State of Maine

Department of Education

Part C State Performance Plan (SPP) for 2005-2012

Update for FFY 2010 (July 2010 – June 2011)

February 1, 2012

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Revision History

Original: Mailed paper copy to OSEP – 12-1-05
Submission: Electronic copy to OSERS.capr@ed.gov – 12-02-05
Update: revised indicator 1, e-mailed to Cynthia Bryant at OSEP – 1-20-06
Complete update of all indicators format to present activities, resources and timelines in tabular format – February 1, 2007
Updated 3/31/07 to include required changes to indicators 4, 6 and 14
Updated 0/10/07 to establish improvement trajectory for indicator # 6 above the baseline
Revision February 2008 to include changes presented in the February 1, 2008 FFY2006 Annual Performance Report (APR)
Revision April 7, 2009 to respond to changes presented in the April 7, 2009 FFY2007 Annual Performance Report (APR) update
Revision February 10, 2010 to include changes presented in the February 1, 2010 FFY2008 Annual Performance Report (APR)
Revision April 12, 2010 to respond to items presented in the March 31, 2010 Opportunity for Clarification of SPP/APR Data, as described in "Maine Part C FFY 2008 SPP/APR Status Table
Revision Feb 1, 2011 to include target data and improvement activities for FFY2011 and FFY2012.
Revision April 14, 2011 to respond to items presented in the April 11, 2011 Opportunity for Clarification of SPP/APR Data, as described in "Maine Part C FFY 2009 SPP/APR Status Table - change to page 60 only
Revision February 1, 2012 to remove highlights from April 2011, and highlight subsequent changes.

Overview of the Part C State Performance Plan Development

Maine submitted its State Performance Plan (SPP) on December 2, 2005, followed by revisions periodically as changes in the plan were required by legislation, regulation, or reporting guidance. Additionally, updates have been made to evolve the document with changes in measurements and new data. All versions of the SPP are posted by date of update on the Maine Department of Education website at http://www.state.me.us/education/speced/spp/index.html for public review. A brief list of the change history is included following the Table of Contents on page 2.

Summary of changes in this revision:

Indicator	Change from previous version of the SPP (April 4, 2009)
Throughout	Removed highlighted changes entered in the April 2011 update. Extended indicator title to FFY2012.
TOC	No changes.
1	No changes.
2	No changes.
3	No changes.
4	No changes.
5	No changes.
6	No changes.
7	No changes.
8	No changes.
9	No changes.
10	No changes.
11	No changes.
12	No changes.
13	No changes.
14	No changes.
Appendix	No changes.

Maine Advisory Council for the Education of Children with Disabilities (MACECD) is the stakeholder organization supporting the development of the SPP indicators. Development of indicator content and revision of indicators has been guided by the stakeholder group throughout the past 11 months. The stakeholder group regularly reviews data developed for each measurement, formulates and pursues hypotheses associated with the data, and builds recommendations for the Maine Department of Education to consider in legislation, rule making, procedures and reporting. The quality of Maine's SPP has benefited greatly form the advice and guidance of our stakeholder organization.

Maine's Child Development Services (CDS) is the system at the state level that supports the local work that occurs for the SPP.

Monitoring Priority:

Early Intervention Services in Natural Environments

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 1: Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.

(20 USC 1416(a) (3) (A) and 1442)

Measurement:

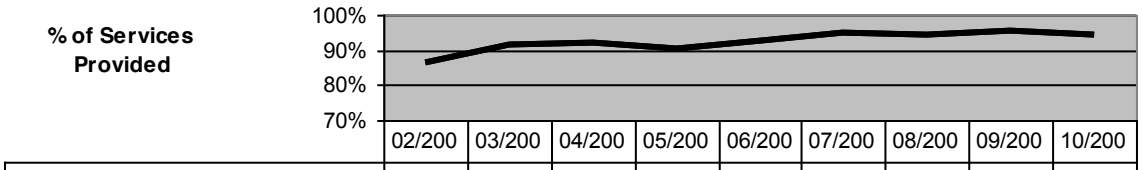
Percent = # of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner divided by the total # of infants and toddlers with IFSPs multiplied by 100.

Overview of Issue/Description of System or Process:

We monitor services to assure that services defined on a child's IFSP are provided in a timely manner. Timely means that services will begin 30 days from the date of the IFSP meeting, barring reasonable exceptions that would be documented in the child's record. CDS sites are required to monitor the status of services and report monthly the number of children whose services are not fully delivered. The monitoring began in February of 2005 and has focused on 4 services. The combined data for the focused monitoring is presented below.

Baseline Data for FFY 2004 (2004-2005):

Figure 1.1: Percent of Services Delivered 2/2005 to 10/2005 Selected Services



	02/200	03/200	04/200	05/200	06/200	07/200	08/200	09/200	10/200
0-2 Children waiting for service	229	139	132	154	122	87	89	78	88
0-2 Children Unduplicated	1676	1650	1639	1638	1612	1620	1624	1623	1622
Services Provided	86%	92%	92%	91%	92%	95%	95%	95%	95%

Month

Discussion of Baseline Data:

Data has been collected on all services in prior years. Given some of the questions related to the accuracy of the data, it was decided to start anew and focus on four specific services: Developmental Delay, Speech Therapy, Occupational Therapy and Physical Therapy. The nine months of data that has been collected shows a positive trend. In the first 6 months, an increased percent of service provision occurred before it has leveled out at 95%. There has been a slight fluctuation in the numbers of services that were not delivered but the number of children in the base population and percents have remained stable. The undelivered services in the data may have been the result of a break in service rather than a delay in the implementation of the service. There was no specific focus on services that had delays in implementation. Children who were waiting for service for any reason were included in the data. Reasons for a break in service or untimely beginnings include but are not limited to the loss of service providers, relocation of children from one CDS site to another, or a shortage of service providers in a specialty.

FFY	Measurable and Rigorous Target

2005 (2005-2006)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2006 (2006-2007)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2007 (2007-2008)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2008 (2008-2009)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2009 (2009-2010)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2010 (2010-2011)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2011 (2011-2012)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.
2012 (2012-2013)	**100%** of infants and toddlers with IFSPs receive the early intervention services on their IFSPs in a timely manner.

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
The data collection system will be modified and specific guidelines for the reporting of the data will be created and CDS site staff trained. Other considerations include:	*X*								
• Collection of data for all services	*X*								
• The potential determination of a reasonable and enforceable numeric definition of timely within the full spectrum of our system	*X*								
• Further evaluation of why services are interrupted and the need for supplemental codes	*X*								
• Determination of the best format for feedback reports	*X*								
• Training and support of the sites	*X*								
Notify CDS sites of the requirements and provide preliminary instruction related to the reporting of the data Work with Site directors to remove any procedural impediments.	*X*								

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Develop ways to classify problems that affect service delivery.	X								
Develop policies for the CDS sites that standardize service delivery practices.	X								
State of Maine's Commissioner of the MDOE has authorized a number of initiatives that focus attention on delivery of services. Though not originally focused on the indicators of the SPP, some of the initiatives work toward the same goal, timely delivery of services A sub-group of CDS site directors and representatives of Maine's community of contracted providers meets regularly to help stay aligned with their combined task of providing services for Maine's children in need. They will continue to look for ways to assure the timely delivery of services.	X								
During the development of the SPP, one of the largest stakeholders in the process, the Maine Advisory Council on the Education of Children with Disabilities (MACECD) has taken a strong interest in this indicator and will be focusing its resources to assist with the development of an effective delivery system.	X								
CDS Central Office staff has been working closely with the State's MaineCare division to clarify and refine payment policies that impact children ages 0-2. This work will continue.	X								
Modify and distribute the updated electronic data collection forms and train CDS site staff in their use.	X								
Collect and analyze submitted data.		X							
Review annual targets.		X							
Use the formula prescribed in "Measurement" above to calculate the actual percent of children who received services in a timely manner.		X							
Build on outcomes from the first year's interactions with site directors and providers to continue the development of policies and procedures to remove impediments to timely service.		X	X						
Continue ongoing data collection, evaluation and review of active IFSPs.			X						
Monitor compliance status through quarterly reports.			X						

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Develop strategies to eliminate known reasons for delays in service delivery.			*X*						
Evaluate active IFSPs quarterly.			*X*						
Review the goals of this indicator and reevaluate all facets of data delivery and current practices to assure alignment.				*X*					
Modify the system as needed.				*X*					
Review targets.				*X*					
Utilize procedures developed and refined in the prior years for ongoing monitoring.					*X*	*X*	*X*	*X*	*GSST*
Continue to provide strategies and assistance for meeting the 100% targets.					*X*	*X*	*X*	*X*	*GSST*

The data for this indicator show we have made a good start toward the 100 percent target, but there is still much to be done. One of the purposes for the collection of service provision data is to create a benchmark for the data collection system and allow us time to consider some of the needs related to the collection and analysis of the data electronically.

We have codes that allow us to identify services that are not being delivered and these will be expanded to tell us the reason e.g. whether the services are implemented in a timely fashion or whether the services were interrupted. (need to consider whether this is needed with the new data)

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 2: Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or community-based settings.

Measurement:

Percent = [(# of infants and toddlers with IFSPs who primarily receive early intervention services in the home or community-based settings) divided by the (total # of infants and toddlers with IFSPs)] times 100.

Overview of Issue/Description of System or Process:

Children age 0-2 learn more easily and effectively in their natural environments e.g. in their homes or in programs including other children of their age and abilities. An Early Childhood Team (ECT), composed of parents, service providers and a Child Development Services (CDS System) Early Intervention service coordinator, is charged with evaluating the children to determine eligibility and the specific areas of need. The setting of service delivery is one of the elements they determine.

Maine is a rural state where children often live long distance from service provider locations or community-based early childhood centers. Multiple approaches are used to move early childhood environments as close to children as is possible. Infants and toddlers with special education or developmental needs are served at home, day-care settings or in other community settings among their typically developing peers throughout the state, when it is possible. When necessary, service providers travel to children at their homes and other settings to provide services.

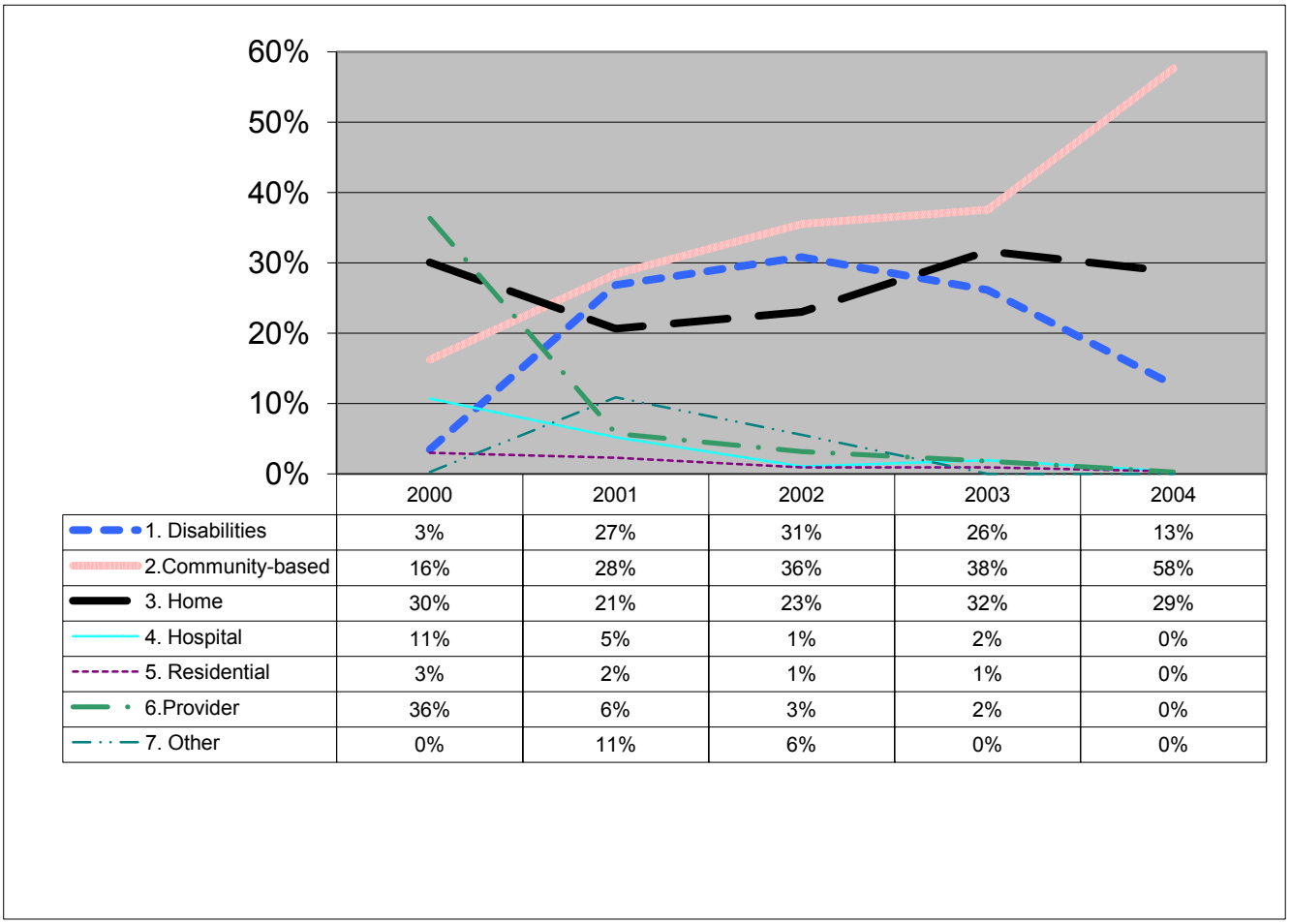
Methods for providing service to the 0-2age group in Maine are evolving. The CDS System has been the agency in the MDOE charged with providing services to all children 0-5. Improvements in administrative efficiency and consistency of reporting are driving changes in the structure of the CDS System. Efforts are under way to centralize the administrative functions of the 16 CDS sites and additional training is being provided to assure consistency among the CDS sites. It is expected that these changes will improve the delivery of services for all children and ensure that eligibility determination is consistent across the state. These changes and changes to the data system will also enhance efforts to determine the effectiveness of Part C services.

Children will benefit from the ongoing evaluation of Maine's service delivery system. The Maine Advisory Council on the Education of Children with Disabilities (the Stakeholder Group), the State's Commissioner of MDOE and several other advisory groups composed of direct service providers, concerned parents, consultants and CDS System staff have already spurred efforts that have made an impact, as can be seen in the data displayed below.

Baseline Data for FFY 2004 (2004-2005):

The percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or community-based settings in FFY2004 is 87% (58% + 29%). Previously the state had been asked to submit data "as to the number of children who received early intervention services primarily in environments other than the home or community-based settings, and whether these children had appropriate justifications on their IFSPs." The State provided data regarding the percentage of children who receive EIS in environments other than the home or community-based settings.

Figure 2.1: Settings for Children 0-2 2000 – 2004



	2000	2001	2002	2003	2004
1. Disabilities	3%	27%	31%	26%	13%
2.Community-based	16%	28%	36%	38%	58%
3. Home	30%	21%	23%	32%	29%
4. Hospital	11%	5%	1%	2%	0%
5. Residential	3%	2%	1%	1%	0%
6.Provider	36%	6%	3%	2%	0%
7. Other	0%	11%	6%	0%	0%

Table 2.1: Total Counts of Children 0-2 in December 1 Child Counts 2000 – 2004

	2000	2001	2002	2003	2004
Children	842	964	1,078	1,105	1,169

Expanded category titles:

1. Program Designed for children with developmental delay or disabilities
2. Community-based Settings

3. Home
4. Hospital (Inpatient)
5. Residential Facility
6. Service provider location
7. Other

Discussion of Baseline Data:

The Childlink data system captures the setting that the ECT determines to be appropriate for the child. The data table above displays the results of the data analysis. This data is reported on an ongoing basis by each CDS site as children are served throughout the year. By February 1 of each year, the State reports Child Count data to the Office of Special Education Programs (OSEP) as part of the Individuals with Disabilities Education Act (IDEA) Part C data collection. In November of each year, Table 2 (TABLE 2 – REPORT OF PROGRAM SETTING WHERE EARLY INTERVENTION SERVICES ARE PROVIDED TO INFANTS AND THEIR FAMILIES IN ACCORDANCE WITH PART C) is sent to OSEP. The data in Table 2 is based on the children in the Child Count.

The data show that the setting for delivery of services has moved to those settings that are most appropriate for infants and toddlers. Over the past 5 years we have experienced an increased divergence of two areas "Programs designed for children with developmental delay or disabilities" and "Community-based Settings." In the same period the number of children served in "Hospital Inpatient settings" and "Provider locations" has dropped almost to none. Though the chart does not show it, there is a fractional percent of services being provided in those locations. These changes have come about partially because of a changed awareness of the definitions of the settings and partially due to a renewed effort to serve children in the environments that reinforce the service provided.

Systemic changes will continue to focus on ways to serve children in the environment that best suit their needs.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	**90%** of infant and toddlers will be served in the home or community-based settings.
2006 (2006-2007)	**91%** of infant and toddlers will be served in the home or community-based settings.
2007 (2007-2008)	**92%** of infant and toddlers will be served in the home or community-based settings.
2008 (2008-2009)	**93%** of infant and toddlers will be served in the home or community-based settings.
2009 (2009-2010)	**94%** of infant and toddlers will be served in the home or community-based settings.
2010 (2010-2011)	**95%** of infant and toddlers will be served in the home or community-based settings.

2011 (2011-2012)	**95%** of infant and toddlers will be served in the home or community
2012 (2012-2013)	**95%** of infant and toddlers will be served in the home or community

Improvement Activities/Timelines/Resources:

Emphasis on providing services in a natural environment stimulated a review of settings data beginning in the 2002–2003 period and continued into the 2004-2005 base year period. The review resulted in the clarification of setting definitions and the guidelines for their use. The data at this point indicate that we are serving about 87 % of infant and toddlers in the home or community-based settings. We will continue to seek ways to provide services in the setting that best suits the needs of the children in the CDS system.

The CDS system staff, MDOE staff, and the Stakeholder Group maintain a list of improvement activities that are pursued actively in operational sessions and planning activities. The groups regularly analyze data, monitor legislation, review regulations, evaluate environmental factors, and discuss opportunities as they become apparent. The list below depicts those items highlighted during the development of this indicator, but will change throughout the year as new concerns arise:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Settings data will be monitored to assure that children are served in the home or in community settings, the natural environments. For personnel who develop IFSP/IEPs, provide training on strategies to assure that children are served in a home or community setting.	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Data personnel in the reporting sites will continue to receive regular professional development to assure that the data sustains high accuracy regarding settings data definitions. Monitor and assess data collection method, data definitions, and reporting requirements to insure consistent and compatible criteria are applied for all children.	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*CDS Sites*
Sites will continue to recruit and retain qualified service providers throughout the state in order to assure availability of service in all communities and rural regions.	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*CDS Sites*

Continue to evaluate service delivery mechanisms to assure that they focus on the natural environment.	*X*				*X*	*X*			During the development of the SPP, one of the largest stakeholders in the process, the Stakeholder Group, has taken a strong interest in this indicator and will be focusing its resources on helping to develop an effective delivery system.
Develop policies that align the sites in service delivery practices.	*X*				*X*	*X*	*X*	*X*	*GSST*
For personnel who develop IFSP/IEPs, provide training on strategies to assure that children are served in a home or community setting.	*X*				*X*	*X*	*X*	*X*	*GSST*
A sub-group of CDS site directors and representatives of Maine's community of contracted providers meets regularly to help stay aligned with their combined task of providing services for Maine's children in need. They will be looking for ways to ensure the delivery of services in the home or in community settings.	*X*								
Building on outcomes from the first year's interactions with site directors and providers, continue to develop policies and procedures that encourage the delivery of services in the home or in community settings.		*X*							
As changes continue in the CDS system, settings data will be monitored to ensure that children are served in the home or in community settings, the natural environments.		*X*							
Continue ongoing data collection and evaluation.			*X*						
Monitor settings' status through quarterly reports based on of active IFSPs.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Review the goals of this indicator and reevaluate all facets of data delivery and current practices to assure alignment.				*X*					
Modify the system as needed.				*X*	*X*	*X*	*X*	*X*	*GSST*
Review targets.				*X*	*X*	*X*	*X*	*X*	*GSST*
Continue ongoing monitoring using procedures developed and refined in the prior years.				*X*	*X*	*X*	*X*	*X*	*GSST*

Part C State Performance Plan (SPP) for 2005-2012

(The following items are to be completed for each monitoring priority/indicator.)

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 3: Percent of infants and toddlers with IFSPs who demonstrate improved:

A. Positive social-emotional skills (including social relationships);

B. Acquisition and use of knowledge and skills (including early language/ communication); and

C. Use of appropriate behaviors to meet their needs.

Measurement:

Progress categories for A, B and C:

a. Percent of infants and toddlers who did not improve functioning = [(# of infants and toddlers who did not improve functioning) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers = [(# of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it = [(# of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers = [(# of infants and toddlers who improved functioning to reach a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers = [(# of infants and toddlers who maintained functioning at a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

Summary Statements for Each of the Three Outcomes (use for FFY 2008-2009 reporting):

Summary Statement 1: Of those infants and toddlers who entered or exited early intervention below age expectations in each Outcome, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program.

Measurement for Summary Statement 1:

Percent = # of infants and toddlers reported in progress category (c) plus # of infants and toddlers reported in category (d) divided by [# of infants and toddlers reported in progress category (a) plus # of infants and toddlers reported in progress category (b) plus # of infants and toddlers reported in progress category (c) plus # of infants and toddlers reported in progress category (d)] times 100.

Summary Statement 2: The percent of infants and toddlers who were functioning within age expectations in each Outcome by the time they turned 3 years of age or exited the program.

Measurement for Summary Statement 2: Percent = # of infants and toddlers reported in progress category (d) plus # of infants and toddlers reported in progress category (e) divided by the [total # of infants and toddlers reported in progress categories (a) + (b) + (c) + (d) + (e)] times 100.

A. Positive social-emotional skills (including social relationships):	**Number of children**	**% of children**
a. Percent of infants and toddlers who did not improve	**19**	**15.7**

functioning		
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**30**	**24.8**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**24**	**19.8**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**28**	**23.1**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**20**	**16.5**
Total	**N=121**	**100%**
B. Acquisition and use of knowledge and skills (including early language/communication):	**Number of children**	**% of children**
a. Percent of infants and toddlers who did not improve functioning	**15**	**12.4**
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**32**	**26.4**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**43**	**35.5**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**25**	**20.7**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**6**	**5.0**
Total	**N=121**	**100%**

C. Use of appropriate behaviors to meet their needs:	**Number of children**	**% of children**
a. Percent of infants and toddlers who did not improve functioning	**20**	**16.5**
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**29**	**24.0**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**27**	**22.3**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**25**	**20.7**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**20**	**16.5**
Total	**N=121**	**100%**

Summary Statements	**% of children**
Outcome A: Positive social-emotional skills (including social relationships)	

1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	51.5
2. The percent of children who were functioning within age expectations in Outcome A by the time they turned 3 years of age or exited the program	39.7

Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)	
1. Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	59.1
2. The percent of children who were functioning within age expectations in Outcome B by the time they turned 3 years of age or exited the program	25.6
Outcome C: Use of appropriate behaviors to meet their needs	
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	51.5
2. The percent of children who were functioning within age expectations in Outcome C by the time they turned 3 years of age or exited the program	37.2

Overview of Issue/Description of System or Process:

CDS has been involved in the use of the Child Outcomes Summary Form (COSF) since 2005. Since that time we have moved from three sites piloting the COSF to all sites submitting the COSF. The state has adopted the use of the ECO COSF with minor adaptations to the identifying information. Training has occurred with staff from ECO and NECTAC on two occasions.

Trainings with ECO and NECTAC occurred in January 2007 and in November 2008. Since that time ongoing technical assistance has occurred through Lunch and Learn sessions and by regular contact between the CDS State IEU and the regional site personnel. The first Administrative Letter that was given to the regional sites indicates their responsibility for COSF was effective April 1, 2007 (Administrative Letter #2 http://www.maine.gov/education/speced/cds/adminltrs/ltr2cosf.pdf). An updated Administrative Letter has gone into effect as of February 4, 2009 (Administrative Letter #14 http://www.maine.gov/education/speced/cds/adminltrs/adminlet14.pdf). With Administrative Letter #14 regional sites were provided with an updated decision tree, guidelines, and a developmental milestone checklist. The most recent guidance documents were developed by personnel who attended the November 2008 training. Since that training we have moved from having all COSFs submitted on paper with a staff person at the CDS State IEU entering them into a database to having all the forms submitted electronically. This transition has provided CDS State IEU staff additional time to review the information being submitted for accuracy and completeness. The form has been modified throughout the year to ensure information collected is accurate and reliable. In FFY2007, 59 children were assessed and in FFY2008, 121 children were assessed.

In addition to the technical assistance and training provided to the regional site personnel, the CDS State IEU has been chosen to be one of the seven Framework Partner States through ECO. With the assistance of Maine's ECO support team, the CDS State IEU has identified goals to help move our COSF system even further. Over the next two years, as part of the framework partnership, we will assist ECO to develop their COSF Framework and they will assist us to develop parent friendly information, develop strategies to make the COSF process included into the IFSP/IEP process, and assist us to develop training materials. The CDS State IEU will use the materials to provide training to all Early Care and Education personnel in Maine on the understanding and importance of Child and Family Outcomes. In June of 2009 the Part C/619 Policy Manager (formally the Birth to Five Intervention, Programming and Staff Development Consultant) attended the National Outcomes and Data Conferences. She presented with an ECO Representative and two other states at the Outcomes Conference on COSF Quality Assurance. The CDS State IEU will ensure this process continues on its path of growth.

The outcome measure system for Maine includes:

A. Polices and procedures to guide outcome assessment and measurement practices,
B. Provision of training and technical assistance supports to administrators and service providers in outcome data collection, reporting, and use,
C. Quality assurance and monitoring procedures to ensure the accuracy and completeness of the outcome data,
D. Data system elements for outcome data input and maintenance, and outcome data analysis functions,
E. Measurement strategies used to collect data,
F. The criteria used to determine whether a child's functioning was "comparable to same aged peers".

A. Policies and procedures to guide outcome assessment and measurement practices

The population of children for whom outcome data is collected includes all children aged 0-5 who are determined eligible for services and who have an IFSP or IEP. Entry, annual and exit information is gathered on all children who have been in services for more than six months.

A full and individualized evaluation of a child's present level of functioning must be conducted to determine eligibility prior to entry into the CDS system. In 2005, work was initiated to clarify the eligibility

criteria for Part C. Through site, regional and state wide training the differences in eligibility for Part C and 619 are continuously discussed.

Multiple sources of data must be used to determine the eligibility of children. Evaluation and assessment of each child age birth to two referred must include a review of records related to the current health status and medical history of the child. As well as a multidisciplinary assessment of the child's strengths and needs and the appropriate services to meet their needs, a family directed assessment of the resources, priorities and concerns and the identification of the supports and services needed for the family to meet the developmental needs of their child. The evaluation and assessment must be either the Bailey or Battelle Developmental Inventory (BDI). These instruments are the two approved by the State for Part C. A team may use clinical opinion when discussing the eligibility of the child if the child does not meet eligibility through the required standard deviations in State regulations. For a team to use informed clinical opinion they must document why the evaluation produced invalid findings, what objective data was included in determining the child has a developmental delay and indicate an agreement of the team. It is highly suggested that children be observed in their natural environments to document their areas of strengths and concerns. This is the setting within the community where infants and toddlers without disabilities are usually found (e.g. home, child care, play groups). [Maine Unified Special Education Regulation, VII (2)(a)(b)(c)]

The Case Manager (service coordinator) is responsible for collecting and documenting enough information for the team to be able to determine the early childhood outcomes rating for the child (on a scale of 1-7 on the Child Outcomes Summary Form). This discussion is becoming a natural part of the IFSP/IEP meeting. The information gathered includes evaluations and assessments, information provided by the parents of the child, and observations by caregivers and other service providers. Initial levels of performance in the three outcome areas of this indicator will serve as the first data point. CDS sites will also assess all children annually, prior to the renewal of the IFSP, or to transition from Part C to Part B 619. Assessments will also be administered to all children exiting the system who have received services for at least six months.

B. Provision of training and technical assistance supports to administrators and service providers in outcome data collection, reporting, and use

Technical assistance (TA) occurs frequently and is available at any time for all site personnel. An example of the continuous availability for TA is when the COSFs are submitted. At that time, they are reviewed for accuracy. If there is information that is omitted, misplaced, missing, incomplete, inaccurate or unclear the form is returned to the Site Director and/or Case Manager to be reviewed, completed and resubmitted. If the corrections needed are not clear then the Data Distinguished Educator provides TA to the personnel to ensure their competence in the area. The Part C/619 Policy Manager is also available to provide TA to all sites and site personnel. CDS has a training committee that meets monthly to discuss training needs for the system. The training committee recommended that Lunch and Learn sessions be conducted as a refresher to staff as follow up to the November 2008 training done by NECTAC/ECO.

Maine has been selected as one of the seven Framework Partner States with the Early Childhood Outcomes Center. This relationship has been a valuable resource in providing our sites with up to date information and assistance. A representative from ECO met with our Training Committee to discuss implementation processes, usage of, barriers and needs in relation to the COSF. The information gathered was used in developing the Lunch and Learn refresher and is being used to develop information to be shared with the personnel required to monitor and complete the COSF.

The CDS website (http://www.maine.gov/education/speced/cds/cosf/index.html) has been an area of value in providing information and resources in relation to outcomes. Policy statements (Administrative Letter #14 http://www.maine.gov/education/speced/cds/adminltrs/adminlet14.pdf), guidance documents, sample Developmental Milestones, Maine's Early Learning and Infant Toddler Guidelines, COSF, and useful resources are all available on the website. By the end of the year we expect to have completed Training Modules available for training and orientation purposes. The CDS State IEU is developing a COSF monitoring checklist to be used when monitoring files. The checklist will be used as part of an on site visit for a focused monitoring or for the regional site to review their COSF submissions.

In our work with the Framework we are discussing preparation of information to share with parents and staff to ensure understanding of the process used in Maine and how it is beneficial to their child. CDS State IEU staff will work with professionals throughout the Early Care and Education system to support understanding of the outcome data we are tracking and its use to foster growth and performance in programs.

C. Quality assurance and monitoring procedures to ensure the accuracy and completeness of the outcome data

As a part of the CDS monitoring process the file audit form and review ensure outcome information is included in the file. The information submitted is reviewed by the Data Distinguished Educator for completeness prior to entry into the central database. Error checks are built into the data system. Some regional sites have established internal monitoring and review processes prior to submission of the forms to the CDS State IEU.

Over the next year, one of the reports that the CDS State IEU will develop, to assist all of the Regional Site Directors, will include the children who have entered services and who do not have a COSF, if there has been more than a year since an updated COSF has been submitted, and if children have exited and a COSF has not been submitted. This report will provide follow up to sites to ensure they are submitting the information required.

The CDS State IEU is developing a COSF monitoring checklist to be used when monitoring files. The checklist will be utilized as part of an on site visit for a focused monitoring or for the regional site to review their COSF submissions.

D. Data system elements for outcome data input and maintenance, and outcome data analysis

Data continues to be collected, entered and analyzed by the CDS State IEU. The electronic COSFs are submitted to the central office via email. Currently, all sites are submitting forms via email. The COSFs are completed in a standardized MS Word form that is updated on an as needed basis. Streamlining the process from a written process to electronic process has increased the validity of the COSF data, since human interaction has decreased. The State IEU reviews each form submitted for complete information prior to being entered into a central database. The forms are then electronically imported into the central database which is linked to Case-e to verify the information against the child record, previous COSF records, etc. This is an interim process being used while a web based system continues to be developed. Reports based on the data can be produced for other purposes by site or by child and or site.

E. Measurement strategies used to collect data

- Who is included in the measurement, i.e. what population of children? If sampling, share information about your sampling plan.
- What assessment/measurement tool(s) and/or other data sources were used?
- Who conducted the assessments?
- When did measurement occur?
- If multiple data sources were used, what method was used to summarize the data for each child? (e.g., the ECO-developed Child Outcome Summary Form, another method, etc.)
- What data was reported to the state, and how was the data transmitted? (e.g., Programs submit data on paper quarterly to the state agency, data entered through online data system, etc.)
- What data analysis methods were used to determine the progress categories?

In Maine all children aged 0-5 who receive Early Intervention Services receive an entry COSF. If children are in services for more than six months they have a COSF done annually and at exit (from services or from Part C to Part B). For children in Part C they must receive either the Battelle Developmental Inventory (BDI) or the Bailey evaluation (Administrative Letter #1 http://www.maine.gov/education/speced/cds/adminltrs/ltr1bayleybattelle.pdf, March 16, 2007). In addition to the Bayley or the Battelle, teams use observation, other evaluation and assessment tools, screening information and other input from the team members. The assessments/evaluations are conducted by

appropriately certified/trained individuals. Maine uses the COSF developed by ECO using the seven point rating scale. We have made state specific additions to the form which can be found at http://www.maine.gov/education/speced/cds/forms/cosf.doc. All data is reported to the CDS State IEU. For this reporting year the forms have been submitted both electronically and through paper copies mail to the central office. One person in the central office is responsible for entering all information into an internal database. The data is analyzed using the ECO calculator, the state database and by CDS State IEU individuals.

The outcome ratings from entry data are matched to exit outcome ratings for individual children. At the regional CDS sites and CDS central office levels, analysis of matched scores will yield for each of the three outcomes:

a. Percent of children who did not improve functioning:
b. Percent of children who improved functioning but not sufficiently to move nearer to functioning comparable to same age peers;
c. Percent of children who improved functioning to a level nearer to same aged peers but did not reach it;
d. Percent of children who improved functioning to reach a level comparable to same age peers; and
e. Percent of children who maintained functioning at a level comparable to same aged peers.

CDS central analyzes the entry status of children, exit status, and the percentages of children who increased ratings from entry data to exit data (moved nearer to typical development) by site as well as by state.

F. The criteria used to determine whether a child's functioning was "comparable to same aged peers".

Maine utilizes ECO COSF form where the rating 6 and 7 have been defined as the area that meets the OSEP definition requirement for "comparable to same aged peers".

Discussion of Baseline Data:

Maine has chosen to use the ECO Summary Statements Calculator (http://www.fpg.unc.edu/~eco/assets/xls/Summary%20Statement%20Calculator03242009.xls) to generate the baseline data for the table below. Data from the progress charts above are entered into the calculator for each outcome, and the calculator yields the percentages for the Summary Statements table.

Progress Data for Infants and Toddlers Exiting 2008-2009

C. Positive social-emotional skills (including social relationships):	**Number of children**	**% of children**
a. Percent of infants and toddlers who did not improve functioning	**19**	**15.7**
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**30**	**24.8**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**24**	**19.8**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**28**	**23.1**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**20**	**16.5**
Total	**N=121**	**100%**
D. Acquisition and use of knowledge and skills (including early language/communication):	**Number of children**	**% of children**
a. Percent of infants and toddlers who did not improve functioning	**15**	**12.4**
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**32**	**26.4**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**43**	**35.5**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**25**	**20.7**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**6**	**5.0**
Total	**N=121**	**100%**

C. Use of appropriate behaviors to meet their needs:	Number of children	% of children
a. Percent of infants and toddlers who did not improve functioning	**20**	**16.5**
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	**29**	**24.0**
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	**27**	**22.3**
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	**25**	**20.7**
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	**20**	**16.5**
Total	**N=121**	**100%**

Baseline Data for Infants and Toddlers Exiting 2008-2009

Summary Statements	% of children
Outcome A: Positive social-emotional skills (including social relationships)	
1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**51.5**
2. The percent of children who were functioning within age expectations in Outcome A by the time they turned 3 years of age or exited the program	**39.7**

Summary Statements	% of children
Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)	
1. Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**59.1**
2. The percent of children who were functioning within age expectations in Outcome B by the time they turned 3 years of age or exited the program	**25.6**
Outcome C: Use of appropriate behaviors to meet their needs	
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**51.5**
2. The percent of children who were functioning within age expectations in Outcome C by the time they turned 3 years of age or exited the program	**37.2**

Explanation of currently reported progress data

This year's baseline data is based on 121 children who have exited. The intent is for all children to receive an initial, annual and/or exit Child Outcomes Summary Form completed. Therefore, the data is a representation of the children in the CDS program from all 16 regional sites. Reports will be developed, to assist the regional sites in determining children who enter services and who do not have a COSF, if there has been over a year since an updated COSF has been submitted, and if children have exited and a COSF has not been submitted. The will enable the sites to collect data on all children for future analysis and increase data quality.

A comparison from FFY2007 progress data to FFY2008 baseline data, shows an increase in the number of children reported for outcomes. Correspondingly, the percentage of children who did not improve functioning in FFY2007 has decreased in FFY2008 in all three outcome areas. This trend should continue based on more accurate data as staff continues to improve the quality, accuracy, and timeliness of the forms completed.

Measurable and Rigorous Target:

Targets for Infants and Toddlers Exiting in FFY2009 (2009-10) and FFY2010 (2010-2011) and Reported in Feb 2011 and Feb 2012

Summary Statements	Targets for FFY2009 (% of children)	Targets for FFY2010 (% of children)	Targets for FFY2011 (% of children)	Targets for FFY2012 (% of children)
Outcome A: Positive social-emotional skills (including social relationships)				
1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**52**	**53**	**53**	**53**
2. The percent of children who were functioning within age expectations in Outcome A by the time they turned 3 years of age or exited the program	**40**	**41**	**41**	**41**
Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)				
1. Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**59**	**60**	**60**	**60**
2. The percent of children who were functioning within age expectations in Outcome B by the time they turned 3 years of age or exited the program	**26**	**27**	**27**	**27**
Outcome C: Use of appropriate behaviors to meet their needs				
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	**52**	**53**	**53**	**53**
2. The percent of children who were functioning within age expectations in Outcome C by the time they turned 3 years of age or exited the program	**37**	**38**	**38**	**38**

Targets for FFY2009 and FFY2010 have been set based on our evaluation of our baseline data.

Improvement Activities/Timelines/Resources:

Improvement Activities	Timelines								Resources
	FFY Year when activities will occur								
	05	06	07	08	09	10	11	12	
The Battelle II was piloted at three sites (Waterville, Bangor, and Androscoggin)	X								
ECT procedures and policies will be reviewed across CDS sites for consistency		X							
January 2007 on Child Outcomes Summary Form									
All sites will use the COSF		X	X	X	X	X	X	X	CDS Sites
Current data systems will be modified to capture, aggregate, and report the data by site		X							
A training and professional development system related to the child outcome assessment system will be developed and implemented.		X	X						
Continuing assessment of the data collection system			X	X	X	X	X	X	Data Management Team
Continuing training and professional development			X	X	X	X	X	X	CDS Sites

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 4: Percent of families participating in Part C who report that early intervention services have helped the family:

A. Know their rights;
B. Effectively communicate their children's needs; and
C. Help their children develop and learn.

(20 USC 1416(a)(3)(A) and 1442)

Measurement:

A. Percent = [(# of respondent families participating in Part C who report that early intervention services have helped the family know their rights) divided by the (# of respondent families participating in Part C)] times 100.

B. Percent = [(# of respondent families participating in Part C who report that early intervention services have helped the family effectively communicate their children's needs) divided by the (# of respondent families participating in Part C)] times 100.

C. Percent = [(# of respondent families participating in Part C who report that early intervention services have helped the family help their children develop and learn) divided by the (# of respondent families participating in Part C)] times 100.

Overview of Issue/Description of System or Process:

Rather than pilot a survey as was intended in the initial SPP a “census” method was used to survey all parents of children receiving Part C services. To establish baseline a parent survey was sent to all parents with students receiving Part C services. Contact information was obtained from an internal database yielding a total of 1513 prospective respondents.

Survey questions were developed around a modified National Center for Special Education Accountability Monitoring (NCSEAM) parent survey combined with a modified Early Childhood Outcomes (ECO) survey. Together a total of 21 questions were developed around the three target areas of the Indicator. A cover letter, a copy of the survey, and a self-addressed stamped return envelope were sent to all parents during the last week of June 2006.

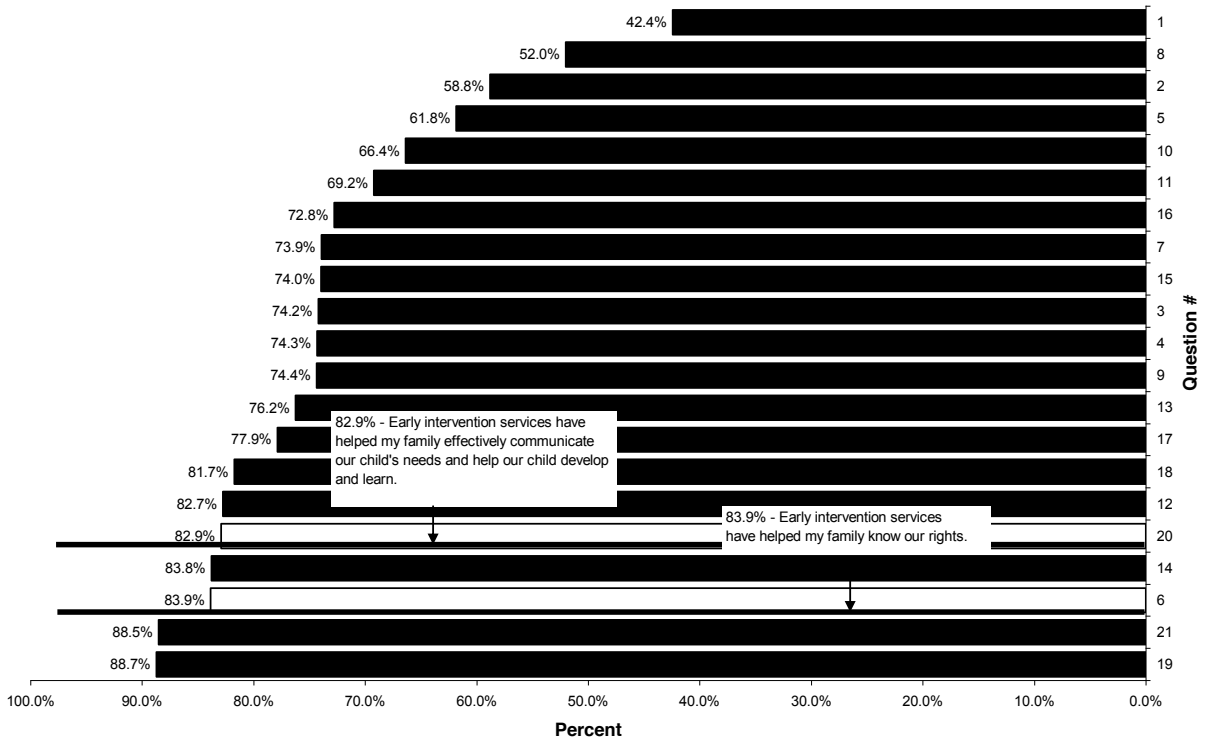
The envelopes included a “Return Service Requested” stamp so that any incorrect address was automatically returned to MDOE rather than sent to a forwarding address. This yielded two groups of incorrect returns, one containing forwarding address and a second for which no forwarding address was available. A second set of envelopes was printed for those with forwarding addresses and a second mailing was done during the third week of November.

Of the 1513 surveys sent 273 were returned, for a response rate of 18%. A stakeholder group (Parent Involvement sub-group of members from the Maine Advisory Council on the Education of Children with Disabilities) was asked to review each of the 21 questions and to rank them in order as to which question they believed most directly represented the target components of the indicator. This exercise was completed three times, once for each of the target components. For 4A, “early intervention services helped the family know their rights,” question 6 – “Over the past year early intervention has helped me and/or my family get the services my child and family need” was selected as most representative. Survey question 20, viz., Over the past year, early intervention has helped me and/or my family understand my child's special needs was chosen as most representative of 4B and 4C.

Discussion of Baseline Data:

To determine the percentage of respondents in agreement with the representative questions, the NCSEAM standard setting process was used. First surveys were scored on a 1-4 basis[1]. This resulted in a possible range of scores from 0 (if someone answered "Never" to all 21 questions) to 84 (if someone answered "Always" to all questions). To determine the percentage of agreement with the target questions, the number of 3s and 4s were summed across all respondents then converted from a 84 point to 100 point scale. The results for all 21 questions were then ranked from lowest percentage of agreement to highest percentage of agreement, and a line was drawn representing the percentage of agreement with the target questions. This method yielded the distribution shown below and indicates that 83.9% percent of parents believe early intervention services helped them know their rights, whereas 82.9% believe that early intervention services help their family "effectively communicate their child's needs" and have "helped my child develop and learn."

Distribution of Part C Parent Survey Returns by Percentage of Often/Always (n = 273)



	Measurable and Rigorous Target		
FFY	**A. Know their rights**	**B. Effectively communicate their children's needs**	**C. Help their children develop and learn**
2006 (2006-2007)	**86%**	**86%**	**86%**
2007 (2007-2008)	**87%**	**87%**	**87%**

[1] Never = 1, Rarely = 2, Often = 3, Always = 4.

	Measurable and Rigorous Target		
FFY	**A. Know their rights**	**B. Effectively communicate their children's needs**	**C. Help their children develop and learn**
2008 (2008-2009)	**89%**	**89%**	**89%**
2009 (2009-2010)	**91%**	**91%**	**91%**
2010 (2010-2011)	**91%**	**91%**	**91%**
2011 (2011-2012)	**91%**	**91%**	**91%**
2012 (2012-2013)	**91%**	**91%**	**91%**

Improvement Activities/Timelines/Resources:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Modify the NCSEAM Early Intervention Part C survey by using the last 22 questions (Impact of Early Intervention Services on Your Family), and a 4 point scale rather than a six point scale with the options of never; rarely; often; always; and selected demographic questions. (See appendix.)	*X*				*X*				
Pilot the survey instrument: CDS Cumberland; CDS Hancock and CDS Androscoggin	*X*								
In coordination with the pilot sites, MDOE will obtain contact information of all parents, foster parents, surrogate parents or guardians who comprise the current caseload of the site. The parents and guardians will be sent the survey with a return postage paid envelope to the Department of Education.	*X*					*X*			
Data entry will be done by a contracted agency.	*X*								
Data analysis will be done by MDOE OSS data analysts.	*X*								

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Provide the survey in accessible modes including Braille, audio, and language translations.	*X*								
Revise the distribution and collection plan as necessary.	*X*								
Set baseline and in January 2007 project annual measurable and rigorous targets based on pilot survey results in January 2007.	*X*								
Develop statewide distribution and collection system based on information from the pilot.		*X*							
MDOE will analyze and interpret the data.		*X*	*X*						
Review the projected annual measurable and rigorous targets.		*X*	*X*						
Publish State and local results disaggregated by CDS site.		*X*	*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Provide technical assistance and professional development workshops using Maine's parent network system: Maine Parent Federation, Southern Maine Parent Awareness, Autism Society and Learning Disabilities Association in partnership with Maine Association of Directors of Children with Special Needs.			*X*	*X*	*X*	*X*			
Continue statewide distribution and collection system.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Review the annual data reaching for the measurable and rigorous targets with the stakeholders group: Maine Advisory Council on the Education of Children with Disabilities.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Distribute State and local results disaggregated by CDS site on the website, through media and to public agencies			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*

Monitoring Priority:

Effective General Supervision Part C / Child Find

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 5: Percent of infants and toddlers birth to 1 with IFSPs compared to national data.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent=[(# of infants and toddler birth to 1 with IFSPs) divided by the (population of infants and toddlers birth to 1)] times 100 compared to national data.

Overview of Issue/Description of System or Process:

The identification of children in need of services has been an integral part of the Early Intervention System in Maine since the development of the CDS System. State agencies, hospitals and private providers to name a few, all refer children to the CDS System. This indicator provides one way of looking at the effectiveness of that system by focusing on a specific age group and showing the percent of children who qualified and are served by the system.

Data for this indicator is from the December 1st Child Counts 1999-2004. The data are maintained in the ChildLink data system by the CDS sites, usually by a specific data coordinator at the site, and entered into the ChildLink database. The data are entered at the sites on an ongoing basis. The individual site databases are submitted to the central office and compiled into a single central database. A preliminary run of the 12/1 Child Count is done at the CDS sites and at the CDS Central Office. The centrally produced report is sent to the CDS sites for verification. The verification process involves distributing lists of children to their case managers. The case managers verify the child's status and return the lists to CDS site's data coordinator. The CDS site's data coordinator works with the CDS Central Office data coordinator to update data in the CDS Central Office database to produce the final Child Count. The database is "frozen" after the data are verified.

Children 0-1 with IFSPs who are included in the annual 12/1 Child Count are identified and the percent of the state population that they represent is calculated.

Baseline Data for FFY 2004 (2004-2005):

For 2004, Maine's Child Count for children 0-1 was 98. The State population of children 0-1 in 2004 was 13,848 so the percent of Maine's children 0-1 served was 0.71 percent. Percents for previous years are compared to those of the US and selected peer groups[1] in the two figures that follow.

Figure 5.1: Percent of Age 0 –1 Population Served in Maine Compared to Selected Groups of States and the US 2002 – 2004

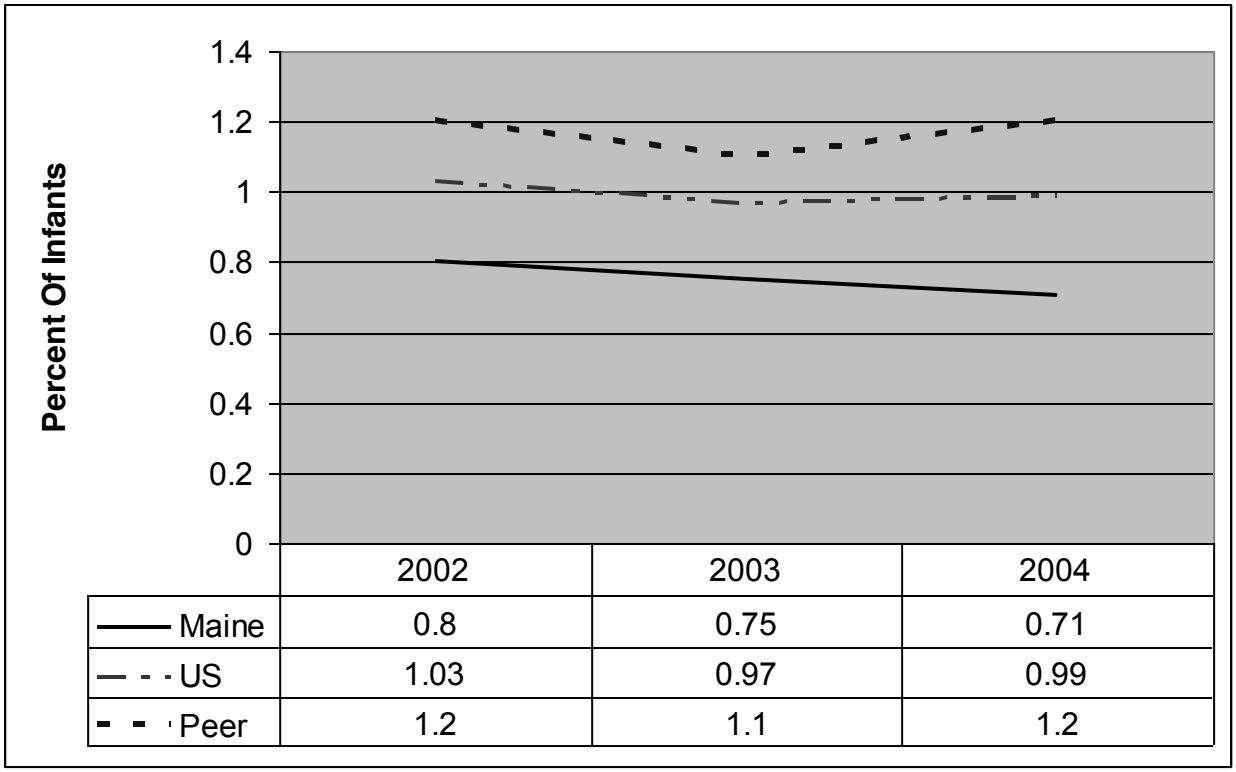


Table 5.1: Percent of Age 0 –1 Population Served in Maine Compared to Selected Groups of States and the US with Peer States, Population and Number of Children 2002 – 2004

Peer Eligibility Subgroup States	2002			2003			2004		
	Pop	Infants	% Served	Pop	Infants	% Served	Pop	Infants	% Served
DELAWARE	10,813	199	1.84	10,786	192	1.78	11,139	148	1.33
MAINE	**13,377**	**107**	**0.8**	**12,985**	**98**	**0.75**	**13,848**	**98**	**0.71**
NEW HAMPSHIRE	14,454	175	1.21	14,694	155	1.05	14,193	164	1.16
SOUTH DAKOTA	10,515	62	0.59	10,384	70	0.67	10,855	97	0.89
VERMONT	6,228	72	1.16	5,861	64	1.09	6,199	54	0.87
WEST VIRGINIA	18,220	321	1.76	20,483	325	1.59	20,649	395	1.91
WYOMING	6,017	82	1.36	6,383	100	1.57	6,600	114	1.73
Peer Average			1.2			1.2			1.2
Peer Median			1.2			1.1			1.2
National			1.03			0.97			0.99
Broad Eligibility Criteria Peer Group									
Broad Average			1.51			1.36			1.34
Broad Median			1.07			1.04			1.1

All data are from published Federal tables.

The "Peer" group for FFY2005 was a subset of 6 states selected from the Broad Eligibility Criteria Peer Group as Maine's peer group[2]. This indicator under A. requires Maine to examine our percentage compared to other states with similar (narrow, moderate, or broad) eligibility definitions. The original baseline data and discussion of the baseline in the State Performance Plan was based upon peers with "comparable population and a few socioeconomic characteristics." With the publication by OSEP in October 2007 of the states ranked by their definitions of developmental delay being narrow, moderate, or broad, Maine is providing a new set of states and their data for comparison.

Arizona	.60
Connecticut	1.23
D.C.	.59
Georgia	.45
Idaho	1.70
Maine	**.63**
Montana	.96
N. Dakota	1.92
Nebraska	.71
Nevada	.67
Oklahoma	1.26
Oregon	.67
S Carolina	.82
Tennessee	.70
Utah	.72

Average of this cohort = .9
National average = 1.04

Displayed data were extracted from:
Percent of Infants and Toddlers Receiving Early Intervention Services, December 1, 2002, 2003, 2004

http://www.ideadata.org/docs/2002PopbyAge.doc
http://www.ideadata.org/docs/2003PopbyAge.doc
http://www.ideadata.org/docs/2004PopbyAge.doc

Discussion of Baseline Data:

Children 0-1 with IFSPs are from the annual 12/1/04 Child Count. They are the population from which the data for the calculation of the base year was drawn.

The selected states within the larger peer group are similar to Maine in population and a few other socio-economic characteristics. Because of the diversity among programs and because of the sizes of the populations that are being compared, it is impossible to know whether the larger or the smaller peer group provides better comparison data.

Regardless of which group Maine is compared to, the data suggest that identification of children under the age of 1 has been fairly consistent in the past 3 years. This is shown in data for Maine and the nation. If there is concern that children in Maine under the age of 3 years are benefiting from liberal criteria for eligibility, it is not borne out in the data. It is possible that they have not been identified. Maine's identified

[2] 2002-2004 Peer Groups were established Based on Table 8.3 Number, Percentage (Based on 2003 Population Estimates), and Difference from National Baseline of Infants and Toddlers Receiving Early Intervention Services December 1, 2003" http://www.federalresourcecenter.org/frc/artbl8_3.xls Selection criteria were based on similarity of population and counts. A comparison of other demographic characteristics of selected states was done to try to assure that the states are similar enough to provide a reasonable comparison.
http://quickfacts.census.gov/qfd/index.html The US Census Bureau's State & County website for basic demographic profiles of each state was the source for comparative demographics in the peer group selection process.

population of children 0 through 2 is higher than the US average, but the 0-1 population is well below the US average.

The trend indicated in all the groups is flat or slightly downward but seems to be consistent across the groups. It is also consistent with a declining birth rate[3].

The percent of children identified by states in the peer group in 2004 are all above Maine's percent of the population. They range from 0.87% to 1.73%. In 2004 they have all, except South Dakota and West Virginia, dropped. The national percent is close to 1.0% from 2002 to 2004.

Based on a review of population under 1 in peer states, it seems that the identification of children in the under1 year age group in Maine is low. This rate may be influencing Maine's low under 5 population growth.

Maine's under 5 population growth is slightly lower than the national growth, 5.5% compared to 6.8%. It may be that having the 0 to 1 identification rate below the national identification rate is the cause. Maine's peers are close to the national growth rate in their under 5 populations and above the national percent of children 0 to 1 identified. It may be that even though Maine's growth rate may be lower than that of the US, the identification rate may be too low and efforts to identify children in that age group may need improvement. http://quickfacts.census.gov/qfd/states/23000.html

Consultants are currently evaluating the ChildFind methods used by the CDS System in Maine. Some of the findings of their evaluation are described briefly below. Based on their final recommendations existing policies and procedures will be revised and supplemented as necessary.

Evaluation findings:

- Public Awareness plans are incomplete,
- Mass screenings need to be more carefully planned and implemented,
- There is a lack of communication among key referral agencies,
- Key referral sources are not referring to the CDS System,
- Waiting lists are a strong deterrent for community members making referrals, and
- There is a lack of confidence in the abilities of the CDS System staff.

Based on the consultants' findings, efforts have been implemented to create solutions that remove each area of concern. Keystones in the process are:

- Clarification of the purpose and need for Early Intervention,
- Enhanced public awareness campaigns,
- Identification sources that should be referring to the CDS System but are not,
- A streamlined central referral system,
- Memorandum's of Understanding (MOU) with referral sources,
- Elimination of waiting lists,

[3] Merritt T. Heminway, Maine's Disappearing Youth: Implications of a Declining Youth Population
Excerpt: "Maine is losing its youth. The number of residents aged 15-29 has been steadily declining throughout the 1980s and 1990s. This unhappy trend can be traced to three separate phenomena: the birth rate among Maine people is continuing a 40-year decline; the rate of out-migration for youth has increased dramatically; and youth in-migration has slowed. This population decline is likely but the leading edge of a much wider problem, a near mirror image of the baby-boom phenomenon, an anti-boom."
http://www.umaine.edu/mcsc/GEDC/presentations/Merritt%20Heminway%20brief.pdf

- Training programs for referral sources,
- Staff improvement programs, and
- Development of protocols for the application of mass screenings.

In the interim period there have been meetings with CDS site staff, associated State agency personnel, and the community at large to create or reinforce the awareness of the CDS System as the focal point for evaluating and providing services to children ages 0 through 2. There have also been efforts made to improve any known areas of concern and develop standard promotional materials from the various materials that exist in the system currently. A public website has been established to provide general information about the CDS System, what we do and how to contact us. The website will be expanded to inform the public about the performance of the agency, provide statistics related to the children we serve, and solicit feedback.

The state's eligibility definition has been determined to be narrow in the October 2007 ranking.

	Measurable and Rigorous Target	
FFY	**Original**	**Revised FFY 2007**
2005 (2005-2006)	**0.75 Percent of the 0 to 1 population.**	**0.75 Percent of the 0 to 1 population.**
2006 (2006-2007)	**0.80 Percent of the 0 to 1 population.**	**0.80 Percent of the 0 to 1 population.**
2007 (2007-2008)	**0.85 Percent of the 0 to 1 population.**	**0.85 Percent of the 0 to 1 population.**
2008 (2008-2009)	**0.90 Percent of the 0 to 1 population.**	**0.75 Percent of the 0 to 1 population.**
2009 (2009-2010)	**0.95 Percent of the 0 to 1 population.**	**0.77 Percent of the 0 to 1 population.**
2010 (2010-2011)	**1 Percent of the 0 to 1 population.**	**.82 Percent of the 0 to 1 population.**
2011 (2011-2012)	**1 Percent of the 0 to 1 population.**	**.82 Percent of the 0 to 1 population.**
2012 (2012-2013)	**1 Percent of the 0 to 1 population.**	**.82 Percent of the 0 to 1 population.**

Improvement Activities/Timelines/Resources:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Review the results of our consultants' findings and begin to implement recommended changes, most of which are mentioned above.	*X*								
Continue to add to our Web presence and other broad media campaigns.	*X*				*X*	*X*			
Determine if the low rate of children with IFSPs is due to low identification rates or criteria for eligibility after they heave entered the system in ChildFind.	*X*								
Develop and maintain communication with a selected group of states to compare methods and results.	*X*								
Continue to solicit input and assistance from stakeholders in the process, the Maine Advisory Council on the Education of Children with Disabilities (MACECD), provider groups, and health care agencies.	*X*								
Review and enhance the ChildLink data system codes to enable more detailed analysis of referral sources. Create periodic reports to provide summaries for analysis.	*X*					*X*			
Review the first year's data to compare referral sources and target low response agencies to determine the reasons for low response.		*X*							
Incorporate any changes to eligibility criteria into the analysis of the rate of children with IFSPs.		*X*							
Ongoing data collection, evaluation including the evaluation of low response referral sources.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Review targets and compare them to peer groups and the US.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 6: Percent of infants and toddlers birth to 3 with IFSPs compared to national data.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent=[(# of infants and toddler birth to 3 with IFSPs) divided by the (population of infants and toddlers birth to 3)] times 100 compared to national data.

Overview of Issue/Description of System or Process:

The identification of children in need of services has been an integral part of the Early Intervention system in Maine since the development of the CDS System. State agencies, hospitals and private providers to name a few, all refer children to the CDS System. This indicator provides one way of looking at the effectiveness of that system by focusing on a specific age group and showing the percent of children who qualified and are served by the system.

Data for this indicator is from the December 1st Child Counts 1999-2004. The data are maintained by the CDS sites, usually by a specific data coordinator at the site, and entered into the ChildLink database. The data are entered at the CDS sites on an ongoing basis. The individual site databases are submitted to the monthly and compiled into the CDS Central Office database. A preliminary run of the 12/1 Child Count is done at the CDS sites and at the CDS Central Office. The report produced by the CDS Central Office is sent to the CDS sites for verification. The verification process involves distributing lists of children at each CDS site to the CDS site case managers. The CDS site case managers verify the child's status and return the lists to the CDS site's data coordinator. The CDS site's data coordinator works with the CDS Central Office data coordinator update data in the CDS Central Office database to produce the final Child Count. The database is "frozen" after the data are verified.

Children ages 0-2 with IFSPs are identified and included in the annual 12/1 Child Count, the percent of the state population that they represent is then calculated.

Baseline Data for FFY 2004 (2004-2005):

In 2004, Maine's annual 12/1 Child Count for children ages 0- 2 was 1,169. The State population of children ages 0- 2 in 2004 was 40,683, so the percent of Maine's children ages 0-2 served was 2.87 percent. Data for previous years are compared to those of the US and selected peer groups in the two figures that follow.

Figure 6.1: Percent of Age 0–2 Population Served In Maine Compared To Selected Groups of States and the US 1999 - 2004

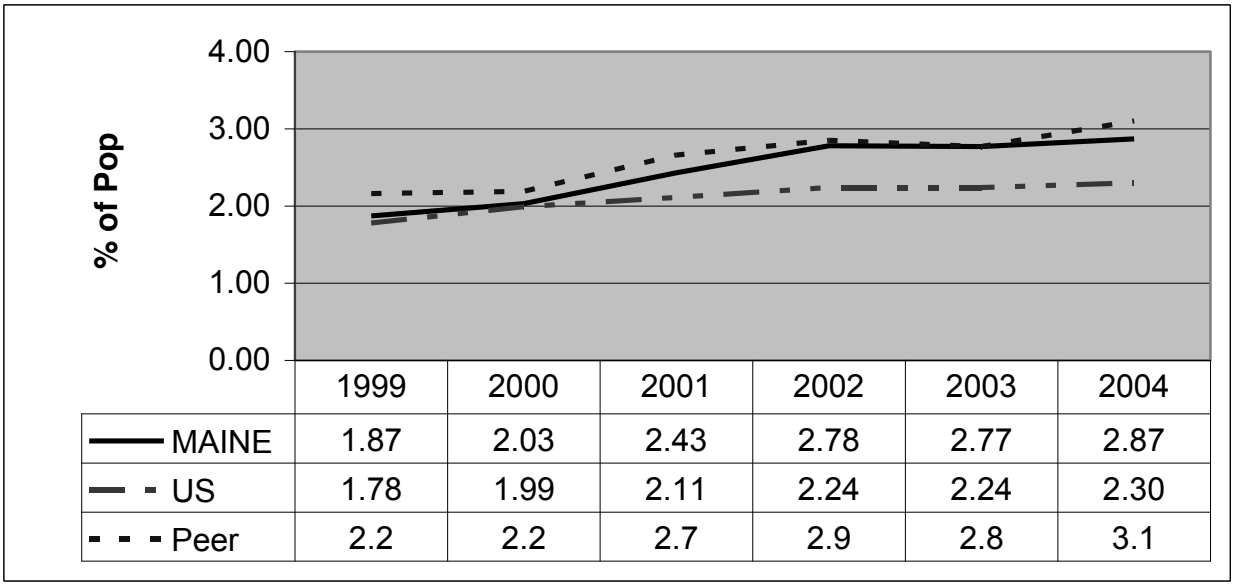


Table 6.1: Percent of Age 0 –2 Population Served In Maine Compared To Selected Groups of States and the US with Peer States 1999 – 2004

Peer Eligibility Subgroup States	1999	2000	2001	2002	2003	2004
DELAWARE	3.08	3.25	2.92	3.29	2.90	3.07
MAINE	**1.87**	**2.03**	**2.43**	**2.78**	**2.77**	**2.87**
NEW HAMPSHIRE	2.25	2.77	2.73	2.82	2.61	2.70
SOUTH DAKOTA	2.06	2.11	2.14	2.28	2.66	2.84
VERMONT	2.16	2.19	2.51	3.10	3.42	3.22
WEST VIRGINIA	1.41	2.13	2.66	2.85	2.73	3.26
WYOMING	2.22	2.46	2.94	3.44	3.57	3.98
Peer Average	2.2	2.4	2.6	2.9	3.0	3.1
Peer Median	**2.2**	**2.2**	**2.7**	**2.9**	**2.8**	**3.1**
National	**1.78**	**1.99**	**2.11**	**2.24**	**2.24**	**2.30**
Broad Eligibility Criteria Peer Group						
Broad Average	2.08	2.33	2.48	2.65	2.66	2.79
Broad Median	1.88	2.12	2.35	2.52	2.53	2.74

Table 6.2: 0–2 Child Count Maine and Selected States 1999 – 2004

Peer Eligibility Subgroup States	1999	2000	2001	2002	2003	2004
Delaware	933	1,003	903	1,036	955	1,006
Maine	748	842	947	1,078	1,105	1,169
New Hampshire	979	1,214	1,174	1,221	1,142	1,164
South Dakota	611	645	655	704	830	897
Vermont	409	434	471	576	622	600
West Virginia	833	1,288	4,553	1,619	1,517	1,985
Wyoming	401	457	531	618	672	759

Table 6.3: 0-2 Population Maine and Selected States 1999 – 2004

Peer Eligibility Subgroup States	1999	2000	2001	2002	2003	2004
Delaware	30,304	30,867	30,959	31,474	32,881	32,810
Maine	39,977	41,453	39,006	38,765	39,831	40,683
New Hampshire	43,559	43,897	43,027	43,222	43,959	43,104
South Dakota	29,625	30,516	30,599	30,885	31,183	31,624
Vermont	18,937	19,807	18,740	18,592	18,161	18,606
West Virginia	59,277	60,404	58,472	56,777	61,008	60,914
Wyoming	18,031	18,561	18,050	17,978	18,826	19,081

All data is from published Federal tables.

Displayed data were extracted from:
Table AH1: Number and Percentage of Infants and Toddlers Receiving Early Intervention Services 1999, 2000, 2001, 2002, 2003, 2004
http://www.ideadata.org/tables/ar_ah1.htm
http://www.ideadata.org/tables24th/ar_ah1.htm
http://www.ideadata.org/tables25th/ar_ah1.xls
http://www.ideadata.org/tables26th/ar_ah1.xls
http://www.ideadata.org/tables27th/ar_ah1.xls

Table 8-3a: Infants and toddlers ages birth through 2 (including children at risk) receiving early intervention services under IDEA, Part C, by eligibility criteria (old), age, and state (in descending order of percent of population): 2004
http://www.federalresourcecenter.org/frc/artbl8_3a.xls

Discussion of Baseline Data:

A review of children identified by peer states indicates that the identification rate for children ages 0 through 2 in Maine has been below the median identification rate of the peer[4] group but is higher than the rate for the US as a whole. The percent of Main's children 0 through 2 has stayed close to the media of the selected peer group. Note that the states in the peer group used above are a subset of the complete peer group defined as having "Broad Eligibility Criteria" in Table 8.3.

[4] 1999-2004 Peer Groups were established Based on Table 8.3 Number, Percentage (Based on 2003 Population Estimates), and Difference from National Baseline of Infants and Toddlers Receiving Early Intervention Services December 1, 2003" http://www.federalresourcecenter.org/frc/artbl8_3.xls Selection criteria were based on similarity of population and counts. A comparison of other demographic characteristics of selected states was done to try to assure that the states are similar enough to provide a reasonable comparison.
http://www.federalresourcecenter.org/frc/artbl8_1.xls provided a comparison of the percent of children 0-2 for each state to the national baseline
http://quickfacts.census.gov/qfd/index.html The US Census Bureau's State & County website for basic demographic profiles of each state was the source for comparative demographics in the peer group selection process.

The states in the subset of the "Broad Eligibility Criteria" peer group have populations and counts of children similar to that of Maine. The means and averages for the subset are a little higher than those of the broad peer group.

The rates for the larger peer group are below Maine's rate for 2003.
Table 8.3: 2003 "Broad Eligibility Criteria" peer group average = 2.49
Table 8.3: 2003 "Broad Eligibility Criteria" peer group median = 2.43

The selected states within the larger peer group are similar to Maine in population and a few other socio-economic characteristics. Because of the diversity among programs, it is impossible to know whether the larger or the smaller peer group provides better comparison data.

This indicator under A. requires Maine to examine our percentage compared to other states with similar (narrow, moderate, or broad) eligibility definitions. As in Indicator #5 's case and now Indicator #6 the original baseline data and discussion of the baseline in the State Performance Plan was based upon peers with "comparable population and a few socioeconomic characteristics." With the publication by OSEP in October 2007 of the states ranked by their definitions of developmental delay being narrow, moderate, or broad, Maine is providing a new set of states and their data for comparison.

Arizona	1.81
Connecticut	3.41
D.C.	1.4
Georgia	1.26
Idaho	2.77
Maine	**2.42**
Montana	1.94
N. Dakota	3.11
Nebraska	1.74
Nevada	1.36
Oklahoma	1.97
Oregon	1.80
S Carolina	1.98
Tennessee	1.67
Utah	1.84

Cohort Average 2.03
National Average 2.43

In the State Performance Plan submitted February 2007 the discussion of baseline data reflected that Maine's identification rate was below the median of the peer group but higher than the rate for the US as a whole. In reality when you examine the cohort group by type of eligibility criteria ranking Maine is actually higher than most of the cohort group, with the exceptions of Connecticut, North Dakota and Idaho and is .01% less than the national average per the www.ideadata.org web listings. The cohort average is 2.03 which Maine is above.

Note: National tables AH1 and 8.3, theoretically, display the same data.

FFY	Original	Revised FFY 2007
2005 (2005-2006)	**2.80% of the 0-2 population.**	**2.80% of the 0-2 population.**

FFY	Original	Revised FFY 2007
2006 (2006-2007)	2.81% of the 0-2 population.	2.75% of the 0-2 population.
2007 (2007-2008)	2.82% of the 0-2 population.	2.43% of the 0-2 population.
2008 (2008-2009)	2.83% of the 0-2 population.	2.55 % to 2.5 % of the 0-2 population.
2009 (2009-2010)	2.84% of the 0-2 population.	2.67 % to 2.5 % of the 0-2 population.
2010 (2010-2011)	2.85% of the 0-2 population.	2.81 % of the 0-2 population.
2011 (2011-2012)	2.85% of the 0-2 population.	2.81 % of the 0-2 population.
2012 (2012-2013)	2.85% of the 0-2 population.	2.81 % of the 0-2 population.

Improvement Activities/Timelines/Resources:

A preliminary review of policies for ChildFind and eligibility determination indicates that too many children may be entering the system due to overly liberal eligibility criteria. The only eligibility category for children ages 0 through 2 is Developmental Delay, so all children qualify for services if they meet the criteria for Developmental Delay. The criteria for eligibility are currently being reviewed for appropriateness.

Consultants are currently evaluating the ChildFind methods used by CDS System in Maine. Some of the findings of their evaluation are described briefly below. Based on their final recommendations, existing policies and procedures will be revised and supplemented as necessary.

Evaluation findings:

- Public Awareness plans are incomplete,
- Mass screenings need to be more carefully planned and implemented,
- There is a lack of communication among key referral agencies,
- Key referral sources are not referring to the CDS system,
- Waiting lists are a strong deterrent for community members making referrals, and
- Lack of confidence in the abilities of the CDS system staff.

Based on the findings, efforts have been implemented to create solutions that remove each area of concern. Keystones in the process are:

- Clarification of the purpose and need for Early Intervention,
- Enhancement of public awareness campaigns,
- Identification of sources that should be referring to the CDS system but, are not,

- Streamlined central referral system,
- Development of Memorandum's of Understanding (MOU) among referral sources,
- Elimination of waiting lists,
- Development of training programs for referral sources,
- Staff improvement programs.
- Development of protocols for the application of mass screenings.

In the interim period there have been meetings with CDS staff, associated State agency personnel, and the community at large to focus attention on CDS as the focal point for evaluating and providing services to the 0-2 age group. There have also been efforts made to improve any other known areas of concern and develop standard promotional materials from the various materials that exist in the system currently.

The state's definition has been determined to be narrow in the October 2007 ranking. A review of the targets will be required to ensure the eligibility definition is consistent with projections.

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Review the results of our consultants' findings and begin to implement recommended changes, most of which are mentioned above.	*X*								
Continue to add to our Web presence and other broad media campaigns.	*X*				*X*	*X*			
Determine if the low rate of children with IFSPs is due to low identification rates or criteria for eligibility after they have entered the system in ChildFind.	*X*								
Develop and maintain communication with a selected group of states to compare methods and results.	*X*								
Continue to solicit input and assistance from stakeholders in the process, the Maine Advisory Council on the Education of Children with Disabilities (MACECD), provider groups, and health care agencies.	*X*								
Review and enhance the ChildLink data system codes to enable more detailed analysis of referral sources. Create periodic reports to provide summaries for analysis.	*X*					*X*			
Review the first year's data to compare referral sources and target low response agencies to determine the reasons for low response.		*X*							
Incorporate any changes to eligibility criteria into the analysis of the rate of children with IFSPs.		*X*							
Ongoing data collection, evaluation including the evaluation of low response referral sources.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*
Review targets and compare them to peer groups and the US.			*X*	*X*	*X*	*X*	*X*	*X*	*GSST*

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 7: Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

(20 U.S.C. 1416(a)(3)(B) and 1442)

Measurement:

Percent = [(# of infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline) divided by the (# of infants and toddlers with IFSPs evaluated and assessed for whom an initial IFSP meeting was required to be conducted)] times 100.

Account for untimely evaluations, assessments, and initial IFSP meetings, including the reasons for delays.

Overview of Issue/Description of System or Process:

Currently this area is being monitored very closely. Monthly counts are submitted by the CDS sites for transmittal to Maine's designated contact at OSEP.

This timeline is clear system wide. The calculation of the timeline has been consistent but strategies for categorizing the reasons for non-compliance have been lacking. A system has been implemented and training has occurred to insure uniform application of codes in the system. The data system has been modified to collect the codes and strategies for handling areas that are identified as problematic have been implemented.

In November 2004, the Commissioner's Steering Committee was formed in order to advise the Commissioner and MDOE on strategies and work plans for improving Maine's compliance with the 45 day timeline. Working with NECTAC and NERRC, Maine continues to move forward with changes to the evaluation and assessment system for children birth through two to ensure consistent practice and compliance.

Baseline Data for FFY 2004 (2004-2005):

Figure 7.1: Assessment and Initial IFSP Meeting by Month

Timeline compliance	Feb #	Feb total pop.	Feb %	March #	March total pop.	March %	April #*	April total pop.	April %
45 day compliance	298	2476	12%	292	1768	16.52%	163	1701	9.58%
45 day - family	77	2476	3.11%	89	1768	5.03%	55	1701	3.23%
45 day- systemic	186	2476	7.51%	143	1768	8.09%	92	1701	5.41%
45 day - other	35	2476	1.41%	60	1768	3.39%	16	1701	0.94%
Timeline compliance	May #	May total pop.	May %	Jun #	Jun total pop.	Jun %	Jul #	Jul total pop.	Jul %
45 day compliance	215	1614	13%	192	1570	12.23%	147	1801	8.16%
45 day - family	43	1614	2.66%	32	1570	2.04%	42	1801	2.33%
45 day- systemic	138	1614	8.55%	123	1570	7.83%	83	1801	4.61%
45 day - other	34	1614	2.11%	37	1570	2.36%	22	1801	1.22%

Timeline compliance	Aug #	Aug total pop.	Aug %	Sept #	Sept Total	Sept %	Oct #	Oct Total[5]	Oct %
45 day compliance	182	1720	10.58%	176	1690	10.41%	148	1660	8.92%
45 day - family	62	1720	3.60%	77	1690	4.56%	46	1660	2.77%
45 day- systemic	105	1720	6.10%	89	1690	5.27%	91	1660	5.48%
45 day - other	15	1720	0.87%	10	1690	0.59%	11	1660	0.66%

Discussion of Baseline Data:

Figure C.7.1 does not contain a full year of baseline data. Since Maine has been working closely with OSEP to bring its 45 day timeline compliance to acceptable levels, changes have taken place in practice and the data system housed data from before February '04 are un-representative of current trends. The data in Figure C.7.1 is compiled at the CDS Central Office from information sent in by all 16 CDS sites in response to the ongoing monitoring of this issue. It is the data being sent to OSEP on a monthly basis and represents current trends.

The Column "Month #" represents the number of children whose IFSPs were not written within the 45 day timeline. The next column represents the total population of children in the system, 0-2, for that month. The final column represents the percentage of children for that month whose IFSPs did not meet the 45 day timeline.

FFY	Measurable and Rigorous Target
2005 **(2005-2006)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2006 **(2006-2007)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2007 **(2007-2008)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2008 **(2008-2009)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2009 **(2009-2010)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2010 **(2010-2011)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline
2011 **(2011-2012)**	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline

[5] 11.30.05 - total population numbers for October are reduced by 32 for Part C and 121 for Part B 619 as one site has not completed their October summary and returned it to the State CDS office at the time these numbers were compiled

FFY	Measurable and Rigorous Target
2012 (2012-2013)	**100%** of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline

Improvement Activities/Timelines/Resources:

Improvement Activities	*Timelines*								*Resources*
	FFY Year when activities will occur								
	05	*06*	*07*	*08*	*09*	*10*	*11*	*12*	
The Professional Development Committee for CDS will develop and implement training in general assessment principles, the use of the Battelle II in determining eligibility, and transdisciplinary teaming will be provided to CDS employees and providers. Continuing professional development is occurring in 2007-08 for providers, parents, and CDS employees.	*X* *X*		*X*	*X*					
Since redefining the data codes, implementing system wide training on the new codes, and beginning to pilot some of the recommendations of the Assessment Committee, sites have already seen reductions in children birth through two whose initial IFSP is not written within the 45 day timeline. It is anticipated that by continuing with the implementation of the Assessment Committee's recommendations, Maine will satisfy the required targets for this indicator.	*X* *X*		*X*	*X*					
Gather Data for lunch and learn to assess response to personal needs and effectiveness of sessions						*X*	*X*	*X*	*GSST*

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Ongoing monitoring of the rates of compliance will inform the necessary training and technical assistance or data management adjustments that are required at the site level to maintain acceptable. • The CDS State IEU reviews the compliance reports site by site on a monthly basis. • The Monitoring consultant reviews the compliance reports before going to do both the on-site training before the monitoring visit and the onsite file review. • During 2006-2007 and ongoing, the State IEU reviews the monthly monitoring reports to determine the impact of the implementation of the department approved Bayley and Battelle II assessments universally. On site monitoring checks for this as well.		*X*	*X*	*X*	*X* *X*	*X* *X*	*X* *X*	*X* *X*	*GSST*

We will continue to focus on the analysis of problem areas. Strategies for encouraging parental responses and developing incentives for providers of services are two areas that will be at the center of improvement efforts.

A sub-group of the Commissioner's Steering Committee, the Assessment Committee, has worked over the past nine months to formulate recommendations relating to eligibility determination for children aged 0-2. The Assessment Committee evaluated many tools currently in use today and has recommended that Maine move to the use of either the Battelle II or the Bayley III to determine eligibility. The committee also recommends moving Maine to use of transdisciplinary assessment teams in order to more consistently meet the 45 day timeline.

Monitoring Priority:

Effective General Supervision Part C / Effective Transition

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / Effective Transition

Indicator 8: Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:

A. IFSPs with transition steps and services
B. Notification to LEA, if child potentially eligible for Part B: and
C. Transition conference, if child potentially eligible for Part B.

(20 USC 1416(a) (3) (B) and 1442)

Measurement:

Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.

Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

Overview of Issue/Description of System or Process:

Maine currently has a seamless system 0-5. Chapter 180(IX.7) currently states: "The Regional Site (CDS site) Board is responsible for ensuring that all children age 2 who have been identified through the Childfind process as meeting the eligibility criteria for early intervention services have an ECT meeting, at least ninety (90) days prior to the child's third birthday, for the purpose of developing an IFSP/IEP for implementation at no cost to the family when the child turns age 3."

- Children ages 0-2 in Maine are eligible if they meet the criteria for "Developmental Delay", the only disability category for that group. The fourteen disability categories for children 3-5 include "Developmental Delay" with the same set of qualifying criteria as 0-2

Baseline Data for FFY 2004 (2004-2005):

FFY	Baseline Data		
	IFSPs with transition steps and services	**Notification to LEA, if child potentially eligible for Part B**	**Transition conference, if child potentially eligible for Part B**
2005 (2005-2006)	69%	100%	87%

Data for this indicator was not available at the time of the initial SPP or for the FFY2005 report. Changes were made in each measurement area that provided those data. The initial data were provided in the FFY2006 Annual Performance Report (APR).

A. IFSPs with transition steps and services

Starting in February of 2007, Child Development Services (CDS) will be using a new IFSP form, which includes pages specifically designed to correlate with the Transition Meeting from Part C to Part B 619 (Appendix: ME IFSP). These pages detail both the transition planning process and discussion during the meeting.

During a statewide CDS training in January 2007, Part C employees were trained to use these new forms.

In the ME Guidance Document, there are specific instructions regarding transition meetings: "During the IFSP Meeting, the team must have a conversation with the parent/caregiver regarding **transition planning** when early intervention services are no longer available for or needed by their child. An explanation regarding eligibility and age guidelines should be provided to help frame the discussions and determine potential transition planning activities for the initial IFSP." (Appendix: ME Guidance Document)

The committee that created the document started the process in the fall of 2004 but the actual product was not available until the fall of 2006. One site began using the form in September 2006 as a de facto pilot site in order to field test the IFSP.

A new data system is being developed and will capture information required to provide data for this indicator. Data collection from the forms is expected to begin on March of 2007.

B. **Notification to LEA**, if child potentially eligible for Part B; and

The LEAs for children transitioning from Part C to Part B in Maine are the regional CDS sites. So notification to the LEA a child is transferring is automatic 100% of the time. The transitions from Part C to Part B are handled all within the same "LEA". Children at age three continue to be served by the CDS system, almost always in the same site. There is notification but not in the sense of a separate LEA.

C. **Transition conference,** if child potentially eligible for Part B.

The Maine State Department of Education (MDOE) has proposed Chapter 101: Maine Unified Special Education Regulation, which states, "The regional CDS Site Board is responsible for ensuring that all children age 2 who have been identified through the child find process as meeting the eligibility criteria for early intervention services have an IFSP Team meeting, at least ninety (90) days prior to the child's third birthday with parental consent, for the purpose of developing an IFSP/IEP for implementation, at no cost to the family, when the child turns age 3" (Proposed Chapter 101: IV(2)(C)(1)). The new regulations clearly state the requirement for a transitional meeting from Part C to Part C619.

MDOE hired Glenwood Research in 2005 to examine the strengths and weaknesses of transitions in the Child Development Services system. Their findings from two pilot sites (Cumberland and Hancock County) indicated that sites were generally not conducting *official* transition meetings from Part C to Part C619. These sites were instead conducting an IFSP meeting at the correct time, but with a lack of emphasis on the child's transition (General Supervision Enhancement Grant). This was due in part to the fluidity between Part C and Part B, which instigated less emphasis on an official transition between the two systems.

Te new IFSP format will provide the means to document the specifics for transfer to the CDS database for use in this indicator. See A. above.

Discussion of Baseline Data:

Based on current policies the existing services are uninterrupted by transition to Part B. Because this is a 0-5 system, there is no formal identification to the LEAs until the spring of the year that the child is eligible for Kindergarten. (Chapter 180 IX.7).

FFY	Measurable and Rigorous Target
2005 (2005-2006)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2006 (2006-2007)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2007 (2007-2008)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2008 (2008-2009)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2009 (2009-2010)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2010 (2010-2011)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2011 (2011-2012)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.
2012 (2012-2013)	**100%** of all children exiting Part C received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.

Improvement Activities/Timelines/Resources:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Providing additional training to sites related to the transition process including the following protocols:	*X*								
• Notify the parent that transition will occur in the next 3 to 6 months.	*X*								

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
• Notify the local education agency (school district) that there will be an Early Childhood Team (ECT) meeting to address transition steps.*	X								
• Coordinate meeting date with family and school district.	X								
• Send information to the family about special education eligibility at age 3.	X								
• Proceed with steps to prepare the toddler and family for changes in service delivery.	X								
• Provide information about community resources.	X								
• Review the IFSP to document transition outcomes by age 3.	X								
• For a child whose first eligibility meeting is held after age 2 years, 6 months, the IFSP developed must include transition information.	X								
Monitor sites for compliance and verify data and data entry.		X	X	X	X	X	X	X	GSST
Expanding the data collection system to include elements specific to transition including but not limited to the following transition steps:		X	X		X	X	X	X	GSST
• The date of the final ECT meeting to review the IFSP for inclusion of transition needs,		X	X						
• The date of notification to the LEA,		X	X						
• Codified results of the meeting. The codes will provide references to special conditions encountered at the transition meeting in addition to the standard Part C Exit Codes.		X	X						
Receipt of Evaluations from contracted/ employed evaluators					X	X			
IEP meetings will be set up after referral					X	X			

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
The data system will be expanded to allow the transition portion of the IFSP to be viewed.					*X*	*X*	*X*	*X*	GSST

Monitoring Priority:

Effective General Supervision Part C / General Supervision

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 9: General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification:

B. Percent of noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification:

C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification:

Overview of Issue/Description of System or Process:

This indicator will require constant dialog between Maine's Part C coordinator and a clearly designated federal coordinator to develop and maintain a vision of what constitutes priority areas, correction, and timelines for correction. Currently, the State and federal coordinators are in place and have an established relationship that is conducive to dialog. Measurement specific:

A.) This document sets out the priority areas. OSEP's annual review and feedback letter specify the findings that will provide the basis for the numerical analysis of this indicator.
B.) Documented dialog between the Part C and federal coordinators will provide the information necessary for this calculation.
C.) The Due Process section of Maine's Department of Education will maintain data for this part of the indicator and will provide a numerical summary of activities. In addition, the Part C coordinator will maintain a documented history of complaints and their subsequent correction that occur outside the MDOE's Due Process purview.

Baseline Data for FFY 2004 (2004-2005):

Level of compliance was though to be 100%, but a thorough mechanism for compliance measurement is being developed as major changes in the CDS system are evolving. The APR for FFY2006 (submitted February 1, 2008 presents the status of ongoing work and the method of measurement being performed to determine compliance. The child record audit form currently in use is included in the appendix.

Discussion of Baseline Data:

A.) Base year data are from the March 2005 feedback letter. The letter defines 9 specific findings. All the recommendations and requirements specified have been fulfilled. During the summer months of 2005, monitoring visits to all 16 CDS sites have identified a number of technical assistance needs and improvement opportunities.

B and C) There is no non-compliance for Part C due process.

This is a compliance indicator so the target is set by OSEP at 100%.

FFY	Measurable and Rigorous Target		
	Noncompliance related to monitoring priority areas and indicators	Noncompliance related to areas not included in the above monitoring priority areas and indicators	Noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.)
2005 (2005-2006)	**100%**	**100%**	**100%**
2006 (2006-2007)	**100%**	**100%**	**100%**
2007 (2007-2008)	**100%**	**100%**	**100%**
2008 (2008-2009)	**100%**	**100%**	**100%**
2009 (2009-2010)	**100%**	**100%**	**100%**
2010 (2010-2011)	**100%**	**100%**	**100%**
2011 (2011-2012)	**100%**	**100%**	**100%**
2012 (2012-2013)	**100%**	**100%**	**100%**

Improvement Activities/Timelines/Resources:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Training and professional development opportunities will be planned to answer needs identified through the site file reviews.	X	X			X	X	X	X	GSST

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
The focused monitoring plan for the Child Development Services System will be developed and will be implemented starting in the Autumn of 2006. This includes:	X	X							
• The transition between Part C and Part B (619)	X	X							
• Documentation and the process in regard to ESY determinations that are not consistent from site to site	X	X							
• Use of Prior Written Notice	X	X							
• Consistency of IFSP / IEP writing	X	X							
• Tracking dates of service and current service providers	X	X							
In April of 2005, MDOE staffed a monitoring position for Part C and Part B 619. In the summer of 2005, all 16 sites received on site file reviews to ascertain a baseline for needed training for the coming year.	X								
Utilization of contracted consultants to provide technical assistance to sites regarding all facets of Part C required.					X	X			

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 10: Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent = (# complaints with reports issued within timelines + # of complaints issued within extended timelines) divided by (# of complaints with reports issued) times 100.

Overview of Issue/Description of System or Process:

Complaints are tracked in detail using the Due Process Office database (DOCKET). The database includes the report issued date and resolution dates for all complaint investigations. Timeline extensions can be granted under specific guidelines.

The DPO provided training to Complaint Investigators during the spring of 2005.

Baseline Data for FFY 2004 (2004-2005):

Most recent data available are for the 2005 calendar year as reported in the September 2005 letter to OSEP:

Table 10.1: Signed, Written Complaints 2005

Part C Signed, written complaints	
Signed, written complaints total	1
Complaints with reports issued	0
Reports with findings	0
Reports without findings	0
Reports within timeline	0
Reports within extended timelines	0
Complaints withdrawn, dismissed, or no jurisdiction	1
Complaints pending	0
Complaint pending a due process hearing	0

Percent = 100%

Discussion of Baseline Data:

One complaint pertaining to children 0-2 years in age was not investigated, because it was withdrawn.

Complaints are very rarely filed for children aged 0-2 years of age. Compliance with this measure in 2005 is likely.

This is a compliance indicator so the target is set by OSEP at 100%.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2006 (2006-2007)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2007 (2007-2008)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2008 (2008-2009)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2009 (2009-2010)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2010 (2010-2011)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2011 (2011-2012)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
2012 (2012-2013)	**100%** of signed written complaints with reports issued were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

Improvement Activities/Timelines/Resources:

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
DPO finalized an internal list of "extenuating circumstances" distributed to complaint investigators as guidance for the joint (with DPO) consideration of requests for extensions.	X	X	X						
Review data on complaint investigations to monitor closure timeliness and ensure consideration of support required.		X	X	X	X	X	X	X	DPO

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 11: Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent = (hearing decisions within timeline + hearing decisions within extended timeline) divided by Hearings (fully adjudicated) times 100.

Overview of Issue/Description of System or Process:

Hearings are tracked in detail using the Due Process Office (DPO) database (DOCKET). The database includes the *report issued date* and *resolution dates* for all hearings. Timeline extensions can be granted by the hearing officer at the request of either or both parties. If a hearing officer grants an extension, the hearing officer must provide to the parties and the DPO a new date certain for the issuance of the hearing decision.

Resolution sessions and agreements are new requirements that will be discussed in Indicator 18.

Baseline Data for FFY 2004 (2004-2005):

Table 11.1: Hearing Requests 2004-2005

Part C Hearing requests	
Hearing requests total	0
Resolution sessions	
Settlement agreements	0
Hearings (fully adjudicated)	0
Decisions within timeline	0
Decisions within extended timeline	0

Table 11.1: Expedited Hearing Requests 2004-2005

Part C Expedited hearing requests	
Expedited hearing requests total	0
Resolution sessions	0
Settlement agreements	0
Expedited hearings (fully adjudicated)	0
Change of placement ordered	0

Percent = 100%

Discussion of Baseline Data:

No cases pertaining to children 0-2 years in age.

This is a compliance indicator so the target is set by OSEP at 100%.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2006 (2006-2007)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2007 (2007-2008)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2008 (2008-2009)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2009 (2009-2010)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2010 (2010-2011)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2011 (2011-2012)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.
2012 (2012-2013)	**100%** of fully adjudicated due process hearing requests will be fully adjudicated within the applicable timeline.

Improvement Activities	Timelines								Resources
	FFY Year when activities will occur								
	05	06	07	08	09	10	11	12	
Review data on hearings to monitor rates of agreement, timeline compliance and reasons for extension.		X	X	X	X	X	X	X	DPO

From January 2005 through May 23, 2005, the DPO had only one hearing officer. This was due to the fact that the DOE received a very poor response to the RFP's for hearing officers and complaint investigators. By June of 2005, the DPO had appointed two more hearing officers. On August 2, 2005, the DPO met with six hearing officers, four of whom are on the regular hearing roster and two of whom are back-up/emergency basis hearing officers. The appointment of more hearing officers is a significant improvement to our hearing services.

After the October 2003 OSEP review and the subsequent letter, the DPO improved the hearing extension request form; it requires the hearing officer to let the parties and the DPO know a new date certain for issuance of the hearing decision when an extension is granted (extensions can only be requested by the parties).

In response to the July 1, 2005 effective date of the IDEA, the Commissioner issued Informational Letters #18 and #20 regarding filing for hearings and expedited hearings.

Due to the relatively small pool of attorneys in Maine who represent schools and families, often there are multiple hearings scheduled during the same time period. If these attorneys are representing the parties, the hearing officers will frequently receive numerous requests for extensions for the hearings over which they are presiding.

In response to the IDEA statute and in order to promote resolution of the issues brought to a hearing, the DPO is scheduling mediations to occur on the 21st day after the LEA has received the request for hearing if both parties are willing to participate in mediation. Then, if the resolution session is waived by both parties or unsuccessful, the parties can participate in mediation.

A peer reviewer has been contracted to read and comment on drafts of hearing decisions.

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 12: Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements (applicable if Part B due process procedures are adopted).

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent = # of settlement agreements divided by # of resolution sessions times 100.

Overview of Issue/Description of System or Process:

This is a new indicator that is resolved from new data inputs "Resolution sessions" and "Settlement agreements" that will be counted in our due process data. The Maine Department of Education Due Process Office (DPO) has developed a resolution session status form for LEAs to fill out when they have received a request for a hearing from parents. In response to the IDEA, the DPO has added to its docket database status drop-down list the following:

1. "Partially resolved resolution session" to indicate that part of the issues brought in a hearing request have been resolved in a resolution session, (NOTE: If the hearing request is withdrawn and the rest of the issues are not taken forward for adjudication, the withdrawal of the hearing status would be "withdrawn with and without prejudice". The issues not resolved in the resolution session could be brought to DPO in a new hearing request.)

2. "Resolved resolution session" to indicate that all of the issues brought in a hearing request have been resolved in a resolution session,

3. "Voided" to indicate the LEA or the parents exercised their right to void the resolution session agreement within three business days of the execution of the agreement,

4. "Waived" to indicate the parties have agreed to waive the resolution session and either have chosen to participate in mediation or wish to proceed directly to a due process hearing,

5. "Not applicable" to indicate that the initiating party is the LEA and a resolution session is not required in this sort of hearing or that an expedited hearing has been requested,

6. "DPO decision" to indicate that the DPO has declined to make arrangements for an expedited hearing request for reasons other than disciplinary issues,

7. "Not resolved" to indicate that a resolution session was held but did not result in an agreement.

The performance data will be accounted for in the charts shown in Indicator 17.

The Maine DOE Commissioner has sent out an informational letter #12 regarding resolution sessions.

Baseline Data for FFY 2004 (2004-2005):

No hearing requests were made for infants and toddlers aged birth to two. Value for Measurable and Rigorous Targets are set based on performance in Part B Indicator 18, where hearing quantities are large enough to provide statistical confidence.

Discussion of Baseline Data:

FFY	Measurable and Rigorous Target
2006 (2006-2007)	**0%** of resolution sessions will result in settlement agreements
2007 (2007-2008)	**0%** of resolution sessions will result in settlement agreements
2008 (2008-2009)	**0%** of resolution sessions will result in settlement agreements
2009 (2009-2010)	**5%** of resolution sessions will result in settlement agreements
2010 (2010-2011)	**6%** of resolution sessions will result in settlement agreements
2011 (2011-2012)	**6%** of resolution sessions will result in settlement agreements
2012 (2012-2013)	**6%** of resolution sessions will result in settlement agreements

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 13: Percent of mediations held that resulted in mediation agreements.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent = (mediation agreements for mediations related to due process + mediation agreements for mediations NOT related to due process) divided by # mediations completed times 100.

Overview of Issue/Description of System or Process:

Mediations are tracked in detail using the Due Process Office (DPO) database (DOCKET). The database includes the report issued date and resolution dates for all mediations.

The DPO provided training to mediators on March 18, 2005.

Baseline Data for FFY 2004 (2004-2005: (Actual data for 2005 calendar year only.)

Table 13.1: Mediation Requests 2004-2005

Part C Mediation requests	
Mediation requests total	0
Mediations	0
Mediations related to due process (for hearings & expedited hearings)	0
Mediation agreements	0
Mediations not related to due process (for stand-alone mediations & complaint investigations)	0
Mediation agreements	0
Mediations declined	0
Mediations open	0

Percent = 100%

Discussion of Baseline Data:

One 1 mediation associated with a request for a complaint investigation pertaining to children 0-2 years in age was mediated in 2005. Value for Measurable and Rigorous Targets are set based on performance in Part B Indicator 19, where mediation quantities are large enough to provide statistical confidence.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	**76%** of mediations held that resulted in mediation agreements.
2006 (2006-2007)	**77%** of mediations held that resulted in mediation agreements.
2007 (2007-2008)	**78%** of mediations held that resulted in mediation agreements.

FFY	Measurable and Rigorous Target
2008 (2008-2009)	**80%** of mediations held that resulted in mediation agreements.
2009 (2009-2010)	**82%** of mediations held that resulted in mediation agreements.
2010 (2010-2011)	**85%** of mediations held that resulted in mediation agreements.
2011 (2011-2012)	**85%** of mediations held that resulted in mediation agreements.
2012 (2012-2013)	**85%** of mediations held that resulted in mediation agreements.

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
The DPO changed the docket designation of stand-alone mediations to "S" so as to differentiate them from mediations associated with complaint investigations, hearings and expedited hearings. This improves the data collection process.	X								DPO
When a dispute resolution request is received for a complaint investigation, hearing or expedited hearing & the initiating party has indicated an unwillingness to participate in mediation, DPO staff follow up with the initiating party to discuss the benefits of mediation, the difference between mediation & an IEP meeting, the expertise & objectivity of the mediator & the wide scope of issues in hopes that the person will choose to participate in mediation.	X	X	X	X	X	X	X	X	DPO

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
With the advent of the resolution session for hearings initiated by parents, the DPO mediation process has been put in a deferential position vis-à-vis the resolution session timeframe. If both parties agree to participate in mediation within the timelines of a hearing requested by a family, the DPO sets up the mediation to occur on or after the 21st day from the receipt of the request for hearing.	X	X	X	X	X	X	X	X	DPO

Part C State Performance Plan (SPP) for 2005-2012

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 14: State reported data (618 and State Performance Plan and Annual Performance Report) are timely and accurate.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement: Submitted on or before due dates (February 1 for child count, including race and ethnicity, settings and November 1 for exiting, personnel, dispute resolution)

Overview of Issue/Description of System or Process:

The Maine Department of Education is required to report annually to the US Department of Education, Office of Special Education Programs on elements of the special education data. Data for these reports are taken from the annual student count done at each LEA in December and subsequent data analysis completed within the Maine Department of Education.

Baseline Data for FFY 2004 (2004-2005):

Table 14.1: Data Submission Dates 2004-2005

Data requirement	Content	Due Data	Actual Date
Table 1	Child Count	February 1, 2005	January 28, 2005
Table 2	Settings	November 1, 2004	October 29, 2004
Table 3	Exiting	November 1, 2004	October 29, 2004
Table 4	Services	November 1, 2004	October 29, 2004
Table 5	Personnel	November 1, 2004	October 29, 2004
Part C APR	Annual Performance Report	April 1, 2005 deferred by letter to May 4, 2005	May 4, 2005

Discussion of Baseline Data:

Submitting data on time has been a priority for the Data Management/Finance and Federal Programs/Research and Evaluation team in the Office of Special Services. Reports are submitted on time. The annual performance report for the 2003-2004 school year was delayed to address a March 4, 2005 letter (page 22 - "within 60 days of this letter") form the Office of Special Education Programs (OSEP) in order to provide adequate response to specific inquiry posed and non-compliance indicated in the letter. The deferred date was May 4, 2005.

Maine's current and sustained performance to this indicator is 100%. This is a compliance indicator so the target is 100%.

Maine has chosen to use the Rubric for Part C - Indicator 14 to compute the measurement for the indicator. This rubric is a worksheet to assist in compiling data for Indicator 14. An example of the data

input worksheet is shown below. The structure is a simple spreadsheet application that accepts data and calculates a percentage of “Timely and Accurate” data submissions weighted as described in the instructions and tables below. The data included in the worksheet are those data related to the FFY2006 submission of the Annual Performance Report (APR).

Instructions: In each cell, select 1 if the requirements were met for the given APR indicator or 618 data collection, 0 if the requirements were not met, and "N/A" if the requirement is not applicable. Note that any cell marked as N/A will decrease the denominator by 1 for APR and 2 for 618.

Definitions of terms used in this worksheet:

SPP/APR Data:

1) Valid and Reliable Data - Data provided are from the correct time period, are consistent with 618 (when appropriate) and the measurement, and are consistent with previous indicator data (unless explained).
2) Correct Calculation - Result produced follows the required calculation in the instructions for the indicator.
3) Instructions Followed - APR provides information required in the instructions for the indicator.

SPP/APR Data - Indicator 14				
APR Indicator	**Valid and Reliable**	**Correct Calculation**	**Followed Instructions**	**Total**
1	1	1	1	3
2	1	1	1	3
3	1	1	1	3
4	1	1	1	3
5	1	1	1	3
6	1	1	1	3
7	1	1	1	3
8a	1	1	1	3
8b	1	1	0	2
8c	1	1	1	3
9	0	0	0	0
10	1	1	1	3
11	1	1	1	3
12	1	1	1	3
13	1	1	1	3
			Subtotal	39
APR Score Calculation		**Timely Submission Points** - If the FFY2006 APR was submitted on-time, place the number 5 in the cell on the right.		5
		Grand Total - (Sum of subtotal and Timely Submission Points) =		46

Part C indicator 8B data are valid and reliable and can be calculated overall, but presenting notification data by site was not possible for 2006-2007. Indicator 9 data have been collected in terms of the identification and notification of finding, but insufficient times has elapsed to evaluation sites’ ability to correct non-compliance within the twelve month timeline.

618 Data:

1) Timely – All data for the APR are submitted on or before February 1, 2008. Data for tables for 618 are submitted on or before each tables' due date. NO extensions.
2) Complete Data – No missing sections. No placeholder data. Data submitted from all districts or agencies.
3) Passed Edit Check - 618 data submissions do not have missing cells or internal inconsistencies.
4) Responded to Data Note Requested - Provided written explanation of year to year changes for inclusion in Data Notes to accompany 618 data submissions.

618 Data - Indicator 14					
Table	**Timely**	**Complete Data**	**Passed Edit Check**	**Responded to Data Note Requests**	**Total**
Table 1 - Child Count Due Date: 2/1/07	1	1	1	1	4
Table 2 - Program Settings Due Date: 2/1/07	1	1	1	1	4
Table 3 - Exiting Due Date: 11/1/07	1	1	1	1	4
Table 4 - Dispute Resolution Due Date: 11/1/07	1	1	1	1	4
				Subtotal	16
618 Score Calculation			**Grand Total** (Subtotal X 3) =		48

Data are summarized in the table below (a continuation of the spreadsheet application) by summing values form above and producing a percentage based on the weighted values. In order to develop an example based upon data, these entries reflect the scoring that represents FFY2006 data reflecting the quality of the submission of the Annual Performance Report (APR) of February 1, 2008. Data are believed to be timely and accurate with the exceptions noted. Maine submitted its complete and accurate 618 data on time, and responded promptly to the data note requests for all tables with one exception.

Indicator #14 Calculation	
A. APR Grand Total	46
B. 618 Grand Total	48
C. APR Grand Total (A) + 618 Grand Total (B) =	94
Total NA or N/A in APR	0
Total NA or N/A in 618	0
Base	**98**
D. Subtotal (C divided by Base*) =	0.959
E. Indicator Score (Subtotal D x 100) =	95.9

FFY	Measurable and Rigorous Target
2005 (2005-2006)	100% of data submitted will be on time and accurate.
2006 (2006-2007)	100% of data submitted will be on time and accurate.
2007 (2007-2008)	100% of data submitted will be on time and accurate.
2008 (2008-2009)	100% of data submitted will be on time and accurate.
2009 (2009-2010)	100% of data submitted will be on time and accurate.
2010 (2010-2011)	100% of data submitted will be on time and accurate.
2011 (2011-2012)	100% of data submitted will be on time and accurate.
2012 (2012-2013)	100% of data submitted will be on time and accurate.

Improvement Activities	***Timelines***								***Resources***
	FFY Year when activities will occur								
	05	***06***	***07***	***08***	***09***	***10***	***11***	***12***	
Maine will continue to track required report deadlines and ensure completion on time.	X	X	X	X	X	X	X	X	MDOE
Child count data are being provided in-part using an electronic upload to the OSEP EDEN database.	X	X	X	X	X	X	X	X	MDOE
Additional data elements and other improvement will continue as they are defined.	X	X	X	X	X	X	X	X	MDOE

Part C – SPP /APR Table 4

2006-2007

Report of Dispute Resolution Under Part C of the Individuals with Disabilities Education Act Complaints, Mediations, Resolution Sessions, and Due Process Hearings

SECTION A: Signed, written complaints	
(1) Signed, written complaints total	1
(1.1) Complaints with reports issued	0
(a) Reports with findings	0
(b) Reports within timeline	0
(c) Reports within extended timelines	0
(1.2) Complaints withdrawn or dismissed	1
(1.3) Complaints pending	0
(a) Complaint pending a due process hearing	0

SECTION B: Mediation requests	
(2) Mediation requests total	1
(2.1) Mediations	1
(a) Mediations related to due process	0
(i) Mediation agreements	0
(b) Mediations not related to due process	1
(i) Mediation agreements	1
(2.2) Mediations not held (including pending)	0

SECTION C: Hearing requests	
(3) Hearing requests total	0
(3.1) Resolution sessions	0
(a) Settlement agreements	0
(3.2) Hearings (fully adjudicated)	0
(a) Decisions within timeline	0
(b) Decisions within extended timeline	0
(3.3) Resolved without a hearing	0

Appendix

PART C PARENT SURVEY

The survey is for parents whose **child or children are under 3.** It is for parents of children who are getting early intervention services thru CDS. This survey is important to you and your child in Maine because your answers will help to improve services for children and families.

If you would like help completing this survey, please provide your phone number. Someone from the Maine Parent Federation will contact you.
Phone number _____

Directions: For each question below, put an "X" in the box under **Never**, or **Rarely**, or **Often,** or **Always** based on your experiences. Skip any item that you feel does not apply to you or your child.

	Never	Rarely	Often	Always
Over the past year, early intervention has helped me and/or my family:				
1. participate in typical activities for children and families in my community				
2. know about services in the community				
3. improve my family's quality of life				
4. know where to go for support to meet my child's needs				
5. know where to go for support to meet my family's needs				
6. get the services my child and family need				
7. feel more confident in my skills as a parent				
8. keep up friendships for my child and family				
9. make changes in our routines that benefit my child with special needs				
10. be more effective in managing my child's behavior				
11. do activities that are good for my child even in times of stress				
Over the past year, early intervention has helped me and/or my family:				
12. feel I can get the services and supports my child and family need				
13. understand how the early intervention system works				
14. be able to evaluate how much progress my child is making				
15. feel that my child will be accepted and welcomed in the community				
16. feel that my family will be accepted and welcomed in the community				
17. communicate better with the people who work with my child and family				
18. understand the roles of the people who work with my child and family				
19. do things with and for my child that are good for their development				
20. understand my child's special needs				
21. feel that my efforts are helping my child				

22. What is your current involvement with CDS

a. __ My child has only been referred to CDS
b. __ My child is eligible for services
c. __ We are waiting for services to begin
d. __ We are receiving services

23. How old was your infant/toddler at the time you completed this survey?
a. __ Birth to 1 year b. __ 1-2 years c. __ 2-3 years d. __ Over 3 years

24. How old was your child when he or she was first referred to CDS?
a. __ Birth to 6 months b. __ 6 months to 12 months c. __ 12 months to 18 months
d. __ 18 months to 24 months e. __ 24 months to 30 months

25. Is your child a male or a female? a. __ Male b. __ Female

26. What is your child's race / ethnicity?
a. __ White b. __ African-American c. __ Hispanic
d. __ Asian or Pacific Islander e. __ American Indian/Alaskan Native

27. What is your relationship to the child?
a. __ Mother b. __ Father c. __ Guardian
d. __ Surrogate Parent e. __ Foster Parent f. __ Grandparent

28. Which statement best describes how well you understand your child's development?
___ a. We are just starting to understand our child's development.
___ b. We understand our child's development a little, but still have a lot to learn.
___ c. We have a pretty good understanding of our child's development.
___ d. We understand our child's development very well.

29. How well do you know your rights and what to do if you are not satisfied?
___ a. We aren't sure about our rights or what to do if we aren't satisfied.
___ b. We understand our rights but aren't sure about options if we are not satisfied.
___ c. We think we know of our rights and what to do if we are not satisfied.
___ d. We know our rights well and know exactly what to do if we are not satisfied.

30. How much has early intervention helped you know and understand your rights?
___ a. It has not helped us know about our family's rights.
___ b. It has done a few things to help us know about our rights.
___ c. It has provided good help so that we know our family's rights.
___ d. It has done an excellent job of helping us know our family's rights.

31. How would you describe your ability to help your child develop and learn?
___ a. We need to know a lot more about how to help our child develop and learn.
___ b. We know the basics of helping our child, but still have many questions.
___ c. We feel pretty sure that we know how to help our child develop and learn.
___ d. We are very sure that we know how to help our child develop and learn.

32. How much has early intervention helped your family be able to help your child develop and learn?
___ a. It has not helped us help our child develop and learn.
___ b. It has done a few things to help us help our child develop and learn.
___ c. It has done a good job of helping us help our child develop and learn.
___ d. It has done an excellent job of helping us help our child develop and learn.

Thank you. Please return the survey as soon as possible. Your answers will be combined with others who completed this survey and kept in the strictest confidence. The results will be posted on the Maine Department of Education website http://www.state.me.us/education/homepage.htm

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

Maine's Part C Program

Child's Name:

Date of Birth:

☐ **Female** ☐ **Male**

MaineCare #

Referral Date:

45 Day Timeline Date:

Eligibility Determination Date:

Date of Third Birthday:

IFSP Date:

Expected Date for IFSP Review:

This Plan is the: (check one)

- ☐ Interim IFSP
- ☐ Initial IFSP
- ☐ Annual IFSP (requires new form)

Actual IFSP Review Date(s):

Expected Date for Annual IFSP Meeting:

Transition Conference Date:

Parent/Guardian:

Relationship:

Telephone:

Mailing Address:

Parent/Guardian:

Relationship:

Telephone:

Mailing Address:

Child's Physical Address:

School System:

Service Coordinator:

Phone Number:

Email Address:

Primary Care Physician:

Phone Number:

Email Address:

Child's Name: DOB:

FAMILY ROUTINES AND PRIORITIES

Everyday Routines, Activities, and Places

Young children learn best through routines and activities that they are interested in and that they participate in often. It is helpful for the team to know where your child regularly spends time so that together we can plan for early intervention supports and services for your family.

I choose **not** to share information about my concerns, priorities and resources and/or include this information in the IFSP. I understand that if my child is eligible, he/she can still receive services if I do not complete this section. _____(parent's initials)

Where and with whom does your child spend time?

Please tell us a little about your child's and family's routines and activities. In addition to your child's day-to-day activities, you might want to tell us about some of the things that you do every now and then that are important to your child/family, like visits to friends and family members, religious or spiritual celebrations, community and/or cultural activities.

Describe activities that your family would like to do now or in the future and that you would like some help with.

If there is nothing like this that is important to you right now, we will just write "none".

Child's Name: DOB:

Family Routines and Priorities

Describe the people, toys, activities, routines, and places your child enjoys the most:	Describe the people, toys, activities, routines, and places your child finds challenging or difficult:

Child's Name: DOB:

FAMILY ROUTINES AND PRIORITIES

Family Concerns, Priorities, and Resources related to enhancing the child's development and challenges in everyday activities and routines

I choose **not** to share information about my concerns, priorities and resources and/or include this information in the IFSP. I understand that if my child is eligible, he/she can still receive services if I do not complete this section. _____(parent's initials)

SUMMARY OF FAMILY CONCERNS: (based on challenges in everyday routines)

PRIORITIES OF THE FAMILY: (based on concerns identified above)

STRENGTHS, RESOURCES THAT FAMILY HAS TO MEET CHILD'S NEEDS: (include family, friends, community groups, financial supports, etc. that are helpful to you)

In addition to the information you have already provided, is there anything else you would like to tell us that would be helpful in planning supports and services with you to address what is most important to your child and family?

Child's Name: DOB:

PRESENT ABILITIES, STRENGTHS AND NEEDS

This form is for recording information gathered at the developmental evaluation/assessment with your child. This information helps us understand your child's developmental strengths, as well as some of the things that are challenging for your child and may be affecting how he/she is able to participate in family and community activities. Enough information should be recorded on this form to substantiate eligibility decisions and to be meaningful to families and service providers for developing a plan with outcomes and strategies that fit well with your child's developmental strengths and needs.

A. Summary of Relevant Health Status (Including Vision and Hearing)

B. Using Hands and Moving Body (Gross and Fine Motor Skills) _____

Things child likes and does well:	Things that child doesn't like and needs help with:

Child's Name: DOB:

PRESENT ABILITIES, STRENGTHS AND NEEDS

C. Understanding/Communicating (Receptive & Expressive Language)

Things child likes and does well:	Things that child doesn't like and needs help with:

D. Playing, Thinking, Exploring (Cognitive Skills) : _____

Things child likes and does well:	Things that child doesn't like and needs help with:

Child's Name: DOB:

PRESENT ABILITIES, STRENGTHS AND NEEDS

E. Expressing and Responding to Feelings & Interacting with Others (Social and Emotional)

Things child likes and does well:	Things that child doesn't like and needs help with:

F. Eating, Dressing, and Toileting (Self-help or Adaptive Skills)

Things child likes and does well:	Things that child doesn't like and needs help with:

Child's Name: DOB:

PRESENT ABILITIES, STRENGTHS AND NEEDS

Evaluator(s)' Name, Credentials, Role/Organization, Signature and Date				
Printed Name	**Credentials**	**Role/Organization**	**Signature**	**Date**

Child's Name: DOB: Age at Evaluation: months

PRESENT ABILITIES, STRENGTHS AND NEEDS

Team Summary			
Area of Development	**Developmental Evaluation Results** *(including standard deviation and standard score)*	**Methods/ Instruments Used**	**Evaluation Date**
Cognitive (Thinking and learning)			
Communication - Expressive (Makes sounds, gestures and talking) - Receptive (Understanding sounds, words, and gestures)			
Physical - Gross Motor (Moving and using large muscles) - Fine Motor (Using hands and fingers)			
Social/Emotional (Interacting with others)			
Adaptive (Feeding, eating, dressing and sleeping)			

Child's Name: DOB: Age at Evaluation: months

Eligibility for Maine's Part C Services

☐ Child is **eligible** for Part C Services* because he/she has (check one or more below and describe):

☐ **Developmental Delay**

☐ A delay of 1.5 standard deviations from the mean score of the selected developmental assessment tool in two or more of the five developmental domains

List areas:

☐ A delay of 2.00 standard deviations from the mean score in at least one developmental domain with a focus on the area(s) in which first contact information and/or developmental screening indicated a concern.

List areas:

☐ Informed Clinical Opinion

Explain: **

☐ **Established condition** that is likely to result in developmental delay:

Name condition(s):

☐ Child is **not eligible** for Part C service because he/she does not meet the above criteria. As a result, this form serves as an evaluation record only.

* If child is found eligible, complete the IFSP Cover Page and attach to the front of this document. Supporting information must be reflected throughout the present abilities, strengths and needs form.

** Supporting information must be reflected throughout the present abilities, strengths and needs form.

Child's Name: DOB:

CHILD/FAMILY OUTCOME

Outcome # 1: Service Coordination (Case Management)

Outcome Statement

The family will receive assistance in fulfilling the Individualized Family Service Plan (also called the plan of care) through intervention of the Service Coordinator such that the child and family receive the supports and services they need.

Short Term Objectives

What short term goals will help us make progress toward the outcome?

Short-Term Goal	Target Date	Date Met
1. The family's identified concerns, priorities and resources are addressed in the IFSP.		
2. The services provided to the child/family are appropriate and adequate.		
3. The family's rights are protected.		

Strategies

The service coordinator:

- assists the family with the development and ongoing review and revision of the IFSP (plan of care)
- reviews the IFSP to make sure that it is in accordance with all applicable rules and regulations
- maintains ongoing contact with the family to monitor and review IFSP implementation
- informs the family of all available services and providers and links them with appropriate community resources
- communicates with the family and all individuals/agencies that provide support, assistance or services about any changes and progress
- assists with problem solving
- determines family satisfaction
- assists in any program transitions

Progress

When will we as a team measure progress towards this outcome? (timeline)

At all Early Childhood Team (ECT) meetings
Annually (in writing)

How will we, as a team, measure progress towards this outcome? (procedure)

Progress towards the outcome will be measured by:

Family report at ECT meetings
Feedback from all providers
Evaluation form at exit from Part C

Our team will be satisfied we are finished with this outcome when: (criteria)

The child and family are receiving the supports and services they need.
The services are coordinated and relate to the child and family outcomes identified on the IFSP.
The family and child experience a smooth transition at age 3 or when the child exits the Part C program.

Child's Name: DOB:

CHILD/FAMILY OUTCOME

OUTCOME #2 (Long term functional goal)

Outcome Statement

(What does the family want to see for their child/family as a result of early intervention supports and services?)

Short Term Objectives

(What short term objectives will help us make progress toward the above outcome statement?)

Short-Term Objective	Target Date	Date Met
1.		
2.		
3.		
4.		
5.		
6.		

Strategies

(*Who* will do *what* in *which* everyday routines, activities and places?)

Natural Environment ☐ Yes
☐ No (Justify)

Progress

(What will progress look like?)

Procedure (How will we, as a team, measure progress towards this outcome?
Criteria (What do we need to see for the team to be satisfied we are finished with this outcome?)
Timeline (When will we, as a team, measure progress towards this outcome?)

Child's Name: DOB:

CHILD/FAMILY OUTCOME

OUTCOME #3 (Long term functional goal)

Outcome Statement

(What does the family want to see for their child/family as a result of early intervention supports and services?)

Short Term Objectives

(What short term objectives will help us make progress toward the above outcome statement?)

Short-Term Objective	Target Date	Date Met
1.		
2.		
3.		
4.		
5.		
6.		

Strategies

(*Who* will do *what* in *which* everyday routines, activities and places?)

Natural Environment ☐ Yes
☐ No (Justify)

Progress

(What will progress look like?)

Procedure (How will we, as a team, measure progress towards this outcome?
Criteria (What do we need to see for the team to be satisfied we are finished with this outcome?)
Timeline (When will we, as a team, measure progress towards this outcome?)

Child's Name: DOB:

CHILD/FAMILY OUTCOME

OUTCOME #4 (Long term functional goal)

Outcome Statement

(What does the family want to see for their child/family as a result of early intervention supports and services?)

Short Term Objectives

(What short term objectives will help us make progress toward the above outcome statement?)

Short-Term Objective	Target Date	Date Met
1.		
2.		
3.		
4.		
5.		
6.		

Strategies

(*Who* will do *what* in *which* everyday routines, activities and places?)

Natural Environment ☐ Yes
☐ No (Justify)

Progress

(What will progress look like?)

Procedure (How will we, as a team, measure progress towards this outcome?
Criteria (What do we need to see for the team to be satisfied we are finished with this outcome?)
Timeline (When will we, as a team, measure progress towards this outcome?)

Child's Name: DOB:

NATURAL ENVIRONMENT JUSTIFICATION

Supports and services must be provided in settings that are natural or typical for children of the same age (i.e., natural environments). If, as a team, we decide that we cannot achieve an outcome in a natural environment, we need to describe how we made that decision and what we will do to move services and supports into natural environments as soon as possible.

Outcome #	Service(s)/Support(s)	**Setting and Location Code** (Non-Natural Environment Setting Where Service(s)/Support(s) Will be Provided)

Explanation of Why Outcome Cannot be Achieved in a Natural Environment:

Plan for Moving Service(s) and/or Support(s) into Natural Environments:

Child's Name: DOB:

TRANSITION PLAN

Date of child's 3rd birthday:		**Anticipated Date of Transition:**	
Date for Transition Conference:**		☐ Beginning of the school year in which child turns 3	
Date Child Exited from EI Program:		☐ Beginning of the school year following child's 3rd birthday ☐ Other date during the school year in which child turns 3	

[**At least 90 days but no more than 9 months prior to ANTICIPATED date of transition, but no later than 90 days prior to third birthday.]

Priorities and goals for child's transition:

Transition Planning Requirements and Activities	Person(s) Responsible	**Date Initiated**	**Date to be Completed**
a) Discuss with parents what "transition" from early intervention means, including eligibility and age guidelines for early intervention services. and what can be done to plan for this transition.			
b) Discuss with parents possible program options (including preschool special education services; Head Start; child care and other community services) that may be available when our child is no longer eligible.			
c) Provide notice of the child's name, address, phone number and date of birth to the school division no later than _____unless parent disagrees.			
d) Provide opportunity for parents to meet and receive information from pre-school or other community program representatives as appropriate.			
e) Help the child and family prepare for the changes and adjustments to a new setting.			
f) With parental consent, pass on information (including evaluation and assessments and the IFSP).			
g) Assist parents to understand their rights and to develop advocacy skills.			
h) Schedule the transition conference and invite participants.			
i) Other transition planning activities:			

Child's Name: DOB:

TRANSITION CONFERENCE

A Transition Conference must be convened at least 90 days prior to the anticipated date of transition **but** no later than 90 days prior to the child's third birthday. Invite parents, early intervention personnel, local education agency, Head Start, and other community providers as appropriate. ***Use Signature Page** to document attendance/participation of team members.

Transition Conference Requirements	Action Steps / Activities	Person(s) Responsible	**Date Initiated**	**Date to be Completed**
a) Review with parents the program options for their child from the child's third birthday through the remainder of the school year				
b) With parental consent, transfer records (including evaluation and assessment information and current IFSP).				
c) Decide what other activities need to be completed before the child moves into the new service setting (including enrollment; immunizations; transportation issues, medical needs etc.).				
d) Review current evaluation and assessment information. Decide if any further evaluations are needed to determine eligibility prior to transition.				
e) Schedule IEP meeting date (at least 15 days before first day services are to be provided) if the child will transition into preschool special education.				
f) Help family to decide where their child will transition to and when.	Child will transition to: Date:			
g) Decide if there is a need for post transition follow-up (including service coordination, consultation with new staff).				
h) Decide how to evaluate whether the transition process was smooth and effective.				

Child's Name: DOB:

SUPPORTS AND SERVICES NEEDED TO ACHIEVE OUTCOMES

This is a summary of the decisions made by the Early Childhood Team (ECT) regarding supports and services needed to achieve ALL Outcomes. The method of service delivery is documented on each IFSP Outcome page.

***IFSP* Supports and Services**	To help with **Outcome #s**	Setting	***Method*** *Group or Individual*	Frequency **Example 1x/mo, 2x/wk)**	**Intensity** (Write # of minutes)	Qualified Enrolled Provider	Funding Source	**Start Date**	**End Date**
Service Coordination	All								

Our Early Intervention Staff will keep you informed of CDS holiday closings, staff vacations and any unplanned absences that may arise. Thank you for the opportunity to work with you and your family.

Child's Name: DOB:

SUPPORTS AND SERVICES NEEDED TO ACHIEVE OUTCOMES

Other Services:

These are services needed by your child and family, but not entitled under Part C. Other services may include medical services such as well baby checks, follow-up with specialists for medical purposes, etc.

Service	Provider	Location	Funding Sources or Steps to be Taken to Ensure Services are Available

Child's Name: DOB:

INDIVIDUALIZED FAMILY SERVICE PLAN – SIGNATURES

The following individuals have participated in the development of this ISFP and/or will assist in carrying it out. This form must also be used to document signatures of participation in the Transition Conference.

Note: The IFSP team must include parent(s)/guardian; service coordinator; person(s) directly involved in conducting the evaluations and assessment; others as requested by parents (family, friends, advocates); and personnel providing services to the child and family.

Print Name (include role/discipline licensure/certification)	**Signature**	**Date**	**Method of Participation**	**Agency/Contact Information**	**Time Attended**
Service Coordinator					

In addition to the team members listed above, this IFSP should also be mailed to *

Primary Care Provider: _____

Other: _____

* Note: Complete authorization to release form

Consent by Parents/Guardians for Provision of Early Intervention Services

- ☐ I have received a written copy of and verbal explanation of my rights. I understand these rights.
- ☐ I participated fully in the development of this plan; and
- ☐ I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written. (Consent means that I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes the activity(ies); and that the granting of my consent is voluntary and may be revoked in writing at any time.); or
- ☐ I do not accept this IFSP to be carried out as written however I do give consent for the following service(s) to begin: _____
- ☐ I understand that my child is eligible to receive all of the services listed on the IFSP. I am fully aware of the nature of the IFSP service(s) being offered and that I must give written consent in order to receive the service(s). I understand that declining a service or services does not jeopardize any other early intervention service(s) my child or family receives through CDS. I understand that I may change my mind and, if so, will call my service coordinator.
- ☐ I understand that my child's IFSP will be shared among the CDS providers who are working with my child and family and implementing the IFSP.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Child's Name: DOB:

PERIODIC REVIEW OF THE IFSP

A review of the IFSP must occur at least every six months. Note dates of all revisions on cover page.
Revise the **Child/Family Outcome** page(s) and the **Supports and Services** page if:

1) the strategies or services need to be changed or added;
2) an outcome is being modified; or
3) a new outcome is being added.

Note: The periodic review of the IFSP must include the include parent(s)/guardian and the service coordinator and others as appropriate.

Outcome #	Date Reviewed	**Describe Progress**	**Status (Check One)**
			☐ Outcome reached ☐ Continue with outcome ☐ Modify outcome / strategies / services
			☐ Outcome reached ☐ Continue with outcome ☐ Modify outcome / strategies / services
			☐ Outcome reached ☐ Continue with outcome ☐ Modify outcome / strategies / services
			☐ Outcome reached ☐ Continue with outcome ☐ Modify outcome / strategies / services
			☐ Outcome reached ☐ Continue with outcome ☐ Modify outcome / strategies / services

Child's Name: DOB:

PERIODIC REVIEW OF THE IFSP

Consent by Parents/Guardians for Provision of Early Intervention Services Based on the IFSP Review

- ☐ I have received a written copy of and verbal explanation of my rights. I understand these rights.
- ☐ I participated fully in the development of this plan; and
- ☐ I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written. (Consent means that I have been fully informed of all information about the activity(ies) for which consent is sought, in my native language (unless clearly not feasible to do so) or other mode of communication; that I understand and agree in writing to the carrying out of the activity(ies) for which consent is sought; the consent describes the activity(ies); and that the granting of my consent is voluntary and may be revoked in writing at any time.); or
- ☐ I do not accept this IFSP to be carried out as written however I do give consent for the following service(s) to begin: _____
- ☐ I understand that my child is eligible to receive all of the services listed on the IFSP. I am fully aware of the nature of the IFSP service(s) being offered and that I must give written consent in order to receive the service(s). I understand that declining a service or services does not jeopardize any other early intervention service(s) my child or family receives through CDS. I understand that I may change my mind and, if so, will call my service coordinator.
- ☐ I understand that my child's IFSP will be shared among the CDS providers who are working with my child and family and implementing the IFSP.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Team Member Signatures

Print Name (include role/discipline *licensure/certification)*	Signature	Date	Method of Participation	Agency/Contact Information	Time Attended
Service Coordinator					

In addition to the team members listed above, this IFSP should also be mailed to *

Primary Care Provider: «tblProvider 1ProvName»

Other:

* Note: Complete authorization to release form

Child's Name:

FINANCIAL RESOURCES: Resources that may be used to support the services specified in this plan.

	Do You Have?	**Do You Authorize the Use of?**	**Number**
Maine Care	Pending Yes No	Yes No	

			Do You Authorize the Use of?	**Restrictions**
Insurance	Pending Yes No	**Please fill in below**	Yes No	
Company Name:				
Policy Holder's Name:				
Holder's Social Security Number:				
Policy Number:				
Policy Group Number:				

My rights concerning use of third party financing for my child's services have been explained to me in writing.

_____ _____/_____/_____

Parent/Guardian Signature **Date**

_____ _____/_____/_____

FAPE Certification Signature **Date**

Child Development Services Piscataquis County
P.O. Box 326
Dover-Foxcroft, ME 04426

PRIMARY HEALTHCARE PROVIDER APPROVAL

Child's Name:	
D.O.B.:	
Current IFSP Date:	
Is this an Amendment?	
Date of Amendment:	
Physician:	

I have read the Individualized Family Services Plan / Amendment for this child.

_____ I approve of this plan _____ I disapprove of this plan

_____ _____
Signature of Primary Healthcare Provider Date

MAINE CARE REQUIRES THAT THE IFSP BE APPROVED BY THE CHILD'S PRIMARY HEALTHCARE PROVIDER.

Comments:

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INTRODUCTION

The purpose of this document is to provide early intervention personnel in Maine's Part C program, including service coordinators and service providers, with guidelines on the process and the necessary steps that must be completed while working with children and families, beginning with referral to Part C (children birth to age three) through evaluation and assessment, Individualized Family Service Plan (IFSP) development, IFSP implementation/review, and transition. The guidelines are designed to streamline procedures, provide a framework for consistent and quality practices, while ensuring compliance and supporting efficient use of existing resources. (NOTE: When child is 45 days or less from 3rd birthday, procedures for the 3-5 year olds will be followed.)

Information contained in the guidelines attempts to assist Part C service coordinators and service providers in understanding the interconnectedness of the various steps of the process with the statewide forms (and instructions for filling them out) that were developed in conjunction with this guide. Information is provided regarding which forms are used and completed during the specific steps of the process. The guidelines also emphasize steps and practices that support positive relationships with the parent/caregiver and the use of the family's interests, concerns, and priorities for their child as the foundation for service provision. As a result, guidance is embedded through the document on how best to gather and use information from families when conducting the Initial Contact, First Visit, evaluation and assessment, developing a meaningful IFSP, and implementing IFSP services and supports that are fluid, meet the needs of children and families, and ensure positive results. A separate section on the roles of families in Maine's Part C Program is also provided.

The guidelines are based on evidence-based practices that are reflected in current early intervention literature. The information included reflects a paradigm shift from the professional addressing the child's development, to the professional enhancing the family's capacity to support their child's learning and development through everyday routines and activities. A summary of the current early intervention literature regarding evidenced-based practices in working with infants and toddlers with disabilities and their families is included in the Appendices.

MISSION AND MODEL OF MAINE'S PART C PROGRAM

The mission of Maine's Part C Program for infant and toddler services is to identify young children (birth through two years of age) with disabilities and who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delays; to provide supports to families that meet the individualized developmental needs of their child; and to facilitate the child's learning and participation in family and community life through the partnerships of families, caregivers, and service providers.

The purpose of Maine's Part C Program is to provide services that promote the child's learning through participation in everyday routines and activities while supporting the parent/caregiver in enhancing their child's development, learning and participation in family and community life.

To accomplish its mission, Maine's Part C Program promotes the following approaches as its service model:

- Use of a **collaborative partnership** with regular communication among team members as professionals and families work together;
- Use of a **multi-disciplinary, family-centered** approach in the evaluation and assessment process;
- Use of **functional outcomes** on the Individualized Family Service Plan to address family concerns and priorities;
- Use of a **primary service provider** in the team approach for service delivery;
- Use of **coaching,** modeling and information sharing to support families' and caregivers' confidence and competence;
- Use of a **relationship-based** approach that increases positive interactions between Parent and child as the foundation upon which new developmental skills can be built;
- Use of **naturally occurring routines** in which instruction is embedded as selected and preferred by the child's family.

Current literature identifies some key concepts that support the implementation of these purposes through effective quality practices. These key concepts are critical to keep in mind.

- Children learn best:
  - when participating in natural learning opportunities that occur in everyday routines and activities as part of family and community life; and
  - when interested and engaged in an activity, which in turn strengthens and promotes competency and mastery of skills.
- The parent/caregiver has the greatest impact on their child's learning since parents know their child best and already intervene in their child's development everyday through planned or naturally occurring learning opportunities.
- Learning opportunities facilitated within the context of family and community life have greater impact on child progress than intervention sessions.

- The parent/caregiver prefers interventions that are easy to do, fit into their daily lives, and support their child in learning skills that help them be a part of family and community life.
- Embedding instruction in routines selected and preferred by families will greatly increase the likelihood that the family will repeat therapeutic activities independently.
- There is a direct correlation between families' perceptions of themselves as competent and empowered to the families' level of follow-through in facilitating learning opportunities throughout daily activities and routines.
- Frequency and intensity of services need to be based on the amount of support the family needs in using natural learning opportunities throughout everyday routines and activities of family and community life. Visits provided too frequently can be disempowering or send the message that the parent/caregiver is not competent.
- Providing early intervention through a primary provider approach does not preclude other team members from consulting or interacting with the family or caregivers.
- Team consultation and collaboration are critical to support family and caregiver competence and confidence related to child learning.
- Supports and services need to be tailored to meet the unique needs and characteristics of every child and family.
- "More is better". This means <u>more learning opportunities</u>, not more services. Learning is what happens between intervention visits. Learning occurs for all children through daily child-initiated play, multiple repetitions and lots of practice with family and friends in their community.

These concepts are not necessarily new to those who have been practicing early intervention. What has changed, however, is how these concepts are translated into practice. Effective early intervention services are not achieved by "taking clinical practice" into the child's home. The practitioner is no longer viewed as "the expert with the toy bag," but as a resource and partner for families and caregivers who are enhancing their child's development and learning. In this new role, the practitioner shares his/her knowledge and resources with the child's key caregivers and provides support to them in their day-to-day responsibilities of caring for their child and in **doing the things that are important to them**. The primary focus of each individual intervention session is on enhancing family capacity and competence in facilitating their child's learning and **participation** in family and community life. Intervention sessions focus on **what's working and what's challenging for the child's and family's functional participation in their everyday routines and activities of community life**.

GUIDING PRINCIPLES OF MAINE'S PART C PROGRAM

Children are special and unique:

- All children are unique, with their individual strengths and talents. The presence of a disability or special need is not the defining characteristic of a child.
- Children grow, develop, and learn within the context of relationships with their families and other caregivers in the activities of everyday routines in their caring environments as well as activities within their community settings.
- Early intervention services enhance and support the capacity of community partners in serving and including young children with disabilities and their families. All children have the right to belong, to be welcomed, and to participate fully in their community.

Families are central to decision making:

- Each family's priorities, values, hopes and diversity are honored throughout the service delivery process.
- Families are partners and decision-makers in all aspects of services; they are the experts about their child's and family's needs.

The early intervention role:

- Service providers across all disciplines value and encourage family participation and collaboration throughout delivery of intervention services.
- The family-provider relationship builds on family strengths and is characterized by mutual trust, respect, honesty and open communication.

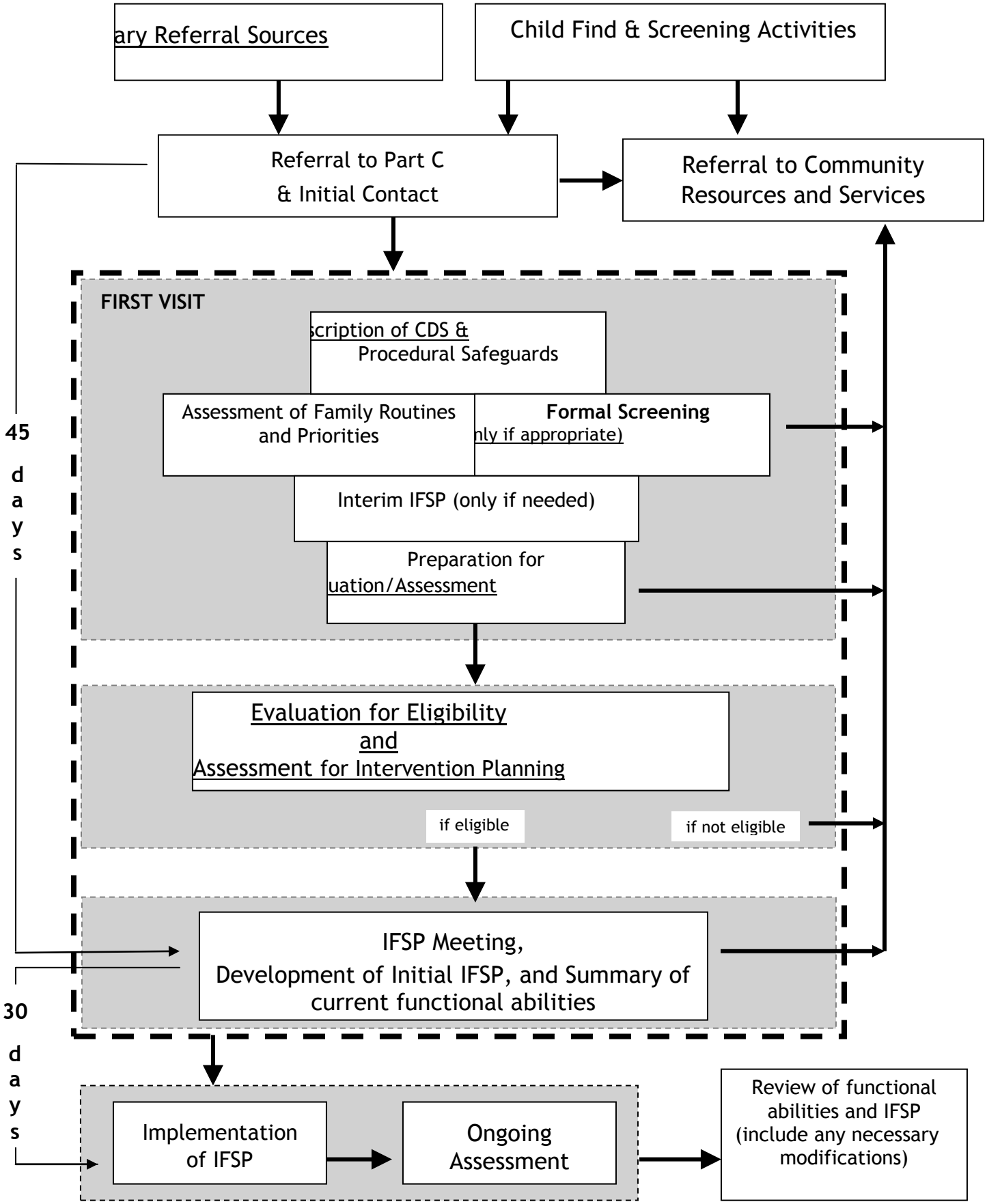
Services and supports:

- Supports, services and resources need to be timely, flexible, individualized and responsive to the changing needs of each child and the child's family.
- Supports and services must be in compliance with federal and state laws and regulations, fiscally responsible, and coordinated with other agencies.

PROCESS FOR MAINE'S PART C PROGRAM

The following flow chart illustrates Maine's Part C program's process of Part C programming, beginning with referral to Maine's Part C Program, intake (Initial Contact and First Visit), evaluation and assessment, IFSP development, followed by intervention/services, ongoing assessment, and IFSP modifications and reviews.

Maine's Early Intervention System



FAMILY ROLES IN MAINE'S PART C PROGRAM

Families play a key role in the successful implementation of Maine's Part C program. Beginning with the first contact, families are provided with information about the purpose of early intervention to enhance the capacity of families to meet their children's developmental needs. Families are also provided with information on what they can expect from Maine's Part C Program as well as the important role families play as a member of the team throughout the process. Once families have this information, they can make informed decisions to define their particular role and involvement in their child's Part C programming.

Essential roles of families/caregivers in Maine's Part C Program are as follows:

• **Initial Contact and First Visit, including Family Assessment** – Families share their concerns related to their child's development, provide the multi-disciplinary team with information regarding their current family routines and schedule, and identify what interactions are working well at home. Families are invited to answer questions (those which they are comfortable answering) and share any additional information they feel the team needs to gain a holistic, ecological view of their family. During this time, families also receive information about Maine's Part C program, including rights and procedural safeguards, and they complete required paperwork.

• **Evaluation and Assessment Process** – Families participate with their child during the evaluation and assessment process; communicating whether their child's functioning during the evaluation and assessment process is typical. They also begin sharing their priorities for the focus of early intervention supports and services.

• **IFSP Development** – Families are active participants in the IFSP meeting. They add pertinent information regarding their child's skills to complement the information gained through the evaluation and assessment. They also identify their priorities for outcomes for their child and their family as well as collaborate with the other team members on strategies for embedding skill development. This will include ways to develop their child's skills within the context of everyday routines and activities as well as through relationships with the people who are important to their child.

• **Part C Programming** – Families work with service providers to identify and learn a variety of strategies to enhance their child's learning and development within their typical, everyday, home and community routines.

• **Review and Evaluation of IFSP Outcomes, Strategies, Supports and services** – Families talk with service providers continually about what is making a difference in their child's and family's life. Families and service providers discuss which strategies are working, how much support the family needs in order to incorporate the strategies into their everyday routines and activities, whether outcomes have been achieved, and what changes, if any, need to be made.

REFERRAL AND INITIAL CONTACT
Demographics, Description of Maine's Part C Program,
And Child Medical/Developmental History

Families find out about Maine's Part C Program in a wide variety of ways, including through public awareness materials (e.g., brochures, posters), communication with their child's caregivers, physicians or other health professionals, and/or information shared by relatives, friends or acquaintances. Regardless of how families are connected with the program, the Initial Contact with families made by the designated CDS staff member serves as the foundation for building a trusting partnership between families and service providers. Professional staff (e.g., service coordinator, referral coordinator, case manager) are usually designated the responsibility for carrying out the steps and procedures included in the Initial Contact.

The Initial Contact is usually completed by phone with the family. Since phone contact is not possible for all families, some Initial Contact steps may occur through written communication while other steps are completed during the first face-to-face visit. Part C program sites have procedures that specify how steps and activities associated with the Initial Contact may be carried out in such situations.

During the Initial Contact, conversations are used by designated CDS staff members to gather relevant information in order to plan for next steps and to share information about the program/community resources that may be available to the family. Open-ended questions and prompts are used to support families in sharing their story and other important information about their child in a way that suits the family's communication style. When referral concerns about the child are uncertain/unclear, questions about the child's development are asked to determine whether the parent/caregiver wishes to proceed to the next step.

Procedures: Referral and Initial Contact

(NOTE: When child is 45 days from 3rd birthday, follow procedures for 3-5 year olds)

1. Designated CDS staff member assigned to take referral information completes ***Referral Information*** **(Form 1)** that covers demographic information about the child and family, information about the referral source and the reason for referral. If the referral source has any information about the child's medical and developmental status, designated CDS staff members should document this information in the relevant sections of ***Child Medical and Developmental Information*** **(Form 2)**.
2. Designated CDS staff member assigned to take referral information determines the family's primary language and means of communication and, if necessary, arranges for an interpreter in accordance with Maine's Part C programming procedures to be available during the Initial Contact and subsequent steps.
3. Designated CDS staff member contacts the child's parent/caregiver by phone. If phone contact is not possible, they use alternative means of connecting with families in accordance with Maine's Part C program site procedures.
4. If the referral source was anyone else besides the family, designated CDS staff members should review developmental and medical information with the family that was shared by the referral source. Designated CDS staff members should ask the family to supply any additional relevant information and document it in the appropriate portions of ***Child***

Medical and Developmental Information **(Form 2)**. Some families may be able to readily share information about their child over the phone while others may prefer to complete the discussion during the First Visit.

5. The designated CDS staff member explains the following to the parent/caregiver:
   - The purpose of Maine's Part C programming is designed to assist and support the family in enhancing their child's development through participation and learning in everyday routines and activities;
   - Maine's Part C programming and supports may not necessarily take the place of medical services prescribed by their child's physician or existing service provider;
   - Maine has a family cost participation provision. For children covered by Maine's Medicaid insurance program (MaineCare), the insurance will be accessed. For families with private insurance coverage, parents will be asked to choose between contributing toward the cost of their child's Part C programming on the basis of a sliding fee scale or authorizing access for their private insurance to be billed for some services. If a service is not covered by the insurance policy, the family will be expected to contribute the calculated fee; and
   - Maine's Part C programming and supports are provided in the child's natural environment. Natural environment is each child's existing daily routines and activities and can include the family's home, the community, child-care locations, etc. See Natural Environments section, Federal Part C Regulations.
6. Designated CDS staff member confirms with the family whether they wish to access Maine's Part C programming at this time. The following decisions are made:
   - **Family decides to proceed to the next step in the process:**
     - In accordance with each CDS site's procedures, the designated CDS staff member creates a file that at minimum includes the following forms in preparation for the First Visit:
       - ***Referral Information*** **(Form 1)** and ***Child Medical/Developmental Information*** **(Form 2)**. These will have already been filled out. The rest of the forms will be blank at this point;
       - Relevant IFSP pages (i.e., ***Cover Page***, ***IFSP Pages 2-2a: Family Routines and Priorities***, ***IFSP Pages 3-3d: Present Abilities***, ***Strengths and Needs***) needed for the First Visit; and
       - Consent Forms (i.e., ***Authorization to Share Information***, ***Consent for Evaluation and Assessment***, ***Consent for Screening***, ***Prior Notice Form and Notice of Child and Family Safeguards***);
     - Designated CDS staff member determines whether formal screening is needed prior to making a decision that an evaluation and assessment is needed. Formal screening may be appropriate if the designated CDS staff member has questions about whether the child's developmental needs warrant an evaluation and assessment. Guidance about making this decision is located in the First Visit section that follows. Formal screening is usually conducted during the First Visit. A designated CDS staff member schedules a time with the family to conduct the formal screening and to complete all necessary procedures related to the First Visit. When formal screening is completed, results are documented with the child's medical/developmental information **(Form 2)**; OR
     - If the designated CDS staff member determines that **evaluation and assessment is appropriate** and that a formal screening is not needed, the designated CDS staff member schedules the First Visit with the family to further explain the

program, procedural safeguards, and complete the family assessment.

- Designated CDS staff members determine whether an interpreter is needed or if there are any other communication needs;
- Designated CDS staff members determine if a surrogate parent needs to be appointed; and
- Designated CDS staff members compile information for entry into Maine's Part C Program data systems.

➢ **Family decides not to proceed to next step in the process:**

- Designated CDS staff members must complete the following:
  - Inform the family of the right to contact Maine's Part C Program at any time in the future;
  - Share information with the family about other appropriate community resources they may access and connect them to these resource if the family requests; and
  - Send Written Prior Notice and Declining EI form to the family documenting their desire to not access early intervention services at this time and their right to contact Maine's Part C Program at any time in the future.

Service Coordination Assignment and Responsibilities

Federal Part C Regulations: Service Coordination Requirements

34 CFR Part 303.23: Service coordination (case management).

(a) General.

(1) As used in this part, except in Sec. 303.12(d)(11), service coordination means the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.

(2) Each child eligible under this part and the child's family must be provided with one service coordinator who is responsible for--

(i) Coordinating all services across agency lines; and

(ii) Serving as the single point of contact in helping parents to obtain the services and assistance they need.

(3) Service coordination is an active, ongoing process that involves--

(i) Assisting parents of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan;

(ii) Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;

(iii) Facilitating the timely delivery of available services; and

(iv) Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

(b) Specific service coordination activities. Service coordination activities include--

(1) Coordinating the performance of evaluations and assessments;

(2) Facilitating and participating in the development, review, and evaluation of individualized family service plans;

(3) Assisting families in identifying available service providers;

(4) Coordinating and monitoring the delivery of available services;

(5) Informing families of the availability of advocacy services;

(6) Coordinating with medical and health providers; and

(7) Facilitating the development of a transition plan to preschool services, if appropriate.

(c) Employment and assignment of service coordinators.

(1) Service coordinators may be employed or assigned in any way that is permitted under State law, so long as it is consistent with the requirements of this part.

(2) A State's policies and procedures for implementing the statewide system of early intervention services must be designed and implemented to ensure that service coordinators are able to effectively carry out on an interagency basis the functions and services listed under paragraphs (a) and (b) of this section.

(d) Qualifications of service coordinators. Service coordinators must be persons who, consistent with Sec. 303.344(g), have demonstrated knowledge and understanding about--

(1) Infants and toddlers who are eligible under this part;

(2) Part C of the Act and the regulations in this part; and

(3) The nature and scope of services available under the State's early intervention program, the system of payments for services in the State, and other pertinent information.

Note 1: If States have existing service coordination systems, the States may use or adapt those systems, so long as they are consistent with the requirements of this part.

Note 2: The legislative history of the 1991 amendments to the Act indicates that the use of the term ``service coordination" was not intended to affect the authority to seek reimbursement for services provided under Medicaid or any other legislation that makes reference to ``case management" services. See H.R. Rep. No. 198, 102d Cong., 1st Sess. 12 (1991); S. Rep. No. 84, 102d Cong., 1st Sess. 20 (1991). [58 FR 40959, July 30, 1993. Redesignated at 63 FR 18294, Apr. 14, 1998].

Federal Part C regulations require that every child in a Part C Program be assigned a service coordinator to; coordinate services across agency lines; to serve as the point of contact; to support the family through the multiple steps of the process and ensure receipt of the rights, procedural safeguards, and necessary services and supports. The service coordinator is assigned for each child and family following referral in accordance with each Maine Part C Program site's procedures.

The intent of service coordination is to guide families toward greater confidence and independence in enhancing their child's learning and development through everyday routines and activities. The service coordinator has a role of great responsibility, one that is equally as important as the role of service provider. The service coordinator assists the family in understanding the early intervention process and the family's roles throughout the process. They also ensure that the family receives sufficient information to make informed decisions and to participate as an equal partner in decision making. To ensure this, the service coordinator must assist the family to fully understand what is happening at each juncture, why, and what the impact is for their child and family. In addition, the service coordinator is responsible to ensure that the child and family are receiving all of the services and supports needed to meet their unique needs. This requires coordination within the early intervention program as well as knowledge of other community services and resources. It is also hoped that service coordinators can assist families to effectively communicate their children's needs in order to prepare them for the future as they transition from Maine Part C Program supports and services.

Procedures: Service Coordination Assignment and Responsibilities
1. Each CDS site assigns a service coordinator following referral to early intervention services in accordance with state requirements and local procedures. 2. Each CDS site can designate the title of the position that is responsible for carrying out service coordination responsibilities (e.g. case manager, intake coordinator, service coordinator, etc.) 3. Each CDS site ensures that personnel assigned to carry out service coordination responsibilities have competencies to carry out these functions. 4. Each CDS site has procedures to ensure that service coordination activities are carried out as required. Note: Specific service coordinator (e.g., case manager, intake coordinator, etc.) responsibilities are embedded in subsequent steps of the early intervention process.

FIRST VISIT
Screening, Procedural Safeguards, Family Assessment, Interim IFSP, and Preparation of Family for Evaluation and assessment

A designated CDS staff member conducts this part of the process with the child's parent and/or caregiver face-to-face in the child's home or a natural environment appropriate to the child and family.

The information obtained during the First Visit builds upon the results of the Initial Contact to achieve several different outcomes. The combined information is the informed screening process used to determine next steps for the family. If the next steps include evaluation and assessment by Maine's Part C Program, the screening information will be used in the following ways:

- To determine the composition of the evaluation and assessment team;
- To prepare the team for the evaluation and assessment of the child; and
- To determine the next steps of the process for children with diagnosed physical or mental conditions.

Procedures: General Steps and Responsibilities
1. The First Visit is conducted face-to-face with a child's family in a natural environment. 2. Designated CDS staff members will be assigned the responsibility for carrying out the steps and procedures included in the First Visit. 3. The child will need to be present for at least part of the First Visit. 4. These steps are to be completed within 15 calendar days from referral in order to ensure that the 45 day timeline from referral to IFSP meeting is met. 5. If any of the demographic information on ***Referral Information*** **(Form 1)** or any information on ***Child Medical and Developmental Information*** **(Form 2)** was not completed during the Initial Contact, this information should be completed at this point.

In addition, appropriate information should be entered onto the ***IFSP Cover Page***.

6. Designated CDS staff members provide information about the family-centered focus of Maine's Part C Program and eligibility criteria to the parent/caregiver during this visit. Designated CDS staff members provide clarification about the program, including a detailed review of the family cost participation provision.
7. Designated CDS staff members inform the parent/caregiver that participation in Maine's Part C Program is voluntary and that the family can decide what information they chose to share with the program about their child and family. They are, however, encouraged to share information that will be helpful in meeting the needs of their child and family. They are informed that all information shared is confidential.
8. Designated CDS staff members are responsible for providing the family with a copy of and explaining the ***Notice of Child and Family Safeguards*** and completing the following with the parent/caregiver:
   - ***Authorization to Share Information***, *when appropriate*
   - ***Consent for Screening***, *when appropriate*
   - ***Consent for Evaluation and Assessment***, *when needed*
   - ***Written Prior Notice***
   - ***Family Cost Participation Form***

Screening

One of the objectives of the First Visit is completing a screening of the child. The First Visit and the information and observations provided by the parent/caregiver serve as the screening process for the child. In most instances, formal screening (e.g. administering a screening tool) will **not** be necessary, especially when sufficient developmental information is available to determine that an evaluation and assessment is appropriate.

Note: Part C regulations require that information provided by hospitals, physicians and others involved with the child be reviewed as part of the child's evaluation and assessment; therefore, developmental assessments, including screening results, conducted prior to referral to CDS will be considered in determining whether an evaluation and assessment of the child is appropriate.

Formal screening is not required under Part C of IDEA (34 CFR Part 303). However, formal screening can be very helpful when insufficient developmental information is available to determine whether conducting an evaluation and assessment is appropriate. Gathering developmental information from the referral source and parent/caregiver during the referral and Initial Contact is an appropriate step prior to determining if a formal screening is needed.

Procedures: Screening

1. Based on information gathered during Referral and Initial Contact, CDS staff decides if formal screening is needed to determine if evaluation and assessment is necessary. The following information guides decision-making about whether screening needs to be completed and how best to conduct the screening. A child may not be determined eligible based on the results of a screening tool alone.

(NOTE: When child is 45 days from 3rd birthday, follow procedures for 3-5 year olds)

NO FORMAL SCREEN NECESSARY	
Information Received	Action Needed
Child has a diagnosed physical or mental condition (an established condition)* that has a high probability of resulting in development delay *** see Appendix for list of established conditions that have a high probability of resulting in developmental delay**	**a. Formal screen is not necessary.** **b. A Part C evaluation and assessment is scheduled.** **c. Designated CDS staff members obtain information from the physician that documents the established condition.**
Child is referred to a Maine Part C Program with an existing evaluation and assessment	**a. A Part C evaluation and assessment is scheduled.** **b. Designated CDS staff members inform the evaluation and assessment team that one or more areas have already been evaluated/assessed. This information is considered as part of the assessment process and if the child is found eligible can be used to develop the IFSP.**
Child is referred to a Maine Part C Program with existing formal screening.	**a. Determine if existing formal screening information is reliable. Proceed to next appropriate step.** **b. If previous screening results seem unreliable and it is questionable that the child needs an evaluation and assessment, then another formal screening may be administered.**

REASONS FOR CONDUCTING A FORMAL SCREENING (IN PERSON OR BY PARENT/CAREGIVER RESPONSE)
The referral source or initial family phone call reveals that the parent has some difficulty when asked to verbally share accurate or sensitive information about their child's development to determine if the child is in need of an evaluation and assessment.
There may be qualitative developmental concerns that cannot be easily conveyed through verbal report.
No other professional has seen the child and it is highly likely that it would be difficult to get clear information from the parent.
During conversations with the family, the child's developmental skills and behaviors fall within a typical developmental range (i.e., screens out) but the family requests a developmental screening.
In the case of a child with an international adoption history or a family in which English is a second language, special care will need to be taken to determine whether the child and family (due to language or other cultural issues) may require a different evaluation/assessment procedure.

2. If a decision is made to conduct a formal developmental screening, designated CDS staff members explain and provide the parent/caregiver with the ***Notice of Child and Family***

Safeguards, explain the ***Consent to Screen*** form, and obtain the signature of the parent/caregiver. ***Written Prior Notice*** is also provided and explained. Copies of the signed ***Consent to Screen*** and ***Written Prior Notice*** forms are maintained and placed in the child's record.

3. When formal screening is conducted, a nationally normed and standardized tool will be used. A child may not be determined eligible based on the results of a screening tool alone.
4. If formal developmental screening is conducted, screening results are documented in ***Form 2: Child Medical and Developmental Information***.

NEXT STEP DECISIONS AND ACTIONS NEEDED	
The following steps summarize the necessary actions related to whether an evaluation and assessment is appropriate or desired by the family based upon formal screening results and/or information gathered from Referral and Initial Contact:	
Decision	**Actions Needed**
➢ **Family chooses not to proceed to evaluation and assessment** at this time.	a. *Declining Early Intervention Services* is explained and signed and *Notice of Rights* is explained and provided to the parent/caregiver. A copy of the *Declining Early Intervention Services* is maintained and filed in the child's record. b. Parent/caregiver is provided with Maine Part C Program contact information and is informed that they may contact a Maine Part C Program at any point in the future if they have concerns about their child's development. [Maine Part C Program sites may also choose to offer re-screening at intervals determined with the family. Offers to re-screen are not required by federal or state law, and do not initiate timelines for compliance or imply entitlement to the same parental rights as those of an eligible child with a disability.] c. Parent/caregiver is provided with information about child development. d. Available community resources are discussed with the parent/caregiver and assistance in accessing these services is provided if requested by the family.
➢ **Family chooses to proceed to evaluation and assessment.**	a. *Consent for Evaluation and* Assessment is explained and signature of the parent/caregiver is obtained for the child's record. b. *Written Prior Notice* is completed, a copy is provided to the family, and a copy is placed in the child's record. Notice of Child and Family Safeguards is explained and a copy is provided to the Parent/caregiver.
Child screens at age level in all developmental areas and family requests a development evaluation and assessment	a. Compliance timeline ends; designated CDS staff members schedule an evaluation and assessment. All applicable notices must be completed, provided, and placed in the child's record (see box above).

Family Assessment

Federal Part C Regulations – Family Assessment

Sec. 303.322: Evaluation and Assessment

(d) Family Assessment.

(1) Family assessments under this part must be family-directed and designed to determine the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

(2) Any assessment that is conducted must be voluntary on the part of the family.

(3) If an assessment of the family is carried out, the assessment must –

(i) Be conducted by personnel trained to utilize appropriate methods and procedures;

(ii) Be based on information provided by the family through a personal interview; and

(iii) Incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development.

Family assessment is usually completed during the First Visit once it is clear that the evaluation and assessment is appropriate and desired by the family. The purpose of the family assessment is to gather information from the family about their everyday routines and activities, their child's and family's interests, as well as their concerns, priorities, and resources. In accordance with federal Part C regulations, the identification of concerns, priorities and resources is **voluntary, with the concurrence of the family**.

Designated CDS staff members will be assigned the responsibility for carrying out the steps and procedures included in the family assessment

Gathering family priorities, concerns, and resources should be as conversational as possible. To do this, the person asking for the information should create a climate in which the family feels free to talk about their child and family. This individual must have sufficient training in conducting interviews, including rapport-building, active listening and use of appropriate and effective questions. Using conversations to learn about the child's and family's background, strengths and needs, as well as their interests and activities in which they participate is imperative. For some children, it is also important to learn about the child's early care and education settings. During this exchange, the family is given the opportunity to share their "story", including their experiences with their child as well as previous medical, health, or developmental evaluation information, and to describe their concerns, priorities and information about their child's development. It is important that families be asked to provide information about their child's day, including what is working and what is challenging.

Procedures: Family Assessment

1. The family assessment is usually conducted during the First Visit. Information gathered from the family during the Initial Contact should be used as a foundation for the family assessment.
2. Information gathered through the family assessment process is documented on ***IFSP Pages 2-2a: Family Routines and Priorities*** which has two parts: (a) *Everyday Routines, Activities and Places*, and (b) *Family Concerns, Priorities, and Resources*.
3. Prior to initiating the family assessment, designated CDS staff members inform the parent/caregiver that:

- the family assessment is voluntary
- the information that the parent/caregiver chooses to share about their child and family is confidential; and
- the family helps determine what information is recorded on the IFSP regarding their family routines and priorities.

4. Designated CDS staff members inform the parent/caregiver of the purpose of family assessment including identifying the following:
   - the child's and family's strengths and interests.
   - the settings where the child and family currently live and play (home, community, and child care or preschool settings), along with the people who are involved.
   - The way the child has affected the activities that the family is involved in.
   - the family's concerns and priorities for the child's participation in family, community, and early care and education activities and routines.
   - the family's need for additional supports, including information, materials, and emotional supports.
5. Designated CDS staff members use conversations, rather than a structured interview, to gather this information about the child and family.
6. Designated CDS staff members may use a number of specific family assessment tools/methods in conjunction with conversations with families based on local program procedures. (See Appendices for examples of family assessment tools/methods).
7. Designated CDS staff members may wish to incorporate some of the following kinds of questions when conversing with the family to complete *Everyday Routines, Activities, and Places* of the ***IFSP Pages 2-2a: Family Routines and Priorities***, especially if the parent/caregiver struggle(s) in telling their story:
   - Can you tell me about your day? Where do you go? What do you do? Who do you spend time with?
   - What types of things happen on most mornings? Afternoons? Nights? Weekends?
   - What types of things or activities do you and your child like to do (e.g., hiking, going on picnics, playing games at home)?
   - What are your child's interests? What things does your child enjoy and what holds your child's attention (e.g., people, places, things such as toys, dog, being outside)?
   - What makes your child happy, laugh and/or smile?
   - What routines and/or activities does your child not like? What makes these routines and/or activities difficult and uncomfortable for your child? What does your child usually do during these routines/activities?
   - Who are key family members, other caregivers, or important people who spend time with your child, and in what settings does this occur?
   - Are there activities that you used to do before your child was born that you would like to do again?
   - Are there any other activities that you and your child would like to try?
3. Designated CDS staff members summarize for the parent/caregiver the **concerns** that they heard identified during the conversation regarding everyday routines, activities and places and confirm these concerns with the family. Designated CDS staff members assist the family in identifying which of these concerns are their most important **priorities**.
9. Designated CDS staff members summarize for the family any **resources** including family members, friends, community groups, financial supports, and other community resources etc. that were identified during their conversation about everyday routines and activities

that may be helpful in addressing their priorities. The parent/caregiver is asked if this "summary of resources" is accurate and if they can think of others that were not previously mentioned.

10. Designated CDS staff members summarize for the family strengths that were identified during the conversation about everyday routines and activities.
11. Concerns, priorities and resources confirmed by the family are recorded on the *Family Routines and Priorities* section of ***IFSP Pages 2-2a: Family Routines and Priorities***.
12. Additional information gathered from the family about their interests, concerns and priorities following the evaluation and assessment and during the IFSP meeting should be incorporated into the Family Assessment.

Preparation of Family for Evaluation and Assessment

Preparing for the evaluation and assessment of the child is a critical step, not only for the family, but also for the designated CDS team members who will be conducting the evaluation and assessment. It is important that the family understand the purpose of the evaluation and assessment, the process that will be used in the evaluation and assessment, an idea of who might be involved in conducting the evaluation and assessment, when eligibility will be determined, and what happens if their child is or is not found eligible.

Each team will conduct a transdisciplinary evaluation and assessment **in which all members of the team are involved in planning based on information received from the Initial Contact and other available information. A transdisciplinary model allows for an interactive and integrated process across domains to get a holistic picture of the child.**

Evaluation and assessment activities are conducted for two different purposes. The outcome of *evaluation* **is to expeditiously confirm eligibility for Maine's Part C Program and to determine the child's level of functioning in all five required developmental domains. An** *assessment* **is conducted for intervention planning through the identification of the child's unique strengths and needs in each developmental area and the supports and services appropriate to meet those needs.**

Procedures: Preparation for Evaluation and Assessment

1. Prior to completing the visit with the family, designated CDS staff members inform the family about evaluation and assessment and the eligibility determination processes. The following points are included in the explanation:
   - The purpose of the initial evaluation and assessment is to determine eligibility and to identify the unique strengths and needs of the child;
   - At least two (2) professionals and the parent will be involved in conducting the initial evaluation and assessment and determining eligibility. Designated CDS staff members who conduct the First Visit and family assessment should participate in the child's evaluation and assessment of and be responsible for preparing the evaluation and assessment team.
   - During the initial evaluation and assessment, the team will use procedures including a standardized developmental evaluation tool, pertinent records, observation of child (whenever possible involved in their everyday routines and activities), parent/caregiver feedback, etc. to determine the child's developmental status and

unique strengths and needs in each developmental area;

- The family will have an opportunity to identify their concerns, provide their observations, and ask questions of the team;
- If the child is eligible for Maine's Part C Program, a meeting to develop the initial IFSP must be conducted within 45 days of the date of referral. The professionals who complete the evaluation and assessment will work with the family to develop an IFSP that identifies supports and services appropriate to meet the child's and family's needs; and
- If the child is not eligible for Maine's Part C Program, the team will discuss other options that might be appropriate for the child and family.

2. **Designated CDS staff members discuss with the family their potential roles in the evaluation and assessment process. The parent/caregiver is encouraged to be an active team member, but they have the final decision regarding their level of participation. Designated CDS staff members ask the family about the best time and place to conduct the evaluation and about any suggestions the family might have to make the process go smoothly. This information is recorded on *Preparation for Evaluation and Assessment* and is used to prepare all individuals involved in conducting the process.**
3. **The family and designated CDS Staff member should discuss and determine whether the IFSP Meeting will be conducted at the same time as the Evaluation and Assessment. If holding the Evaluation and Assessment and IFSP Meeting on the same day, then CDS staff must also prepare the family for their participation in developing the IFSP. (Guidance relating to this, including appropriate procedural safeguards, can be found in the section of this document on the IFSP Meeting and Development of Initial IFSP.)**

EVALUATION AND ASSESSMENT OF THE CHILD

Federal Part C Regulations: Evaluation and Assessment, Nondiscriminatory Procedures, and Multi-disciplinary

Sec. 303.322: Evaluation and Assessment

(a) General.

(2) Each system must include the performance of a timely, comprehensive, transdisciplinary evaluation of each child, birth through age two, referred for evaluation, and a family-directed identification of the needs of each child's family to appropriately assist in the development of the child.

(3) The lead agency shall be responsible for ensuring that the requirements of this section are implemented by all affected public agencies and service providers in the State.

(b) Definitions of evaluation and assessment. As used in this part--

(4) Evaluation means the procedures used by appropriate qualified personnel to determine a

child's initial and continuing eligibility under this part, consistent with the definition of "infants and toddlers with disabilities" in Sec. 303.16, including determining the status of the child in each of the developmental areas in paragraph (c)(3)(ii) of this section.

(5) Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify--

(i) The child's unique strengths and needs and the services appropriate to meet those needs; and

(ii) The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

(c) Evaluation and assessment of the child. The evaluation and assessment of each child must--

(1) Be conducted by personnel trained to utilize appropriate methods and procedures;

(2) Be based on informed clinical opinion; and

(3) Include the following:

(i) <u>A review of pertinent records related to the child's current health status and medical history.</u>

(ii) <u>An evaluation of the child's level of functioning in each of the following developmental areas:</u>

(A) Cognitive development.

(B) Physical development, including vision and hearing.

(C) Communication development.

(D) Social or emotional development.

(E) Adaptive development.

(iii) An assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c)(3)(ii) of this section, including the identification of services appropriate to meet those needs.

(e) Timelines.

(1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in Sec. 303.321(e).

(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will--

(i) Document those circumstances; and

(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with Sec. 303.345 (b)(1) and (b)(2).

Sec.303.323 Nondiscriminatory procedures

<u>Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that—</u>

(a) Tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so;

(b) Any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory;

(c) No single procedure is used as the sole criterion for determining a child's eligibility under this part;

and

(d) Evaluations and assessments are conducted by qualified personnel.

Sec. § 303.17 Transdisciplinary.

As used in this part, transdisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in § 303.322 and development of the IFSP in § 303.342.

Evaluation and assessment are conducted ***concurrently as a convenience*** to the family, eliminating the need for an additional visit before implementation of the IFSP for an eligible child. Need for additional assessments may be determined based on the findings of the initial evaluation and assessment.

Evaluation and Assessment Team Selection and Preparation

Prior to conducting the evaluation and assessment of the child, appropriate team members must be selected to ensure that sufficient information is gathered during the evaluation and assessment to support the determination of eligibility and the identification of the unique needs of the child for intervention planning. Team composition is one of the most important components of the evaluation and assessment process.

Preparing for the evaluation and assessment of the child is a critical step, not only for the family, but also for the team members who will be conducting the evaluation and assessment. Team preparation is critical to ensure the following:

- **The transdisciplinary team is familiar with the relevant information regarding the child and family, including relevant health, developmental and medical information; and**
- **The evaluation and assessment team uses procedures in the evaluation and assessment process that are non-discriminatory and that are appropriate to the needs of the child.**

Procedures: Transdisciplinary Team Selection and Preparation

1. Procedures for selection must specify the following:
   - The selection of the transdisciplinary team members must be based on information gathered during the Referral/Initial Contact and the First Visit;
   - Circumstances when more than 2 disciplines need to be involved in the transdisciplinary team;
   - Designated CDS staff members who conduct the First Visit are strongly encouraged to be involved in the transdisciplinary team to ensure a complete understanding of the child's unique needs, and the supports and services necessary to meet those needs;
   - The team must include those individuals who are appropriately trained to conduct a transdisciplinary evaluation and assessment;
   - To the extent possible, the use of assessors and service providers with specialized expertise is encouraged to address the needs of children with complex medical needs or other issues; and
   - Other team members as appropriate to the child's needs.

2. Designated CDS staff members that conduct the First Visit are responsible for preparing the transdisciplinary team members for the evaluation and assessment. Preparation of the team must include the following:
   - Sharing relevant medical and developmental information on the child, including information from other sources as well as results of any screenings that are conducted;
   - Providing a summary of information gathered from the family during Initial Contact and the First Visit. This information should be summarized on ***IFSP Pages 2-2a: Family Routines and Priorities***;
   - Determining with the team any specific focus that should be included in the evaluation and assessment (e.g. observation of feeding or positioning).
3. The transdisciplinary team will designate a team leader who will:
   - ensure that all arrangements for the evaluation and assessment are completed including confirming MaineCare eligibility and obtaining physician referrals/prescriptions when necessary;
   - ensure that all procedural safeguards have been provided to the family prior to conducting the evaluation and assessment; and
   - confirm the evaluation and assessment appointment with the parent/caregiver to ensure timely completion of the child's evaluation and assessment. All efforts to contact the parent/caregiver must be documented in the child's record.
4. Preparation for the evaluation and assessment may be combined with the preparation for the IFSP Meeting or may be completed separately if the IFSP Meeting is scheduled for a different day than the evaluation and assessment. (See Preparation for the IFSP Meeting in this document)

Conducting the Evaluation and Assessment and Determining Eligibility

The evaluation and assessment process builds on the concept of using everyday places, routines, and activities to facilitate early intervention. If possible, the evaluation and assessment should include opportunities to observe the child in typical routines, especially those that the family reports as challenging and a priority. Developmental information and functional skills complete a whole picture of a child's abilities.

The evaluation shall include:

- Administration of the most recent version of the Battelle Developmental Inventory (BDI) or the Bayley Scales of Infant Development (Bayley) by individuals trained to utilize appropriate methods and procedures;
- Review of pertinent records related to the child's health status, medical history, and the assessment of the unique needs of the child; and
- When possible, observation of the child in typical routines, especially those that the family reports as challenging and a priority.

The results of the BDI or Bayley determine the child's level of functioning in each of the five developmental domains [Cognitive, physical (including vision and hearing), communication, social or emotional, and adaptive] and serve as the foundation for eligibility determination. Additional specialized assessment instruments may be used by the team based on the child's established condition (for example, visual impairment, hearing impairment, or autism spectrum

disorder). The informed clinical opinion of qualified evaluators is occurring throughout the entire process of interview, assessment, and administration of evaluative instruments.

The combined information of 1, 2, and 3 above is used by the team to determine eligibility. No one member of the team, nor the results of a single evaluation, can be the sole determiner of eligibility. Informed clinical opinion may be used as the primary determinant of eligibility under the following conditions:

- If the BDI or Bayley cannot appropriately be used with a child because instrument validity and reliability would be compromised (e.g. lack of culturally or linguistically appropriateness, adaptations must be used to elicit responses from children, etc.);
- If Professional Standards (related to the evaluation of children with disabilities) would be breeched (e.g. inability to follow publisher's administration requirements, etc.);
- When the informed clinical opinion is combined with the input of the designated CDS staff member, parent, and other team member(s) AND the informed clinical opinion is formed by individual(s)formally trained to use appropriate evaluation methods and procedures.

When informed clinical opinion is the primary determinant of eligibility, the Team must document the following in writing:

- An explanation of the reason(s) that the evaluation standards and procedures used with the majority of children resulted in invalid findings for this child;
- The objective data used to conclude that the child has a developmental delay (data may include test scores; parent input; childcare provider comments, observations of the child in his/her daily routine, use of behavior checklists or criteria-referenced measures, and other developmental data including current health status and medical history, etc.);
- Which data had the greatest relative importance for the eligibility decision; and
- The IFSP Team members agree to the necessity of the use of informed clinical opinion as the primary determinant for eligibility. If one or more team members disagree with the decision, the dissenting team members will develop a written statement of the areas of disagreement, signed by those members.

When the results of the evaluation are combined with the information of an assessment to determine the unique needs of the child, including pertinent records related to the child's health status and medical history, the IFSP team is prepared to address the resources, priorities and concerns of the family, and determine the eligibility of the child. The supports and services necessary to enhance the family's capacity to meet the developmental needs of the eligible infant or toddler with a disability, are designed and articulated in the IFSP.

The verification of eligibility for early intervention services is obtained through a transdisciplinary evaluation which utilizes the infant's or toddler's history which has been obtained from parental input and pertinent records related to the child's current health status and/or medical history.

For children with established conditions, eligibility has been determined prior to the evaluation and assessment. *A licensed physician, or in the case of severe attachment disorder a licensed psychologist or clinical social worker, may provide verbal report of an established condition for determining eligibility in order to meet the 45-day timeline. However, verbal report must be followed-up with a written, signed confirmation of the child's condition. When necessary, medical services are accessed by a physician only for this diagnostic or evaluative purpose.*

Nonetheless, evaluation and assessment continues to be needed in order to develop a meaningful IFSP for children with established conditions.

During the evaluation and assessment, the team should also begin to note the preferred learning styles of the family and other primary caregivers, as they will be the primary learners in the intervention process. The team should determine how the family and other primary caregivers prefer information to be presented and what information will be most useful to them based on their preferred learning styles. This should be documented on ***IFSP Pages 2-2a: Family Routines and Priorities***.

> NOTE: Evaluations and assessments not ordered by designated CDS staff members and conducted by non-CDS staff members or contractors cannot be reimbursed as Part C evaluations.

Procedures: Evaluation and Assessment and Eligibility Determination

1. The evaluation and assessment should be conducted in the home or a natural setting where the child normally participates. In unusual circumstances, the evaluation and assessment may be conducted elsewhere; reasons must be documented in the child's file.
2. The evaluation and assessment team members also participate in the development of the initial IFSP.
3. The ongoing team leader/service coordinator must be a participant in the evaluation process. For children who are not eligible for MaineCare, the team leader/service coordinator may serve as one of the required disciplines if s/he meets the personnel standards and competencies as an evaluator.
4. All team discussions regarding the evaluation and assessment must include the family.
5. The multi-disciplinary **team** (not individual evaluators) **determines eligibility** based on the results from the initial evaluation and assessment. Eligibility for Maine's Part C program requires the following:
   - A delay of at least 1.5 standard deviations from the mean score of the BDI or Bayley in two or more of the five developmental domains, or
   - A delay of at least 2.0 standard deviations from the mean score in at least one of the five developmental domains.
6. The designated CDS staff member must provide the family with ***Written Prior Notice*** regarding the child's eligibility, along with a copy and explanation of the ***Notice of Child and Family Safeguard***
7. If the child is not found eligible for Maine's Part C Program, the designated CDS staff member must also complete the following steps:
   - The parent/caregiver is provided with Maine's Part C Program contact information and is informed that they may contact the Part C Program at any point in the future if they have concerns about their child's development. If regional programs have established re-screening or follow-up procedures, families must also be provided with this information.
   - The parent/caregiver is provided with information about child development.
   - Available community resources are discussed with the parent/caregiver and contact information is provided
8. If the child is found eligible and the family chooses not to participate in Maine's Part C Program, the designated CDS staff member must complete the following steps:
   - The ***Declining Early Intervention Services*** form is explained, signed, and a copy is

filed in the child's record. A copy and explanation of the ***Notice of Child and Family Safeguards*** is provided to the family.

- The parent/caregiver is provided with Maine's Part C Program contact information and is informed that they may contact the Part C Program at any point in the future if they reconsider their decision to decline Maine's Part C services.
- The parent/caregiver is provided with information about child development.
- Available community resources are discussed with the parent/caregiver and contact information is provided.

9. Results of the evaluation and assessment are documented in the IFSP on the ***IFSP Pages 3- 3d: Present Abilities, Strengths and Needs.*** These pages of the IFSP serve as the evaluation and assessment report.
10. Eligibility is documented in the IFSP on ***IFSP Pages 3-3d: Present Abilities, Strengths and Needs***. Information gathered at the time of evaluation and assessment will be used as baseline for measuring the child's progress over time.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) TEAM MEETING

Federal Part C Regulations: Individualized Family Service Plans (IFSPs)

Sec. 303.340 General

(a) Each system must include policies and procedures regarding individualized family service plans (IFSPs) that meet the requirements of this section and Secs. 303.341 through 3.3.346.

(b) As used in this part, individualized family plan and IFSP means a written plan for providing early intervention services to a child eligible under this part and the child's family. The plan must—

(1) Be developed in accordance with Secs. 303.342 and 303.343;

(2) Be based on the evaluation and assessment described in Sec. 303.322; and

(3) Include the matters specified in Sec. 303.344.

(c) 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 this part. If there is a dispute between agencies as to who has responsibility for developing or implementing an IFSP, the lead agency shall resolve the dispute or assign responsibility.

NOTE: In instances where an eligible child must have both an IFSP and an individualized service plan under another Federal program, it may be possible to develop a single consolidated document, provided that it –

(1) Contains all of the required information in Sec. 303.344, and

(2) Is developed in accordance with the requirements of this part.

Sec. 303.342 - Procedures for IFSP Development, Review, and Evaluation

(a) Meeting to develop initial IFSP--timelines.

For a child who has been evaluated for the first time and determined to be eligible, a meeting to develop the initial IFSP must be conducted within the 45-day time period in Sec.303.321(e).

(d) Accessibility and convenience of meetings.

(1) IFSP meetings must be conducted--

(i) In settings and at times that are convenient to families; and

(ii) In the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

(2) Meeting arrangements must be made with, and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend.

Sec. 303.343 - Participants in IFSP meetings and periodic reviews

(a) Initial and annual IFSP meetings.

(1) Each initial meeting and each annual meeting to evaluate the IFSP must include the following participants:

(i) The parent or parents of the child.

(ii) Other family members, as requested by the parent, if feasible to do so;

(iii) An advocate or person outside of the family, if the parent requests that the person participate.

(iv) The service coordinator who has been working with 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.

(v) A person or persons directly involved in conducting the evaluations and assessments in Sec. 303.322.

(vi) As appropriate, persons who will be providing services to the child or family.

(2) If a person listed in paragraph (a)(1)(v) of this section is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including--

(i) Participating in a telephone conference call;

(ii) Having a knowledgeable authorized representative attend the meeting; or

(iii) Making pertinent records available at the meeting.

Preparing the Family for the Individualized Family Service Plan (IFSP) Team Meeting

The initial Individualized Family Service Plan (IFSP) is developed at a meeting following the child's evaluation and assessment and determination of his/her eligibility. The IFSP builds on those things that are working well in everyday routines/activities and that are valued and enjoyed by the child and family. The IFSP also addresses the priorities, resources and concerns of the family (what is the family unable to do as a result of the child's disability).

The IFSP does the following:

- Summarizes information that the family chooses to share about their child and family;
- Identifies the developmental status of the child;

- Develops outcomes for the child and family based on their priorities, resources and concerns;
- Builds family capacity to meet desired outcomes as part of everyday routines and activities;
- Identifies necessary supports to achieve outcomes. The supports and plans for meeting the identified outcomes should be flexible enough to accommodate the child and family's changing needs.

Procedures: Preparing the Family for the Individualized Family Service Plan (IFSP) Team Meeting:

1. The designated CDS staff member prepares the family for the IFSP Team Meeting by:
   - Explaining the purpose of the meeting and the IFSP;
   - Explaining the importance of family participation on the Team;
   - Reviewing the family priorities, resources and concerns; and
   - Reviewing the relevant medical and developmental information.
2. In planning and preparing the family for the IFSP Team meeting, the family and designated CDS staff member discuss and determine the following:
   - A meeting date, time and place that is mutually convenient;
   - If the meeting is not held at the family's home, whether transportation is an issue for the family; and
   - Whether the family wishes to invite other participants (other family members, an advocate or person outside the family) .
3. The designated CDS staff member must also provide the family with a copy and explanation of the ***Notice of Child and Family Safeguards***, along with written notification of the meeting date and time.

Preparing the Team for the Individualized Family Service Plan (IFSP) Team Meeting

Developing a meaningful IFSP with the family is a team responsibility.

Procedures: Preparing the Team for the IFSP Meeting

1. Team members who conducted the initial evaluation and assessment participate in the meeting in order to develop the initial IFSP.
2. The designated CDS staff member is responsible for preparing the team for the IFSP Team Meeting by:
   - Providing advance written notification of the date and time of the IFSP meeting to

Team members (including participants that the family invites). The child's primary health care provider will always be invited to participate in IFSP meetings.

- Determining whether team members can attend the IFSP Team Meeting or if alternate arrangements must be made for team member involvement (e.g., participate by phone, having an authorized representative, providing written information).
- Summarizing pertinent medical, developmental and other information related to the child and family that are useful in the development of the IFSP.
- Providing copies of all necessary IFSP forms.

Conducting the Individualized Family Service Plan (IFSP) Team Meeting and Developing the Initial IFSP

The IFSP is intended to be a fluid document that is modified as necessary to address the evolving needs of the child and family. Initial development of the IFSP is based on conversations and collaboration with the family. The initial IFSP must include the identification of outcomes based on those concerns that are most important to the family and the necessary supports and services to address these concerns. Revisions to the initial IFSP to address additional family concerns may occur after initiation of supports and services.

In developing the IFSP, it is critical for service providers to keep in mind several key purposes of Maine's Part C Program that are in accordance with IDEA 2004:

- enhancing the development of infants and toddlers with disabilities;
- minimizing the effects of the child's disability on everyday routines;
- recognizing that significant brain development occurs during the first three years of the child's life; and
- enhancing the capacity of the family to facilitate their child's development.

The process of developing the initial IFSP is another opportunity to strengthen the collaborative partnership with the family and to foster mutual understanding of the needs of the child and family. It is critical that service providers recognize and respect the role that a family plays in enhancing their child's development, and that this role varies from family to family. As a result, the team needs to ensure that the family is supported as a partner in the development of the IFSP. The family should be given the opportunity to understand other team members' perspectives, make informed decisions, and reach consensus about the process that will help them reach their goals for their child and family.

Procedures: Conducting the IFSP Team Meeting and Developing the Initial IFSP

1. When a parent prefers, an IFSP may be developed through an IFSP Meeting on the same day that the evaluation and assessment is conducted. The family may request, however, that the IFSP meeting be held on a separate day and time.
2. The service coordinator is responsible for facilitating and participating in the IFSP meeting and the development of the IFSP.
3. The service coordinator is responsible for ensuring that all necessary IFSP forms are available and that the purpose of each form is described to the Parent/caregiver.
4. The parent/caregiver assists the team in deciding the information that is documented on the IFSP.
5. IFSP **decisions are made by the team**. No one team member dictates the IFSP content, including the outcomes, strategies, and/or the necessary services and supports.
6. The evaluation and assessment team leader is responsible for summarizing developmental information about the child and determining with the family if the summary reflects the family's perspective of the child's development.
7. The designated CDS staff member is responsible for reviewing with the Parent/caregiver their prioritized concerns shared during the First Visit and to confirm the accuracy and completeness of this information. The team discusses with the family which priorities are most important to address immediately.
8. The team and the family identify **functional outcomes** for the child, and if appropriate, outcomes for the family based on:
   - Family concerns and priorities;
   - Everyday routines and activities, interests of the child and family, and important people and places;
   - The child's current functional skills; and
   - Input from that child's medical provider for a child who has a complex medical condition.
9. The number of IFSP outcomes that are developed on the initial IFSP depends on the family's priorities that are most important to address immediately. The team needs to reflect what is reasonable and not overwhelming to the family.
10. The team develops outcomes that are functional and measurable and that can be realistically achieved within a reasonable time frame (usually 6 months).
11. The team develops short-term objectives that are developed for each outcome to help document how progress will be made. In addition, the team determines when and how progress will be measured and identifies how the team will know that the outcome has been achieved.
12. The service coordinator and service providers use information shared by the family regarding everyday routines and activities, child and family interests, and important people and places, to assist in the development of appropriate **strategies**, including natural learning opportunities, to meet the outcomes.
13. All information related to outcomes and strategies are documented in the IFSP on ***Page 4: Child/Family Outcomes***. More specific instructions for completing this page can be found in ***IFSP Instructions***.
14. Some guidance on the Targeted Case Management outcome page needs to be added by the small group that is working on revising the existing content of the form.
15. Services must be provided in a child's natural environment. The IFSP Team determines for each outcome, whether or not the outcome can be achieved (and if services needed to meet the outcome can be provided) in a **natural environment**. Since children learn best

when interested and engaged in activities and when they can practice new skills during natural learning opportunities that occur in everyday routines and activities,

16. In developing the IFSP, outcomes and strategies are identified prior to determining the necessary services and supports and where they will be provided
17. In determining where services and supports are provided, the IFSP Team must value and preserve the family's typical routines when identifying services, supports and strategies necessary to achieve the outcomes. Services must "fit the family" instead of making the family "fit the service"
18. No individual member of the team may unilaterally determine the setting for service delivery. Every effort is made to select a setting that the entire IFSP team, including the parent, supports. The US Department of Education has clarified that family preferences, or the preferences of one IFSP team member, is not sufficient justification for not providing services in a natural setting.
19. The team must develop a **natural environment justification** if they determine that an outcome cannot be achieved in a natural environment. The justification must include the reasons why the team determined that the outcome could not be achieved in the context of everyday routines and activities of the child and family as well as steps that will be taken to generalize services and supports provided in specialized settings into everyday routines and activities, including timelines for moving services/supports into natural environments
20. The team must document the natural environment justification in the IFSP on ***IFSP Pages 4-4a: Child and Family Outcomes*** under *Natural Environment Justification*. (See ***IFSP Instructions***)
21. During the IFSP Meeting, the team must have a conversation with the parent/caregiver regarding **transition planning** when early intervention services are no longer available for or needed by their child. An explanation regarding eligibility and age guidelines should be provided to help frame the discussions and determine potential transition planning activities for the initial IFSP.
22. The ***IFSP Pages 6-6a: Transition Plan*** provides a range of potential transition activities that may be applicable depending on the age of the child. (See ***IFSP Instructions*** for more information on how to use and complete these pages.)
23. The IFSP Team identifies the **services and supports**, including frequency, intensity and methods necessary to meet the identified outcomes. In determining necessary supports and services, the team must consider research findings indicating that visits provided too frequently can be disempowering or send the message that the parent is not competent. In addition, the team should determine frequency and intensity of services based on the amount of support the family needs in identifying and using natural learning opportunities throughout everyday routines and activities to promote their child's attainment of functional skills.
24. The team documents services and supports decisions in the IFSP on ***IFSP Page 7: Supports and Services Needed to Achieve Outcomes.*** (See ***IFSP Instructions*** for guidance on completing this page of the IFSP.)
25. Whenever possible, the IFSP is completed in one meeting of the IFSP Team. However, some circumstances may require that the team reconvene to complete the IFSP.
26. Whenever the IFSP is completed, all IFSP Team members need to sign the IFSP on the ***IFSP Page 9: Signature*** (See ***IFSP Instructions*** for guidance on completing this form.)
27. The service coordinator explains to the Parent or guardian(s) that prior to initiating IFSP services and supports, their consent is required. They are informed that they have the option to accept all, some or none of the IFSP services and supports. If for any reason

they chose to decline an IFSP service(s)/support(s), doing so does not jeopardize any other early intervention service their child and/or family receives. A copy of the ***Notice of Child and Family Safeguards*** is provided and explained to the Parent, including that they have the right to file a complaint and/or request due process and/or mediation. ***Written Prior Notice*** is sent describing the decisions made at the meeting.

28. Service providers should respect the family's decision to decline any or all IFSP services and supports.

Interim Individualized Family Service Plan

Federal Part C Regulations: Interim IFSP

Sec. 303.345 Provision of services before evaluation and assessment are completed.

Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment in Sec. 303.322, if the following conditions are met:

(a) Parental consent is obtained.

(b) An interim IFSP is developed that includes--

(1) The name of the service coordinator who will be responsible, consistent with Sec. 303.344(g), for implementation of the interim IFSP and coordination with other agencies and persons; and

(2) The early intervention services that have been determined to be needed immediately by the child and the child's family.

(c) The evaluation and assessment are completed within the time period required in Sec. 303.322(e).

Note: This section is intended to accomplish two specific purposes:

(1) To facilitate the provision of services in the event that a child has obvious immediate needs that are identified, even at the time of referral (e.g., a physician recommends that a child with cerebral palsy receive physical therapy as soon as possible), and

(2) to ensure that the requirements for the timely evaluation and assessment are not circumvented.

Sec 303.322(e) Evaluation and Assessment Timelines

(1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in Sec. 303.321(e).

(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will--

(i) Document those circumstances; and

(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with Sec. 303.345 (b)(1) and (b)(2).

Interim IFSPs are applicable for those circumstances when early intervention services need to begin immediately. An interim IFSP is also appropriate in the event of exceptional circumstances (i.e. the child is seriously ill, preventing completion of the evaluation and assessment within 45 days). Developing interim IFSPs should be an **exception** rather than common practice. For the most part, interim IFSPs are applicable for children who will most likely be eligible for services based on diagnosed conditions.

If eligibility has already been determined through the evaluation and assessment process, the IFSP team will develop a comprehensive IFSP rather than an Interim IFSP. In situations where specific services are necessary immediately, those IFSP services should be implemented immediately, and all other IFSP services will be implemented as soon as possible. Under no circumstances can an interim IFSP be used only to extend the 45-day timeline.

Procedures: Interim IFSP Development

1. The service coordinator determines if an Interim IFSP is needed based upon individual circumstances for each child.
2. The service coordination documents in the child's record the specific circumstances that warrant the development of an interim IFSP.
3. The service coordinator is responsible for the following, prior to developing an Interim IFSP:
   - Providing the family with ***Written Prior Notice;*** and
   - Providing a copy of and explaining the ***Notice of Child and Family Safeguards*** to the family.
4. The service coordinator is responsible for developing the Interim IFSP using the IFSP forms.
5. The service coordinator is responsible for coordinating the implementation of the Interim IFSP.
6. If early intervention needs to begin immediately, an interim IFSP is appropriate. (Guidance relating to this can be found in the section of this document about when and how to develop interim IFSPs.)

Natural Environments

Federal Part C Regulations: Natural Environments

Sec. 303.12 Early Intervention Services

(b) Natural Environments. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate.

Sec. 303.167 Individualized Family Service Plans

(c) Policies and procedures to ensure that--

(1) To the maximum extent appropriate, early intervention services are provided in natural environments; and

(2) The provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment.

Sec. 303.18 Natural environments

As used in this part, natural environments means settings that are natural or normal for the child's age peers who have no disability.

Sec. 303.344 Content of an IFSP

(d) Early intervention services.

(1) The IFSP must include a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified in paragraph (c) of this section, including--

(i) The frequency, intensity, and method of delivering the services;

(ii) The natural environments, as described in Sec. 303.12(b), and Sec. 303.18 in which early intervention services will be provided, and a justification of the extent, if any, to which the services will not be provided in a natural environment;

(iii) The location of the services

Note 1: With respect to the requirements in paragraph (d) of this section, the appropriate location of services for some infants and toddlers might be a hospital setting--during the period in which they require extensive medical intervention. However, for these and other eligible children, early intervention services must be provided in natural environments (e.g., the home, child care centers, or other community settings) to the maximum extent appropriate to the needs of the child.

Providing services in natural environments is the law and supports the purpose of early intervention services to enhance the capacity of the family in facilitating their child's development. Natural learning opportunities occur in community settings where children live, learn, and play. Providing early intervention within activities (bath time, mealtime, reading, playing, etc.) that occur in natural settings (home, childcare, playground, etc.) offers numerous opportunities for the child to learn and practice new skills to enhance growth and development. The provision of services in natural settings and in daily routines and activities fosters the use and development of natural supports in a family's social and cultural network, promoting the child's and family's full participation in community life.

In developing the IFSP, outcomes and strategies are identified prior to determining the necessary services and supports and where they will be provided. Determining intervention strategies begins with identifying and understanding the family's routines and daily activities. Services and supports provided within these activities maximize the child's opportunities for learning and practicing new skills and effectively problem solving challenges.

In accordance with federal Part C requirements, each IFSP service is required to be provided in natural environments unless an outcome or outcomes cannot be achieved satisfactorily by doing so. If a service cannot be provided in a natural environment, a **justification** must be provided on the IFSP (see Conducting the IFSP Meeting and Developing the IFSP above and ***IFSP Instructions***, regarding documenting natural environment justifications.)

The US Department of Education, Office of Special Education Programs (OSEP) has clarified that family preferences, or the preferences of one IFSP team member, is not sufficient justification for not providing services in a natural setting through the following letters to states:

- OSEP states in a letter to ***Heskett, Missouri, May 26, 1999*** in response to a question about whether it violates Part C for a parent to chose a non-natural environment (e.g., center-based program or clinic for children with disabilities) that they deem is best for their child: "*Although Part C recognizes the importance of, and requires, parent involvement throughout the IFSP process, Part C does not relieve the State lead agency of its responsibility to ensure that other regulatory and statutory requirements, including the natural environments provisions, are met. While the family provides significant input regarding the provision of appropriate early intervention services, ultimate responsibility for determining what services are appropriate for a particular infant or toddler, including the location of such services, rests with the IFSP team as a whole. Therefore, it would be inconsistent with Part C for decisions of the IFSP team to be made unilaterally based solely on preference of the family. The State bears no responsibility under Part C for services that are selected exclusively by the parent; however the State must still provide all other services on the IFSP for which the parents did consent.*"
- OSEP states in a ***Letter to Elder, Texas, July 17, 1998*** in response to a question about whether it violates Part C to provide services in a setting selected by the parent, which does not meet the definition of a natural environment even if the parents are incurring the cost of the setting, if the IFSP team determines services can be satisfactorily achieved in the natural environment: "*… if the parents do not consent to a particular location for a service specified in the IFSP, the State may not use Part C funds to provide that service in a location different from that identified on the IFSP. The parents are free to reject any service(s) on the IFSP by not providing written consent for that service(s) or by withdrawing consent after first providing it. If the parents do not provide consent for a particular early intervention service, which also includes the location, that service may not be provided....*".

When determining if a setting is a natural environment, the following guidance established by the Infant Toddler Coordinator's Association should be considered:

- Children and families participate in a variety of community activities that are natural for them including those that occur in their home. Therefore, **if the family does not want services in their home, another community setting is identified** where the child's needs may be addressed.
- **Natural groups of children are groups that would continue to exist with or without children with disabilities.** Groups that are not "natural groups" include playgroups, toddler groups or childcare settings that include only children with disabilities. However, even the most "natural" of groups is not a natural setting for a particular child if it is not part of that child's family's routine or community life.
- Programs originally designed as a program for only children with disabilities and would not be considered a natural environment. However, if the program now includes children without disabilities then it could be considered a natural environment. OSEP has provided guidance in this instance and in all of its policy letters since August 2000 has stated:

  *"Many center-based programs that formerly served only children with disabilities have now integrated children without disabilities, creating a child care or preschool program constituting a natural environment. If services were provided to an eligible child in such an integrated environment, the child's IFSP would not require a justification for services in that integrated setting." (**Letters to: Morris, Washington, June 7, 2005; Individual (personally identifiable information redacted), July 30, 2002; Shelby, August 6,***

2001;, June 14, 2001; Individual (personally identifiable information redacted), November 1, 2000)

- **Service settings that are not "natural settings" include clinics, hospitals, therapists' offices, rehabilitation centers, and segregated group settings.** This includes any settings designed to serve children based on categories of disabilities or selected for the convenience of service providers.
- **Justification for providing services in a setting outside of a natural environment** includes sufficient documentation to support the IFSP Team's decision that the child's outcome(s) could not be met in natural settings and identifying a plan on how such services will be transitioned to a natural setting. OSEP has provided guidance in a Letter to ***Shelby, District of Columbia, August 6, 2001*** regarding IFSP team decision-making requirements around providing services in non-natural settings:

  "*Early intervention services provided to infants and toddlers with disabilities and their families are designed to meet the unique needs of the child, taking into consideration the strengths and challenges of the child and the child's family. After careful evaluation of the child and significant input from the family as to its typical routines and dreams for the future of the child, a team that includes qualified professionals and the parents, meets to determine the types of early intervention services needed, how often the services will be provided, by whom, where services are to be provided, and who will pay for these services. The discussion of, and decision about, the location of any service takes place in the context of an IFSP meeting. In all instances, supports and services are to be determined based on the individual needs of the child. Nothing in Part C of IDEA or its implementing regulations at 34 CFR Part 303 requires that early intervention services always be provided in a child's home or in a day care center where there are other children without disabilities. In general, providing services in a setting limited exclusively to infants and toddlers with disabilities would not constitute a natural environment. However, 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. In such cases, a justification must be included on the child's IFSP.*"
- Since parent-to-parent support through parent groups or other means, is critical for families of children with disabilities. OSEP has determined that such parent activities do not have to be provided in a natural environment. Specifically, OSEP states in a ***Letter to Yarnell, Pennsylvania, October 19, 1999*** that "*….for services directed solely at the parent such as parent support, those services are not required to take place in a natural environment. No justification, therefore, is needed on the IFSP.* ***Such services solely for the parent, however, cannot be used as a justification for providing services to the child in other than natural environments.***"

Documents from which information was pulled to develop Maine's EI process guide:

NV- Effective Practice Guidelines: Foundation and Philosophy

- Mission & Guiding Principles (p. 5)
- adapt whole of Module I- (pp. 6-16)
- Common Themes: Review of Literature
- Key concepts and frameworks underlying effective practice

NV –Effective Practice Guidelines: Intake, Evaluation and Eligibility

NV- Effective Practice Guidelines: IFSP

FL- Service Delivery Policy and Guidance, p.26-38

- Team-based Primary Service Provider Model, including key role of families
- First Contacts and Family Assessment
- Eligibility Evaluation
- Assessment

FL- Component 3 on Evaluation and Assessment

Shelden & Rush, 2001

Dunst & Bruder, 1999

McWilliam & Scott, 2001

Record Audit Form – Part C

CDS site:_____ Review Team Member_____ Date_____

PART C
CHILD RECORD AUDIT FORM

Names

ITEMS	COMMENTS			
INITIAL REFERRAL AND EVALUATION	**DOB**			
1. Initial referral form completed and includes the following information: • **Child's name** • **Parent's name and contact information** • **Date of Birth** • **Areas of concern** • **Referral Source / Date** • **Physician's name** • **Insurance source** • **Initiation of screening process / date of initial screening**	Referral Date 1. 2. 3.			
2. Written notice to parent of initial referral • **State form (as of 9/1/07)** • **Filled out completely**				
3. Documentation of Parents provided with procedural safeguards				
4. Receipt of consent for initial evaluation • **State form (as of 10/1/07)**				
5. Input from the IFSP team to determine evaluation needs (if any)				
6. Appropriate referrals for evaluations documented				

7. Bailey / Battelle must be utilize to satisfy 303.322(c)(3)ii as part of initial evaluation (as of 3/30/07)				
8. Completion of evaluations and IFSP meeting held to review to determine eligibility within • (B-2) 45 days from the regional site Board's receipt of referral				
9. Development of IFSP with written consent for initial placement • New IFSP state form as of 9/1/07				
9a. On the initial IFSP the signature of the parent, to indicate the informed and voluntary consent to the initial placement (services of the child)				
10. Written notice to parent for initial placement				
CURRENT IFSP Team Notices and Procedures				
10. Parental written notice of IFSP meeting • State form as of 10/1/07				
For children B-2 attendance should include to determine eligibility: • parent • case manager • physician (encouraged) • evaluator • service providers (if appropriate • Others as appropriate at site or parent discretion				
11. IEU shall provide at least seven days prior notice of each IFSP meeting or have evidence of a waiver				
12. For children who will be transitioning from Part C to Part B …the notice must include a statement of: • The purpose of the meeting is to consider • transition • Appropriate representatives of Part C and • B and Local public school system has been • invited • Identify any other agency that will be • invited to send a representative				
B-2 transition into Part B: • must be held at least 90 days prior to the child's 3rd birthday with explanation of Part B, and the parents makes informed decision of using IEP of IFSP				

13. Documentation that a copy of the evaluation report was provided to the parent a reasonable time prior to the IFSP meeting at which the evaluation is discussed.				
14. Copy of IFSP to parents within 21 days of the meeting				
15. Written Notice to parent if SAU proposes or refuses to initiate or change identification, evaluation, educational program, placement, …(Appendix 1 34 CRF 300.503)				
16. Prior written notice of implementation of an IEP of a transferring child				

EVALUATIONS				
18. Each SAU shall obtain informed parental consent prior: • for initial screening / evaluation • for each reevaluation and • before initiation of services * State Form as of 10/1/07				
19. Input from the IEP Team to determine evaluation needs (if any) A. Written notice of reevaluation Determinations (State form)				
20. Use a variety of assessment tools and strategies; not use any single procedure as the sole criterion; use technically sound instruments				
20a. Child Outcome Summary form (as of 4/1/07) upon entry into services (within 30 days of identification) and upon exit from program if the child has been in services for 6 months or longer				
IFSP TEAM PROCEDURES				
21. Required members present at the meetings –				
22. If parent not present, the SAU shall maintain a record of its efforts to arrange a mutually agreed upon time and place				
TEAM CONSIDERATIONS IN DEVELOPING AN IFSP				
23. State IFSP form as of 9/1/07				
A. Family Routines and Priorities				
B. Present Abilities, strengths and needs: • Summary of relevant Health Status				
• Using hand and Moving Body (Gross and Fine motor)				
• Understanding / Communicating (receptive				

and expressive language)				
• Playing, Thinking, Exploring (Cognitive Skills)				
• Expressing and Responding to Feelings & Interacting with others (Social and Emotional)				
• Eating, Dressing, and Toileting (Self –Help or Adaptive Skills)				
• Evaluator (s)' name, crendentials, role/ organization, signature and date				
• Team Summary chart of five domains				
C. Eligibility for Maine Part C Services Page with determination of eligibility indicated				
INDIVIDUAL FAMILY SERVICE PLAN				
24. Child / Family Outcomes including: • Outcome statement • Short term objectives • Strategies • Progress				
24a. Natural Environment Justification and documentation				
• The EI services are being provided in the child's natural environment				
25. Transition Plan • Date of Child's 3rd birthday				
• Date for transition conference (at least ninety days before the child's third birthday)				
• Date Child exited from EI program				
• Anticipated Date of Transition				
• Priorities and goals for child's transition				
• Transition Planning requirements and activities with person(s) responsible, date initiated and date to be completed.				
26. Transition Conference				
27. Supports and Services needed to achieve Outcomes including: • Specific supports and services				
• Setting				
• Method				
• Frequency				
• Intensity				
• Qualified Enrolled Provider				
• Funding Source				

• **Start and End Dates**				
• **Other Services (other services needed by the child but not entitled under part C)**				
28. IFSP Signature Page with consent from parent for EI services				
29. Periodic Review of the IFSP documentation				
30. Financial Resources listed on IFSP				
31. Primary Health Care Provider Approval				