outcomes Summary Ratings

The Child Outcome Summary Form with Evidence Organized by Level of Functioning (October 15, 2009) developed by the Early Childhood Outcomes Center (ECO) is used to assess and report child progress in accordance with federal reporting requirements under Part C of IDEA for Indicator 3 of the state's Annual Performance Report to the Office of Special Education Programs. The Child Outcome Summary (COS) is to be completed at initial entry into Babies Can't Wait for children less than or equal to 30 months of age and at exit for all children who are enrolled with an active IFSP for at least six months. Entry and exit ratings are entered and reported in the state database as well as a hard copy placed in the permanent record for each child. See COS procedures document.

B. Child Outcomes Summary Process

The COS process is a team process for summarizing information related to a child's progress on each of three child outcome areas on a 7-point scale. The COS process must be explained to the family at entry and exit.

The COS process is used:

1. To describe a child's functioning on each of the three outcome areas based on multiple sources of information. The information could include one or more norm-referenced or curriculum-based assessments, parent report on child's skills and behavior, progress notes of therapists working with the child, observations by a teacher or childcare provider, or other sources; and/or
2. To aggregate outcome data across local programs throughout the state for federal reporting.

The three outcome areas that must be rated and reported in the state database for each child are:

1. Development of positive social-emotional skills (including social relationships)
2. Acquiring and using knowledge and skills (including early language/ communication and early literacy)
3. Use of appropriate behaviors to meet needs

C. Entry Ratings

The entry COS ratings must be determined by the team of evaluators who participate in the initial eligibility evaluation or program planning assessment for each eligible child. The team should include the Service Coordinator, the evaluator(s) and the parent. The rating must be entered into the state database by the local program when finalizing eligibility in BIBS. In determining COS ratings, evaluators will use the Decision Tree developed by the ECO Center. Information from an approved five domain evaluation/assessment tool (examples: AEPS, BDI-2, Hawaii Early Learning profile, Carolina Curriculum or other approved instrument) is used as the reference for typical child development in conjunction with the Decision Tree. In addition, the following sources of information must be considered in determining COS ratings: input from Service Coordinators, parent report, crosswalks of evaluation/assessment tools developed by the ECO Center, other approved evaluation/assessment tools, observation and informed clinical opinion.

D. Exit Ratings

The exit COS ratings must be determined in collaboration with a child's team that includes, at a minimum, a family member, the Primary Service Provider and the Service Coordinator. Other IFSP team members who are familiar with the child may be included. The COS exit rating must be completed within the last 30 days prior to the child's exit date. In determining COS ratings, providers will use the [Decision Tree](#) developed by the ECO Center. Information from an approved five domain evaluation/assessment tool can be used as the reference for typical child development in conjunction with the Decision Tree. A formal assessment or evaluation is not required for determining exit ratings. Additional information from crosswalks of evaluation/assessment tools developed by the ECO Center, other approved evaluation/assessment tools, observation and informed clinical opinion can be considered in determining COS exit ratings.

E. Team Participation

Ratings must be determined by a team as defined under **Entry Ratings** and **Exit Ratings** including family members, professionals who work with the child (including Service Coordinators), and others familiar with the child's functioning. COS ratings should not be determined by individuals who do not know the child's abilities. Ratings should not be assigned based only on information available in the child's records. Ratings should be determined by providers in collaboration with each other, not in isolation. BCW personnel must receive training, guidance and instruction on the COS process prior to determining ratings for a child. It is the responsibility of the local program EIC to ensure that BCW professionals in their local program receive training required by the state BCW program before completing COS ratings for a child.

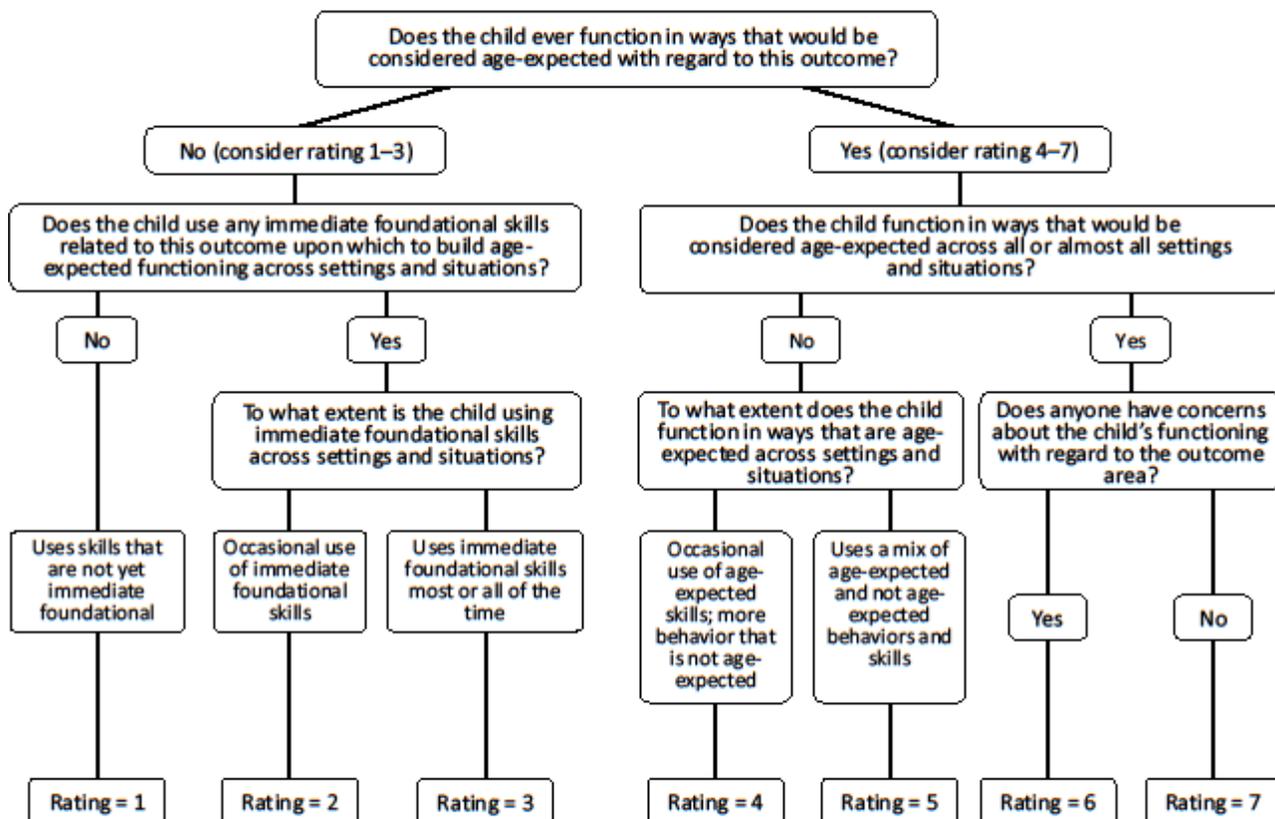
F. State COS Training Requirements

All BCW providers with the exception of interpreters and translators, must complete the online COS training as part of their contract onboarding requirements. After each module there is a test. The provider will receive a certificate of completion.

G. The Decision Tree

The [Decision Tree](#) was created by the ECO Center as a tool for training in the use of the COS Form. The Decision Tree is a series of questions about the extent to which a child exhibits age-appropriate skills and behaviors in each outcome area. Responses guide the user to a specific rating category on a 7-point scale.

Decision Tree for Summary Rating Discussions



CHAPTER 1100 - FISCAL POLICIES/SYSTEM of PAYMENT/REIMBURSEMENT

1100.1 - INTRODUCTION

Babies Can't Wait (BCW) is Georgia's comprehensive, coordinated, statewide, interagency service delivery system for infants and toddlers, birth thru 2 years of age, who have developmental delays, and their families. The program is established under Part C of the Individuals with Disabilities Education Act (IDEA), as amended. Family-centered care and family empowerment are important concepts in IDEA. Through participation in Babies Can't Wait, families are assisted in identifying and accessing resources that may be available to them. Equipped with information, families become more effective advocates for themselves and their children.

The philosophy of family empowerment drives the service coordination that all eligible children and families receive. Babies Can't Wait early intervention services are to be family-centered, provided in natural environments and culturally competent. Family members have an integral and equal role in identifying outcomes for the Individualized Family Service Plan (IFSP), determining services and supports necessary to achieve those outcomes, and promoting the child's development through participation in family activities and routines. Babies Can't Wait personnel and early intervention providers ensure that early intervention services are provided based upon the identification of child and family strengths and interests and desired skills to be acquired by each eligible infant and toddler in order to promote maximum inclusion and participation in home and community settings. Intervention is integrated throughout activity settings and learning opportunities within locations where families typically spend time. Babies Can't Wait personnel and early intervention providers ensure that intervention focuses on working with and coaching families and caregivers to support each child to achieve optimal participation and inclusion in home and community activities and settings.

IDEA requires that all children enrolled in the Part C Program must have an active IFSP. The IFSP is developed in partnership with families and providers through a multidisciplinary team process. Each IFSP includes outcomes for the child and family; describes strategies to achieve the outcomes; and identifies resources to implement the strategies. Many of these strategies involve costs, and BCW funds are used as a payor of last resort when no other resources are available to the family.

1100.2 – SYSTEM OF PAYMENTS POLICY

The purpose of Babies Can't Wait Fiscal Policies is to establish and define the state's system of payments as federally required under Part C of IDEA §303.521. This policy document establishes procedures for funding services to eligible children and families, defines the funding hierarchy for Part C Early Intervention services and establishes procedures for access and utilization of BCW funds in order to ensure payor of last resort.

A. Services Provided at No Cost to Eligible Children/Families

BCW funds are used to support federally required Early Intervention Services when *no other resources are available*.

All services must be attached to specific strategies related to achieving individual outcomes on the Individualized Family Service Plan (IFSP). All strategies are recorded in the IFSP (see IFSP Policy).

Services that must be made available and provided to families and children at no cost include:

1. Child find
2. Evaluation and/or assessment activities
3. Service coordination services
4. Activities related to procedural safeguards
5. Development, review, and evaluations of IFSPs and interim IFSPs
6. All Part C services when the parent of family meets the State's definition of inability to pay (§303.521 (a)(4)(ii), (b), and (c))

B. Services Subject to the Funding Hierarchy

The following services are subject to the funding hierarchy and BCW funds may be used to support the following federally required Early Intervention Services when no other resources are available:

1. Applied Behavior Analysis
2. Assistive technology
3. Audiology
4. Family training and counseling and home visits
5. Health services (does not include a medical device that is surgically implanted or replacement of such device)
6. Medical Services (diagnostic)
7. Nursing
8. Nutrition
9. Occupational therapy
10. Physical Therapy
11. Psychological services
12. Service Coordination
13. Social Work
14. Special Instruction
15. Speech-Language Pathology
16. Transportation services
17. Vision services

C. Policy Revision Statement

Policy revisions will be necessary from time to time due to changes in federal and State Laws and Department of Public Health's guidelines. When such revisions are made to the policy manual, they will be initially redlined in the body of the draft document, with the date of the change denoted in the left boarder next to the change. The effective date of the revision will be contingent upon review and approval by the Office of Special Education Programs (OSEP), pending the public notice and comment period or as specified by the notice itself. Providers are responsible for complying with the policy change provisions as of the effective date(s).

1100.3 – SECTION 1: GENERAL POLICIES

The purpose of this section is to describe policies and parameters for the use of Babies Can't Wait (BCW) services funds.

A. Babies Information and Billing System (BIBS)

The BCW program has a web-based data and centralized billing system. The Babies Information and Billing System (BIBS) will accept, authorize and adjudicate claims, render payment to private providers and house BCW billing and claims information for the BCW program. The Case Management module will house *all* child and family information, including the Individualized Family Service Plan (IFSP) and associated activities. The Provider module will house provider payment and billing information.

B. “Chase and Pay” Provider Payment Process

The provider payment process will be offered through a “chase and pay” method. The “chase and pay” method is a method in which providers submit claims to the appropriate fund source (private insurance, Medicaid, CMOs) independently.

1. Providers must submit coordination of benefits information into BIBS for claims as appropriate.
2. Providers may seek reimbursement through BIBS for the difference in payment from private insurance only up to the established BCW rate from the program by filing a claim in BIBS. Providers must have the capability to scan and upload the “Explanation of Benefits” (EOBs) to verify that the claim was submitted and denied or reimbursed at a lower rate in order to receive reimbursement from BCW as payor of last resort.
3. **Providers are never to share their login and password with anyone.**

Early Intervention services may only be provided by professionals who have a signed contract with the state lead agency prior to delivery of services. The local or state lead agency will not authorize the use of funds to pay providers for services that were rendered prior to having a contract in place. All contractors must meet personnel requirements described in the Personnel policy.

All service providers must obtain prior authorizations and plans of care if applicable **and original signed parent vouchers for each service rendered**. This documentation must be maintained in the provider’s child record. At least twice per year local lead agencies must perform child record audits to review supporting documentation.

All contracted professionals and local program staff must ensure that they maintain a current email address in BIBS. Email addresses must be unique to each individual provider and not the agency they are affiliated with, if applicable.

C. Use of BCW Funds

1. Use of BCW funds is based upon an appropriately developed IFSP, developed by the Primary Service Provider (PSP) team (which includes the parents.) The IFSP must be designed to ensure that eligible infants and toddlers receive services in natural environments (in home and community settings in which children without disabilities participate) and that families receive services that support their ability to enhance their child's development.

2. BCW funds must only be used to support services in the natural environment unless there is justification which supports why IFSP outcomes cannot be achieved in the natural environment. Justification must be time-limited and must include plans for timely transition of services to the child's natural environment(s). Justifications are not to be used in order to continue provision of services in non-natural environment settings for the duration of an IFSP and/or a child's eligibility for BCW.
3. BCW funds are used to implement strategies on a child's IFSP when other means and/or resources are not available. Allowable expenditures are defined in the section entitled Authorized Goods and Services. These funds reflect a coordination of all existing resources (local, state, federal, other public, private, and fees) and serve as a payor of last resort. BCW funds may only be used after ALL other resources have been identified and accessed.

Local Practice Guidance or Clarification

BCW funds are to be used as "last dollar" **only when**:

- A. No other resources are available including the identification of family resources and an assessment of family cost participation, or
- B. When all other resources have been exhausted.

Accessing other funds, including Medicaid/Peach Care for Kids, private family insurance, Children's Medical Services (CMS) etc., to support an IFSP service in whole or in part is required before BCW funds are either committed through the IFSP process, or actually used to reimburse or otherwise pay for an early intervention service. "At No Cost" early intervention services (service coordination, evaluation and assessment, IFSP development, and procedural safeguards) will not be suspended based on a family's inability to pay as determined by completion of the Babies Can't Wait Financial Analysis form. Part C (Babies Can't Wait) is the payor of last resort, therefore the provider with consent will seek reimbursement from public and private insurance and other State agency or third-party funding mechanisms to cover these services prior to billing Babies Can't Wait for the service rendered. However, if a family is determined able to pay by completion of the Babies Can't Wait Financial Analysis form, the family is assigned a family cost participation. Failure to document the procedures used by the local lead agency to identify and access other fund sources may result in an audit finding and subsequent recovery of state or federal funds. Documentation of other resources must be located in the IFSP meeting minutes. Identification of other potential resources should be included in the IFSP and researched through resource coordination activities with the family by the Service Coordinator. Documentation that other resources have been investigated, or that these funds are exhausted, must be included in the local BCW Early Intervention client record. The child's legal name (name on birth certificate) and the name listed on the Medicaid or insurance card must be documented on the IFSP, the Cost Participation Analysis form and the benefits tab in BIBS.

D. Provision of Services "At No Cost"

Georgia is committed to ensuring the provision of those services to families that must be made available at no cost. Services that must be made available and provided to families and children at no cost include child find, evaluation and/or assessment activities, service coordination services, administrative and coordinative activities related to procedural safeguards and the development, review, and evaluations of IFSPs and

interim IFSPs and all Part C services when the parent or family meets the State's definition of inability to pay (§303.521(a)(4)(ii), (b), and (c)). Families participate in a process that identifies their ability to pay, pursuant to Title 34 CFR §303.521 , including the assignment of cost participation or sliding fee scales. Part C (Babies Can't Wait) is the payor of last resort, therefore the provider with consent will seek reimbursement from public and private insurance and other State agency or third-party funding mechanisms to cover these services prior to billing Babies Can't Wait for the service rendered. Families are advised of their rights, opportunities, and responsibilities available to them through mediation (Title 34 CFR §303.431), state administrative complaint procedures, and/or impartial due process hearing should they disagree with the determination of ability to pay (Title 34 CFR §303.13(a) (3) Early Intervention Services).

If a family is determined unable to pay by completion of the Babies Can't Wait Financial Analysis form and assigned a 0 percent family cost participation, all Part C services will be provided at no cost to the child and family.

Licensed therapists completing evaluations and assessments for eligibility to the BCW program must bill Medicaid and CMO, if applicable, with consent. Evaluations completed after the eligibility process must be billed to the appropriate funding source, with consent. BCW funds are available to support the costs for an evaluation when parents have not given consent to use their private insurance or to disclose the child's personally identifiable information for public insurance.

Regardless of the approval of the funding source, services must be rendered to the child and family per required timelines.

PROCEDURES FOR IMPLEMENTATION

The Babies Can't Wait Financial Analysis form must be completed by all families in order to determine their ability or inability to pay for early intervention services. If families choose not to complete the Babies Can't Wait Financial Analysis form, then the family will assume 100 percent family cost participation if their public or private insurance does not cover the service. Family cost participation only applies to IFSP services which are **not covered** by third-party fund sources (e.g., Medicaid, Peach Care for Kids, Children's Medical Services, private insurance, etc.). For example:

1. A child's IFSP states that special instruction and physical therapy services are necessary, and the child is enrolled in Medicaid. The family has a 0 percent cost participation for physical therapy services only. Cost participation (based on family adjusted income from the completion of the Babies Can't Wait Financial Analysis form) applies to special instruction services because Medicaid does not cover Special Instruction.
2. A child's IFSP states that special instruction and occupational therapy services are necessary. The family gives consent to access their private insurance, which covers occupational therapy services. In this case, family cost participation only applies to special instruction. BCW is responsible for copayments and deductibles (up to the BCW rate) for occupational therapy.
3. A child's IFSP states that speech therapy and physical therapy services are necessary. The family has private insurance and gives consent to access their insurance. Private insurance will not cover speech but will cover physical therapy. Family cost participation

applies to speech therapy. BCW is responsible for copayments and deductibles (up to the BCW rate) for physical therapy.

E. Private Insurance and the Natural Environment

Parental consent must be obtained when the local EI program seeks to use the family's private insurance to pay for EI services in the IFSP and each time consent is required due to a change in frequency, length, duration, or intensity. All BCW families are provided a copy of the Fiscal Policies (System of Payments) document when providing consent for use of private insurance to pay for Part C services. If a family provides consent to access private insurance, but the insurance company will not cover the IFSP service(s) in natural environments, then the family will be responsible for their cost participation for the service(s) as determined on the Financial Analysis form.

If the family chooses to receive services in the non-natural environment by a provider who does not have a contract with BCW, they are choosing to go "outside" of the Part C system and this service(s) should be listed on the IFSP under - Other Services. The family is responsible for all costs associated with this service.

If the family gives signed consent to access private insurance and the insurance company will not cover the service(s), regardless of the location, then family cost participation applies to these non-covered IFSP services according to the Babies Can't Wait Financial Analysis form. Families will not be charged more than the actual cost of the Part C service factoring in any amount received from other sources for payment for that service (§303.521 (a)(4)(iii)). Families with public insurance or benefits or private insurance will not be charged disproportionately more than families who do not have public insurance or benefits or private insurance. If a family wishes to contest the imposition of a fee, or the State's determination of the parent's ability to pay, the family may do one of the following:

1. Participate in mediation in accordance with §303.431
2. Request a due process hearing under §303.436 or §303.441, whichever is applicable.
3. File a State complaint under §303.434.
4. Use any other procedure established by the State for speedy resolution of financial claims, provided that such use does not delay or deny that parent's procedural rights under this part, including the right to pursue, in a timely manner, the redress options listed above.

Families are not required to sign up or enroll in public benefits or insurance programs as a condition of receiving Part C services. Consent must be obtained prior to using public benefits or insurance of a child or parent if that child or parent is not already enrolled in such a program.

All Babies Can't Wait Families are informed of these Procedural Safeguards options by receiving a copy of the Fiscal Policies (System of Payment) document.

Consent is required for the use of public benefits or insurance to pay for Part C services that would:

1. Decrease available lifetime coverage or any other insured benefit for that child or parent under that program;
2. Result in the child's parent paying for services that would otherwise be covered by the public benefits or insurance program;
3. Result in any increase in premium or discontinuation of public benefits or insurance for that child or that child's parents; or
4. Risk loss of eligibility for the child or that child's parents for home and community-based waivers based on aggregate health-related expenditures (§303.520(a) (2) (ii)). If the parent does not provide consent for use of public insurance or benefits when required under 34 CFR §303.520 (a)(2)(ii), the State must still make available those Part C services on the IFSP to which the parent has provided consent (§303.520 (a)(2)(iii)).

F. Use of Public Insurance (Medicaid)

In order for the BCW program to use Medicaid to pay for Part C services, the program must obtain parental consent to disclose a child's personally identifiable information to the State agency responsible for administering the State's public benefits or insurance program for billing purposes only. A parent has the right to withdraw their consent to disclosure of personally identifiable information to the State agency responsible for administration of the State's public benefits or insurance program at any time. This consent will be obtained by completion of the Disclosure of Personally Identifiable Information for Public Benefits, which is in the Babies Can't Wait Financial Analysis form. Families with public insurance or benefits or private insurance will not be charged disproportionately more than families who do not have public insurance or benefits or private insurance. All BCW families are provided a copy of the Fiscal Policies (System of Payment) document when seeking consent for use of Personally Identifiable Information for Public Benefits.

Families are not required to sign up or enroll in public benefits or insurance programs as a condition of receiving Part C services. BCW will not enroll families in public benefits or insurance and BCW will not use public benefits or insurance to pay for Part C services for families that are not already enrolled in those programs.

Consent is required for the use of public benefits or insurance to pay for Part C services that would:

1. Decrease available lifetime coverage or any other insured benefit for that child or parent under that program;
2. Result in the child's parent paying for services that would otherwise be covered by the public benefits or insurance program;
3. Result in any increase in premium or discontinuation of public benefits or insurance for that child or that child's parents; or
4. Risk loss of eligibility for the child or that child's parents for home and community-based waivers based on aggregate health-related expenditures. (§303.520 (a) (2) (ii)).

Consent must be obtained prior to using the public benefits or insurance of a child or parent if that child or parent is not already enrolled in such a program.

Federal Regulations

If the parent does not provide consent for use of public insurance or benefits when required under 34 CFR §303.520 (a)(2)(ii), the State must still make available those Part C services on the IFSP to which the parent has provided consent (§303.520 (a)(2)(iii).

The parent also has the right under §303.414 to withdraw their consent to disclosure of personally identifiable information to the State public agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid) at any time.

G. Procedural Safeguards for Billing

In order for families to be fully informed of their rights and safeguards, they must also understand their participation in all aspects of the EI system, including what is available to them at no cost, what services might involve cost, and all options available to them. Informed consent ensures that families understand their options and choices so they can make good decisions for their child and for themselves, and that they understand the implications of their decisions. Families will not be charged more than the actual cost of the Part C service factoring in any amount received from other sources for payment for that service (§303.521 (a)(4)(iii). Families with public insurance or benefits or private insurance will not be charged disproportionately more than families who do not have public insurance or benefits or private insurance.

If a family's cost participation changes, the five-day prior written notice must be given to the family using the prior written notice form.

H. Provider Billing

1. Prior Authorization

The provider is responsible for obtaining prior authorization for the service and maintaining all required documentation needed for authorizations and entering a claim into BIBS. **Provider must start services by the 45th day whether they have obtained the prior authorization or not unless there is a documented parent delay reason.**

- The Provider must seek to obtain the prior authorization for at least 45 days prior to beginning services with the child/family.
- Provider must show documentation of continued effort to obtain prior authorization, including dates.
- The provider can seek payment from the BCW program if they were unable to obtain an authorization after 45 days with documentation of due diligence.
- Provider must inform the Service Coordinator and the EIC of any challenges with obtaining the prior authorization.

2. Submitting Claims to Public Insurance (Medicaid)

- Claims are to be submitted to public insurance no more than 90 calendar days following the date of service.

3. Vouchers

- Providers must complete a parent signed voucher documenting the service was rendered and must maintain this documentation in the provider records. Local programs will be required to perform audits for financial supporting documentation. In addition, DPH will conduct fiscal audits and the provider must provide all requested documentation within 10 business days from the request.

I. Utilization of Available Resources

The priorities for use of BCW funds are the specific early intervention services set forth in these fiscal policies, pursuant to the identification and assignment of cost participation for each individual family. If BCW funds are used while other fund sources are being accessed, or during conflict resolution to identify fund sources, the early intervention service provider must **in all instances** seek reimbursement from the proper fund source to cover the period of time and actual costs incurred for early intervention services and reimburse BCW for any payments from third-party pay sources within 30 days of receipt of payment.

J. Authorized Goods and Services

Each child enrolled in Babies Can't Wait has an IFSP that includes developmental outcomes with strategies to achieve the desired outcomes. Any federally required Early Intervention service (good or portion thereof) which requires funds and is documented as needed in a family's IFSP may be funded fully or in part with BCW funds if no other resources are available. Part C of IDEA requires the state to make these services available according to individual need. These services must be listed in the IFSP.

Other services listed on the IFSP may include services identified in order to address the comprehensive needs of children and families. However, the "other" services are not protected by IDEA. This differentiation is necessary to ensure that Georgia meets the federal requirements for full participation in Part C of IDEA.

K. Eligibility for BCW Service Funds

For the purpose of BCW service funds, "family" may be defined as a group of two or more persons related by birth, marriage, adoption or co-habitation who live together as a unit in which there is at least one infant or toddler with developmental delays or a disability. The parent(s), if not the birth or adoptive parent, may be a full guardian, legal custodian, or a person acting in place of a parent in an official living arrangement. While families are the principal targets, a family's eligibility for BCW funds is determined by the presence of an infant or toddler who meets the State's definition for eligibility and is enrolled in Babies Can't Wait.

Cost participation for individual families will be determined once the child is determined eligible for Babies Can't Wait. The assessment of cost participation may only be made by the local lead agency. Eligibility for BCW service funds is based upon the completion of the Financial Analysis for Cost Participation (referenced in this document) with each family. Families will not be charged more than the actual cost of the Part C service factoring in any amount received from other sources for payment for that service (§303.521 (a)(4)(iii)). Families with public insurance or benefits or private insurance will not be charged disproportionately more than families who do not have public insurance or benefits or private insurance.

The Babies Can't Wait Financial Analysis is completed at least annually in conjunction with the evaluation of the IFSP, or more frequently if the family's needs change or new circumstances arise. If a family wishes to contest the imposition of a fee, or the State's determination of the parent's ability to pay, the family may do one of the following:

1. Participate in mediation in accordance with §303.431.
2. Request a due process hearing under §303.436 or §303.441, whichever is applicable.
3. File a State complaint under §303.434.

4. Use any other procedure established by the State for speedy resolution of financial claims, provided that such use does not delay or deny that parent's procedural rights under this part, including the right to pursue, in a timely manner, the redress options listed above.

L. Payment Mechanisms

BCW funds may be used to provide early intervention services in the following manner:

1. BCW will render payments for all billable Early Intervention services directly to the provider or as direct reimbursement to the family based upon the payment provisions as set forth and agreed to within the IFSP in accordance with the policies of and contract with the lead agency.
2. Contracts must be finalized and signed prior to initiation of services.

M. Portability of the IFSP

If a family moves from one local program to another, the IFSP moves with them and continues to be valid and in place for a period not to exceed the six-month review. The receiving local lead agency and PSP team will review the current IFSP and revise if needed based on the current identified needs of the eligible child and family.

If a family moves to Georgia with an active IFSP from a Part C program in another state, the receiving local lead agency and PSP team will treat the child as a new referral to the Part C system in Georgia, completing intake, evaluation and assessment (unless any accompanying evaluations/assessments meet Georgia's requirements), determination of eligibility, and IFSP development within the 45-day timeline.

N. Individualized Family Service Plans

The IFSP process drives the services provided through Babies Can't Wait as the family's road map to services. All contracted service providers are required to use and follow the IFSP (see IFSP Section). The IFSP team, which includes the family, Service Coordinator, professionals who assess the child, service providers, and others as determined by or with the consent of the family, participate in a team process, using evaluation/assessment data and family resources and priorities to assist the family in determining functional developmental outcomes for the child. The team also assists the family in identifying strategies necessary to achieve each outcome as well as resources and supports to implement the strategies.

The Service Coordinator is responsible for helping the family identify resources available to them, and for including those resources in the IFSP. This should be documented in the IFSP meeting minutes. An IFSP may contain a variety of resources, both requiring and not requiring reimbursement, depending upon the strategies and family's eligibility for various programs. The IFSP is reviewed at least every six months and annually. However, specific outcomes may be reviewed more frequently as family or child priorities change.

An IFSP review meeting and/or consensus of the family and the PSP team is required when changes occur in: funding resources; service delivery (including frequency, intensity, duration); and/or the parent(s)/provider(s) request a meeting.

The local lead agency is responsible for ensuring that the IFSP includes the following components:

1. Required documentation of all other means/sources for authorized goods and services;

2. Documentation of the goods and services that are projected to be funded by BCW funds with the estimated duration of need;
3. Parent signatures on the IFSP indicating his/her agreement to implement the IFSP and funding decisions and commitments relative to this plan;
4. Statement of natural environments and justification of the extent, if any, to which early intervention services will not be provided in a natural environment;

Local Guidance or Clarification

All funding sources and services available through existing programs will be documented as not available and/or thoroughly exhausted prior to utilization of BCW service funds. Services will not be delayed or denied based on inability to pay.

IFSPs that include justification of the extent, if any, to which early intervention services will not be provided in a natural environment must be entered into BIBS. Justification **must be time-limited** and **must** include plans for timely transition of services to the child's natural environment(s). Justifications are not to be used in order to continue provision of services in non-natural environment settings for the duration of an IFSP and/or a child's eligibility for BCW.

The system of payments which ensures the payor of last resort must be followed. IFSP meeting minutes should document that all resources have been identified and the Early Intervention Coordinator must ensure that all resources have been exhausted pursuant to Title 34 CFR [§303.510](#). BIBS will allow the Babies Can't Wait Program Manager the capability to electronically access to the information and be aware of system's issues that prevent adherence to the payor of last resort principle before using BCW funds in this way. This will protect the local lead agency against an audit finding and help direct state efforts toward systems/interagency issues.

1100.4 - AUTHORIZED USES OF BABIES CAN'T WAIT SERVICE FUNDS

A. Provision of IFSP Services Not Currently Identified and Defined

The listing of services defined under Part C is not exhaustive. There may be other required early intervention services that are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's developmental progress that are not included in any other service component definition. These services are directly related to the child's disability or developmental delay and must be documented in the IFSP under at least one outcome with further documentation in the child's EI record as to this relationship.

PROCEDURES FOR IMPLEMENTATION

Other required early intervention services beyond those defined in Section Two are available to infants and toddlers from birth to age three in accordance with the existing state eligibility policy or any amendments. The quantity and type of services provided to infants and toddlers and their families must be documented by IFSP meetings and be reflected in the IFSP. General coordination, preparation, documentation, and report development time is not billable time. Rather, the cost of these activities is included in the rate per unit of direct services, which is a flat rate paid to providers.

Signed prior approval from the Early Intervention Coordinator or his/her designee and the State Babies Can't Wait office, through the waiver process, must be obtained prior to the provision of any other required service meeting this definition.

The other required early intervention services must be provided by personnel who have met state-approved or recognized certification, licensing, registration, or other comparable requirements for the discipline as recognized by Babies Can't Wait. BCW will facilitate all reimbursement for units of service from BCW service providers whose services are under the general supervision and monitoring of Babies Can't Wait. All providers must have a contract with the local or state lead agency prior to provision of other required early intervention services. Documentation of eligibility and a need for the other required services must be in the child's file and must be evaluated at least annually (need for services).

Those services reimbursable under Maternal and Child Health, Medicare, Medicaid, or Peach Care for Kids to eligible recipients will be referred for financing through Title V, Title XVIII, Title XIX, and Title XXI respectively. Written, informed parental consent shall be sought from eligible recipients to claim private insurance for those services covered under private insurance.

Local Practice Guidance or Clarification

Providers receiving state and federal funds from Babies Can't Wait to provide early intervention services shall comply with the terms and conditions set forth in the provider contract between the local lead agency and the service provider. Services may not be rendered prior to the start date on a contract.

B. Use of Funds Pending Resolution of Disputes

PROCEDURES FOR IMPLEMENTATION

For providers, BCW funds may be used for a period not to exceed 90 days from the last denial date that the claim was submitted to a third-party payor to pay for Early Intervention services (limited to federally required services on the IFSP) pending resolution of disputes regarding responsible payment source or other Part C participation issues for an individual child, and also during the period of time it takes for a child, ages birth to three, and his family to become eligible for services in another program.

Local Practice Guidance or Clarification

This does not require State-level approval. Justification must be documented in the local BCW Early Intervention Record.

C. Support of Multidisciplinary Team Activities/Services in the Natural Environment

State lead agency will use BCW funds to support and to facilitate multidisciplinary team activities and facilitate service delivery in the natural environment if there is a need to remove barriers to such settings.

PROCEDURES FOR IMPLEMENTATION

Funds used in this manner must be used in accordance with the BCW Policy Manual.

1. Providing opportunities for parents to enhance their understanding of services in their natural environments; and
2. Strategies for increasing and enhancing inclusion community options.

Examples of activities that cannot be covered include:

1. "Home visit" or "travel" stipends or fees.
2. The provider will not be compensated for "no shows."
3. General coordination, preparation, documentation, and report development time.
4. Any activities or functions that are existing, designated responsibilities of one or more team members (i.e., payment for coordination of scheduling of evaluations is not an allowable use of BCW funds because this activity is the role of the Service Coordinator in accordance with IDEA and would be supplanting of existing funds).

1100.5 – UNAUTHORIZED GOODS & SERVICES UNDER BCW SERVICE FUNDS

A. Child Care

Childcare is not a covered service under these funds.

B. Services Which May Be Funded from Other Sources

1. If the family/child is eligible for other federal, state, or private resource programs which cover the desired good or service, BCW funds may not be used.
2. Families may not be denied services based on inability to pay. Ability to pay is determined by the Babies Can't Wait Financial Analysis form for cost participation sliding fee schedule.
3. BCW funds may not be used to replace or supplant those funding sources in excess of what is covered under the BCW Policy Manual.

C. Non-IFSP Services

BCW funds will not be used to pay for goods and services that are not related to outcomes on the IFSP and so specified on the IFSP.

D. Non-Natural Environment Settings

BCW funds may only be used to support services in the non-natural environment only if there is justification which supports why IFSP outcomes cannot be achieved in the natural environment. Justification must be time-limited and must include plans for timely transition of services to the child's natural environment(s). Justifications are not to be used in order to continue provision of services in non-natural environment settings for the duration of an IFSP and/or a child's eligibility for BCW.

E. Payment for Services for Out-Of-State Providers/Out-of-State Travel

BCW funds may not be used to pay for services provided outside of Georgia or by non-Georgia providers who travel to Georgia with the exception of providers from states who have agreements with or a contract with the local or state lead agency.

F. Costs Incurred Prior To Referral to BCW

BCW funds may not be used to cover costs incurred prior to a referral to Babies Can't Wait program.

G. Costs Incurred Prior To Contracts

BCW funds may not be used to pay for services that were rendered prior to the service provider having signed a contract with the local or state lead agency.

1100.6 – REIMBURSEMENT RATES FOR BCW SERVICE FUNDS

The purpose of this section is to describe policies and parameters for the determination of the rate of reimbursement for early intervention services funded in whole or in part with Babies Can't Wait service funds. Actual BCW rates of reimbursement are contained in the Appendix: Babies Can't Wait Rate Schedule in this document.

A. Policy for Services

The Babies Can't Wait rate for purchased services will be a "chase and pay" method.

Utilizing the "chase and pay" method providers who are able to conduct billing submit claims to the appropriate fund source (private insurance, Medicaid, CMOs) independently.

Providers must submit coordination of benefits information for claims as applicable.

Providers must enter all supporting documentation into BIDS including provider progress notes for each date of service.

Providers that select this mechanism must have the capability to scan the "Explanation of Benefits" (EOBs)/Remittance Advice to verify that the claim was submitted and denied in order to receive reimbursement from BCW as payor of last resort.

The Provider, Funds Management, Fund Recovery modules will assist with financial management and BIDS will house provider payment and billing information.

Hospital rehabilitation programs which provide therapies that are not acute, as well as individual therapists or group practices, must use the Medicaid Children's Intervention Services (CIS) rates.

B. Travel Policy

Travel payments for families will be supported via the Special Situation Payment Request and Payment Adjustment process.

Travel payments for providers are not supported as Babies Can't Wait does not pay for mileage for providers. Independent Contractors can contact the IRS for more information on how to claim their mileage on their income tax return.

C. Special Instruction

Special instructors will enter all claims into BIDS for provider payments. Payment will be disseminated to special instructor providers on a monthly cycle from the date of a submission of a claim. Special Instruction rates are based on personnel qualifications.

The levels of Special Instruction are as follows:

Special Instruction for Non-Employee Special Instructor (Contractor) in Non-Contracted Community Settings (ex: Day care)

These rates are based upon the provision of Special Instruction to the child within the context of activities and routines of the family/care provider that provide opportunities for learning. Special Instruction may occur in the home of the family or other locations in which activities involve children without disabilities including homes of relatives and friends, on the playground, mother's morning out, recreation centers, library story time, day care, preschool, etc., and must include opportunities for family/care provider participation. If Special Instruction is provided within the context of a group, the intervention must not be a "pull-out" model. Rather, intervention is to be provided with the child as part of group activities. The individuals providing this service must be BCW staff and/or contractors(s) who meet BCW personnel requirements (see BCW Policies, Personnel Section) for one of the following:

- Early Intervention Specialist/Special Instruction Level 1 (Approved Master's Degree)
- Early Interventionist/Special Instruction Level 2 (Approved Bachelor's Degree)
- Early Intervention Assistant/Special Instruction Level 3 (Associate Degree)

D. Teleintervention

Payment to providers for service delivery via Teleintervention shall be at the BCW rate for that discipline. The child and provider must be present in order to bill. Teleintervention may be billable to third party insurance.

E. In-service Training

Attendance at In-service/Training Sessions made mandatory by the State or local BCW program

Payment to providers for attendance at in-service/training sessions that are made mandatory by the State or local program may be reimbursed for travel expenses or paid their appropriate rate per hour for attendance at the training depending on the local program's budget not to exceed \$200.00.

1100.7 – USE OF INSURANCE

The purpose of this section is to clarify the requirements and procedures pertaining to the use of private third-party insurance and public insurance.

A. Policy

It was the intent of Congress that third party insurance be used to help pay for early intervention services (Title 34 CFR §303.520). Part C of IDEA states that it is "the policy of the United States to provide financial assistance to states... to facilitate the coordination of payment for early intervention services from federal, state, local, and private sources (including public and private insurance coverage)." BCW must request consent from the family in order to gain access to their private insurance to cover the costs of early intervention services if a financial cost would be incurred. The lack of consent may not be used to delay or deny any services to the child or family (§303.520 (c)).

In order for the BCW program to use (Public Insurance) Medicaid to pay for Part C services the program must obtain consent (§303.414) to disclose a child's personally identifiable information to the State agency responsible for administering the State's public benefits or

insurance program for billing purposes only. A parent has the right to withdraw their consent to disclosure of personally identifiable information to the State agency responsible for administration of the State's public benefits or insurance program at any time. Consent is required for the use of public insurance to pay for Part C services that would:

1. Decrease available lifetime coverage or any other insured benefit for that child or parent under that program;
2. Result in the child's parent paying for services that would otherwise be covered by the public benefits or insurance program;
3. Result in any increase in premium or discontinuation of public benefits or insurance for that child or that child's parents; or
4. Risk loss of eligibility for the child or that child's parents for home and community-based waivers based on aggregate health-related expenditures. (§303.520 (a)(2)(ii).

B. Accessing Family Private Insurance

The family is fully informed and understands the following regarding the use of private insurance for IFSP covered services:

1. The BCW program will assume the cost of the family's deductibles and copayments. BCW will assume this cost up to the BCW rate, if the payment from the insurance company is below the BCW established rate. **The BCW Program will not pay for premiums with Part C funds.** It is not allowable for providers to bill families' co-pays, deductibles or any other fees if insurance has paid any portion of the claim or the cost was applied to the deductible. BCW will include this information in the Procedural Safeguards to give to all families in the BCW program.
2. Regardless of whether the use of insurance will or will not result in a cost, The *Consent to Use Private Insurance* form must be used (Appendix B) to document the family's decision regarding access to insurance.
 - a. Family cost participation is determined through completion of the Babies Can't Wait Financial Analysis form using the sliding fee scale.
 - b. The family may choose to receive IFSP Team identified needed services that are covered by insurance in a non-natural environment, therefore choosing to go "outside" of the Part C system. Such service(s) should be listed in the IFSP – Other Services. The family must sign the **prior written notice and consent**. The family is responsible for all costs associated with this service.
 - c. If the family does not give permission to access their private insurance for covered IFSP services, they will be responsible for their cost participation for all IFSP services according to the Babies Can't Wait Financial Analysis for Cost Participation. The lack of consent may not be used to delay or deny any services to the child or family (§303.520 (c)).
3. If the child is enrolled in Medicaid as well as private insurance, BCW must request consent from the family to bill their private insurance and to disclose the child's personally identifiable information to the State agency responsible for administering the State's public benefits or insurance. If the family does not give consent to use private insurance, then the family will be responsible for their Family Cost Participation for those services.
4. Within 90 calendar days following the date of service, providers, with consent, must bill the family's private/public insurance to request reimbursement for services rendered. If the provider receives any portion of the claim from private insurance or any portion goes toward the deductible or copay and it is less than the BCW rate, the provider will be allowed to bill BIBS the difference between the payment amount the provider received from private insurance and the BCW rate. If any portion of the

payment is applied toward the deductible or copay, the family will not have any family cost participation.

Providers are not allowed to bill families:

- a. If the provider has received any portion of the payment from the third-party payors or if any part went toward a deductible. If the provider does not receive any portion of the claim due to it being a non-covered service, the provider should bill the family their Family Cost Participation and bill BCW the remainder up to the BCW rate.
 - b. For any additional fees for services or travel.
 - c. If the provider receives any portion of the claim from Medicaid, the provider must consider that payment as payment in full. Parents are not required to pay any costs (including copayments or deductibles) as a result of the State's using a child's or parent's public benefits or insurance to pay for Part C services.
5. Proceeds or funds from public insurance or benefits or from private insurance are not treated as program income for purposes of Title 34 CFR 80.25. If the State receives reimbursements from Federal funds (e.g., Medicaid reimbursements attributable directly to Federal funds) for services under Part C of the Act, those funds are considered neither State nor local funds under Title 34 CFR §303.225 (b). If the State spends funds from private insurance for services under this part, those funds are considered neither State nor local funds under Title 34 CFR §303.225. Funds received by the State from a parent or family member under the State's system of payments established under Title 34 CFR §303.521 are considered program income under Title 34 CFR 80.25. These funds must be used for the State's Part C early intervention services program, consistent with Title 34 CFR 80.25 (g)(2); and are considered neither State nor local funds under Title 34 CFR §303.225 (b) (Title 34 CFR §303.520)(d)(2)(3)(e)(2)(3). Parental consent must be obtained when the local EI program seeks to use the family's insurance to pay for EI services in the IFSP and each time consent is required due to a change in frequency, length, duration or intensity. Consent must be obtained prior to using the public benefits or insurance of a child or parent if that child or parent is not already enrolled in such a program. All BCW families are provided a copy of the Fiscal Policies (System of Payments) document when seeking consent for services.

Family Cost Participation (FCP)

The local EI program must provide a copy of the Babies Can't Wait Financial Analysis form and Parent's Guide to Family Cost Participation and Fiscal Policies to the family to identify the potential cost that the parents may incur as a result of the use of their private insurance to pay for Part C services.

A. Policy for Financial Analysis for Family Cost Participation

The Babies Can't Wait Financial Analysis form for family cost participation application (Appendix B) must be completed with all families prior to IFSP development in order to determine their "Ability to Pay" and assignment of cost participation. **If families choose not to complete the Babies Can't Wait Financial Analysis form, then the family will assume 100 percent family cost participation if their public or private insurance does not cover the service.**

Service Coordinators must assist families with financial case management activities to ensure equitable implementation and access to BCW funds. Activities include identification of all resources available to a family to implement the IFSP. The Babies Can't Wait Financial Analysis form (Appendix B) will be collected prior to the

development of the IFSP to ensure that families are fully informed of their financial commitment. The Babies Can't Wait Financial Analysis form must be completed at initial and annual IFSP meetings and when a Service Coordinator and/or family recognize a change in financial status. The form must be completed by the Service Coordinator and the family. Upon completion, the family receives a copy of the form.

"Ability to Pay" is determined through the use of the Babies Can't Wait Financial Analysis form for cost participation. The Babies Can't Wait Financial Analysis form for cost participation will be applied as a per-service fee to all Early Intervention Services prescribed in a child's IFSP with the exception of service coordination and any evaluation/assessment services that are determined necessary by the PSP team. Part C (Babies Can't Wait) is the payor of last resort, therefore the provider with consent will seek reimbursement from public and private insurance and other State agency or third-party funding mechanisms to cover these services prior to billing Babies Can't Wait for the service rendered.

All pages of the Babies Can't Wait Financial Analysis form must be completed, and originals must be placed in the child record. Families will not be charged more than the actual cost of the Part C service factoring in any amount received from other sources for payment for that service (§303.521 (a)(4)(iii)). Families with public insurance or benefits or private insurance will not be charged disproportionately more than families who do not have public insurance or benefits or private insurance.

The Babies Can't Wait Financial Analysis form for cost participation must be signed by the parent and the Service Coordinator to ensure that families understand the commitment and agree to their assignment of cost participation/ability to pay.

The Babies Can't Wait Financial Analysis form for cost participation must be completed with every family of an eligible infant or toddler, regardless of Medicaid eligibility status, prior to the development of each IFSP. If families choose not to complete the Babies Can't Wait Financial Analysis form, then the family will assume 100 percent family cost participation if their public or private insurance does not cover the service. If the child is placed in foster care the family will not be required to verify their income. Parent(s) or Guardian(s) must provide prior to the development of the IFSP a copy of one of the following documents: prior year W-2, two pay stubs, the prior year tax return documents, or Self Declaration form for the Service Coordinator to visually verify income. If a family reports no income, they must provide information by letter from the person or family member supporting them. If the family does not have a family member supporting them, then the family must provide a listing of resources supporting the family to the Service Coordinator. If a family does not supply documentation prior to the development of the IFSP, the family is responsible for covering 100 percent of cost for non-covered IFSP services until it is presented. If families are unable to pay their cost participation, the Babies Can't Wait Financial Analysis form should be repeated to ensure that the level of cost participation is accurate.

B. Provider Billing of FCP

Providers cannot bill applicable Family Cost Participation until after receipt of third-party Explanation of Benefits (EOB) for the service. They have within 30 days to bill the family after receiving an EOB. FCP only applies for non-covered services by third party pay sources (public and private insurance).

C. Policy for Suspension of Services for Failure to Pay Family Cost Participation

Families with cost participation, who fall 90 days behind in payments, will have services suspended. Georgia is committed to ensuring the provision of those services to families that

must be made available at no cost, which includes child find evaluation and/or assessment activities, service coordination services, administrative and coordinative activities related to procedural safeguards and the development, review, and evaluations of IFSPs and interim IFSPs and all Part C services when the parent of family meets the State's definition of inability to pay §303.521 (a)(4)(ii), (b), and (c). The service provider must supply the family with an invoice outlining the date of service, CPT code billed, number of units billed, total amount of claim and the amount the family is responsible for. The service provider will send all notices and bills directly to the family for collection of funds. At 60 days past due from the date of the first invoice requesting payment after a provider receives an Explanation of Benefits (EOB) from private insurance or public benefits denying coverage of an IFSP service, provider will send a late notice to parents allowing 30 more days to make full payment before services are suspended. The provider will send the notice of suspension directly to parents, Service Coordinator and local Babies Can't Wait Program/EIC to place in the child's primary chart 30 days prior to suspension. The effective date of suspension is 90 days from the date of the first invoice requesting payment after a provider receives an Explanation of Benefits (EOB) from private insurance or public benefits denying coverage of an IFSP service. Full payment of the past due amount must be made to the provider by this date to avoid suspension of services. Once services have been suspended full payment of the past due amount plus the amount currently due must be made to the provider before services can be restored. During the suspension period, service coordination, IFSP development, evaluation and assessment and procedural safeguards will continue. Service visits that do not occur during the suspension period will not be "made up" by the provider.

PROCEDURES FOR IMPLEMENTATION

In order for families to be fully informed of their rights and safeguards, they must also understand their participation in all aspects of the EI system, including what is available to them at no cost, what services might involve cost, and all options available to them. Informed consent ensures that families understand their options and choices so they can make good decisions for their child and for themselves, and that they understand the implications of their decisions.

It is the responsibility of the Service Coordinator to inform the parent(s) that third-party insurance is typically a routine payment source for early intervention services, and to explain to the parent(s) that the use of private insurance maximizes resources to support the state's participation in Part C. Further, the use of insurance may reduce the family's out-of-pocket costs.

1100.8 - DEPARTMENTAL RESPONSIBILITIES

A. Administration

Location of Funds - The Department of Public Health is responsible for oversight and statewide administration of BCW funds

B. Reporting

The State Department of Public Health, *Babies Can't Wait* office collects, compiles, and analyzes data from each local lead agency including, but not limited to, the following:

1. Number of children served;
2. Types of services purchased;
3. Cost data including total funds expended, and expenditures by service category.

C. Technical Assistance and Training Activities

The Department of Public Health/Babies Can't Wait provides technical assistance, training, monitoring, and supervision to the local lead agencies (local Babies Can't Wait program).

1100.9 – BOARD OF HEALTH/LOCAL LEAD AGENCY RESPONSIBILITIES

A. Administration

Location of Funds - Within each local lead agency's administration, the Early Intervention Coordinator is responsible for oversight of the use of BCW funds.

The local Area Board of Health/Local Lead Agency (LLA) retains ultimate responsibility for appropriate administration of Babies Can't Wait and for all BCW documentation. Coordination with all other relevant agencies is also the responsibility of the Board/LLA. The Board of Health/LLA shall adhere to the contents of this document including the Babies Can't Wait Financial Analysis for Cost Participation.

B. Budgets

The Board of Health/LLA is responsible for monitoring approval of the use of funds. In so doing, the Board/LLA must consider that early intervention services are protected by federal requirements under IDEA and are governed by federal and state (Babies Can't Wait) regulations. Use of funds is mandated by the Program Annex to the Master Agreement or contract if the local program is a private entity.

C. Early Intervention Coordinator

The Early Intervention Coordinator plans, develops, and oversees operation of the BCW program at the local lead agency. The Early Intervention Coordinator is responsible for ensuring that all IFSP plans are appropriate to ensure that applicable services are placed on the IFSP and implemented timely. The Early Intervention Coordinator is responsible for quality assurance for the child's record as well as data entered into the BIBS system. The Early Intervention Coordinator must perform random child record audits to review for accuracy and ensuring BCW funds as payor of last resort.

D. Reporting

The Board of Health/LLA must submit programmatic and expenditure data for quarterly reports as required by the Department of Public Health. Please see the Master Agreement/contract for the reporting requirements and timelines. The reports must be

submitted 10 calendar days after the end of each quarter. (The following Monday if it falls on a weekend.) The Board of Health/LLA must submit programmatic data for federal reports as required by the Department. Please see the Master Agreement/contract for the reporting requirements and timelines. The reports must be by designated reporting dates specified in the Master Agreement.

E. Records

The Board of Health/LLA is responsible for maintaining all financial records including transaction service vouchers/purchase orders; records must be maintained according to Department of Public Health policy in an easily accessible place for monitoring/auditing purposes.

F. Contracts

The State lead agency is responsible for finalizing contracts with providers prior to the initiation of early intervention services. All qualified contracted providers who agree to provide services in the child's natural environment(s) must submit applicable billing claims through the BCW centralized billing system (BIBS).

1100.10 - OTHER FISCAL POLICIES

A. Policy for Services Rendered

1. Denial of Service Claims:
 - a. BCW will not reimburse claims that are denied due to same day of service for the same discipline. Service Coordinators need to coordinate with families to ensure two services that have the same discipline are not rendered within the same day.
 - b. Coordinators must be advised of this policy prior to delivering services
 - c. BCW will not reimburse claims that are the same discipline for more than one service per day.

PROCEDURES FOR IMPLEMENTATION

The Division of Medicaid only pays the first case management claim that it receives in a given month for a child or family. This means that if a child is receiving case management services from BCW and the Department of Family and Children Services, only the first claim received will be paid from Medicaid. If the child is in Foster Care funds may be recouped once the DFCS Case Manager bills for their services. This affects both public and private sector service coordination claims. BCW Private Service Coordinators will receive payment from BCW for services rendered in these cases.

B. Service Coordination During the Transition Period

During the transition planning process for children whose third birthdays fall during, June, July, or August, the need for Service Coordination as a transition activity must be discussed with the family. If Service Coordination is needed in order to assist the family with medical/health or other needs which might be met by the community during the period from the third birthday until Aug. 31 or the Individualized Education Program (IEP) begins, whichever comes first. This need and expected outcome must be documented in the transition plan.

Private Service Coordination activities must be billed to BCW for all children. Note: this is the only service that may be funded with BCW funds for a child after the child's third birthday. This service is provided under a transition plan, rather than the IFSP (which ends

the day before the child's third birthday) because these children are no longer enrolled in BCW.

1100.11 – Policy for Coaching Visits and Supplemental Visits

The selection of coaching as a method when billing refers to visits where there are two providers in the home at the same time to provide early intervention services. One provider is delivering the early intervention service, and the other provider is being “coached” by the provider on how to work with the child and family.

Coaching will be selected as the method for one of the providers when two providers are in the home at the same time.

When billing for this type of visit, please adhere to the following:

1. If the PSP provider is being coached, they will be authorized for Coaching and they will bill the T2022 CPT code.
2. If the PSP is the one providing the hands-on service during the visit, then the PSP should be authorized as Primary.
3. The supporting provider should be authorized as Supplemental if they are providing the hands-on service.
4. The supporting provider should be authorized as Coaching and bill the T2022 CPT code if they are serving in a consultative role.

It is important to authorize each service separately so that the providers can bill and receive reimbursement at the correct rates.

Clarification of Definitions:

1. **Method/Location**- refers to the type of visit that is being authorized.
2. **Primary Method/Location** – refers to the Primary Service Provider providing services and supports to the child and family.
3. **Coaching Method/Location** will include those visits in which there are two providers in the home at the same time. The provider observing should be the one authorized as Coaching.
4. **Supplemental Method/Location** will include visits when the provider is not the Primary Service Provider (PSP) but will be providing supports to the family with or without the presence of the PSP during the meeting.
5. **AT Method/Location** - refers to when the provider is ordering an assistive technology device or providing an Assistive Technology assessment to the family.

1100.12 – POLICY FOR SERVICE PROVIDER MATRIX

Service providers must have and be in compliance with a current signed contract with the local or state lead agency in order to be included in the local or state service provider matrix.

PROCEDURES FOR IMPLEMENTATION

IDEA requires that the Early Intervention Program be provided under public supervision (Title 34 CFR §303.12). IDEA defines “**Early Intervention Services**” in accordance with the **IFSP of the infant or toddler with a disability as services which are provided in conformity with an IFSP and that meet the standards of the State (Title 34 CFR §303.12 (b)(2))**. Such services must be, among other things, provided by qualified personnel as established by the State (Title 34 CFR §303.31). IDEA mandates that the ultimate responsibility for the supervision of services remains with the Lead Agency (Title 34 CFR §303.501), and authorizes the Lead Agency to establish contractual procedures with public or private service providers (Title 34 CFR §303.501). The Department of Public Health extends some of the State Lead Agency requirements to the local program through the program annex to the Master Agreement. Thus, the local programs function as the Local Lead Agency and share all the responsibilities cited from the statute herein.

These regulatory citations, along with the definition of “early intervention services” as defined in (Title 34 CFR §303.13) support the listing of only those early intervention service providers under contract with the local or state lead agency in the Service Provider Matrix. Only early intervention service providers who have contracts with the local or state lead agency can be held accountable to these requirements.

The requirements to have and be in compliance with a current signed contract and meet BCW personnel qualifications may not be waived. Local or state lead agencies are required to only list service providers who agree to provide services in the child’s natural environment and with whom a contract has been signed. The contract between the Local or state Lead Agency and the service provider is only to provide services to BCW- enrolled children and families. If a service provider chooses not to contract with the local or state lead agency, no restraint of free trade exists because non-contracted providers are not prohibited from doing business with BCW-enrolled children and families at the family’s expense, nor does this restrain them from doing business in general, an essential element of restraint of trade. These non-contracted providers must be paid from another source. Their services are considered external to the IFSP since the local or state lead agency cannot assure families that non-contracted providers will provide services within the intent of IDEA.

As local or state lead agencies recruit providers or as families recommend new providers, such providers are added to the matrix after a contract is signed with the local or state lead agency.

There are constraints to freedom of choice regarding selection of service providers who provide services on a child’s IFSP. These are:

1. Service Provider must meet BCW personnel qualifications and have a signed contract with the local or state lead agency, including Department of Public Health criminal record background check;
2. Service Provider must accept the funding source available to the family that is assigned to pay for that service;
3. Service Provider must provide services in the child’s natural environment.

PROCEDURES FOR IMPLEMENTATION

Families are free to make choices outside of BCW. However, they have the financial liability for those choices. If a family chooses a provider who does not have a contract with the local or state lead agency, despite the availability of contracted providers, the family will assume all costs associated with this choice.

In order for families to be fully informed of their rights and safeguards, they must also understand their participation in all aspects of the Part C system, including what is available to them at no cost, what services might involve cost, and all other options available to them. Informed consent ensures that families understand their options and choices so they can make good decisions for their child and for themselves, and that they understand the implications of the decisions.

1100.13 – Policy for End of Fiscal Year

Each local program's fiscal year ends June 30. When completing closing journal entries, local programs should include the accruals for any outstanding estimated funds for May and June of the current year. Local programs must use a projection of expenditures to cover expected year-end cost by obligating current year funds for expenditures that are realized in the new fiscal year. Invoices for non-third-party billable services must be submitted to the local program within 30 days of services rendered.

Early Intervention Coordinators are responsible for obtaining projections of monthly levels of service. Chief Financial Officers are responsible for encumbering funds. Encumbered funds should be submitted back to the state by Dec. 31 of the following fiscal year if applicable to the local program.

CHAPTER 1200 – FISCAL POLICIES TO SUPPORT PRIMARY COACH MODEL OF SERVICE DELIVERY

The guidance provided in Part III is intended for use by local programs to support the implementation of a Primary Service Provider Teaming Model of early intervention service delivery within the Babies Can't Wait system.

A. Criteria for Use of Policies Outlined in This Chapter

1. Multidisciplinary Team participation in the Primary Service Provider (PSP) Teaming Model training provided by BCW State Office Staff and/or BCW contracted Training/Technical Assistance providers.
2. At least one active multidisciplinary team in place in the local program, receiving ongoing opportunities for practice, coaching, mentoring and support provided and/or overseen by BCW State Office Staff and/or BCW contracted Training/Technical Assistance providers.
3. At least one active multidisciplinary team in place in the local program, actively engaged in PSP teaming model of service delivery with families of infants and toddlers enrolled in Babies Can't Wait.

B. Rates of Payment

Actual BCW Rates of Payment are contained in Appendix section of this document. BIFS will house provider payment and billing information. Travel reimbursements for families will be paid via the Special Situation Payment Request.

BCW will pay the Service Provider through BIFS on a monthly cycle with submission of claims in BIFS. Supporting documentation that authorized services were provided and delivered must be entered into BIFS. Providers will not be paid for service claims entered into BIFS after 90 calendar days from date of service unless the provider has supporting documentation of seeking third-party reimbursement, then the provider has up to 90 calendar days from primary payor's last denial to enter the claim information into BIFS.

PROCEDURES FOR IMPLEMENTATION

1. Team Meetings

Providers and Service Coordinators will be paid through BIFS at the established BCW rate(s). The Team Leader or designee is responsible for confirming the attendance of providers and Service Coordinator and for the entering their attendance into BIFS. Payment to include attendance at PSP Team Meetings

2. Initial IFSP Meetings

Providers and Service Coordinators will be paid through BIFS at the established rate(s) upon entering and adjudication of claims. **Providers** must submit progress notes and other supporting documentation within 14 calendar days of a service rendered. **Service Coordinators** must submit Coordination Notes into BIFS within 7 calendar days of the event. Initial IFSP meetings cannot be billed by a Service Coordinator in conjunction with a Face-to-Face meeting for the same month.

The costs associated with team meetings or IFSP meetings are not included in Family Cost Participation (FCP) calculations.

**CHAPTER 1300 – FUNDING HIERARCHY FOR BABIES CAN'T WAIT
FEDERALLY REQUIRED EARLY INTERVENTION SERVICES**

Babies Can't Wait Funding Hierarchy
Level 1 – Private Insurance
Level 2 - Medicaid /CMO/ Early and Periodic Screening, Diagnosis and Treatment
Level 3 - Family cost participation
Level 4 - MCH Title V Maternal and Child Health (Children's Medical Services)
Level 5 - State Funds

CHAPTER 1400 – APPENDICES

APPENDIX A – Glossary

ADA - Americans with Disabilities Act - gives civil rights protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

Adaptive development – Self-care skills such as dressing, eating, and toileting.

Adjusted Age - age adjustment for the baby's prematurity calculated by starting with the chronological age and subtracting the number of weeks of prematurity from that age. (e.g., Actual age is six months and born three months premature, the adjusted age is three months.)

Advocacy – Speaking or acting on behalf of a child to achieve change and/or to ensure that the services that are appropriate for the child are received.

Assessment – Strengths-based examination of the child's performance and development and monitoring for progress by qualified personnel. This information is useful for program planning. The planning process identifies all of the appropriate supports and resources to address the child and family's needs which may include community, private or other service options.

Assistive technology (AT) - Includes devices and services. Assistive technology devices include any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Assistive technology services include any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

Babies Can't Wait (BCW) – Georgia's statewide early intervention (IDEA, Part C) system.

BIBS – Babies Information and Billing System utilized by the Department of Public Health Babies Can't Wait program to process and pay provider claims

Category 1 – Established list of automatically eligible mental or physical conditions that may lead to developmental delay.

Category 2 – Eligibility category based on a significant developmental delay in one or more areas of development or moderate delay in two or more areas of development.

CAPTA – Child Abuse Prevention and Treatment Act

Chase and Pay – A method in which providers submit claims to the appropriate fund source (private insurance, Medicaid, CMOs) independently.

Child Abuse Prevention and Treatment Act – Federal legislation that includes provisions requiring referral of all children birth to 2 years of age with substantiated cases of abuse or neglect to the Part C system in each State. In Georgia, the Part C system is Babies Can't Wait.

Child Find – A comprehensive and coordinated system to locate, identify, refer and evaluate (determine eligibility) for all infant and toddlers with disabilities in Georgia who are eligible for services under Part C.

Children 1st – Georgia’s system that provides families of children 0-5 years of age with a single point of entry into a wide range of public health and community programs.

Children’s Medical Services – Public Health program that provides care coordination and a comprehensive system of medical/health care for eligible children, birth to 21, with chronic medical conditions. Eligibility for the program includes medical and financial requirements.

Chronological Age – The age of the baby from the day of birth to the current date – the number of days, weeks, or years old of the baby. It may also be referred to as the “actual age.”

Coaching – A voluntary, collaborative partnership between early intervention providers and the important people in a child’s life designed for sharing knowledge and promoting the development of one’s competence in a specific role or situation.

Cognitive development – The developmental area that involves thinking skills, including the ability to receive, process, analyze and understand information.

Communication – Talking, gesturing, or signing; listening and understanding.

Day – Calendar Day, unless otherwise indicated.

DBHDD – Department of Behavioral Health and Developmental Disability

Destruction of Records – Physical destruction of the record or ensuring that personal identifiers are removed from a record so that the record is no longer personally identifiable.

Developmental Delay – Not attaining developmental milestones expected for the child’s age adjusted for prematurity in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social-emotional, or adaptive development.

DFCS – Division for Family and Children Services, within the Department of Human Services.

Disability – A person who has a physical or mental impairment that substantially limits one or more major life activity.

Disclosure – To permit access to or the release, transfer, or other communication of education records, or the personally identifiable information contained in those records, to any party. Disclosure may be by multiple means, including oral, written, or electronic means.

DOE - Department of Education

DPH – Department of Public Health

Due Process – The legal procedures or steps available to protect the early intervention rights of the infant/toddler and family.

Early Intervention – A system of services that helps babies and toddlers with developmental

delays or disabilities. Early intervention focuses on helping eligible babies and toddlers learn the basic and brand-new skills that typically develop during the first three years of life, such as:

- Physical (reaching, rolling, crawling, and walking);
- Cognitive (thinking, learning, solving problems);
- Communication (talking, listening, understanding);
- Social/emotional (playing, feeling secure and happy); and
- Self-help (eating, dressing).

Early Intervention Coordinator (EIC) - An individual who is responsible for the management and administration of one of the local BCW programs.

Early Intervention Records – means all records regarding a child that are required to be collected, maintained, or used under Part C and covered by the (FERPA) 20 U.S.C. 1232g.

Eligibility – The criteria used to determine if a child qualifies for early intervention

Evaluation – The procedures used by appropriate, qualified personnel to determine a child's initial eligibility under BCW.

Family – A group of two or more persons related by birth, marriage or adoption.

Family Assessment – Identification of the family's resources, priorities, and concerns, and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

Family Cost Participation (FCP) - The maximum amount the family must pay per month based on the family's ability to pay, considering the family's adjusted income as determined on the previous year's federal income tax form. The fee is based on a family unit, not per individual child.

FERPA – Family Educational Rights and Privacy Act [20 U.S.C. 1232g](#); is a federal statute that deals with the parental right to inspect and review records. The purpose of FERPA is two-fold, to ensure that parents have access to their children's educational records and to protect the privacy rights of parents and children by limiting access to these records without parental consent.

Goals – see Outcomes

First Care – Georgia's public health program that provides care coordination through home visiting to families with infants from birth to 1 year of age who are at increased risk for morbidity &/or mortality.

HIPAA – Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. Section 1181 et seq., a federal law that includes requirements to protect patient privacy, security, and data integrity of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers and participating hospitals

Inclusion - The full and active participation of young children with disabilities in programs and settings with typically developing children.

Individualized Education Program (IEP) - A written statement of special education and related services that meets the unique needs of a child with a disability. The IEP is developed, reviewed and revised in a meeting by an appropriately staffed IEP team, including the child's parents.

Individualized Family Service Plan (IFSP) – A documented plan designed to support the individual needs of an infant or toddler and their family. The IFSP is developed, reviewed and revised in a meeting by the IFSP Team of qualified professionals and the child's parents.

Individuals with Disabilities Education Act (IDEA) – The federal law that provides the regulations for early intervention, and special education and related services for children birth through age 21. Part B outlines services for children ages three through 21, and Part C outlines services for children birth to age two and their families.

Informed Clinical Opinion – Use of qualitative and quantitative information gathered by certified Early Intervention professionals in the evaluation and assessment process in order to form a determination regarding the child's current developmental status and the potential eligibility for early intervention.

Intervention – All of the efforts made on behalf of the child to help the family support their child's participation in the environments where children grow, learn and play.

Lead Agency (LA) – The Georgia Department of Public Health is designated by the State's Governor under section 635(a) (10) of the Act to administer the Federal Part C funds the State receives under section 643 of the Act and to be responsible for implementing the statewide Early Intervention System. Local BCW programs take the lead on the district level.

Learning Opportunities – Opportunities that occur within the context of an activity setting that promotes the child's growth and development.

LICC – Local Interagency Coordinating Council

Local Interagency Coordinating Council - The regional compliments of the State ICC. The LICCs work collaboratively with the State ICC to advise and assist the local program in planning and implementing local early intervention service delivery systems for the local Babies Can't Wait programs.

Local Lead Agency – Refers to one of the Boards of Health or contracted agency which administers the local Babies Can't Wait system through each of Georgia's 18 local districts.

LSS - Local School System

Local School System – Operates local public education from Kindergarten through high school. Special Education services begin at age 3 if the child meets the public-school eligibility requirements.

Mediation – A voluntary, no cost, and confidential process offered by the Georgia Department of Public Health that assists BCW programs, parents, and early intervention providers resolve a dispute through the use of a neutral mediator to facilitate communication. Mediation may not be used to deny or delay parents’ right to a due process hearing.

Multidisciplinary – The involvement of two or more separate disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in [§303.321](#) and development of the IFSP in [§303.342](#). In the evaluation and assessment of the child and family this may include one individual who is qualified in more than one discipline or profession. The IFSP Team must include the involvement of the parent and two or more individuals from separate disciplines or professions and one of these individuals must be the Service Coordinator.

Multidisciplinary Team – At least two professionals representing two different disciplines in addition to the Service Coordinator and the parent/family member.

MDT - Multidisciplinary Team.

Native Language –

1. When used with respect to an individual with limited English means:
 - A. The language normally used by child or the parents of the child;
 - B. For evaluations and assessments, the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.
2. When used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, Native Language means the mode of communication that is normally used by the individual (such as sign language, Braille, or oral communication).

Natural Environment – Settings that is natural or typical for infants and toddlers who are your child’s age and who do not have a disability, may include the home or community settings.

Outcomes – Broad, general target areas of development documented by the IFSP Team.

Parent – In accordance with 34 C.F.R § 303.27:

1. A biological or adoptive parent of a child
2. A foster parent
3. A guardian generally authorized to act as the child’s parent, or authorized to make early intervention, educational, health or developmental decisions for the child. (NOTE: A service provider from a State agency or EI program may **not** act as a parent for the purposes of Part C. (e.g., if the child is a ward of the State, DFCS cannot act as the parent)
4. An educational surrogate appointed by the Office of Special Education
5. An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child’s welfare or destruction of records

Part B - Part of IDEA that regulates educational services to children with disabilities ages 3-21.

Part C - Part of IDEA that governs early intervention services for infants and toddlers (ages birth

thru 2) with disabilities and their families.

Participating agency – Any individual, agency or entity that collects, maintains or uses personally identifiable information to implement the requirements in Part C with respect to a particular child.

Payor of Last Resort – Federal law requires that states identify and coordinate the usage of all available resources (public and private insurance, as well as sliding fee scale, such as the Family Cost Participation) to pay for early intervention services before using Part C funds (BCW funds).

Personally Identifiable Information (PII) – Any information that can be used to uniquely identify, contact, or locate an individual, or can be used with other sources to uniquely identify a person.

Physical Development – Includes movement, gross and fine motor functioning, height, weight, vision, and hearing.

PII – Personally Identifiable Information

Primary Service Provider (PSP) – The Early Intervention team member who will be the family's primary contact for EI services and help the family address the child's development from a holistic perspective.

Prior Written Notice – A written explanation provided to parents a reasonable time before an Early Intervention provider proposes or refuses to initiate or change the identification, evaluation, or placement of the infant or toddler. Prior written notice contains sufficient information to inform parents about the action being proposed or refused, the reason for the action, and all procedural safeguards available to parents.

Procedural Safeguards – Policies and practices to establish and document that all guaranteed rights of the parent and child with a disability are enacted as mandated by IDEA.

PSP – Primary Service Provider

SEA/LEA – State/Local Educational Agency – The Georgia State Department of Education and its local school systems (Division for Exceptional Students) take the lead in the provision of free and appropriate preschool educational services for children determined eligible according to Part B of IDEA.

Section 619 of Part B of the IDEA – The federal regulations for special education and related services for children ages three through five; also referred to as preschool special education.

Service Coordinator – An individual who assists and enables a child eligible for Babies Can't Wait and the child's family to receive the rights, procedural safeguards, and supports that are authorized to be provided under Part C of IDEA.

SICC – State Interagency Coordinating Council - The State Interagency Coordinating Council (ICC) is appointed by the Governor, advises and assists the Department of Public Health in providing an appropriate, family-centered, comprehensive service delivery system which promotes optimal child development and family functioning within natural environments.

Significant Developmental Delay – A category of eligibility used by Babies Can't Wait under IDEA, Part C.

Single Point of Entry (SPOE) – The single entity designated by the local lead agency in each local Part C system where families and primary referral sources make initial contact with the local Part C system.

Social-emotional development – The developmental area that involves skills that enable a child to function in a group and to interact appropriately with others.

SPOE – Single Point of Entry

State Complaint – A signed complaint filed by an individual or an agency to the Georgia Department of Public Health (DPH) against a local BCW program or early intervention provider that is violating a requirement of the Part C program. DPH is responsible for conducting an investigation and making a decision about the complaint.

Supplemental Visits – Additional service(s) authorized on the IFSP to support the Primary Service Provider.

Transition conference – A meeting of the family, representatives from Babies Can't Wait and others who will be working with the child and family after the child leaves Babies Can't Wait. This can include staff from the local school, Head Start staff, staff from the local childcare center, or anyone else who will be caring for the child. These individuals meet to begin discussions and planning for the child at least 90 days prior to the child's third birthday in order to ensure a smooth and effective transition on or before the child's third birthday.

APPENDIX B –Babies Can’t Wait Financial Analysis Form

The latest version of the Financial Analysis Form and the most current version of the Sliding Fee Scale can be found at:

<https://www.bcw-bibs.com/UI/Home/ReleaseNotesAndHelpfulDocuments.aspx>

APPENDIX C – Babies Can't Wait Rate Schedule

INTRODUCTION

Babies Can't Wait (BCW) is Georgia's comprehensive, coordinated, statewide, interagency service delivery system for infants and toddlers, birth to 3 years of age, who have developmental delays or are at risk for delay, and their families. The program is established under Part C of the Individuals with Disabilities Education Act (IDEA), as amended. Babies Can't Wait early intervention services are to be family-centered, provided in natural environments and culturally competent. The purpose of this document is to define the authorized providers, settings and rates for Part C early intervention services in Georgia. Although service settings for natural and non-natural environments are listed below, please be advised it is essential that children should be receiving services in the natural environment. Non-natural service settings should be used only when necessary to appropriately deliver the related service.

The following describes the BCW methodology for providing reimbursement for services rendered by providers. This rate schedule shall be used in conjunction with the BCW Policy Manual and DPH Provider Contract/Agreement.

REIMBURSEMENT METHODOLOGY

1. Reimbursement for eligible services shall be on a fee-for-service basis, in accordance with and as described in the applicable BCW fee schedule(s). The BCW rates may be consistent with the Medicaid fee schedule for applicable codes.
2. Note: while the BCW program may elect to adopt the Medicaid rates, the Department, in its sole discretion, may elect NOT to adopt certain Medicaid code(s) or rate(s), in part or. In such cases, the Department shall describe the alternate code and associated BCW rate, denoted by an asterisk*.
3. The Department shall be the payor of last resort and shall ONLY provide reimbursement for eligible early intervention services, at the BCW rate, not otherwise covered by the primary payor (FFS Medicaid, Medicaid CMO, or private insurance), in accordance with the BCW Fiscal Policy.
4. The Department shall ONLY provide reimbursement for the difference between the private insurance payment and the BCW rate, where the private insurance rate is the lesser.

BABIES CAN'T WAIT RATE TABLES

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ASSISTIVE TECHNOLOGY

The IDEA definition of assistive technology devices is broad and covers a wide range of technology devices. Assistive Technology for children with disabilities may include any of the following:

1. Augmentative communication devices (i.e., single or multiple message devices with speech or picture output);
2. Vision and hearing devices (i.e., magnifying glasses, backlit surfaces, amplification systems, and tape recorders). Does not include a medical device that is surgically implanted, or the replacement of such device. (34CFR§ 300.5);
3. Mobility and positioning equipment (i.e., supports for seating, adapted tricycles/scooters, etc.);
4. Appliance control devices (i.e., electrical control units for switch activation. Note: In catalogs these devices are also referenced as “environmental control units”);
5. Learning tools (i.e., built-up writing instruments, knobbed puzzles);
6. Adaptive daily living tools (i.e., built- up spoons, bath supports); and
7. Adaptive toys (i.e., switch activation, built-up handles, amplified sounds or actions).

ASSISTIVE TECHNOLOGY DEVICE	PROCEDURE CODE	UNIT OF SERVICE	BCW RATE
Device*		NA	
Device – Rental borrowed from local program BCW Office		NA	\$0

* To purchase a device that is over \$5,000.00, approval from the state office must be received.

AUDIOLOGY SERVICES

Audiology includes

1. Identification of children with auditory impairment, using at-risk criteria and appropriate audiologic screening techniques;
2. Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;
3. Referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;
4. Provision of auditory training, aural rehabilitation, speech reading, and listening device orientation and training, and other services;
5. Provision of services for prevention of hearing loss;
6. Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices. (Title 34 CFR 303.12(d) (2))

AUTHORIZED SETTING: Clinic or Hospital

AUTHORIZED PROVIDER: Licensed Audiologist

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING AUDIOLOGY SERVICES:

AUDIOLOGY SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Aural rehabilitation	92507	UC, HA	8 units per month, 1 unit per visit	\$62.53
Pure tone audiometry (threshold); air only.	92552	HA	2 units per year; 1 unit per visit	\$15.63
Speech audiometry; threshold only.	92555	HA	2 units per year; 1 unit per visit	\$13.38
Basic comprehensive audiometry (Pure tone, air and bone, and speech, threshold)	92557	HA	2 units per year, 1 unit per visit	\$42.04
Tympanometry (impedance testing)	92567	UC, HA	4 units per year	\$18.46
Acoustic reflex testing.	92568	HA	2 units per year 1 unit per visit	\$13.38
Visual Reinforcement Audiometry	92579	HA	1 unit = 1 visit 4 units per year	\$25.19
Conditioning play audiometry.	92582	HA	2 units per year 1 unit per visit	\$25.19
Brainstem evoked response recording (evoked response (EEG) audiometry). Auditory evoked potentials for comprehensive evoked response audiometry and/or testing of the central nervous system.	92585	HA	2 units per year; 1 unit per visit	\$109.76

Auditory evoked for evoked response audiometry and/or testing of the central nervous system; limited (AABR).	92586	HA	2 units per year 1 unit per visit	\$65.99
Evoked Otoacoustic Emissions, Limited (OAE).	92587	HA	3 units per year 1 unit per visit	\$52.51
Evoked Otoacoustic Emissions. Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product of otoacoustic emissions at multiple levels and frequencies).	92588	HA	3 units per year 1 unit per visit	\$70.52
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 1 HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

HEALTH SERVICES

Health Services means services necessary to enable a child to benefit from the other early intervention services under this part during the time that the child is receiving the other early intervention services. (Title 34 CFR 303.13(a))

AUTHORIZED SETTING: Clinic, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Licensed Physician, Licensed Nurse Practitioner

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING HEALTH SERVICES:

HEALTH SERVICES	PROCEDURE CODE	UNIT OF SERVICE	BCW RATE
Office or other outpatient visit	99213	1 unit = 15 minutes/visit	\$40.70
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 1 HOUR Face to Face		1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means		1 unit = 1 visit	\$20.00*

MEDICAL SERVICES

Medical Services only for diagnostic or evaluation purposes means services provided by a licensed physician to determine a child's developmental status and need for early intervention services. (Title 34 CFR 303.12(d) (5))

AUTHORIZED SETTING: Clinic, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Licensed Physician, Licensed Nurse Practitioner

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING MEDICAL SERVICES:

MEDICAL SERVICES	PROCEDURE CODE	UNIT OF SERVICE	BCW RATE
Office consultation, new or existing patient, minor severity	99241	1 unit = 15 minutes/visit	\$48.05
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 1 HOUR Face to Face		1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means		1 unit = 1 visit	\$20.00*

NURSING SERVICES

Nursing services include the assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems; provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and administration of medications, treatments, and regimens prescribed by a licensed physician. (Title 34 CFR 303.12(d) (6))

AUTHORIZED SETTING: Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Registered Nurse, Licensed Practical Nurse, Physician Assistant

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING NURSING SERVICES:

NURSING SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Medical Records Review (Other Licensed Health Professional-LPN, Physician Assistant)			1 unit = 15 minutes	\$5.00
Medical Records Review (RN)			1 unit = 15 minutes	\$8.00
IFSP Development/ Meeting (for multidisciplinary team). INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 1 HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

NUTRITION SERVICES

Nutrition Services includes 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. (Title 34 CFR 303.12(d) (7))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Dietitian

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING NUTRITION SERVICES:

NUTRITION THERAPY	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Nutrition Therapy Evaluation- Limited to 1 per year.	97802	HA	Limited to one evaluation per year. 1 visit = 3 units of 15 minutes each	\$14.89 per unit
Nutrition Therapy	97803	HA, TS	1 visit = 2 units of 15 minutes each	\$14.89 per unit
Coaching Visit	T2022		1 unit = 15 minutes	\$12.50*
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

OCCUPATIONAL THERAPY

Occupational Therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior, and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings. Title CFR 303.12(d) (8)

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Occupational Therapist

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING OCCUPATIONAL THERAPY:

OCCUPATIONAL THERAPY SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Evaluation	97165, 97166, 97167	HA	1 per year	\$67.21
Re-evaluation	97168	HA	1 every 180 days	\$44.40
Aquatic therapy with therapeutic exercises	97113	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$22.32
Manual therapy techniques (e.g., mobilization/ manipulation manual traction) one or more regions	97140	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$24.18
Therapeutic activities, Direct (one-on- one) member contact by the provider (use of dynamic activities to improve functional performance)	97530	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$28.23
Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on- one) member contact by the provider	97533	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$24.46
Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider	97535	HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$28.23
Wheelchair management/ prosthetic use, established member	97542	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$14.82

Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report	97750	GO, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$22.31
Orthotic(s) Management and training (including assessment and fitting when not otherwise reported). Upper extremity(s), Lower Extremity (s) and/or trunk.	97760	HA	1 unit = 15 minutes Limited to 8 units per calendar month or combination of 8 units per calendar month.	\$27.38
Subsequent Orthotics and/or prosthetics mgt. visit	97763		8 units/mth 1 unit = 15 mins.	\$41.69
Coaching Visit	T2022		1 unit = 15 minutes	\$12.50*
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit= 1 visit	\$20*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speakerphone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

PHYSICAL THERAPY

Physical Therapy includes 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. (Title 34 CFR 303.12(d)(9))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital,
Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Physical Therapist

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING PHYSICAL THERAPY:

PHYSICAL THERAPY SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Evaluation - Limit 1 evaluation per calendar year	97161, 97162, 97165	GP HA	1 per year	\$69.34
Re-evaluation - Limit 1 reevaluation every 180 days	97164	GP HA	1 every 180 days	\$47.14
Therapeutic procedure, one or more areas, therapeutic exercises to develop strength and endurance, range of motion and flexibility	97110	HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$25.91
Neuromuscular reeducation of movement, balance, coordination, kinesthetic senses, posture and proprioception	97112	HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$27.07
Aquatic therapy with therapeutic exercises	97113	GP, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$22.32
Gait training (includes stair climbing)	97116	HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$23.03
Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	97124	HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$17.29
Manual therapy techniques (e.g., mobilization/manipulation, manual traction) one or more regions	97140	GP HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$24.18

Therapeutic activities, direct (one-on-one) member contact by the provider (use of dynamic activities to improve functional performance)	97530	GP, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$28.23
Wheelchair management/prosthetic use established member	97542	GP, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$14.82
Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report.	97750	GP, HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$22.31
Prosthetic training, upper and/or lower extremities, initial prosthetic encounter	97761	GP HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$24.98
Orthotic(s)/prosthetic(s) mgt. and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent encounter	97763	GP HA	1 unit = 15 minutes 8 units per calendar month or combination of 8 units per calendar month	\$41.69
Coaching Visit	T2022		1 unit = 15 minutes	\$12.50*
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

PSYCHOLOGICAL SERVICES

Administering psychological and developmental tests and other assessment procedures; interpreting assessment results; obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs. (Title 34 CFR 303.12(d) (10))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Psychologist

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING PSYCHOLOGICAL SERVICES:

PSYCHOLOGICAL SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Psychological Testing, per hour of psychologist's or physician's time, both face-to- face time for test administration and for interpretation of test results and report preparation	96130	U2, U6, U7 – based on location	1 unit = 1 episode/1 hour	\$100.88
	96131		1 unit = 1 episode /additional hour	\$76.71
Neuropsychological testing evaluation	96132	U2, U7	1 unit = 1 episode/First hour	\$113.32
	96133		1 unit = 1 episode/ additional hour	\$86.45
Psychological or neuropsychological test administration and scoring, two or more tests	96136	U2, U7	1 unit = 1 episode/first 30 mins.	\$40.59
	96137		1 unit = 1 episode /additional 30 mins.	\$37.51
IFSP Development/ Meeting (for multidisciplinary team) <u>INITIAL ONLY - PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR</u> Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) <u>INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR</u> Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

SERVICE COORDINATION (CASE MANAGEMENT)

Service coordination services means assistance and services provided by a Service Coordinator to a child eligible under this part and the child’s family that are in addition to the functions and activities included under Sec. 303.23. (Title 34 CFR 303.12(d) (11))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Intake Coordinator or Service Coordinator

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING CASE MANAGEMENT SERVICES:

SERVICE COORDINATION SERVICES	SPECIALTY	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Intake Coordination – Consists of: <ul style="list-style-type: none"> • Intake • Screening • Evaluation completed and Eligibility entered into BIBS 	Intake Coordinator	T2003		1 unit = 1 visit	\$67.50*
Evaluation Only– Consists of: <ul style="list-style-type: none"> • No screening conducted • Evaluation completed <u>and</u> Child not eligible 	Intake Coordinator			1 unit = 1 visit	\$25.00*
Pre-IPC Telephonic Development <ul style="list-style-type: none"> • Screening only (case closed) 	Intake Coordinator			1 unit = 1 visit	\$15.00*
Pre-IPC Face-to-Face Development <ul style="list-style-type: none"> • Screening only (case closed) 	Intake Coordinator			1 unit = 1 visit	\$25.00*
Pre-IPC Face-to-Face <ul style="list-style-type: none"> • Face to Face meeting held • No Developmental Screening • Case closed 	Intake Coordinator			1 unit = 1 visit	\$22.00*
ASD 18-month Initial Screening ASD 24-month Initial Screening	Intake Coordinator Service Coordinator	96110	EPUA	Episode	\$11.77
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY-SERVICE COORDINATOR MUST STAY FOR THE DURATION OF THE MEETING (Applicable <u>only</u> if Service Coordinator is unable to obtain the 3 ancillaries after the initial IFSP meeting)	Service Coordinator	T2003		1 unit = 1 visit	\$67.50*
Face-To-Face Visit with child and family plus 3 ancillaries in the same calendar month	Service Coordinator	T2022			\$135.00*
PSP Meeting – Face-to-Face participation	Service Coordinator			1 unit= 15 mins	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method	Service Coordinator			1 unit= 15 mins	\$6.25*

SOCIAL WORK SERVICES

Social Work services include making home visits to evaluate a child's living conditions and patterns of parent-child interaction; preparing a social or emotional developmental assessment of the child within the family context; providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents; working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services. (Title 34 CFR 303.12(d) (12))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Licensed Clinical Social Worker

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING SOCIAL WORK SERVICES:

SOCIAL WORK SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Evaluation/assessment (on-site or off-site)	96156	HA	1 unit = 1 visit	\$84.57
Health behavior intervention, individual, initial visit	96158	HA	1 unit = 15 mins.	\$28.85
Health behavior intervention, ind., supplemental visit	96159	HA	1 unit = 15 mins.	\$20.15
Health behavior intervention, Family, initial visit	96167	HA	1 unit = 15 mins.	\$30.99
Health behavior intervention, Family, supplemental visit	96168	HA	1 unit = 15 mins.	\$21.98
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting - Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

SPECIAL INSTRUCTION

The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan; providing families with information, skills, and support related to enhancing the skill development of the child; and working with the child to enhance the child's development. (Title 34 CFR 303.12 (d) (13))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDER: Early Intervention Specialist, Early Interventionist, Early Intervention Assistant

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING SPECIAL INSTRUCTION SERVICES:

SPECIAL INSTRUCTION	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Initial Evaluation	T2003		1 unit = 1 visit	a) \$50.00* b) \$50.00*
Service	T2003		1 unit = 15 minutes	a) \$8.75* b) \$7.50* c) \$6.25*
Coaching Visit	T2022		1 unit = 15 minutes	a) \$8.75* b) \$7.50* c) \$6.25*
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting – Face-to-Face			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25*

- a) Rate for Early Intervention Specialist
- b) Rate for Early Interventionist
- c) Rate for Early Intervention Assistant

SPEECH-LANGUAGE PATHOLOGY SERVICES

Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and provision of services for the habilitation, rehabilitation or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.
(Title 34 CFR 303.12(d) (14))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Speech-Language Pathologist, CFY - Speech-Language Pathologist

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING SPEECH-LANGUAGE PATHOLOGY THERAPY:

SPEECH THERAPY SERVICES	PROCEDURE CODES	MODIFIER	UNIT OF SERVICE	BCW RATE
Evaluation of: <ul style="list-style-type: none"> • speech fluency • Speech sound production • Speech sound production & comprehension & expression • Behavioral & qualitative analysis of voice & resonance 	92521 92522 92523 92524	HA	2 units per year; 1 unit per visit; 1 unit per 180 days	\$97.14 \$78.86 \$163.81 \$82.12
Speech-Language Therapy, (includes aural rehabilitation); individual treatment of speech, language, voice, communication, and/or auditory processing disorder	92507	GN, HA	8 visits per calendar month; 1 unit per visit	\$62.53
Treatment of swallowing dysfunction and/or oral function for feeding	92526	HA	8 visits per calendar month; 1 unit per visit	\$44.66
Tympanometry	92567	GN, HA	4 units per calendar year	\$18.46
Evaluation of voice prosthesis or augmentative communication	92597	HA	1 per calendar year; 1 unit per visit	\$85.57
Therapeutic services for use of speech-generating device, including programming & modification	92609		1 unit = 1 visit	\$54.75
Evaluation of oral and pharyngeal swallowing function	92610	HA	Limited to 2 per year 1 unit per visit; 1 unit/180 days	\$117.54
Assessment of Aphasia	96105	HA	2 units per calendar year; 1 unit per visit; 1 unit/180 days	\$62.10
Developmental testing	96110	HA	2 units per calendar year; 1 unit per visit	\$11.77

Developmental test administration, including assessment of fine &/or gross motor, language, cognitive level, social, memory &/or executive functions by standardized developmental instruments, first hour	96112	HA	2 units per calendar year; 1 unit per visit	\$110.42
Developmental test administration, including assessment of fine &/or gross motor, language, cognitive level, social, memory &/or executive functions by standardized developmental instruments, each additional 30 mins after 1 st hour	96113	HA	Episode/30 mins.	\$50.48
Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one- on-one) member contact by the provider	97533	GN, HA	1 unit = 15 minutes Limited to 8 units per calendar month or combination of 8 units per calendar month	\$24.46
Coaching Visit	T2022		1 unit = 15 minutes	\$12.50*
IFSP Development/ Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR Face to Face			1 unit = 1 visit	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting – Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth, or other remote real-time method			1 unit = 15 minutes	\$6.25 *

- a) Rate for a Speech-Language Pathologist
- b) Rate for a CFY-Speech-Language Pathologist

VISION SERVICES

Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays and abilities; Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and communication skills training, orientation, and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities. (Title 34 CFR 303.12(d) (16))

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Ophthalmologist, Optometrist and Vision Teacher (for *Orientation and Mobility Services*)

AUTHORIZED PROCEDURE CODES TO BE BILLED WHEN PROVIDING VISION SERVICES:

VISION SERVICES	PROCEDURE CODE	PROVIDER	UNIT OF SERVICE	BCW RATE
Evaluation new patient intermediate	92002	Ophthalmologist Optometrist	1 unit = 1 visit	\$54.28
Evaluation new patient comprehensive	92004	Ophthalmologist Optometrist	1 unit = 1 visit	\$90.69
Evaluation established patient intermediate	92012	Ophthalmologist Optometrist	1 unit = 1 visit	\$46.16
Evaluation established patient comprehensive	92014	Ophthalmologist Optometrist	1 unit = 1 visit	\$66.56
New Patient Office Visit (problem-focused)	99201	Ophthalmologist Optometrist	1 unit = 1 visit	\$35.13
Office or other outpatient visit (expanded problem focused)	99202	Ophthalmologist Optometrist	1 unit = 1 visit	\$54.57
Office or other outpatient visit (detailed)	99203	Ophthalmologist Optometrist	1 unit = 1 visit	\$76.53
Office or other outpatient visit (comprehensive, moderate)	99204	Ophthalmologist Optometrist	1 unit = 1 visit	\$110.51
Office or other outpatient visit (comprehensive, high)	99205	Ophthalmologist Optometrist	1 unit = 1 visit	\$137.12
Office or other outpatient visit (minimal)	99211	Ophthalmologist Optometrist	1 unit = 1 visit	\$17.46
Office or other outpatient visit (problem-focused)	99212	Ophthalmologist Optometrist	1 unit = 1 visit	\$29.67
Office or other outpatient visit (expanded)	99213	Ophthalmologist Optometrist	1 unit = 1 visit	\$40.70
Office or other outpatient visit (detailed)	99214	Ophthalmologist Optometrist	1 unit = 1 visit	\$62.71
Office or other outpatient visit (comprehensive, high)	99215	Ophthalmologist Optometrist	1 unit = 1 visit	\$93.46
Orientation and Mobility Evaluation		Vision Teacher	1 unit = 15 mins.	\$12.50
Orientation and Mobility Services		Vision Teacher	1 unit = 15 mins.	\$8.75
Coaching Visit	T2022		1 unit = 15 minutes	\$12.50*

IFSP Development/ Meeting (for multidisciplinary team) <u>INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO ONE HOUR</u> Face-to-Face			1 unit = 1 visit 1 visit \geq 30 minutes.	\$40.00*
IFSP Development/Meeting (for multidisciplinary team) <u>INITIAL ONLY- PARTICIPANTS MUST STAY FOR THE DURATION OF THE MEETING OR UP TO 30 MINUTES</u> Telephonic/Other Means			1 unit = 1 visit	\$20.00*
PSP Meeting – Face-to-Face participation			1 unit = 15 minutes	\$12.50*
PSP Meeting – Participation by speaker phone, telehealth or other remote real-time method			1 unit = 15 minutes	\$6.25 *

OTHER RELATED SERVICES

AUTHORIZED SETTING: Child Care Center, Clinic, Community Setting, Home, Hospital, Residential Facility, Special Purpose Facility

AUTHORIZED PROVIDERS: Language Translators, Sign Language Interpreters for the Deaf

RELATED SERVICES	PROCEDURE CODE	MODIFIER	UNIT OF SERVICE	BCW RATE
Spanish Language Translator	T2221		Face-to-Face: 1unit = 15 minutes	Face-to-face: \$10.00 *
			Telephonic: 1 unit= 15 minutes	Telephonic: \$5.00*
Non-Spanish Foreign Language Translator	T2222		Face-to-Face: 1unit = 15 minutes	Face-to-face: \$15.00*
			Telephonic: 1 unit= 15 minutes	Telephonic: \$7.50*
Interpreters for the Deaf	T2223		Face-to-Face: 1unit = 15 minutes	Face-to-face: \$15.00*
			Telephonic: 1 unit= 15 minutes	Telephonic: \$7.50*

– Districts may use the Language Line for Telephonic Interpretation Services

ADDENDUM A: MODIFIER CODES

(For use with CPT Codes)

MODIFIER	DETAIL/COMMENT
GN	Service delivered under an outpatient speech-language pathology plan of
GO	Service delivered under an outpatient occupational therapy plan of care
GP	Service delivered under an outpatient physical therapy plan of care
HA	Child/adolescent program
TD	RN
TS	Follow-up service
U2	Medicaid level of care 2, as defined by each state
U6	Medicaid level of care 6, as defined by each state
U7	Medicaid level of care 7, as defined by each state
UC	Medicaid level of care 12, as defined by each state

APPENDIX D – BCW Category 1 Conditions List

ICD 10	Description
A50	Congenital viral diseases
A50.0	Early congenital syphilis, symptomatic Any congenital syphilitic condition specified as early or manifest less than two years after birth.
A50.01	Early congenital syphilitic oculopathy
A50.02	Early congenital syphilitic osteochondropathy
A50.03	Early congenital syphilitic pharyngitis
A50.04	Early congenital syphilitic pneumonia
A50.05	Early congenital syphilitic rhinitis
A50.06	Early cutaneous congenital syphilis
A50.07	Early mucocutaneous congenital syphilis
A50.08	Early visceral congenital syphilis
A50.09	Other early congenital syphilis, symptomatic
A50.1	Early congenital syphilis, latent Congenital syphilis without clinical manifestations, with positive serological reaction and negative spinal fluid test, less than two years after birth.
C69.2	Malignant neoplasm of retina Excludes1: dark area on the retina (D49.81) neoplasm of unspecified behavior of retina and choroid (D49.81) retinal freckle (D49.81)
C69.21	Malignant neoplasm of right retina
C69.22	Malignant neoplasm of left retina
D55.2	Anemia due to disorders of glycolytic enzymes Triose-phosphate isomerase deficiency anemia
D81.810	Biotinidase deficiency
D82.1	Di George's syndrome
E03.0	Congenital hypothyroidism with diffuse goiter Congenital parenchymatous goiter (nontoxic) Congenital goiter (nontoxic) NOS Excludes1: transitory congenital goiter with normal function (p72.0)
E03.1	Congenital hypothyroidism without goiter Aplasia of thyroid (with myxedema) Congenital atrophy of thyroid Congenital hypothyroidism NOS
E70.0	Classical phenylketonuria
E70.1	Other hyperphenylalaninurias
E70.2	Disorders of Tyrosine metabolism Excludes1: transitory tyrosinemia of newborn (P74.5)
E70.21	Tyrosinemia Hypertyrosinemia
E70.32	Oculocutaneous albinism Excludes1: Chediak-Higashi syndrome (E70.330) Hermansky-Pudlak syndrome (E70.331)

ICD 10	Description
E71.0	Maple-syrup-urine disease
E71.111	3-Methylglutaconic aciduria
E71.120	Methylmalonic acidemia
E71.121	Propionic acidaemia
E71.3	Disorders of fatty-acid metabolism
E71.310	Long chain/very long chain acyl coa dehydrogenase deficiency
E71.311	Medium chain acyl coa dehydrogenase deficiency
E71.313	Glutaric aciduria type II
E71.41	Primary carnitine deficiency
E71.510	Zellweger syndrome
E71.511	Neonatal adrenoleukodystrophy
E72.02	Hartnup disease
E72.03	Lowe's syndrome
E72.04	Cystinosis Fanconi (-de Toni) (-Debre) syndrome with cystinosis Excludes1: Fanconi (-de Toni) (-Debre) syndrome without cystinosis (E72.09)
E72.1	Disorders of sulfur-bearing amino-acid metabolism Excludes1: cystinosis (E72.04), cystinuria (E72.01), transcobalamin II deficiency (D51.2)
E72.11	Homocystinuria
E71.118	Other branched-chain organic acidurias
E72.21	Argininaemia
E72.22	Arginosuccinic aciduria
E72.23	Citrullinemia
E72.3	Disorders of lysine and hydroxylysine metabolism Glutaric aciduria (type I)
E72.4	Disorder of ornithine metabolism Ornithine transcarbamylase deficiency Excludes1: hereditary choroidal dystrophy (H31.2-)
E72.8	Other specified disorders of amino-acid metabolism Disorders of beta-amino-acid metabolism Disorders of gamma-glutamyl cycle
E74.02	Pompe disease Cardiac glycogenosis Type II glycogen storage disease
E74.04	McArdle disease
E74.21	Galactosemia
E74.4	Disorders of pyruvate metabolism and gluconeogenesis Deficiency of pyruvate carboxylase Deficiency of pyruvate dehydrogenase Excludes1: disorders of pyruvate metabolism and gluconeogenesis with anemia (D55.-) Leigh's syndrome (G31.82)
E75.01	Sandhoff disease
E75.02	Tay-Sachs disease

ICD 10	Description
E75.2	Other sphingolipidosis
E75.22	Gaucher disease
E75.23	Krabbe disease
E75.24	Niemann-pick
E75.240	Niemann-Pick disease type A
E75.241	Niemann-Pick disease type B
E75.242	Niemann-Pick disease type C
E75.25	Metachromatic leukodystrophy
E75.4	Batten disease
E75.5	Other lipid storage disorders Cerebrotendinous cholesterosis [van Bogaert-Scherer-Epstein]
E76.01	Hurler's syndrome
E76.1	Mucopolysaccharidosis, type II- Hunter's syndrome
E76.2	Other mucopolysaccharidoses
E76.22	Sanfilippo mucopolysaccharidoses Mucopolysaccharidosis, type III (A) (B) (C) (D) Sanfilippo A syndrome Sanfilippo B syndrome Sanfilippo C syndrome Sanfilippo D syndrome
E77.1	Defects in glycoprotein degradation Fucosidosis
E77.8	Other disorders of glycoprotein metabolism
E78.6	"Lipoprotein deficiency Abetalipoproteinaemia
E78.72	Smith-Lemli-Opitz syndrome
E79.1	Lesch-Nyhan syndrome HGPRT deficiency
E83.01	Wilson's disease
E83.09	Other disorders of copper metabolism Menkes' (kinky hair) (steely hair) disease
E88.41	MELAS syndrome
E88.42	MERRF syndrome
E88.49	Other mitochondrial metabolism disorder
E88.8	Other specified metabolic disorders
F84	Pervasive developmental disorders
F84.0	Childhood autism
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger syndrome
F84.8	Other pervasive developmental disorders Overactive disorder associated with intellectual disabilities and stereotyped movements
G00.8	Other Bacterial meningitis
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]

ICD 10	Description
G12.1	Other inherited spinal muscular atrophy Juvenile form, type III spinal muscular atrophy [Kugelberg-Welander]
G23.0	Hallervorden-Spatz disease
G31.8	Other specified degenerative diseases of nervous system
G31.82	Leigh syndrome
G31.89	Other specified degenerative diseases of nervous system
G40	Epilepsy and recurrent seizures
G40.00	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable
G40.001	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus
G40.009	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus
G40.1	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures
G40.10	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizure, not intractable
G40.101	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus
G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
G40.11	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable
G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.2	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
G40.20	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable
G40.201	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40.21	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable
G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic

ICD 10	Description
	syndromes with complex partial seizures, intractable, without status epilepticus
G40.3	Generalized idiopathic epilepsy and epileptic syndromes
G40.30	Generalized idiopathic epilepsy and epileptic syndromes, not intractable
G40.301	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.31	Generalized idiopathic epilepsy and epileptic syndromes, intractable
G40.311	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.4	Other generalized epilepsy and epileptic syndromes
G40.40	Other generalized epilepsy and epileptic syndromes, not intractable
G40.401	Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.409	Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.5	Epileptic seizures related to external causes
G40.50	Epileptic seizures related to external causes, not intractable
G40.501	Epileptic seizures related to external causes, not intractable, with status epilepticus
G40.509	Epileptic seizures related to external causes, not intractable, without status epilepticus
G40.8	Other epilepsy and recurrent seizures
G40.80	Other epilepsy
G40.801	Other epilepsy, not intractable, with status epilepticus
G40.802	Other epilepsy, not intractable, without status epilepticus
G40.803	Other epilepsy, intractable, with status epilepticus
G40.804	Other epilepsy, intractable, without status epilepticus
G40.81	Lennox-Gastaut syndrome
G40.811	Lennox-Gastaut syndrome, not intractable, with status epilepticus
G40.812	Lennox-Gastaut syndrome, not intractable, without status epilepticus
G40.813	Lennox-Gastaut syndrome, intractable, with status epilepticus
G40.814	Lennox-Gastaut syndrome, intractable, without status epilepticus
G40.82	Epileptic spasms
G40.821	Epileptic spasms, not intractable, with status epilepticus
G40.822	Epileptic spasms, not intractable, without status epilepticus
G40.823	Epileptic spasms, intractable, with status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus
G40.89	Other seizures
G60.0	Hereditary motor and sensory neuropathy

ICD 10	Description
	Dejerine-Scottas disease
G60.1	Refsum disease Infantile Refsum disease
G71.0	Muscular dystrophy
G71.11	Myotonic muscular dystrophy Dystrophia myotonica [Steinert] Steinert disease
G71.12	Myotonia congenita Dominant myotonia congenita [Thomsen disease]
G71.2	Congenital myopathies Central Core disease
G80	Cerebral palsy
G80.0	Spastic quadriplegia cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left non-dominant side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting the left dominant side
G81.13	Spastic hemiplegia affecting the right non-dominant side
G81.14	Spastic hemiplegia affecting the left non-dominant side
G81.22	Paraplegia, incomplete
G82.2	Paraplegia
G82.21	Paraplegia, complete
G82.51	Quadriplegia c1 - c4 complete
G82.52	Quadriplegia c1 - c4 incomplete
G82.53	Quadriplegia C5 - C7 complete
G82.54	Quadriplegia C5 - C7 incomplete
G83	Diplegia of the upper limbs
G83.11	Monoplegia of the lower limb affecting right dominant side
G83.12	Monoplegia of the lower limb affecting the left dominant side
G83.13	Monoplegia of the lower limb affecting the right non-dominant side
G83.14	Monoplegia of the lower limb affecting the left non-dominant side
G83.21	Monoplegia of the upper limb affecting the right dominant side
G83.22	Monoplegia of the upper limb affecting the left dominant side
G83.23	Monoplegia of the upper limb affecting the right non-dominant side
G83.24	Monoplegia of the upper limb affecting the left non-dominant side
G90.1	Familial dysautonomia [Riley-Day]
G91.0	Communicating hydrocephalus

ICD 10	Description
G91.1	Obstructive (noncommunicating) hydrocephalus
G93.1	Anoxic brain damage, not elsewhere classified
G93.41	Metabolic encephalopathy
G93.49	Other encephalopathy Encephalopathy NEC
G93.81	Temporal sclerosis
G93.89	Other specified disorders of the brain
G98	Other disorders of nervous system not elsewhere classified
H35.02	Exudative retinopathy Coats retinopathy
H35.15	Retinopathy of prematurity, stage 4
H35.151	Retinopathy of prematurity, stage 4, right eye
H35.152	Retinopathy of prematurity, stage 4, left eye
H35.153	Retinopathy of prematurity, stage 4, bilateral
H35.16	Retinopathy of prematurity, stage 5
H35.161	Retinopathy of prematurity, stage 5, right eye
H35.162	Retinopathy of prematurity, stage 5, left eye
H35.163	Retinopathy of prematurity, stage 5, bilateral
H35.5	Hereditary retinal dystrophy
H35.51	Vitreoretinal dystrophy
H35.52	Pigmentary retinal dystrophy
H35.53	Other dystrophies primarily involving the sensory retina
H35.54	Dystrophies primarily involving the retinal pigment epithelium
H47.21	Primary optic atrophy
H47.211	Primary optic atrophy, right eye
H47.212	Primary optic atrophy, left eye
H47.213	Primary optic atrophy, bilateral
H47.61	Cortical blindness
H47.611	Cortical blindness, right side of the brain
H47.612	Cortical blindness, left side of the brain
H49.81	Kearns-Sayre syndrome
H54.0	Blindness, both eyes Visual impairment categories 3, 4, 5 in both eyes
H54.1	Blindness one eye low vision other eye
H54.11	Blindness in right eye, low vision in left eye
H54.12	Blindness left eye, low vision right eye
H54.2	Low vision, both eyes Visual impairment categories 1 or 2 in both eyes
H90.0	Conductive hearing loss, bilateral
H90.3	Sensorineural hearing loss, bilateral
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
ICD 10	Description
P04.1	Newborn affected by other maternal medications

ICD 10	Description
	Newborn (suspected to be) affected by cancer chemotherapy Newborn (suspected to be) affected by cytotoxic drugs Excludes1: dysmorphism due to warfarin (Q86.2) Fetal hydantoin syndrome Maternal use of drugs of addiction (P04.4-)
P04.8	Newborn (suspected to be) affected by other maternal noxious substances
P35.0	Congenital rubella syndrome Congenital rubella pneumonitis
P35.1	Congenital cytomegalovirus infection
P35.2	Congenital herpesviral [herpes simplex] infection
P35.8	Other congenital viral diseases Congenital varicella [chickenpox]
P37.1	Congenital toxoplasmosis Hydrocephalus due to congenital toxoplasmosis
P52.21	Intraventricular (nontraumatic) hemorrhage, grade 3, of newborn Subependymal hemorrhage with intraventricular extension with enlargement of ventricle
P52.22	Intraventricular (nontraumatic) hemorrhage, grade 4, of newborn Bleeding into cerebral cortex Subependymal hemorrhage with intracerebral extension
P91.2	Neonatal cerebral leukomalacia Periventricular Leukomalacia
P91.6	Hypoxic ischemic encephalopathy
P91.61	Mild hypoxic-ischemic encephalopathy [HIE]
P91.62	Moderate hypoxic-ischemic encephalopathy [HIE]
P91.63	Severe hypoxic-ischemic encephalopathy [HIE]
P94.0	Transient neonatal myasthenia gravis Excludes1: myasthenia gravis (G70.0)
Q00.0	Anencephaly- acephaly, acrania, amyelencephaly, hemianencephaly, hemiccephaly
Q00.1	Craniorachischisis
Q00.2	Iniencephaly
Q01	Encephalocele
Q01.0	Frontal encephalocele
Q01.1	Nasofrontal encephalocele
Q01.2	Occipital encephalocele
Q01.8	Encephalocele of other sites
Q02	Microcephaly: hydro microcephaly, mesencephalon
Q04.8	Other specified congenital malformations of brain
Q03.1	Atresia of foramina of Magendie and Luschka Dandy-Walker Syndrome
Q04.0	Congenital malformations of brain Agenesis of corpus callosum
Q04.2	Holoprosencephaly

ICD 10	Description
Q04.3	Other reduction deformities of brain Lissencephaly
Q04.4	Septo-optic dysplasia of brain
Q04.5	Megalencephaly
Q04.6	Congenital cerebral cysts Porencephaly
Q05	Spina bifida
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q06.2	Diastematomyelia
Q06.4	Hydromyelia
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q11.1	Other anophthalmos
Q11.2	Microphthalmos
Q14.2	Congenital malformation of optic disc Coloboma of optic disc
Q22.4	Congenital tricuspid stenosis Congenital tricuspid atresia
Q23.4	Hypoplastic left heart syndrome
Q24.8	Other specified congenital malformations of heart
Q25.5	Atresia pulmonary artery
Q26.2	Total anomalous pulmonary venous connection
Q74.3	Arthrogryposis multiplex congenita
Q76.1	Klippel-Feil syndrome
Q77.3	Congenital cerebral cysts Chondrodysplasia Punctata
Q82.3	Incontinentia pigmenti
Q85.1	Tuberous sclerosis
Q85.8	Other phakomatoses, not elsewhere classified Sturge-Weber (-Dimitri) syndrome
Q86.0	Fetal Alcohol syndrome (dysmorphic)
Q86.8	Other congenital malformation syndromes due to known exogenous causes
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
Q87.1	Congenital malformation syndromes predominantly associated with short stature Cockayne syndrome De Lange syndrome

ICD 10	Description
	Noonan syndrome Prader-Willi syndrome Robinow-Silverman-Smith syndrome Excludes1: Ellis-van Creveld syndrome (Q77.6) Smith-Lemli-Opitz syndrome (E78.72)
Q87.2	Congenital malformation syndromes predominantly involving limbs Rubinstein-Taybi syndrome
Q87.40	Marfan's syndrome
Q87.89	Other specified congenital malformation syndromes, not elsewhere classified
Q90	Down syndrome
Q90.0	Trisomy 21, nonmosaicism (meiotic nondisjunction)
Q90.1	Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2	Trisomy 21, translocation
Q91.0	Trisomy 18, nonmosaicism (meiotic nondisjunction)
Q91.1	Trisomy 18, mosaicism mitotic nondisjunction)
Q91.2	Trisomy 18, translocation
Q91.4	Trisomy 13, nonmosaicism (meiotic nondisjunction)
Q91.5	Trisomy 13, mosaicism (mitotic nondisjunction)
Q91.6	Trisomy 13, translocation
Q92	Other trisomies and partial trisomies of the autosomes, not elsewhere classified
Q92.5	Duplications with other complex rearrangements
Q92.7	Triploidy and polyploidy
Q92.8	Other specified trisomies and partial trisomies of the autosomes
Q93.3	Wolf-Hirschhorn Syndrome 4p
Q93.4	Deletion of short arm of chromosome 5: Cri-du-chat syndrome
Q93.5	Other deletions of part of a chromosome
Q93.8	Other deletions from the autosomes
Q93.81	Velo-cardio-facial syndrome- Deletion 22q11.2
Q93.88	Other microdeletions: Miller-Dieker syndrome, Smith-Magenia syndrome
Q96	Turner's syndrome
Q97.0	Karyotype 47, XXX
Q97.1	Female with more than three X chromosomes
Q98.0	Klinefelter syndrome karyotype 47, XXY
Q98.1	Klinefelter syndrome, male with more than two X chromosomes
Q98.5	Karyotype 47, XYY
Q99.2	Fragile X chromosome
Q99.8	Other specified chromosome abnormalities
S09.8XXA	Other specified injuries of head, initial encounter
T86.2	Complications of heart transplant Excludes1: complication of: artificial heart device (T82.5) heart-lung transplant (T86.3)
T86.21	Heart Transplant rejection

APPENDIX E – Notice of Infant/Toddler and Family Rights Under Babies Can't Wait

This section is provided to families to describe the child's and family's rights to participate in Babies Can't Wait.

Foreword

The Notice of Infant/Toddler and Family Rights under Babies Can't Wait (BCW) describe your child's and family's rights, as defined by Part C of the Individuals with Disabilities Education Act as amended (IDEA). IDEA is a federal law which includes descriptions of the types of early intervention services provided for eligible children starting at birth.

Georgia has developed policies and procedures which meet these federal and state Part C requirements. Because this document is an official notice of your rights under federal law and regulations, some terms may be unfamiliar to you. For this reason, some words are defined where they are used in the document and others are defined in the Glossary. The Service Coordinator working with your family can suggest additional materials to help you understand your rights. He/she can also suggest ways that you and other family members can be partners with professionals to help meet the developmental needs of your child.

For more information contact:

Babies Can't Wait Program
Office of Early Intervention
Maternal and Child Health Section, Georgia Department of Public Health
2 Peachtree Street, NW, 11th Floor
Atlanta, GA 30303-3186
(404) 657-2762 or 1-888-651-8224 (Toll-Free)

Introduction

The Early Intervention Program (Part C of the IDEA) in Georgia, known as Babies Can't Wait (BCW), is designed to support family involvement and ensure parental consent in each step of the process from referral, through service delivery. Safeguards or rights have been established to protect parents and infants and toddlers with disabilities. Parents must be informed about these rights or safeguards so they can have a leading role in services for their children. Participation in the Georgia BCW program for infants and toddlers is voluntary for you and your family. A parent or legal guardian may request information in their native language. The Georgia Department of Public Health is committed to ensuring that all families who primarily communicate in another language other than English or parents with a sensory impairment have meaningful access to all programs and activities, conducted or supported by the department. A parent can request these services by notifying their local Babies Can't Wait office or Service Coordinator.

Under BCW in Georgia, you as a parent, have the following rights:

- The right to a timely multidisciplinary evaluation and assessment and the development of an Individualized Family Service Plan (IFSP) within forty-five (45) calendar days from referral to BCW;
- The right to appropriate early intervention services for your child and family as addressed in an IFSP if eligible under BCW;

In Georgia, “appropriate early intervention services” are determined through the IFSP process. The IFSP must contain a statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler with disabilities and the family to achieve the outcomes identified in the IFSP. Federal regulations define early intervention services under IDEA Section [303.13](#) as services that “are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant’s or toddler’s development as identified by the IFSP Team, in any one or more of the following areas including physical development, cognitive development, communication development; social or emotional development or adaptive development.”

- The right to evaluation, assessment, IFSP development, service coordination, and procedural safeguards at no cost to you. You may be charged for other early intervention services based on the Financial Analysis for Cost Participation. However, your inability to pay, as defined by the Financial Analysis for Cost Participation, will not prevent your child or your family from receiving early intervention services;
- The right to refuse screenings, evaluations, assessments, and services;
- The right to dispute the eligibility determination through dispute resolution mechanisms, including mediation;
- The right to be invited to and participate in all IFSP meetings;
- The right to receive written notice five (5) calendar days before a change is proposed or refused in the identification, evaluation, or placement of your child, or in the provision of services to your child or family;
- The right to receive an initial copy of your child’s early intervention record at no cost to you.
- The right to receive services in your child’s natural environment to the extent appropriate;
- The right to maintenance of the confidentiality of personally identifiable information;
- The right to review and, if appropriate, correct early intervention records;
- The right to an impartial due process hearing to resolve parent/provider disagreements;
- The right to file a state complaint.

In addition to the general rights listed above, you are entitled to be notified of specific procedural safeguards under BCW. These rights include:

- Confidentiality of Personally Identifiable Information and Early Intervention Records;
- Parental Consent and Notice;
- Surrogate Parents, and
- Dispute Resolution Options including Mediation, State Complaint Procedures and Due Process Hearing Procedures.

Key points in the process from referral to IFSP development are outlined below with additional information on your specific rights under the areas described above.

1. Key Points in Process from Referral to IFSP Development Referral

1. Your child can be referred to Babies Can't Wait (BCW) by you or another individual (pediatrician, nurse, childcare provider, therapist, another parent, etc.).
2. Referrals may be made by telephone, fax, in writing, or in person.
3. A referral may be made without prior parental consent; however, as a parent you will be informed of this referral.
4. **The 45-day timeline begins on the day the referral is received by Children 1st**, which serves as the Single Point of Entry (SPOE) or the front door for Georgia’s Public Health Child Health programs including BCW or when referred directly to Babies Can’t Wait.

2. Intake

The intake meeting will be your first face-to-face contact with Babies Can't Wait personnel. During this meeting, you will be asked about your child and his/ her developmental and medical history as well as your priorities as a family. You will also be provided with prior written notice and asked for your consent to evaluate your child. You may also be asked for your written consent for Babies Can't Wait to request specific information about your child from his/her doctors and others involved in his/her life.

3. Prior Written Notice

Prior written notice must be given to parents/legal guardians at least five (5) calendar days before Babies Can't Wait proposes or refuses to initiate or change the identification, initial screening, all evaluations and assessments, or placement of your child or providing appropriate early intervention services to your child and family. You will be given prior notice before your child's evaluation, if he/she is found to be eligible for Babies Can't Wait, and before his/her individualized family service plan is developed or changed.

4. Parental Consent

Consent means that you, as your child's parents/legal guardians, have been fully informed of all information about the activity for which you are asked to agree to. Information must be provided to you in your native language or other mode of communication unless it is clearly not feasible to do so. If translation into the native language is not practical, the notice is translated verbally (orally) or by other means to you in your native language or other method of communication. You will be asked to provide signed permission before each screening, evaluation and assessment is conducted and prior to the use of public benefits or private insurance if such funding sources are used to pay for Part C services and before disclosing personally identifiable information.

5. Screening

Screening involves the use of selected tools or procedures during the intake visit or other appropriate time to determine whether further evaluation and assessment activities are needed for your child. However, as a parent you have the right to request an evaluation at any time during the screening process even if the screening results do not indicate a suspected delay(s). In some instances, if your child is diagnosed with certain conditions such as Down syndrome or Cerebral Palsy a screening may not be necessary, and eligibility will be determined based on receipt of a medical report that confirms a diagnosis.

6. Evaluation & Assessment

Evaluation means the use of tools and procedures by qualified professionals to determine your child's initial eligibility for Babies Can't Wait.

Assessment means the ongoing use of tests and procedures by qualified professionals to identify your child's unique strengths, needs, as well as the resources, priorities and concerns of your family and the supports and services necessary to improve your family's capacity to meet the developmental needs of your infant or toddler with special needs.

Assessment of a child's progress is ongoing. The local lead agency must provide a copy of each evaluation/ assessment to the parent within 21 calendar days, at no cost to you.

7. Individualized Family Service Plan (IFSP) Development

The Individualized Family Service Plan (IFSP) is a plan of early intervention services for your child and family. The plan is developed with input from you, the parent and the team that conducts the evaluation and assessment to determine eligibility.

Babies Can't Wait standards require that each child's individualized family service plan (IFSP) must be developed within 45 days of the receipt of the referral. When delays are requested or initiated by a family for any reason (such as illness, hospitalization, vacation, work schedules, etc.), this timeline requirement is not in effect and may delay the initiation of services for your child and family.

8. Confidentiality of Personally Identifiable Information & Early Intervention Records

Confidentiality of records begins at referral and continues until the participating agency is no longer required (In Georgia that is 5 years after the child exits) to maintain personally identifiable information regarding the child under applicable Federal and State LEAs. Sharing information can occur between agencies that are part of the Georgia Department of Public Health, Maternal and Child Health programs, when written parental consent is obtained for each program. This includes consent to request, receive, and release information and other relevant authorizations from the parent/legal guardian.

The local lead agency gives you the opportunity to inspect and review any early intervention records relating to your child which are collected, maintained, or used by BCW. The local lead agency complies with a request not more than 15 calendar days after the request has been made and before any meeting regarding an IFSP or any hearing related to identification, evaluation, placement or provision of early intervention services.

The right to inspect and review early intervention records includes:

- The right to a response from the local lead agency to reasonable requests for explanations and interpretation of the early intervention record;
- The right to request that the local lead agency provide copies of early intervention records containing the information if failure to provide these copies would effectively prevent you from exercising the right to inspect and review the early intervention records; and
- The right to have someone who is representing you to inspect and review the early intervention record. A parent must give signed consent for this representative to review the early intervention records by completing a release of information form.

The local lead agency may assume that you have the authority to inspect and review early intervention records relating to your child unless the local lead agency has been advised that you do not have the right under applicable State law or court order governing such matters as guardianship, separation, and divorce.

Each local lead agency shall keep a list of people obtaining access to early intervention records collected, maintained, or used under BCW (except access by parents and authorized employees of the participating agency), including the name of the person, the date access was given, and the purpose for which the party is approved to use the early intervention record.

If any early intervention record includes information on more than one child, you have the right to inspect and review only the information relating to your child, or to be informed of that specific

information. The local lead agency shall provide you, upon request, a list of the types and locations of early intervention records collected, maintained, or used by the agency.

A participating agency must make available to you an “initial copy” of your child’s early intervention record and a copy of each evaluation, assessment of your child, family assessment, and IFSP as soon as possible after each IFSP meeting at no cost to you. A participating agency may not charge a fee to search for or to gather the information. The local lead agency may charge a fee for copies of early intervention records which are made for parents under BCW if the fee does not effectively prevent you from exercising your right to inspect and review those early intervention records.

If you believe that information in the early intervention records collected, maintained, or used under BCW is inaccurate or misleading, or violates the privacy or other rights of you or your child, you may request that the local lead agency make changes to the information. The right to change records only applies to information about the parent and child, not other family members.

- The agency decides whether to make changes to amend the information in accordance with the request, within a reasonable period of time after receiving the request, but in no case not later than 30 calendar days from receipt of the request.
- If the agency refuses to make changes to the information as you requested, you will be informed of the refusal and be advised of the right to a hearing.

9. Right to a Hearing

- The local lead agency, on request, provides an opportunity for a due process hearing or a hearing directly under the state complaint procedure that are consistent with [FERPA](#) hearing requirements to challenge information in the early intervention records to insure that it is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child.
- If, as a result of the hearing, it is determined that the information is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, the local lead agency will change the information accordingly and will inform you in writing.
- If as a result of the hearing, it is determined that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, you will be informed of your right to place in the early intervention records of the child a statement commenting on the information and setting forth any reasons for disagreeing with the hearing decision.
- Any explanation placed in the early intervention records of the child under this section:
 - (a) Must be maintained by the local lead agency as part of the early intervention records of the child, as long as the early intervention record or contested portion (that part of the record with which you disagree) is maintained by such agency; and
 - (b) If the early intervention records of the child or the contest portion are disclosed by such agency to any party, the explanation must also be disclosed to the party.

A hearing held under this section must be conducted according to the procedures under the Family Education Rights and Privacy Act (FERPA), which is found in statute at 20 U.S.C. §1232g, and in regulations at 34 CFR [Part 99](#). These procedures may also be found in the Procedural Safeguards Policy.

Parental consent must be obtained before personally identifiable information is (1) disclosed to anyone other than officials of participating agencies collecting or using information under

BCW, subject to the next paragraph of this section; or (2) used for any purpose other than meeting a requirement under BCW.

Information from your child's early intervention record cannot be released to participating agencies (including the lead agencies and EIS providers) without your consent unless the agency participating in BCW is permitted to do so under [FERPA](#). If you and your child relocate to another BCW local program in Georgia, the records are sent to the new local program. Parental consent is not needed in the transfer of BCW records in this situation.

Local lead agencies are permitted to identify all children potentially eligible for services under Part B of the IDEA by sending information to the Georgia Department of Education and the appropriate local educational agency (LEA) (your local school program). BCW is required to provide directory information that includes child's name, birth date, and parent(s) contact information (including the parents' names, addresses, and telephone numbers) to the state educational agency (SEA) and the local educational agency (LEA) unless the parent opts out.

A parent has the choice to refuse to allow the local lead agency to send their child's name, birth date and parent's contact information to the local school local program where the child lives by signing an "Opt-Out" form and returning the original copy to the local Babies Can't Wait Office within 5 calendar days from the date that the information is presented to you.

The local lead agency must make reasonable efforts to make sure that you are fully aware of the nature of the referral and services that would be available under Part B and understand that your child will not be able to receive services unless consent is given to proceed with the referral.

The following safeguards must be in place to ensure confidentiality of records:

- Each local lead agency protects the confidentiality of personally identifiable information at collection, storage, disclosure, and destruction stages;
- One official of each local lead agency is responsible for ensuring the confidentiality of any personally identifiable information;
- All persons collecting or using personally identifiable information receive training or instruction regarding Georgia's BCW policies and procedures which comply with IDEA and [FERPA](#);
- Each local lead agency maintains, for public inspection, a current listing of the names and positions of those employees within the agency who have access to personally identifiable information;
- The local lead agency informs parents when personally identifiable information collected, maintained, or used under BCW is no longer needed to provide services to the child; and
- The information is destroyed, at the request of the parents. (However, a permanent early intervention record of the child's name, date of birth, parent contact information including address, phone number, names of Service Coordinator's and EIS providers and exit data shall be maintained.)

10. Parental Consent and Notice

Consent means that you as your child's parent or legal guardian:

1. Have been fully informed of all information about the activity for which consent is sought in your native language or other method of communication;
When used with respect to an individual with limited English means:

- a) *The language normally used by child or the parents of the child;*
 - b) *For evaluations and assessments, the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.*
2. Understand and agree in writing to the carrying out of the activity for which your consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and
 3. Understand that the granting of consent is voluntary on your part and may be reversed at any time.

Your written consent must be obtained before each:

1. Screening, evaluation(s) and assessment(s) of your child is conducted; (2) Early intervention services are provided; and
2. Prior to the use of public benefits or insurance and before disclosing personally identifiable information.

If you do not consent, the local lead agency shall make reasonable efforts to make sure that you:

1. Are fully aware of the nature of the evaluation and assessment or the services that would be available;
2. Understand that your child will not be able to receive the evaluation and assessment or services unless consent is given.

If you do not give your consent for an initial evaluation, the local lead agency may:

1. Provide you with information including handouts, brochures and a list of books or other materials;
2. Offer you resources you may contact to help your understanding of the value of early intervention and to address your concerns about participation in the BCW system;
3. Contact you, on an established time schedule to see if you changed your mind about participation in BCW.

In addition, as the parent of a child eligible under BCW, you may determine whether you, your child, or other family members will accept or refuse any early intervention service(s) under this program. You may also refuse such a service after first accepting it without losing other early intervention services under BCW.

Finally, you have the right to written notice of and written consent to the exchange of any **personally identifiable information** collected, used, or maintained under BCW. (See section on Confidentiality and Opportunity to Examine Records)

Prior written notice must be given to you five (5) calendar days before the participating agency or Early Intervention Service (EIS) provider proposes or refuses to initiate or change the identification, screening, evaluation, or placement of your child or the provision of early intervention services to your child and your family. The notice must inform you about:

1. The action that is being proposed or refused;
2. The reasons for taking the action;
3. All procedural safeguards that are available under BCW; and
4. The BCW complaint procedures, including a description of how to file a complaint and the timelines under these procedures. (See Dispute Resolution Options).

The notice must be:

1. Written in language understandable to the general public and provided in your native language, unless it is clearly not feasible to do so.
 2. If your native language or other method of communication is not a written language, the local lead agency shall take steps to make sure that:
 - a. The notice is translated verbally (orally) or by other means to you in your native language or other mode of communication;
 - b. You understand the notice; and
 - c. There is written evidence that the requirements of this section have been met.
- (2) If you are deaf, blind or have no written language, the method of communication must be that normally used by you (such as sign language, Braille, or oral communication).

11. Surrogate Parents

The rights of children eligible under BCW are protected even if:

1. No parent can be identified;
2. The local lead agency, after reasonable efforts, cannot locate a parent; or
3. The child is a ward of the state under the laws of Georgia.

The lead agency has 30 days to make reasonable efforts to ensure the assignment of a surrogate parent after a public agency determines that the child needs a surrogate parent. If the child is a ward of the state, the judge overseeing the infant or toddler's case may assign a surrogate parent.

An individual is assigned to act as a "surrogate" for the parent according to the following procedures. The procedures include a method for determining whether a child needs a surrogate parent and assigning a surrogate to the child. The following criteria are employed when selecting surrogates:

1. Surrogate parents are selected in the manner authorized by State LEA.
2. A person selected as a surrogate parent:
 - a. Has no interest that conflicts with the interest of the child he or she represents;
 - b. Has knowledge and skills that ensure adequate representation of the child;
 - c. Is not an employee of any state agency or a person or an employee of a person providing early intervention services to the child or to any family member of the child. A person who otherwise qualifies to be a surrogate parent under this section is not an employee solely because he or she is paid by a public agency to serve as a surrogate parent; and
 - d. Resides in the same general geographic area as the child, whenever possible.

A surrogate parent may represent the child in all matters relating to:

1. The evaluation and assessment of the child;
2. Development and implementation of the child's IFSPs, including annual evaluations and periodic reviews;
3. Providing early intervention services to the child;
4. Any other rights established under BCW.

12. Dispute Resolution Options

If you disagree with the local lead agency on the (1) identification, (2) evaluation, (3) placement of your child, or (4) provision of appropriate early intervention services to your child or family, you have the right to a timely resolution of your concerns through mediation,

state complaint, and/or an impartial due process hearing.

13. Mediation

Georgia offers mediation as a possible alternative to resolving disagreements. Mediation is viewed as voluntary and freely agreed to by both parties. Parties to disputes may request mediation at any time to resolve a matter regardless of whether a due process complaint or State complaint is filed. Parents/providers are not required to use it.

Mediation may not be used to deny or delay your right to an impartial due process hearing under BCW or any other rights under BCW. If mediation is requested, it must be completed within 30 calendar days of the initial request.

A request for mediation must be made to the local lead agency in writing. This request must be signed by the parties filing the request and should contain a statement listing the point(s) of disagreement related to the identification, evaluation, and placement of your child, or providing appropriate early intervention services to your child or family.

Georgia's BCW program uses a rotating list of qualified mediators who have experience and are knowledgeable in laws and regulations relating to providing early intervention services and provide mediation services throughout the state of Georgia. The mediator will be notified of the request for mediation. The mediator will contact both parties to review the complaint and the mediation process and to schedule a time and location for the mediation. The mediation will be scheduled in a timely manner and held in a location that is convenient to both parties. A qualified and impartial mediator who is trained in effective mediation techniques will meet with both parties to help them find a solution to the complaint in an informal, non-adversarial atmosphere. If either party chooses to have an attorney present for the mediation, the mediator must be notified at least 48 hours prior to the scheduled mediation.

A mediation agreement must be to the satisfaction of both parties. It must not conflict with state or federal law or policy of BCW. Both parties must sign the agreement. They are both given a copy of the written agreement at the end of the mediation. If the parties resolve a dispute through the mediation process, they must sign a legally binding written agreement that is enforceable in any State court of competent jurisdiction or in a local program court of the United States. The agreement is signed by both a parent and a representative of the lead agency who has the authority to bind the lead agency.

Discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent impartial due process hearings or civil proceedings. The parties to the mediation process may be required to sign a confidentiality pledge prior to the beginning of the process.

The BCW program is responsible for any costs that are associated with the mediation process. There is no cost to you as the parent(s).

At the same time, you may file a request for mediation and for an impartial due process hearing. If an agreement is reached in mediation, the hearing is canceled.

14. State Complaints

In addition to mediation (discussed in the previous section) an individual or organization,

including an individual or organization from another state, may file a signed complaint that any public agency or private service provider participating in BCW is violating a requirement of the Part C program. The complaint must include:

1. The signature and contact information for the complainant and if the alleged violations relate to a specific child, require that the complainant include the name and address of the child, a description of the nature of the problem, and a proposed resolution of the problem to the extent known and available at the time the complaint is filed. This includes a statement that a requirement of Part C has been violated by the local lead agency, and the facts on which the complaint is based.
2. Complaints must be mailed to:
Georgia Department of Public Health
Maternal and Child Health Section
Babies Can't Wait State Complaint
2 Peachtree Street, NW
11th Floor
Atlanta, GA 30303
3. The complainant must forward a copy of the complaint to the public agency or EIS provider serving the child at the same time the party files the complaint with the lead agency.
4. The complaint must be filed with the State Lead Agency within one year of the alleged violation.

Once the State Lead Agency has received the complaint, they have 60 calendar days (unless exceptional circumstances exist) to investigate the complaint and issue a decision that contains the facts and conclusions, and the reasons for the final decision. The individual or organization filing the complaint has the opportunity to submit additional information, either orally or in writing, about the complaint. The lead agency, public agency or EIS provider has an opportunity to respond to the complaint within 10 business days of the complaint. If the final decision indicates that appropriate services were/are not being provided, the State Lead Agency must address how to remediate the denial of those services, including, as appropriate, the awarding of monetary reimbursement or other corrective action. The State Lead Agency must also address appropriate future provisions of services for all infants and toddlers with disabilities and their families.

The state lead agency offers the opportunity for all of the parties involved to voluntarily engage in mediation.

If a complaint is received that is also the subject of a due process hearing, or contains multiple issues, of which one or more are part of that hearing, the State must set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action must be resolved within the 60-calendar day timeline using the complaint procedures described in this document.

If an issue is raised in a state complaint that has been previously decided in a due process hearing involving the same parties –

1. The hearing decision is binding; and
2. The Lead Agency must inform the complainant to that effect.

A complaint alleging a public agency's or private service provider's failure to implement a due process decision must be resolved by the Lead Agency.

If the disagreement (complaint) involves an application for initial services, your child and family must receive those services that are not in dispute.

15. Due Process Hearing

A due process hearing is a formal procedure conducted by an impartial hearing officer. The due process hearing must be completed, and a decision made and documented, within 30 calendar days of the request. (Mediation, if attempted, must occur within the same 30 calendar days).

As a parent(s), you may initiate a complaint by notifying the local lead agency, in writing, of the request for a due process hearing. You must sign the complaint and include a statement identifying the point(s) of disagreement related to the identification of your child being referred to BCW, evaluation, placement of your child, or providing appropriate early intervention services to your child or family. The local lead agency shall ensure that the process for resolving complaints is explained to you within five (5) business days of receipt of the complaint. The local lead agency shall inform you of any free or low-cost legal services and other relevant services available.

The Office of State Administrative Hearings (OSAH) will assign the hearing officer to conduct the hearing. Hearing officers are impartial persons appointed to conduct the due process hearing.

The hearing officer must:

1. Possess knowledge of, and the ability to understand, the provisions of the Individuals with Disabilities Education Act (IDEA) Part C, Federal and State regulations pertaining to the Act, and legal interpretations of the Act by Federal and State courts;
2. Possess the knowledge and ability to conduct hearings in accordance with appropriate, standard legal practice;
3. Perform the following duties:
 - Listen to the presentation of relevant views about the complaint/disagreement;
 - Examine all information related to the issues;
 - Seek to reach a timely resolution of the disagreement; and
 - Provide a record of the proceedings, documenting a decision which contains findings of fact, conclusions, and the reasons for the decision.

Hearing officers used in a due process hearing and mediators used in mediation must be "impartial." Impartial means that the person appointed to serve as the hearing officer (or mediator) of the due process proceeding:

1. Is not an employee of the lead agency or an EIS provider involved in providing early intervention services to or care of the child;
2. Does not have a personal or professional interest that would conflict with his or her objectivity in implementing the process;
3. Is not a local Board of Health official.

A person who is otherwise qualified under this section is not considered an employee of an agency solely because he/she is paid by the agency to implement the disagreement resolution process.

Under BCW, you are given the rights listed below in any due process hearing carried out under this section.

1. To be accompanied and advised by a lawyer and by individuals with special knowledge or training about early intervention services for children under BCW. If

either party plans to be represented by an attorney, they must notify the opposing party and OSAH within three (3) business days after receipt of the notice of the hearing.

2. To present evidence and confront, cross-examine, and to compel the attendance of witnesses;
3. To prohibit the introduction of any evidence at the proceedings that has not been disclosed to you at least five (5) calendar days before the hearing;
4. To obtain a verbatim (word by word) transcription of the hearing at no cost to you; and
5. To receive a written copy of the findings of fact and decisions at no cost to you as the parent.

Any proceedings for implementing the due process hearing in this section must be carried out at a time and place that is reasonably convenient to you.

No later than 30 calendar days after receipt of your disagreement (complaint), the due process hearing required under this section must be completed and a decision must be documented and mailed to each of the parties. However, the hearing officer may grant specific extensions of time beyond the 30-day timeline at the request of either party.

Any party not satisfied with the findings and decision of the due process hearing has the right to bring a civil action in state or federal court.

During the time-period of any proceeding involving a parent/provider disagreement (complaint), unless the local lead agency and you otherwise agree, your child and family will continue to receive the appropriate early intervention services identified in the IFSP that are agreed to by the parents. If the disagreement (complaint) involves an application for initial services, you child and family must receive services that are not in dispute.

If the disagreement (complaint) involves the initial eligibility for the BCW program, then no early intervention services shall be provided until a resolution is reached. If the disagreement (complaint) involves an application for initial services, your child and family must receive

APPENDIX F – Surrogate Parent Guidelines and Training Manual

This document is designed to guide and assist public local programs serving as Local Lead Agencies for the Part C early intervention system in Georgia. This manual will assist these agencies in fulfilling legal responsibilities to obtain informed, signed consent from parents or other appropriate individuals as specified in federal law (Individuals with Disabilities Education Act) prior to the proposal, initiation, change, and/or refusal of early intervention services. For some infants and toddlers, this may include the appointment and training of surrogate parents as required by the Individuals with Disabilities Education Act (IDEA). IDEA requires the State Lead Agency, the Georgia Department Public Health, to ensure that each local lead agency has a system in place for infants and toddlers in need of surrogate parents which includes (1) appointing qualified surrogate parents for them (2) provisions for training individuals appointed as surrogate parents.

This document will provide guidance for agency personnel who are responsible for ensuring that the surrogate parent provision of Part C regulations are followed. It will also provide information to assist in identifying children who are eligible for the protections of the surrogate parent provision and for implementation of surrogate parent procedures at the local level. Program administrators should use this document as guidance for establishing an appropriate surrogate parent system at the local level that includes:

- How to identify children and verify their eligibility for assignment of a surrogate parent;
- How to identify, train and appoint surrogate parents;
- How and when to recruit and train eligible individuals who may serve as appointed surrogate parents;
- How to coordinate these efforts with other service providers for the benefit of all involved, especially the children; and
- How to obtain assistance in these efforts, if necessary.

This document is intended to be utilized as a resource manual to determine who may provide consent for infants and toddlers to participate in Babies Can't Wait and to provide guidance related to the training of surrogate parents. It also offers detailed guidelines for program administrators who need to establish and maintain best practices when establishing local procedures for linking eligible children with surrogate parents.

3. IDEA Requirements

The Individuals with Disabilities Education Act (IDEA) includes specific provisions to ensure that all children with disabilities have a “parent” to act on their behalf.

According to § 303.27 of the 2004 Reauthorization of IDEA (ACT) Final Part C Federal Regulations 2011) a “parent” is:

1. A biological or adoptive parent of a child unless the biological or adoptive parent does not have legal authority to make educational or early intervention service decisions on behalf of the child, then other qualified person(s) must be presumed to be the “parent” for purposes of Part C of IDEA;
2. A foster parent, unless State LEA, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent; *
3. A guardian generally authorized to act as the child’s parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);

4. An individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or a person who is legally responsible for the child's welfare;
5. An individual appointed to be a surrogate parent, in accordance with
6. [§303.422](#) or section 639 (a) (5) of the Act.

In accordance with Section 602(23) of the Act a surrogate parent must be appointed to ensure that the rights of eligible children are protected if:

1. No parent can be identified;
2. After reasonable efforts, the whereabouts of the parent cannot be discovered; or
3. The child is a ward of the State (pursuant to Georgia State LEA).

According to [§303.37](#) of Part C Regulations 2011 IDEA defines a “**ward of the State**” as “a child who, as determined by the State where the child resides, is a foster child, is a ward of the State, or is in the custody of a public child welfare agency.” IDEA notes that the term “does not include a foster child who has a foster parent who meets the definition of a parent in Section [§ 303.27](#).”

In Georgia, a juvenile court can transfer temporary legal custody of a child found to be deprived to the Division of Family and Children Services (DFCS) since it is the child welfare agency of the State and is authorized by law to receive and provide care to children. O.C.G.A. §§ 49-5-8, 15-11-55(a)(2)(C). Once DFCS receives temporary legal custody of a child pursuant to a court order, it is deemed the legal custodian of the child and is authorized to determine the care and treatment needed for the child, including medical care and education. O.C.G.A. §§ 15-11-2(5), 15-11-13. **A surrogate parent, therefore, can be assigned to a foster child once that child is in DFCS custody and before the court has terminated parental rights.**

“The confidentiality rights and protections in [§§303.401 through 303.417](#) are available to an individual who meets the definition of a parent in [§ 303.27](#), which expressly includes foster parents, and any individual appointed as a surrogate parent under [§303.422](#). However, [§303.422](#)(d)(2) excludes from serving as a surrogate parent for a child, an employee of the lead agency or any other public agency or EIS provider that provides any services to the child or a family member of that child. Thus, the confidentiality rights and protections available to parents under [§§303.401 through 303.417](#) would not be available to agencies responsible for the care of infants and toddlers not residing at home or to the employees of such agencies.”

In Georgia, a foster parent may be appointed as a child's surrogate parent since there is no conflict of interest between the foster parent and the child, and because the foster parent has the requisite knowledge and skills to adequately represent the child. Foster parents are not deemed employees of DFCS, but rather its agents. DFCS provides a per diem to foster parents to assist them with costs associated with caring for the child. This, by itself, does not disqualify a foster parent from serving as a child's surrogate parent. 20 U.S.C. § 1439(a)(5).

2. Foster Parents

If a foster parent meets the foster parent criteria, the foster parent may be considered the parent, and there is no need for the appointment of a surrogate parent. (While foster parents receive reimbursement for the care of a child, they are not employees of the

Georgia Division of Family and Children Services; therefore, this does not constitute an inherent conflict of interest.) When there is a foster parent, the Babies Can't Wait Service Coordinator is still responsible for ensuring that a copy of the court order stating that DFCS has legal custody of the child is maintained in the child's Babies Can't Wait record. The DFCS case worker is responsible for providing a copy of the juvenile court order appointing DFCS as temporary legal custodian of a child to C1st and Babies Can't Wait each time a child is referred to Babies Can't Wait.

When the foster parent serves as the parent, the foster parent has the authority to sign the Individualized Family Service Plan (IFSP) and all related documents, forms, and releases. The DFCS caseworker should sign the IFSP document as a participating team member (not the parent) and should participate in the development and implementation of the IFSP.

If the foster parent is unwilling to serve as the parent, a surrogate parent must be appointed. When the surrogate and foster parent are different, the ultimate decision relating to the provision of Babies Can't Wait early intervention services is determined by the surrogate parent.

3. Person Acting in the Place of a Parent

As stated above, a person acting in the place of a parent such as grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare may be considered the child's parent under IDEA. Before assuming a grandparent or relative is the "parent" under IDEA, the Babies Can't Wait Service Coordinator must interview the person and use Form BCW009 to document that the child lives with the individual and that this person is responsible for the child's day-to-day care.

Documentation of the determination of a "person acting in the place of the parent" (Form BCW009) must be kept in the child's Babies Can't Wait early intervention record. Documentation must include, at a minimum, results of interviews with the person acting in the place of the parent and a face-to-face visit.

Based on case-by-case circumstances concerning a biological parent's absence/return, it must be understood by everyone involved that any time there is an individual acting in the place of the parent, and the parent returns legitimately, all rights immediately revert to the parent (as long as parental rights have not been terminated through the court system). A person whose role is a caregiver and whose contact is only incidental (e.g., babysitter, caretaker, childcare worker) cannot assume the role or responsibility of a parent.

4. Surrogate Parents

A surrogate parent is an individual who has been appointed to represent a child in all matters related to Babies Can't Wait early intervention services. A surrogate parent's responsibility is to ensure that the child is provided with appropriate early intervention services under Part C of IDEA. The surrogate parent has the right to make decisions relating to the development and implementation of the child's Individualized Family Service Plan (IFSP) including evaluation, assessment, ongoing provision of services, annual evaluations and periodic reviews and any other rights established under Part C regulations.

The surrogate parent must always act in a manner that he/she believes is in the best interest of the child. A surrogate parent is not liable to the child for damages that result from any act or

omission in representing the child in decisions relating to participation in early intervention. The surrogate parent would be liable for gross or willful acts of negligence or misconduct.

5. Who Can Be a Surrogate Parent?

[§303.422](#)(d)(2) An employee of the lead agency or any other public agency or EIS provider that provides any services to the child or a family member of that child are excluded from serving as a surrogate parent for a child. Thus, the confidentiality rights and protections available to parents under [§§303.401 through 303.417](#) would not be available to agencies responsible for the care of infants and toddlers not residing at home or to the employees of such agencies.

A person who otherwise qualifies to be a surrogate parent is not considered an employee solely because he or she receives payment by a public agency to serve as surrogate parent. A surrogate parent must:

- Be a citizen of the United States, a resident of the state of Georgia, and above the age of 18;
- Have no personal or professional interest that conflicts with the interest of the child he/she represents;
- Have sufficient knowledge and skill to ensure adequate representation of the child;
- Have time and the desire to become involved in the early intervention process; and
- Possess an understanding of the cultural and linguistic background of the child(ren) he/she represents.

6. Surrogate Parent Responsibilities

What does a surrogate parent do?

1. Visits the child and observes the child's development and environment, as appropriate;
2. Attends the child's evaluations and assessments as appropriate;
3. Participates in the development of the child's IFSP;
4. Participates in development of annual IFSPs and reviews;
5. Reviews the child's Babies Can't Wait record to become familiar with the child as needed;
6. Exercises independent judgment in pursuing the child's interests within early intervention;
7. Represents the child within the Babies Can't Wait early intervention system.

Appointment as a surrogate parent does not mean the surrogate parent has authority over care and maintenance, financial support of the child, custody of the child, foster home placement, or any other matters that **are not** directly related to Babies Can't Wait early intervention services. The Babies Can't Wait Service Coordinator or other responsible designee must document review of a surrogate parent's responsibilities and explanation of the rights of a surrogate parent on Form BCW011 (Surrogate Parent Responsibilities).

7. Surrogate Parent Rights

The surrogate parent has the same rights and privileges of any parent under Babies Can't Wait. These include, but are not limited to:

1. Right to inspect, review, and obtain copies of all early intervention records related to the child;

2. Right to mediation, due process and initiation of a complaint;
3. Right to receive prior written notice of actions proposed or refused by the Babies Can't Wait system;
4. Right to refuse evaluations, assessments, and services;
5. Right to all procedural safeguards;
6. Right to protect the confidentiality of identifiable information collected, maintained or used by the lead agency or Babies Can't Wait Service Coordinator;
7. Right to represent the child in all matters relating to identification, evaluation assessment of the child and the provision of services within natural environments.

Early Intervention information is used to obtain supports for the child and cannot be shared outside of that context. The surrogate parent is responsible for keeping confidential any information he/she gathers from the child's records or the child's service providers. The surrogate parent must return any Babies Can't Wait information related to the child to the Babies Can't Wait Service Coordinator upon termination as a surrogate parent.

8. Appointment of Surrogate Parents

The Babies Can't Wait local program office that serves the county in which the child resides will appoint a surrogate parent only after a determination has been made and documentation provided that the parent as defined in 34CFR [§ 303.27](#) cannot be identified, the agency after reasonable efforts cannot discover the whereabouts of the parent as defined in 34CFR [§ 303.27](#) or the child is a ward of the state of Georgia. The lead agency is required to make reasonable efforts to ensure that a surrogate parent is assigned **not more than 30** days after the lead agency, or a public agency determines that the child needs a surrogate parent. [§303.422\(g\)](#)

“In the case of a child who is a ward of the State, the surrogate parent, instead of being appointed by the lead agency under paragraph (b)(1) of this section, may be appointed by the judge overseeing the infant or toddler’s case provided that the surrogate parent meets the requirements in paragraphs (d)(2)(i) and (e) of this section.” IDEA 2004 Final Federal Regulations 2011, [§303.422](#)

To determine if a child is a ward of the state, the Babies Can't Wait Service Coordinator must obtain a copy of the court order stating that DFCS has legal custody of the child. DFCS case workers will be responsible for providing a copy of the juvenile court order appointing DFCS temporary legal custodian of a child to C1st and Babies Can't Wait each time a child is referred to the program. The court order provides DFCS with the right to act as the parent of the child.

DFCS cannot, however, act as the parent of the child for Babies Can't Wait purposes, since IDEA expressly requires that surrogate parents be named for children who are wards of the state. Foster parents may serve as surrogate parents. Once the Babies Can't Wait Service Coordinator has the court order, it can serve as the documentation that a surrogate appointment is necessary.

If a court has appointed a person to be a legal guardian, established in accordance with O.C.G.A. 15-11-30.1 or 29-4-1 et seq., for a child referred to Babies Can't Wait, a surrogate parent is not required. Documentation of guardianship or legal custody must be maintained in the Babies Can't Wait record.

A surrogate parent **cannot** be appointed simply because a natural/adoptive parent or legal guardian does not agree with the early intervention system's proposal regarding identification,

evaluation, and/or individualized family service plan supports and services. A surrogate parent cannot be appointed because the early intervention lead agency believes that the family is not cooperating. In these situations, the local program must make and document every effort to involve the child's natural/adoptive parent or legal guardian as well as respect their right to disagree and/or to decline early intervention services.

The appointment of a surrogate parent may not be utilized to circumvent the procedures for gaining parental consent for eligibility determination, evaluations, assessments or any other early intervention process requiring consent.

In situations where a natural/adoptive parent or legal guardian disagrees with the agency's initial evaluation or intervention proposals, Babies Can't Wait cannot circumvent their right to due process by appointing a surrogate parent. It should also be noted that IDEA does not allow assignment of a surrogate parent for a child whose natural/adoptive or legal guardians who are simply uncooperative.

9. Termination of Surrogate Appointments

A surrogate parent appointment can be terminated when:

1. The child is no longer eligible for the Babies Can't Wait program;
2. The surrogate parent is no longer willing to serve;
3. The parent who was previously not identified or whose whereabouts were not known is now available;
4. A conflict of interest arises;
5. The Babies Can't Wait local program office and/or DFCS has reason to believe that a surrogate parent is not fulfilling their responsibilities or concerns arise with the surrogate parent;
6. The surrogate parent is no longer eligible under the eligibility criteria set out in these guidelines;
7. The child's permanency plans change;
8. The child's placement changes.

Termination of the appointment of a surrogate parent must be justified through documentation. If a surrogate parent wishes to stop serving in that role, the surrogate parent must notify the Babies Can't Wait Service Coordinator in writing at least 15 calendar days before terminating services as a surrogate parent.

Termination of the appointment of a surrogate parent may **not** be based on the surrogate parent's requests for a due process hearing, filing of a complaint, requests for copies of the child's records, challenges to the content of the child's record, or requests for independent evaluations. The surrogate parent has the right to request a hearing to challenge the non-renewal if non-renewal occurs.

10. Parental Involvement for Children with a Surrogate Parent

For some children, an individual other than the natural or adoptive parent will be providing the necessary consents for participation in early intervention. However, it is important to continue to involve natural and adoptive parents in their child's participation in early intervention, particularly when reunification is a long-term goal for the child and family and when it is not contraindicated due to established negative impact on the child. Where appropriate, the Babies Can't Wait Service Coordinator, therefore, must make and document reasonable efforts to involve each child's natural or adoptive parent(s) in the early intervention

system. Minimally, efforts must be made to invite and involve parent(s) in initial evaluation, assessment, and individualized family service plan (IFSP) development for eligible children. This requirement is waived if it has been determined that reunification is not a long-term goal for the child and family and/or extreme detriment or negative impact on the child has been documented.

“Reasonable efforts” must include a combination of attempts consisting of documented telephone calls, certified letters with receipts, visits to the parent’s last known address, and/or documented contacts with relatives, neighbors, and other agencies. A minimum of three attempts to contact must be documented inviting participation in initial evaluation/assessment and IFSP development activities. These contacts may be phone calls/phone messages, email contacts, letters, and/or home visits. At least two different forms of communication, such as home visit and phone call or letter and email, must be used and documented if multiple attempts are necessary. Multiple attempts may be needed in order to provide varied opportunities and times during which families may receive communication and provide responses. The “reasonable effort” clause is intended to ensure an active search for the parents of a child with a disability or a child suspected of having a disability.

Minimum contacts must be attempted and adequate response time (at least 2 working days for telephone calls/phone messages and 5 business days for letters) allowed following each contact attempt. Contacts in excess of three may occur as appropriate. Documentation of these attempts must be maintained in the child’s Babies Can’t Wait record.

11. Responding to Court Orders and Subpoenas

Judges may issue court orders and/or subpoenas designed to facilitate and expedite the release and sharing of individual child-specific information with entities involved in a child’s case. Under the Family Education Rights and Privacy Act (FERPA), 34 CFR [Part 99](#) Subpart D, Section 99.31 Paragraph (a)(9)(i) and (a)(9)(ii), Babies Can’t Wait may disclose information in accordance with a judicial order or subpoena only after making reasonable efforts to notify the natural /adoptive parent(s) or legal guardian of the order or subpoena prior to compliance with it. “Reasonable efforts” must include a combination of attempts consisting of documented telephone calls, certified letters with receipts, visits to the parent’s last known address, and/or documented contacts with relatives, neighbors, and other agencies. A minimum of three attempts to contact must be documented. These contacts may be phone calls/phone messages, email contacts, letters, and/or home visits. It is required that at least two different forms of communication, such as home visit and phone call, letter and email, be used if multiple attempts are necessary, in order to provide varied opportunities and times during which families may receive communication and provide responses. Adherence to the requirements for reasonable efforts must be attempted and documented to occur w i t h i n 10 business days of receipt of a judicial order or subpoena. If contact with the parent, in accordance with the reasonable effort provisions, cannot be established within 10 business days, Babies Can’t Wait shall proceed to respond to the court order and/or subpoena by releasing the requested information.

12. Responsibilities of the Babies Can’t Wait Service Coordinator

(Or designee as determined by the local program Early Intervention Coordinator)

If it is determined that a surrogate parent is needed for a child receiving Babies Can’t Wait services, the Babies Can’t Wait Service Coordinator must complete the appropriate forms as listed below, attach required documentation, and forward it to the Babies Can’t Wait local

program office for inclusion in the child's Babies Can't Wait early intervention record. In addition, the Service Coordinator must:

- Where appropriate, make a reasonable effort to locate the natural/adoptive parent(s) or legal guardian and invite them to participate in initial evaluation/assessment and IFSP development activities. "Reasonable efforts" include a combination of attempts that may consist of documented telephone calls, certified letters, visits to the parent's last known address, and documented contacts with relatives, neighbors, and other agencies. A minimum of three attempts to contact must be documented prior to appointing a surrogate parent. These contacts may be phone calls/phone messages, email contacts, letters, and/or home visits. It is required that at least two different forms of communication, such as home visit and phone call, letter and email, be used if multiple attempts are necessary, in order to provide varied opportunities and times during which families may receive communication and provide responses. Minimum contacts must be attempted and adequate response time (at least 2 working days for telephone calls/phone messages and 5 working days for letters) allowed following each contact attempt. Contacts in excess of three may occur as appropriate. Documentation of these attempts must be maintained in the child's Babies Can't Wait record;
- Complete the Documentation of a Person Acting in the Place of a Parent Form BCW009 for submission to the Babies Can't Wait Office, when appropriate;
- Obtain the completed Surrogate Parent Application Form BCW010 from the prospective surrogate parent, when appropriate;
- Complete the Surrogate Parent Responsibilities Form BCW011, Verification of Surrogate Parent Training Form BCW012, and Surrogate Parent Appointment Form BCW013 for submission to the Babies Can't Wait local program Office, when appropriate.

13. Babies Can't Wait Local Program Responsibilities

Each local lead agency has the responsibility for recruiting, training and appointing surrogate parents. If local lead agencies develop local policies or procedures in addition to state BCW guidelines, they must be consistent with the Babies Can't Wait guidelines. Local policies and procedures may be more rigorous than State policies and procedures but may not be less so.

Each local lead agency must develop and maintain a list of eligible individuals to serve as surrogate parents. In developing the local listing, it may be necessary for a local lead agency to go beyond jurisdictional limits in generating a list of potentially qualified surrogate parents. Potential surrogate parents may be identified through collaboration with local school systems that have similar requirements for surrogate parents and training under Part B of IDEA. Individuals who are not on the local lead agency's list may be eligible to serve as surrogate parents, subject to the local lead agency's discretion. It should be noted, however, that geographic proximity is essential to the surrogate parent/child relationship. The needs of the individual child and the availability of qualified persons who are familiar with the child and who would otherwise qualify shall be considerations in the local lead agency's determination of surrogate eligibility.

14. Surrogate Parent Training

The role of a surrogate parent is especially important since the individual who is appointed as a surrogate parent will represent the child in all decisions regarding early intervention services. Surrogate parents must have access to information, training and support so they can develop the

knowledge, skills and confidence necessary to advocate effectively for children with disabilities.

For individuals who are interested in becoming a surrogate, training will be provided in order to ensure a “pool” of qualified and trained persons. It is the responsibility of the Babies Can’t Wait local program offices to offer the same information, materials, and training to surrogate parents as is offered to other parents and to ensure that surrogate parents have appropriate training and/or comparable experience.

Training for Surrogate Parents must include:

1. Introduction to Part C of the Individuals with Disabilities Education Act of 2004
- New Part C Regulations 2011;
2. Standards governing the Babies Can’t Wait Early Intervention System, including the federal regulations requiring the appointment of a surrogate parent;
3. The rights and responsibilities of parents, surrogate parents, and the children they represent;
4. Common abbreviations, acronyms, and terminology used during the Early Intervention process;
5. Procedures for referral, evaluation/assessment, eligibility determination, and re-evaluation/re-determination of eligibility;
6. Role of Service Coordinator;
7. Procedures for developing and implementing the Individualized Family Service Plan, including the roles and responsibilities of parents/surrogate parents;
8. Protections and procedural safeguards available to infants and toddlers with special needs and parents/surrogate parents to ensure that the needs of children are met, including access to records and confidentiality;
9. Early Intervention supports and services;
10. Transition;
11. An overview of the Surrogate Parent Guidelines and Training Manual.

Information to be used for Surrogate Parent Training may be found in the BCW Policy Manual.

15. Surrogate Parent Procedures

The following are guidelines for assigning surrogate parents for infants and toddlers eligible for early intervention/Babies Can't Wait.

1. **Identification of Children in Need of a Surrogate Parent**
 - a. The Local Lead Agency (local program) for Babies Can't Wait identifies the child in need of a surrogate parent.
 - b. The Local Lead Agency (local program) obtains a copy of the court order and documentation of effective dates of custody.
 - c. When appropriate, the Local Lead Agency (local program) completes the Documentation of a Person Acting in the Place of a Parent Form BCW009.
 - d. The Local Lead Agency places a copy of the above documentation in the child's Babies Can't Wait record.
2. **Selection, Appointment and Training of Surrogate Parents**
 - a. The Local Lead Agency (local program) for Babies Can't Wait identifies prospective surrogate parents, as needed, for eligible infants and toddlers.

Note: In the case of a child who is a ward of the State, the surrogate parent, instead of being appointed by the lead agency under paragraph (b)(1) of this section, may be appointed by the judge overseeing the infant or toddler’s case provided that the surrogate parent meets the requirements in paragraphs (d)(2)(i) and (e) of this section.” IDEA reauthorization 2004, revised Part C Regulations 2011 §303.422

- b. Prospective surrogate parents complete the Surrogate Parent Application Form - BCW010.
- c. The designee from the Local Lead Agency completes the Surrogate Parent Responsibilities Form - BCW011.
- d. Training of new surrogate parents is completed by Local Lead Agency designee(s) and documented using the Verification of Surrogate Parent Training Form – BCW012.
- e. The designee from the Local Lead Agency completes the Surrogate Parent Appointment Form – BCW013.
- f. The original copy of each of the completed forms is placed in the child’s Babies Can’t Wait record.
- g. If a surrogate parent is actively involved in representing and making decisions for a child enrolled in Babies Can’t Wait, training should be updated only as necessary based upon policy or regulatory changes in IDEA or BCW. Trained surrogate parents who have not been actively involved in representing a child within the prior twelve-month period must be re-trained prior to representing a new child within Babies Can’t Wait.

16. Frequently Asked Questions

Frequently Asked Questions - The Appointment of a Surrogate Parent

Q1 Must a surrogate parent be appointed if the parents and their location are known, but they have moved out of the area?

A1 No, a surrogate parent should not be appointed because an individual who fits the definition of “parent,” per Section 602(23) of IDEA, can be located and contact can be made. The biological parent(s) should be contacted and should be asked to provide necessary consents.

Q2 Should a surrogate parent be appointed where the parents leave the state for one year (for work-related reasons, incarceration, etc.)?

A2 No, the appointment of a surrogate parent is not required when the parents leave the state for a year as long as the parents can be identified and located and have not lost their parental rights. Although not required, it could assist the public agency to have the parents sign a document indicating that another party will be speaking for the parents regarding the early intervention needs of the child while the parents are out-of-state.

There is no guidance from the United States Department of Education Office of Special Education Programs (OSEP) on what should be included in the document stating that the party is speaking for the parent regarding the early intervention needs of the child. This document does not need to be notarized but must have the parent’s signature. This document must be filed in the child’s Babies Can’t Wait record. Potential wording might include:

“_____ has my permission to act on my behalf only regarding decisions made concerning my child, _____ during his/her involvement in Georgia’s Part C early intervention services, beginning on _____ (start date) and ending on _____ (end date). This would include participation in evaluations/assessments,

development of IFSP's, IFSP reviews, provision of early intervention services, transition out of early intervention as appropriate, protection of my child's rights and safeguards through signature on procedural safeguard forms and receipt of Notice of Infant/Toddler and Family Rights Under Babies Can't Wait."

Q3 Should a surrogate parent be appointed where the parents in the military are deployed out of state or out of the country for an extended period of time?

A3 As preparation for deployment, parents in the military typically prepare a Special Power of Attorney that empowers their chosen guardian (primary and alternate) to act "in loco parentis" and make decisions on behalf of the child. The designated guardian would be documented using Form BCW009 and would have the authority to make decisions related to the child's participation in Babies Can't Wait.

Q4 Should Babies Can't Wait appoint a Surrogate Parent if the mother is incarcerated (either locally or within another region/state) and the father's whereabouts are unknown?

A4 If the child is living with a relative such as grandmother, is the grandmother acting in the place of a parent? A person "acting in the place of a parent" is defined as a grandparent, or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare (34 CFR 303.19). If the grandparent is "acting in the place of the parent," then a Surrogate Parent would not need to be assigned. If the child is living with a "family friend," how long will the child be living with this individual? If this is to be a short-term arrangement, it would be best to assign a Surrogate. If the parent has provided documentation that this individual has the authority to make medical decisions for this child, then Babies Can't Wait does not need to assign a surrogate parent.

In both situations, the BCW Service Coordinator must verify specific information related to the individual "acting in place of parent" through completion of the Documentation of Person Acting in the Place of a Parent Form BCW009. It is highly recommended that the Service Coordinator request a copy of any documentation that the parent has provided indicating that the family member or friend can make decisions for the child for inclusion in the child's record.

Q5 The DFCS staff in my community says that they must sign all forms related to Part C as they have legal custody of the child. This seems to be in contradiction to what I'm hearing other people say. What should I do?

A5 Social Workers are an important and valuable asset to the child and IFSP Team. Accordingly, they should be involved to the fullest extent possible and invited to the IFSP and other relevant meetings. Even if a representative from the Division for Family and Children's Services (DFCS) is the legal guardian, no DFCS personnel can serve as a "Surrogate" or "parent" under Part C (unless they are acting on behalf of their own child). DFCS personnel may not provide official consent on BCW forms related to the evaluation and/or assessment of the child, development and implementation of the child's IFSPs including annual evaluations and periodic reviews; the ongoing provisions of early intervention services to the child; and any other rights established under this part [34 CFR [303.406](#)(e)]. This would include Procedural Safeguard forms, the initial and annual IFSPs and any IFSP reviews, Release of Information forms (if the information is related to the information stated above), and a Request for Dispute Resolution.[[§303.422](#)(d)(2) excludes from serving as a surrogate parent for a child, an employee of the lead agency or any other public agency or EIS provider that provides any services to the child or a family member of that child. Thus,

the confidentiality rights and protections available to parents under [§§303.401 through 303.417](#) would not be available to agencies responsible for the care of infants and toddlers not residing at home or to the employees of such agencies.”]

If a social service worker continues to have difficulty understanding this, clarify that Part C is under the Individuals with Disabilities Education Act, just like Part B. They may also want to request additional assistance from DFCS Legal Services. This may help them to understand.

Q6 Who is responsible for determination of the need for and the assignment of a surrogate parent for an infant or toddler with special needs who is referred to Babies Can't Wait?

A6 The State Lead Agency for Babies Can't Wait has established procedures to ensure the appointment of a surrogate parent, when necessary, for infants and toddlers who are eligible and enrolled in Babies Can't Wait throughout Georgia. The Babies Can't Wait local program office (Local Lead Agency) serving the county in which the child currently resides is responsible for the determination of the need for and the assignment of a surrogate parent in compliance with these established procedures. Note: In the case of a child who is a ward of the State, the surrogate parent, instead of being appointed by the lead agency under paragraph (b)(1) of this section, may be appointed by the judge overseeing the infant or toddler's case provided that the surrogate parent meets the requirements in paragraphs (d)(2)(i) and (e) of this section.” IDEA reauthorization 2004, revised Part C Regulations 2011 [§303.422](#)

Q7 What does FERPA (Family Educational Rights and Privacy Act) 20 U.S.C. 1232g or the Buckley Amendment say about surrogate parents?

A7 The Buckley Amendment is the federal law known as the Family Educational Rights and Privacy Act (FERPA) that gives parents and guardians of children under 18 years of age the right to inspect, review, and correct their child's educational records, including early intervention records. Parents, including surrogate parents, are allowed to inspect and review any records relating to their children that are collected, maintained, or used by the early intervention system. Parents also have the right to request that BCW correct records that they believe are inaccurate or misleading. [FERPA](#) also ensures that BCW must have signed permission from the parent in order to release any information from a child's early intervention record, with few exceptions.

Frequently Asked Questions - Foster Parent as a Surrogate Parent

Q1 When a child is placed in foster care, is a surrogate parent always needed?

A1 A surrogate parent should not routinely be appointed for every child in foster or other substitute care. If a foster parent meets the criteria identified on Page 2 of this manual, the foster parent may be considered the parent and there is no need for the appointment of a surrogate parent. If a foster parent is unable or unwilling to serve as a parent to participate in the Part C program, a surrogate parent should be considered. In this instance, the individual functioning as the surrogate parent would provide consent only for those activities related to service delivery in the early intervention system.

Q2 If a child is in foster care and the parental rights HAVE NOT been terminated, does a release of information need to be signed to share information (IFSP, coaching tips, etc.) with the foster parent?

A2 No. The Part C information related to the child is confidential and since the foster parent is authorized under 34CFR [§ 303.27](#) to act as the parent for the child, the foster parent is the

individual who must give permission to release information to other individuals and/or agencies.

A release of information would also need to be signed in order to share information with DFCS and any private caseworker(s) involved with the child unless otherwise court ordered.

Q3 If a child is in foster care and the parental rights HAVE been terminated (surrogate parent is assigned and is NOT the foster parent), and the biological parents want to participate in early intervention with their child, would a release of information need to be signed to share information with the biological parent? If so, who would sign this?

A3 Since neither the parent, neither social services nor the foster parent have any “rights” related to this child under Part C, releases of information must be signed. The release of information would need to be signed by the Surrogate Parent in order for the biological parent, Social Services and/or the foster mother to participate in any part of early intervention and/or to receive any information about the child. Confidentiality about the child must be maintained.

Q4 If a child is in foster care and the parental rights HAVE been terminated (the foster parent has been assigned as the surrogate parent) and the biological parents want to participate in early intervention with their child, would a release of information need to be signed to share information with the biological parent? If so, who would sign this?

A4 Since neither the parent nor social services has any “rights” related to this child under Part C, a release of information must be signed. The release of information would need to be signed by the Surrogate Parent in order for the biological parent and Social Services to participate in any part of early intervention and/or to receive any information about the child. **Confidentiality about the child must be maintained.**

Q5 The biological mother wants to participate in the provision of early intervention services, but the services are provided in the foster parent’s home. The biological parents are not to have knowledge of where the foster parent resides. How should this situation be handled?

A5 This may need to be handled on a case-by-case basis. Early intervention supports and services are provided within the daily routines, activities and places of families. In this situation, it might be important to know if re-unification of the child with the biological parent(s) is a goal and in what timeframe this is hoped to be accomplished. If re-unification of the child and his/her biological parent is the goal, it is important to continue to involve natural and adoptive parents in their child’s participation in early intervention. In such situations, the Babies Can’t Wait Service Coordinator must make and document reasonable efforts to involve each child’s natural or adoptive parent(s) in the early intervention system.

Efforts must be made to invite and involve parent(s) in initial evaluation, assessment, and individualized family service plan (IFSP) development for eligible children. The IFSP Team should consider this information as they develop outcomes, short-term goals, learning opportunities and location of services. It will be important for the IFSP Team to consider the daily activities, routines and environments of the biological parent in addition to those of the foster family.

If re-unification of the child with the biological parent(s) is not a goal, then the IFSP Team must look at all of the daily routines, activities and places in which the foster family participates. The IFSP Team, in collaboration with the DFCS caseworker, should determine acceptable means and levels of participation by the biological parents that would not intrude on the confidentiality of the foster parent. Types of participation should be specified in IFSP strategies.

Extreme caution must be exercised in order to ensure the privacy of foster parent(s) whose identity and/or whereabouts in some situations should not be known to a child's biological parent(s). The Babies Can't Wait Service Coordinator must communicate with the DFCS case worker to ensure appropriate handling of such situations.

Q6 If a relative or private individual (i.e., a non-relative) has been allowed to act as parent by a natural parent, should a surrogate parent be appointed?

A6 No, a surrogate parent would not be appointed under these circumstances. A person acting in the place of a parent such as a grandmother or stepparent with whom the child lives or a person who is legally responsible for the welfare of the child has the authority to represent the child in early intervention matters. Consequently, the child does not require a surrogate parent. Such determination would be documented using Form BCW009.

Any time there is someone acting in the place of the parent, and the parent returns, all rights immediately revert to the parent (as long as parental rights have not been terminated through the court system).

Q7 Can an adult relative sign consent for early intervention services for a child even if that relative does not have legal documentation denoting them as parent?

A7 Georgia's Babies Can't Wait Policy manual state that a child's rights are protected through appointment of a surrogate parent if no parent can be identified, the whereabouts of a parent cannot be determined, or if the child is a ward of Georgia (i.e., the legal custody of the child and all parental rights and responsibilities for the care and custody of the child have been terminated by court order or permanent entrustment agreement pursuant to applicable law). Children who are suspected of being or are determined to be eligible under this part do not require a surrogate parent if someone is acting in the place of a parent. Under federal Part C regulations, the term 'parent' has been defined to include an "individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or a person who is legally responsible for the child's welfare."

Persons acting in the place of the parent may do so with the permission of the parent. In the particular question posed above, a specific answer would require more detailed information. If the adult relative has permission from the parent to act in the place of the parent, then that adult relative may sign consent for early intervention services. Permission from the parent may be a letter from the parent stating that this adult relative may seek medical or educational services for their child (it does not need to be notarized or on an "official" form of any kind).

If, however, the adult relative does not have that signed parental permission, then the situation must be evaluated against the criteria above to determine whether a surrogate

parent must be appointed. The following are questions to consider in determining whether this adult relative is acting in the place of the parent:

1. Is the adult relative aware of the parents' whereabouts and able to contact the parent(s)? If so, permission for the adult relative to act in the place of the parent may be sought/confirmed in writing by contacting the parent.
2. Does the child live with this adult relative? If, for instance, this is an established, long-term living arrangement and the adult relative is unable to contact the parent because his or her whereabouts are unknown, then this adult relative may be considered to be acting in the place of the parent even without signed permission from the parent.
3. Is the child a ward of the State of Georgia? If so, then a surrogate parent must be assigned.

Such determination would be documented using Form BCW009.

Any time there is an individual acting in the place of the parent, and the parent returns, all rights immediately revert to the parent (as long as parental rights have not been terminated through the court system).

Q8 What are some examples/scenarios related to determining when a person is acting in the place of a parent or when a surrogate parent is needed?

A8 **Example 1:** Grandparent refers child to the local Part C system, child lives with grandparent, and grandparent does not know how to contact natural parents.

Based upon the information available and assuming the child is not a ward of Georgia, the grandparent is acting in the place of the parent. The grandparent would be allowed to make early intervention decisions for the child, and no surrogate parent is needed.

Example 2: Grandparent refers child, child lives with grandparent, grandparent has letter from natural parent (not notarized) giving grandparent permission to consent to medical care for child, no court action has been taken to determine custody, grandparent does not know how to contact natural parent.

Based upon the information available and assuming the child is not a ward of Georgia, the grandparent is acting in the place of the parent. The grandparent would be allowed to make early intervention decisions for the child and no surrogate parent is needed.

Example 3: Family "friend" (i.e., no relation to the child) refers child, child lives with this person, and friend does not know how to contact parents. Given that there is no information regarding the legal status of the child's custody and the "friend's" legal status in relation to the child, it is recommended that social services be contacted to determine how best to protect this child's rights. Although the parent appears to be unavailable, there is not clear indication that the "friend" can be considered as acting in the place of the parent without legal action taking place. In such situations, assignment of a surrogate may be necessary.

Example 4: Maternal aunt refers child, child lives with aunt, aunt does not know where father is, mother is incarcerated.

In this situation, the first step must be to determine what, if any, legal arrangements were made for the child's care during the mother's incarceration. If the family is involved with DFCS and the aunt is acting as a "foster parent" for the child, then she would be able to provide necessary consents as the foster parent, or a surrogate parent may be appointed. If the child has been placed in the legal custody of the DFCS, then the child is a ward of

Georgia. The aunt, as the “foster parent” may act as the parent, or a surrogate parent may be appointed. If the family is not involved with DFCS and the mother’s parental rights are intact, then a surrogate parent appointment is not appropriate. Because the mother’s whereabouts are known and she can be contacted, arrangements must be made so that the mother may participate in the child’s Part C early intervention program to the extent possible.

Q9 When a child is in foster care, which has authority to sign IFSPs, consent and prior notice forms, other procedural safeguard forms, etc., the surrogate or foster parent?

A9 The foster parent, if that person is acting as the parent and no surrogate parent has been assigned. If a surrogate parent has been assigned and that person is not the foster parent, then the ultimate decision relative to the evaluation, assessment, development and implementation of the IFSP (including annual evaluations and periodic reviews), and ongoing provision of early intervention services and other rights under Part C to a child who is suspected of having or determined to have a disability rests with the surrogate parent.

Q10 What early intervention decisions can the surrogate parent make while representing the child?

A10 The surrogate parent may make any decisions pertaining to the evaluation, assessment, development and implementation of the child’s IFSP (including annual evaluations and periodic reviews), and provision of early intervention services and other rights under Part C to the child. In addition, the surrogate parent is the appropriate person to request a due process hearing on behalf of the child.

Q11 Who signs the release of information when DFCS requests confidential information?

A11 The individual who meets the definition of “parent” under Section 602(23) of IDEA would sign for release of information of Babies Can’t Wait-related records. That individual, who may be a parent, adoptive parent, foster parent, guardian, person acting in the place of a parent, or surrogate parent signs for release of information if the requested records concern the evaluation, assessment, development and implementation of the IFSP (including annual evaluations and periodic reviews) or the provision of early intervention services to the child with a disability.

Q12 When a child is in the custody of DFCS, who requests a due process hearing?

A12 The individual who meets the definition of “parent” under Section 602(23) of IDEA, who may be a parent, adoptive parent, foster parent, guardian, person acting in the place of a parent, or surrogate parent, has the right to request a due process hearing. DFCS does not have legal authority to request a due process hearing.

Q13 What is the caseload for a surrogate parent?

A13 There is no specific caseload requirement.

Q14 Are there any situations in which the DFCS social worker could sign permission forms, release forms, and/or the IFSP?

A14 According to 34 CFR [303.406\(e\)](#), for a child who has a surrogate parent, that parent represents the child in all matters related to Part C early intervention including signing

permission forms for evaluation and services, release of records forms, and the IFSP. No one but the parent, as defined in 34CFR [§ 303.27](#), who may be a parent, adoptive parent, foster parent, guardian, person acting in the place of a parent, or surrogate parent is authorized to sign any forms that relate to the child's participation in Part C.

However, Babies Can't Wait recognizes that the social workers and caseworkers from local DFCS agencies are an important and valuable asset to the child. Accordingly, they should be involved to the fullest extent possible and invited to the IFSP and other relevant meetings. Helping families get to the appropriate meetings related to the child's participation in early intervention services is just one of the many ways they can help to include families.

Q15 Does Babies Can't Wait need to invite birth parents to participate in their child's developmental evaluation and assessments? How much/what information should BCW send to the birth parents (copies of developmental evaluations, copies of individualized family service plans, etc.)?

A15 It is important to continue to involve natural and adoptive parents in their child's participation in early intervention, particularly when reunification is a long-term goal for the child and family and when it is not contraindicated due to established negative impact on the child. Therefore, within Babies Can't Wait, the Service Coordinator must make and document reasonable efforts to involve each child's natural or adoptive parent(s) in the early intervention system.

Minimally, efforts must be made to invite and involve parent(s) in initial evaluation, assessment, and individualized family service plan (IFSP) development for eligible children. This requirement is waived if it has been determined that reunification is not a long-term goal for the child and family and/or extreme detriment or negative impact on the child has been documented.

If the parent's rights have been extinguished, then any contact or sharing of information with the birth parent(s) shall be determined based upon the court's decision.

A release of information would need to be signed by the individual acting as the parent for Part C purposes, as defined in Section 602(23) of IDEA 2004 in order to share any information about the child. Confidentiality about the child must be maintained.

Q16 An infant lives with a grandparent: Who signs as the parent? What if the parent is gone for several weeks? Can the adult they are staying with sign as the parent?

A16 If the grandparent is acting in the place of the parent (in loco parentis), they would be authorized to sign as the parent. Such determination would be documented using Form BCW009. However, documented reasonable efforts must be made to involve the birth parent(s). If the birth parent(s) continue to make early intervention and other decisions for the child, the local lead agency for Babies Can't Wait should look to the birth parent for necessary involvement and consents.

Q17 A toddler is removed from home due to substantiated abuse or neglect. A court order is provided which indicates that the child's aunt has been granted temporary legal custody of this child. Can the aunt provide the necessary consent for BCW services? Does the aunt need to receive surrogate parent training prior to acting as the parent for this child?

A17 In this situation, the aunt meets the requirements to act as the parent under IDEA and

can consent for BCW services. In such an instance, the individual would not be appointed as a surrogate parent. Such determination would be documented using Form BCW009.

Q18 Can a teenage parent of an infant or toddler who has special needs provide consent for evaluation and/or services provided by Babies Can't Wait?

A18 Any parent, regardless of their age, can provide the necessary consent for their child as long as the parent-child relationship is intact. If a teenage parent's rights have been terminated, then he/she would not have the authority to provide consent. In that case, appropriate procedures should be followed to determine the need for a surrogate parent or other appropriate individual who could provide necessary consent.

Q19 Can a parent who has a cognitive disability provide consent for evaluation and/or services provided by Babies Can't Wait for his/her infant or toddler with special needs?

A19 Any parent, regardless of their cognitive abilities, can provide the necessary consent for his/her child as long as the parent-child relationship is intact, and the parent has not been deemed mentally incompetent to make such decisions. If the parent has been deemed mentally incompetent, there will be a power of attorney in place permitting someone to consent on their behalf. If the parent's rights have been terminated, then he/she would not have the authority to provide consent. In that case, appropriate procedures should be followed to determine the need for a surrogate parent or other appropriate individual who could provide necessary consent

Q20 What procedures should be followed for a child involved with DFCS (or any other child under 3 years of age) who is referred to BCW less than 45 days from his/her third birthday?

A20 Babies Can't Wait must acknowledge receipt of the referral in writing to the referral source within 3 business days of receipt of the referral. Babies Can't Wait should initiate contact with the parent/guardian or person acting in the place of the parent. Babies Can't Wait should explain 45-day timelines for evaluation/assessment and individualized family service plan development and attempt to obtain consent for referral to the local school system or other potential programs/services for which the child may be eligible.

If parent/guardian or person acting in the place of the parent chooses to proceed with screening to determine if further evaluation and assessment are indicated, Babies Can't Wait would proceed with scheduling the necessary appointments to complete screening activities. § [§303.209\(b\)\(1\)\(iii\)](#) provides that if a child is referred to the lead agency fewer than 45 days before that toddler's third birthday, the lead agency is not required to conduct the initial evaluation, assessment, or IFSP meeting, and if that child may be eligible for preschool services or other services under Part B of the Act, the lead agency, with the parental consent required under [§303.414](#), must refer the toddler to the SEA and appropriate LEA.

Q21 How should the following scenarios be handled?

- a. Who provides consent for children who are in foster care and whose birth parents live in other states?
- b. Who provides consent for children who are in foster care and whose birth parents are in prison, jail, rehabilitation?

- c. Who provides consent for children who are in foster care and whose birth parents are reported to have "mental health issues" or are "addicted" to drugs, as reported by caseworkers, family members, or foster parents? Do these parents, if they truly have such issues, need to give informed consent?
- d. Who provides consent for children who are in foster care and whose birth parents are reported to be homeless or have no known address and/or they abandoned their child, as reported by DFCS.
- e. A child that is in foster care and whose birth parent is homeless and shows up in her car once a month (at any given time to see her children). The DFCS caseworker indicated that she has no way of contacting the mother and the mother has six months left on her plan to find housing. How does BCW proceed with obtaining necessary consent?

A21 In each of these scenarios, if a foster parent meets the criteria identified on Page 2 of this manual, the foster parent may be considered the parent and there is no need for the appointment of a surrogate parent. When the foster parent serves as the parent, the foster parent has the authority to sign the Individualized Family Service Plan (IFSP) and all related documents, forms, and releases.

If the foster parent is unable or unwilling to serve as the parent, a surrogate parent must be appointed. When the surrogate and foster parent are different, the ultimate decision relating to the provision of Babies Can't Wait early intervention services is determined by the surrogate parent.

Q22 Who provides consent or makes decisions for a child who is in foster care and whose birth parents are married, but one parent consents and agrees to participate in BCW and the other parent does not consent or is not expected to consent to participation in BCW? Does the answer change if the parents are not married?

A22 If a child is in foster care, the marital status of birth parents does not determine who provides consent for BCW participation. In each of these scenarios, if a foster parent meets the criteria identified on Page 2 of this manual, the foster parent may be considered the parent and therefore has the authority to sign the Individualized Family Service Plan (IFSP) and all related documents, forms, and releases.

If the foster parent is unwilling or unable to serve as the parent, a surrogate parent must be appointed. When the surrogate and foster parent are different, the ultimate decision relating to the provision of Babies Can't Wait early intervention services is determined by the surrogate parent.

General Frequently Asked Questions

Q1 Can the Service Coordinator bill for his/her services on behalf of an eligible child and family when it is not possible for the Service Coordinator to conduct a face-to-face visit with the child and parent jointly during a given month?

A1 In order to bill for service coordination services for an individual child, the Babies Can't Wait (BCW) Service Coordinator must have a minimum of one face-to-face child and family contact in a month. This contact must be documented in the child's active clinical record. In addition, the Service Coordinator must also have a minimum of three indirect contacts that month on behalf of the child. All contacts must be related to the child's IFSP and the documentation must reflect efforts related to the child's IFSP in every direct and indirect contact.

For children who reside with a foster parent, relative, or other adult determined to be “acting in the place of the parent” per Babies Can’t Wait guidelines, a face-to-face visit with the child and that responsible adult [acting in place of the parent] meets the requirement for the minimum of one face-to-face child and family contact in a month for the purposes of Early Intervention Case Management billing.

Q2 If a Babies Can't Wait intake coordinator or designee contacts a family by telephone on behalf of an infant or toddler who has been referred, and the family declines screening and/or evaluation or a determination is made that screening and/or evaluation are not indicated, how should this be documented?

A2 Documentation of such decisions must be clearly stated and included with the child’s early intervention referral information. Copies of any documentation, letters, and forms that are available and completed should also be filed in the child’s early intervention record (e.g., the record created for children referred to but not served by Part C).

Q3 If there is only one form of contact information available for a family, such as a mailing address, does BCW still need to make a minimum of three attempts to contact prior to appointing a surrogate parent?

A3 Yes. A local program should consider sending letters via different mechanisms, such as U.S. Mail, certified mail, return-receipt requested mail, etc.

Q4 What/how much information should BCW share with natural (birth) parents? Should copies of developmental evaluations, individualized family service plans be shared?

A4 Because of the unique challenges presented when children are placed in foster care and the identity of the foster parent is often not to be shared with the natural parent, it is critical that Babies Can’t Wait and DFCS personnel communicate routinely about the allowable level of family involvement and contact between natural and foster parents. BCW and DFCS must work together to determine the best means of sharing information and documents, with signed informed consent from the individual designated as the “parent” to make decisions related to the child’s participation in BCW. If the foster parent’s identity and/or contact information is not to be shared with the natural parent, that information should be removed from or “blacked out” on copies of all Babies Can’t Wait-related documents and records prior to sharing with the natural parent.

Q5 How much information is required in order to be considered a referral that initiates the 45-day timelines for Babies Can’t Wait?

A5 Minimally, the child’s name and date of birth, current address of residence, phone number (unless family does not have a phone), and the name of the parent/legal guardian, foster parent, or person acting in the place of the parent must be provided by the individual making the referral in order to initiate the 45-day timeline for Babies Can’t Wait. The 45-day timeline begins once the referral is received directly by BCW or the lead agency’s single point of entry.

Q6 When a child in foster care moves from one local program (where his/her natural parents continue to reside) to another, who is responsible for obtaining necessary consent and releases in order to evaluate, provide services, and/or transfer Babies Can't Wait records?

A6 Because of the unique challenges presented when children are placed in foster care in

a county that is different from their county of legal residence, it is critical that Babies Can't Wait and DFCS personnel work together to determine the most efficient means of obtaining parental consent and necessary signatures on various documents for Babies Can't Wait participation. In some situations, it may be most expedient for the receiving Babies Can't Wait local program to obtain the necessary signatures via mail. If the original Babies Can't Wait local program is notified in advance of the child's move, efforts should be made to obtain necessary consent prior to the change in local program. In other situations, DFCS may be able to obtain the necessary signatures and consent during scheduled contacts with the individual(s) designated as parent(s).

Surrogate Parents – See Surrogate Parent Policy and Training Guide

1. A case-by-case review is required so that a local lead agency is fully able to determine the need for the appointment of surrogate parent(s) to represent the interest of a child with disabilities. Each local lead agency must have documented procedures for identifying children in its jurisdiction (local program) who are in need of surrogate parents according to the definition. The local lead agency must make reasonable efforts to ensure the assignment of a surrogate parent not more than 30 days after a public agency determines that the child needs a surrogate parent. A local Lead agency's method of determining whether a child needs surrogate parent(s) must include:
 - a. The identification of staff members or BCW service providers responsible for referring children in need of surrogate parent(s);
 - b. The provision of in-service training for determining whether a child needs a surrogate parent(s); and
 - c. The establishment of a referral system within the catchment area (local program) of a local lead agency for the appointment of surrogate parent(s). In developing the local listing, it may be necessary for a local lead agency to go beyond jurisdictional limits in generating a list of potentially qualified surrogate parents. Individuals who are not on the local lead agency's list may be eligible to serve as surrogate parents, subject to the local lead agency's discretion. It should be noted, however, that geographic proximity is essential to the surrogate parent/child relationship. The needs of the individual child and the availability of qualified persons who are familiar with the child and who would otherwise qualify shall be considerations in the local lead agency's determination of surrogate eligibility.
2. Other factors which warrant the local lead agency's attention are:
 - a. Consideration of the appointment of a relative to serve as surrogate parent(s);
 - b. Consideration of the appointment of a foster parent(s) who has the knowledge and skills to represent the child adequately; and
 - c. Consideration of the appointment of a qualified person of the same racial, cultural, and linguistic background as the child.
3. Each local lead agency shall ensure that a person selected as a surrogate parent(s) has no interest that conflicts with the interests of the child he or she represents. A person assigned as a surrogate parent(s) shall not be an employee of the lead agency or any other public agency or EIS provider that provides early intervention services, education, care or other services to the child or any family member of the child. The local lead agency shall ensure that this individual receives in-service training regarding Part C of IDEA.

4. If a child is under the care or supervision of the state, the surrogate parent(s) may not be confused with the state-assigned Division of Family and Children Services (DFCS) case worker responsible under State law for the obligations of the DFCS as custodial parent. In these instances, it is not permissible by federal law for the DFCS case worker to also serve as the child's surrogate parent(s) for the purposes of BCW.
 - a. The surrogate parent(s) and case worker must coordinate and work together for the overall benefit of the child. It is imperative that the surrogate parent(s) communicate regularly with the case worker to inform him/her of all relevant activities and commitments made on behalf of the eligible child by the surrogate parent(s).
 - b. If the child is a ward of the state, the judge overseeing the infant or toddler's case may assign a surrogate parent provided that the surrogate parent meets the requirements of a surrogate parent based on Federal and state rules and regulations.

5. The activities and obligations of the surrogate parent(s) are restricted to those related only to the implementation of Part C of IDEA for the eligible child. A surrogate parent(s) may represent a child in all matters related to the following:
 - a. The evaluation and assessment.
 - b. Development and implementation of the IFSP, including annual evaluations and periodic reviews.
 - c. The ongoing provision of early intervention services to the child.
 - d. Any other rights established under Part C of IDEA and the implementing regulations in 34 CFR Part 303. (See Section 100.5 Notice of Infant /Toddler and Family Rights Under Babies Can't Wait.)

APPENDIX G – Decision Tree to Determine COS Ratings

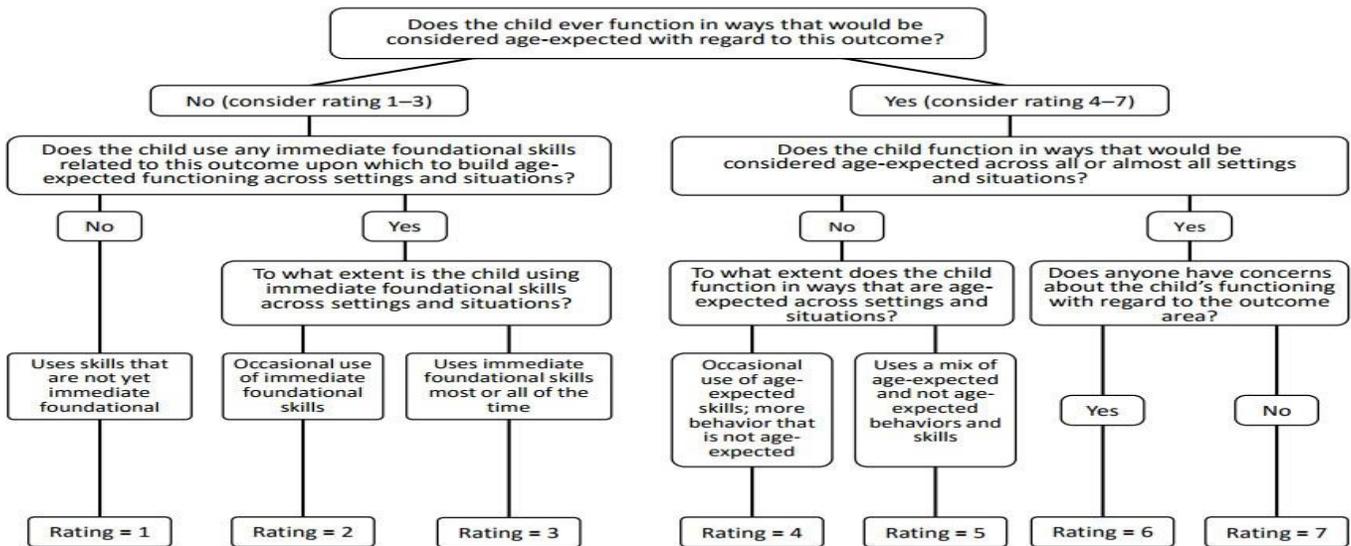
POLICY MANUAL - SUMMARY

Decision Tree to Determine COS Ratings

Chapter 1000

Purpose
 The Child Outcome Summary (COS) is to be completed at initial entry into Babies Can't Wait for children less than or equal to 30 months of age and at exit for all children who are enrolled with an active IFSP for at least six months. Entry and exit ratings are entered and reported in the state database as well as a hard copy placed in the permanent record for each child. The Decision Tree (see figure below) was created as a tool for training in the use of the COS Form. It is a series of questions about the extent to which a child exhibits age-appropriate skills and behaviors in each outcome area. Responses guide the user to a specific rating category on a 7-point scale.

Decision Tree for Summary Rating Discussions



APPENDIX H – Updates to the Procedure for Periodic IFSP Reviews

Chapter 300

Policy

A formal procedure must be followed for a periodic IFSP review for any one of these reasons, change in frequency, intensity and duration of a service, or the addition or termination of a service.

Purpose

To provide guidance to service coordinators and providers when it is necessary to review IFSP services at times other than the annual or six -month reviews.

Document Content

This document highlights recent additions to the policy only. Please review the *BCW Policy Manual* for full policy language

Policy Update

New clarification language added to ensure activities associated with a periodic IFSP reviews follow BCW State policy and procedure.

Periodic review can be initiated for the following:

- Change in service frequency
- Change in service intensity
- Change in the duration of a service
- Addition or termination of a service
- Parent may request a review of an IFSP
- Local program may propose a change in the IFSP

Periodic review and service coordination:

- Ensure adequate notice to facilitate the participation of all team members and other attendees as requested by parents
- Ensure parents understand their rights in requesting a review and agrees with team members with any revision
- Ensure the parent gives signed consent for any changes to the IFSP
- Document all changes agreed upon, and ensure the parent receives a copy of the modified IFSP within 10 business days

APPENDIX I – Participation in IFSP Meetings

Chapter 700

Policy

Provide service coordination to every eligible child and their family receiving Early Intervention (EI) services. Services must be coordinated across providers and agencies.

Purpose

Provide accurate and appropriate service coordination to BCW participants. Clear delineation is now being made to clarify the activities associated with the two levels of service coordination, *Intake Service Coordination* and *Ongoing Service Coordination*.

Intake Service Coordination is the process for reviewing and evaluating referred family and child, to determine eligibility or non-eligibility for EI services. It includes the following:

- Collecting family and child information, medical status, and insurance and financial information
- Educating family on parental rights, procedural safeguards and the voluntary nature of EI services
- Identifying a surrogate parent, if applicable
- Educating the family on evaluation and assessment process, IFSP development and EI service delivery, EI services payment process, and transition
- Scheduling and coordinating the evaluation/assessment with a Multidisciplinary Team (MDT) timely to ensure the development of the initial Individual Family Service Plan (IFSP) within 45 days of the referral
- Ensuring parental consent/ signature and team members signatures on ALL required documents, and documenting in the Babies Information and Billing System (BIBS) all services requiring authorizations or billable services
- Explaining to the family the IFSP and Primary Service Provider (PSP) service delivery process
- Explaining the roles and function of each PSP team member and the role of the ongoing service coordinator
- Referring and linking family and child not eligible for EI services to other agencies or community resources and back to C1st, with parental consent, for monitoring and follow-up.

Ongoing Service Coordination is the process of facilitating, participating, and implementing the early intervention services identified on the IFSP for eligible child and family. It includes the following:

- Ensuring that ALL parental rights/parental consents, procedural safeguards are observed and documented throughout the process
- Identifying and referring family to advocacy source, if applicable
- Ensuring the results of the evaluation/assessment is reviewed with the family so that understands and agree that the results reflect their child and family
- Documenting and entering all IFSP information into BIBS within seven days of the completion of the initial, annual and periodic review, as well as transition activities
- Ensuring that forms applicable to billing public or private insurance are signed and the CYSHCN Financial Analysis is completed and signed by the parent
- Authorizing four (4) face-to-face service coordination visits per IFSP for each family
- Coordinating provision of EI services identified in the IFSP and linking families to other support services as needed
- Validating Medicaid eligibility monthly for active and inactive Medicaid clients, assisting family is applying for Medicaid, and checking third-party payer status
- Coordinating the annual evaluation of the IFSP to ensure the appropriate continuous assessment of the child and family
- Ensuring ALL documents are updated and signed during the annual IFSP evaluation
- Ensuring all necessary transition documents are explained, completed, signed and submitted to ensure the timeliness of the transition process
- Scheduling and coordinating transition activities to ensure the completion of the transition conference and the development of the transition plan is completed no later than 90 days prior to the child's third birthday.

SECTION 1: CHILD INFORMATION

Child's Name:	Child's Date of Birth:
Parent/Guardian Name:	Parent/Guardian Address:
Parent/Guardian Phone Number:	Parent/Guardian Email Address:

SECTION 2: NOTIFICATION OF RECORD RETENTION AND DESTRUCTION

All records pertaining to the provision of Early Intervention/Babies Can't Wait services, including electronic records, shall be maintained (archived) by your local Babies Can't Wait office for **five (5) years** from the date your child leaves the program. At the end of this time, your child's records will be **AUTOMATICALLY** destroyed unless the record is included in an ongoing audit or legal action.

SECTION 3: RIGHTS AND RESPONSIBILITIES

1. I am responsible for requesting that the local Babies Can't Wait office keep the record after my child leaves the program.
2. I may access a full copy of my child's early intervention record at any time they are receiving IDEA/Part C services.
3. Beginning five years from the date my child leaves the program, I have thirty **(30) days** to pick up my child's original file from the District's BCW office.
4. Babies Can't Wait will keep a permanent record of my child's participation in the program to include the following Information:
 - Child's Name
 - Date of Birth
 - Parent Contact Information (including Address and Phone Number)
 - Service Coordinators' and Providers' Names
 - Exit Data Including Year and Age Upon Exit
 - Program(s) Transitioned to Upon Exiting.

SECTION 4: ACKNOWLEDGEMENTS AND SIGNATURES

By signing below, you acknowledge that you have received a copy of this notice and understand the Babies Can't Wait requirements for record retention and destruction.

Signature of Parent/Guardian	Entry Date
Signature of Parent/Guardian	Exit Date

(For office use only)

Child's Exit Date: _____ Destruction Date: _____
(5years and 30 days from the date of exit)

TRANSFER BETWEEN DISTRICTS CHECKLIST

Date Chart Transferred in BIBS _____ Initials _____
 Date Chart Provided to New District ____ Initials _____

Child Name:	SC:
Transfer From:	Transfer To:

SERVICE COORDINATOR CHECKLIST

ACTIVITY	✓ Completed
Notified all providers of transfer and ensured provider notes were entered in BIBS	
Entered all meetings in BIBS and submitted all outstanding documentation to District Office	
Attached Discharge form (for district information only-will not be deactivated)	
Entered all SC billing in BIBS	
Entered all SC notes in BIBS	
Entered all outstanding compliance notes in BIBS	
Entered any outstanding timely service dates in BIBS (do not select "No Service Will Be Given" unless the parent initiated)	
Entered family's new contact information in BIBS (if known)	
Gave family contact information for new district & explained transfer process	
REMINDER: DO NOT ENTER AN EXIT COSF	

DISTRICT CHECKLIST

ACTIVITY	✓ Completed
End dated the current SC assignment on Child Detail page one day prior to transfer date	
Checked all SC coordination notes were entered in BIBS and filed in chart	
Checked all provider notes were entered in BIBS	
Checked that any outstanding compliance notes and service start dates were entered in BIBS	
Notified new district of transfer	
Ensured all outstanding documents from SC were submitted & finalized before electronic record transfer and filed in chart before paper chart mailing	
REMINDER: DO NOT DEACTIVATE CHILD	

BCW Program Policy Manual Acknowledgement of Receipt

I have received the Georgia Department of Public Health Babies Can't Wait Program Policy Manual dated May 2022. I understand that as a Contracted Provider with DPH Babies Can't Wait Program, I am held to the standards set forth in the policy. My signature below certifies that I have received, read and understand the BCW Policy Manual.

Provider Name (Printed)

Date

Provider Signature

Specialty