Table of Contents

|  |  |  |
| --- | --- | --- |
| **STAGES** | **ACTIVITY** | **Additional Forms** |
| I**: Identification:**  ***Referral and Intake*** | Referral CIS-01  Initial Intake CIS-02 | Authorization CIS-03  Insurance Information CIS-02 supplemental |
| **II: Information Gathering & Summary:**  ***Screening, Assessment & Eligibility Determination*** | [Your Resources and Supports](#FamilyResourcesAndSupports)  [Adult Health Information](#AdultHealthInformation) A clients  [Child Health Information](#ChildHealthInformation) C  [Summary](#Summary) **A**  C | Notice and Consent for Evaluations C A  Eligibility/Diagnosis  Routine Based Interview |
| **III: Development of Plan:**  *Individualized Goals and Outcomes* | [Your Concerns, Hopes and Priorities](#FamilyResourcesConcernsPriorities)  [Your Outcomes](#Outcomes)  [Services Grid](#ServicesGrid) | Consent for Initiation of Services **C** A  One Plan Cover |
| **IV: Service Delivery** | [Plan Review](#planreview) | Prior Authorization  Home Visit Notes |
| **V: Transition/Exit** | [Transition Plan](#transitionplan) |  |
| **VI. Toolbox** | Ecomap Process  Guide for Child Development Interview  Diagnosis and Eligibility Determinations  Family Support Application (hard copy)  Guidelines for Using Recommended  Psychosocial and Developmental  Tools with Pregnant/Postpartum  Women and Children Birth to Six (web)  One Plan Cover Page  Home Visit Notes |  |

**Legend:**

**Required Form C Required for child clients**



**Tools available A Required for adult clients**



**Your Resources and Supports**

These are your pages to share your strengths, resources, concerns, and priorities. Only share information that you are comfortable sharing. Your answers will help us:

* answer your questions and address your concerns.
* find out about your needs or those of your child and family, or, for child care providers, the needs of your program.
* develop with you your goals and outcomes for yourself, your child and family, or your child care program.
* assist you in identifying community resources and other supports that will be helpful to you, your child and family, or for those children and families that you serve if you are a child care provider.

|  |  |
| --- | --- |
| **Information provided by:** | **Date:** |
| **People who are important or helpful to me/my family/my child care staff/the children enrolled in my program (e.g., family, extended family members, friends and neighbors, people from place of worship, community agencies, school, child care, other service providers, health care providers)** | |
|  | |

**Adult Health Information**

*(expectant/postpartum families and parent client)*

|  |  |
| --- | --- |
| **Pregnancy, Birth and Medical History *(Expectant or Postpartum People only*)** | |
| Please describe any notable prenatal, birth or family health history: | |
| Date of my first pregnancy medical appointment:       My next appointment: | |
| Weight goals during pregnancy, 3 months post-natal, ongoing: | |
| Cultural/Family beliefs and activities that are important to me about my pregnancy, child birth and/or parenting: | |
| Actual Date of Delivery:       Obstetrician/Midwife: | |
| **Your Health:** (All Adult Clients, Please describe or explain the following) | |
| Ongoing Health Concerns or Diagnosis: | |
| Any medications taken on a regular basis, including herbal preparations or over-the-counter drugs, nutritional supplements? | |
| Your Nutrition – general food preferences/special diet or eating problems: | |
| Your napping, sleep, rest periods: | |
| Your daily/weekly Physical Activity: | |
| Any personal safety concerns: | |
| Are you exposed to alcohol, tobacco, lead or other substances that could affect you, your well-being or pregnancy? | |
| When did your concerns first develop and have you received any services/treatment? | |
| Emergency Contact: | Phone: (   )    -     ext. |

**Child Health Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child’s Name:** | | | **Date:** | |
| **My Child’s Information and History:** | | | | |
| Describe your child’s strengths and interests? | | | | |
| When did your concerns first develop and has your child received any services/treatment? | | | | |
| If so, were services/treatments successful? | | | | |
| Describe your child’s early development or behavior. Did you have any concerns? | | | | |
| Describe any notable prenatal, birth or health history? | | | | |
| Has your child been diagnosed with a physical, developmental or psychological condition? | | | | |
| Are there any early life events that could affect your child’s development or well-being? | | | | |
| **General Health** | | | | |
| Name of your child’s doctor:  Name of your child’s dentist: | | | | |
| Does your child take any medications on a regular basis, including herbal preparations or over-the-counter drugs or Nutritional supplements? | | | | |
| Is your child generally healthy?  If your child is sick a lot, please explain your concerns: | | | | |
| Date of any hospitalizations:       Reason: | | | | |
| Vision screening: | Age: | Hearing screening: | | Age: |
| What does your child like to eat? Is there a special diet? Is your child breastfeeding? | | | | |
| How does your child nap or sleep at night? | | | | |
| Are immunizations up to date? | | | | |
| Is your child exposed/or has your child ever been exposed to alcohol, tobacco, lead or other substances that could affect your child’s development or well-being? | | | | |
| Are there any concerns about your child’s safety? | | | | |

**SUMMARY REPORT**

This report summarizes all the information we gathered to address your concerns. The information was collected with your consent.

This report provides you with a record of your resources and supports, your concerns, relevant health information and recommendations. For children, the report also explains your child’s present abilities, strengths and needs in relationship to your family’s everyday routines, activities, and environments. For Child Care Providers, the report may address program needs, staff development or needs, or identifies areas of strength or needs related to the specialized needs of children enrolled within your program.

The information gathered for this report will help you and your team to develop a plan that addresses your concerns and hopes.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Reason for Referral:** | | | | | | |
|  | | | | | | |
| **Sources of Information:** | | | | | | |
|  | | | | | | |
| **History:** | | | | | | |
|  | | | | | | |
| **Observations and Assessment Results:** | | | | | | |
|  | | | | | | |
| **Summary:** | | | | | | |
|  | | | | | | |
| **Recommendations:** | | | | | | |
|  | | | | | | |
|  |  |  |  |  |  |  |
| Name/Credentials |  | Date |  | Name/Credentials |  | Date |
|  |  |  |  |  |  |  |
| Name/Credentials |  | Date |  | Name/Credentials |  | Date |

**Your Concerns, Hopes & Priorities**

|  |  |
| --- | --- |
| This page of your plan will summarize your concerns and help you decide what is most important for you, your family, or your program to work on right now. Your concerns might be based on your experiences as well as the results of formal screenings or assessments that were done.  In the following section, you and your team will develop a plan for services. The plan will address the concerns that you feel are most meaningful and important to you and/or your child, or your program.  Your plan will identify   * What you want to happen for you, your family or child, or your program. * How you and the team will address your goals. * Who is responsible for providing services * The begin/end dates of services * The location for your services (Feel free to tell the team the best place for you.) * A service coordinator who will support you in identifying and coordinating the services you need * For child care programs – What you want to happen to address your concerns | |
| **Your Concerns and Hopes:** | **Priority (#)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Your Outcomes\***

*(\*Complete an Outcome sheet for each outcome)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| To duplicate this page: using your mouse highlight the entire page, right click, select “Copy”, click to set your cursor at the very top of the page, right click again, select “Paste” | | | | | |  | |
| **Outcome #:**        **Date of Plan:**   -  - | | | | | | |
| We Want:*(What would you like to happen?)* | | So That:*(Why is this important?)* | | | | |
| Outcome: How will we know we are successful?*(Include criteria.)* | | What resources do we have to help with this outcome? | | | | |
| **Strategies and Activities:** | | | **Who will help?** | | **When & Where?** | |
|  | | |  | |  | |
|  | | |  | |  | |
|  | | |  | |  | |
|  | | |  | |  | |
|  | | |  | |  | |
|  | | |  | |  | |
| **How often should the team meet to review this outcome? \_\_\_\_\_\_\_\_\_\_\_ Review Date:** | | | | | | |
| **Date Reviewed** | **Outcome Review** (Describe Progress) | | | **Status** | | |
|  |  | | |  | | |
|  |  | | |  | | |
|  |  | | |  | | |

**Services**

This is a summary of supports/services needed to achieve the outcome(s) identified in your plan. This plan was developed by you and your CIS team.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Supports and Services** | **Outcome**  **#s** | **Qualified Provider’s Title/Agency** | **Location**  (Is the location client’s natural environment?) | **How long/ month?**  (hours/month) | **Planned**  **Start Date** | **Actual Start Date** | **Payer** |
| **Service Coordination** |  |  |  |  |  |  | Private Ins.  Medicaid  POLR |
|  |  |  |  | 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
|  |  |  |  | 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
|  |  |  |  | 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
|  |  |  |  | 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |

**Services (continued\*)**

This is a summary of supports/services needed to achieve the outcome(s) identified in your plan. This plan was developed by you and your CIS team.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Supports and Services** | **Outcome**  **#s** | **Qualified Provider’s Title/Agency** | **Location**  (Is the location client’s natural environment?) | **How long/ month?**  (hours/month) | **Planned**  **Start Date** | **Actual Start Date** | **Payer** |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
| 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
| 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
| 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |
|  | New Outcome  New Frequency  Outcome Cont.  Service Ended |  | Home  Community  Service Provider Location  Justification for SPL on file |  |  |  | Private Ins.  Medicaid  POLR |
| 30 day timeline met or # days past date of consent:  Timeline not met due to family circumstances (Explain): | | | |

\* Add Additional Services Pages As Needed

**Your Team’s Membership and Your Consent**

The following team members have participated in the development of your plan and may assist in carrying it out. Members include you (or parent/guardian), service coordinator, person(s) who conducted assessments, others as requested by you (e.g., friend, family member, community agency staff, etc…) and those who will provide services.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Role/Phone #** | **Signature** | **Date** |
|  | Service Coordinator |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician signature (if applicable) \*\*** **Date**

|  |  |
| --- | --- |
| **Consent for Initiation/Change/Continuation of Services:** | |
| You have completed your plan. Now your consent is needed before any services can begin. Your signature indicates your consent. Whenever there is a review of your plan, you will be asked to give your consent. It is important for you to be involved in every stage of your plan.  If you disagree with any part of your plan or think you are not getting the appropriate services, you have the right to voice your concerns. You may want to talk to your Service Coordinator or CIS Coordinator – their names and contact information appear below.   * I have received a written copy of and a verbal explanation of my rights. I understand these rights. (EI only) * I participated fully in the development of this Plan. * I give consent for this Plan to be carried out as written and for the provision of services. * I do not accept this Plan as written, however I do give consent for the following service(s) to begin: | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Client/Parent(s)/Legal Guardian(s)/Appointed Educational Surrogate**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Parent(s)/Legal Guardian(s)/Appointed Educational Surrogate** | **Date** |
| **Service Coordinator: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **CIS Coordinator: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**Evaluation Consent**

|  |
| --- |
| **Notice and Consent for Evaluations** |
| To address your questions and to help plan services based on your concerns, we will work with you, your child, or your program to gather more information in an evaluation (e.g., interview, screening or assessment). You can help plan the evaluation and will be informed before an evaluation is begun. When the evaluation is finished, your team will meet with you to discuss the results and develop a plan. Please let your service coordinator know if at any time you have questions.  The following evaluation(s) are planned:    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * I give my permission for the evaluation to begin. I understand that my consent is voluntary and that it may be revoked for any reason during the initial evaluation process. For Part C services, the results of this evaluation will be available to the team determining my child’s eligibility. * I do not give permission for this evaluation.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Service Coordinator Name Phone Number |

**Plan Review\***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Reason for review: | | | | | Date: | | |
|  | | | | | | | |
| Current Status: | | | | | | | |
| Sources of Information: | | | | | | | |
| Observations and Assessment Results: | | | | | | | |
| Summary: | | | | | | | |
| Recommendations: | | | | | | | |
|  |  |  |  |  | |  |  |
| Name/Credentials |  | Date |  | Name/Credentials | |  | Date |
|  |  |  |  |  | |  |  |
| Name/Credentials |  | Date |  | Name/Credentials | |  | Date |

*\* attach all new/revised/updated Outcome pages, Service Grid and Consent for Services*

**Transition Plan\***

|  |  |  |
| --- | --- | --- |
| **Reason for Transition**:  Date of Plan:       Actual Transition Date: | | |
| Reason: | Explain:    Relocate to:    Explain: | |
| **Your Concerns and Hopes for the transition** | | **Priority #** |
|  | |  |
|  | |  |
|  | |  |
|  | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Transition Team**: (R=required to be present during Transition Conference when transitioning to EEE) | | | |
| **Team Member’s Name** | **Phone** | **Role** | **Initials/Date** |
|  |  | Parent/legal guardian; Surrogate Parent (R) |  |
|  |  | Parent/legal guardian |  |
|  |  | Service coordinator (R) |  |
|  |  | Current service providers (R) (e.g., Developmental Educator, Occupational Therapist, Physical Therapist, Speech and Language Pathologist) |  |
|  |  | Representative from School District (R) |  |
|  |  | Future service providers |  |
|  |  | Other |  |
|  |  |  |  |

\*attach updated summary of recent assessments and *Outcomes, Service Grid* and *Consent for Services* as needed

Children’s Integrated Services: Early Intervention

(Additional Requirements for Transition from CIS: EI to EEE)

|  |  |  |  |
| --- | --- | --- | --- |
| **Transition Plan:** | | | |
| Steps/Supports/Services needed for family’s successful transition | **Person(s) responsible** | **Date completed** | **Reasons for Delay** |
| Parental Consent (needed only for transition meeting to occur) |  |  |  |
| 6 month notification sent (for children potentially eligible for EEE) Note: Parental consent not required |  |  |  |
| Plan and send meeting notification to all attendees for the Transition Meeting |  |  |  |
| Transition meeting held at least 90 days prior to the child’s third birthday. |  |  |  |
| Copies of Transition Plan with steps and services given to family and team members. |  |  |  |
| Update files to be reviewed with team and copies given to EEE and/or other service providers (with parental permission) |  |  |  |
| IEP is in place by child’s third birthday | LEA |  |  |
| Child’s Outcome data completed |  |  |  |
|  |  |  |  |
|  |  |  |  |