RI Early Intervention
Annual Individualized Family Service Plan Review
Eligibility Redetermination

Child's Name:	**DOB:**	**ID#:**	**Date:**

The Annual IFSP Review includes a review and update of:

- Family concerns, priorities and resources
- The child's present levels of development in all areas
- Child and family outcomes
- Early Intervention services

Please use this ***Annual Individualized Family Service Plan Review - Eligibility Redetermination*** form to document the annual review when there is a question about a child's continued eligibility for Early Intervention and a multidisciplinary evaluation is conducted. If a child's eligibility is not in question, please use the ***Annual IFSP Review*** form.

What current concerns do you have about your child's development, behaviors and/or skills?

What are your current priorities with regard to your child's development, behaviors and/or skills?

What are some of the changes/updates to your resources (individuals and professionals that support you and your family)?

What are some of the supports or resources you would like to learn more about?

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Child's Name:	DOB:	ID#:	Date:

Tell us about any changes to your childs health over the past year? *(New medications, surgery, hospitalizations, diagnosis)*

Tell us about any changes over the past year related to your childs nutrition, feeding (i.e. food preferences, diet, intake, swallowing, chewing**) or sleeeping?**

Tell us about your general daily activities. What are some of the new things you, your child and family have accomplished over the past year? (i.e. going out in the community, playing, meeting other families)

What are some things you would like to accomplish over the next few months? (for yourself, your child or family)

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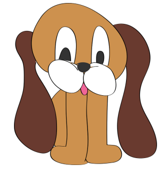

Screening for Hearing Loss or Change in Hearing Level

Child's Name	ID#	DOB

Column 1

Yes	No	
		Do you have any concerns about how your child hears?
	☐	Do you have any concerns about your child's language development?
	☐	Has anyone else expressed concern about how your child hears? If yes, who?
	☐	Has anyone else expressed concerned about your child's language development? If yes, who?
	☐	Has your child had middle ear infections or fluid in the ears for more than 3 months?
	☐	Does your child have a medical condition associated with hearing loss (see a example list on back)?
	☐	Has your child had meningitis?
	☐	Has your child experienced head trauma or excessive exposure to noise?
	☐	Has your child experienced any serious illness requiring hospitalization?
	☐	Does your child have a craniofacial anomaly, such as cleft palate that was not identified at birth?

Column 2

Yes	No	NA or Not Sure	
			Approximately how many spoken words or gestures does your child use consistently? words gestures Compare this information to the developmental milestones expected for children this age. Any child with words/gestures like that of a younger child should be referred for a hearing assessment.
	☐	☐	Did your child pass his/her newborn hearing screening?
			At 2 months, did/does your child coo or make gurgling sounds <u>and</u> turn his/her head toward sounds?
	☐	☐	At 4 months, did/does your child babble with expression and copy sounds he/she hears?
	☐	☐	At 6 months does your child respond to his/her name?
			At 9 months, did/does your child turn toward familiar voices and sounds in the environment?
			At 12 months, did/does your child say single words such as "ma-ma", "da-da"?
	☐	☐	At 18 months, did/does your child follow or respond to simple questions? "Come here" "Where's your shoe?"
			At 18 months, does/did your child say have at least 10 single words, e.g. "puppy", "milk", "cookie"
			At 24 months, did/does your child use two or three word phrases to talk or ask for things?

*If you answered **<u>"yes" to any questions in Column 1</u>and/or <u>"no" to any question in Column 2</u>,** it is recommended that you schedule a comprehensive hearing test for your child by a licensed pediatric audiologist. Testing will ensure your child is hearing all the sounds we would expect. A copy of this hearing screening should be given to the audiologist.*

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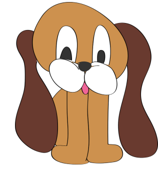
Screening for Hearing Loss or Change in Hearing Level



Based on the results of this assessment:

☐ ***We recommend your child receives a comprehensive hearing assessment with a pediatric audiologist*** (enter FER on Evaluation Summary page)

☐ *Parents/Guardian has received* ***RI Guide to Your Child's Hearing Assessment****, which includes a list of pediatric audiologists*

☐ ***We have learned your child is currently being followed by an audiologist*** (enter FER on Evaluation Summary page)
Audiologist Name: Dr.
Child's next scheduled appointment is on

☐ ***No concerns have been identified at this time. Your child will continue with standard periodic screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review (enter WNL on Evaluation Summary page)***

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's audiologic report.

Are you unsure if your child passed their newborn hearing screen?

If your child was born in RI, results can be obtained from the RI Hearing Assessment Program (phone 401-277-3700, fax 401-921-6937). You can call directly, or your EI provider can assist you. If you would like your EI provider to obtain this information on your behalf, you will be asked to sign consent before the request can take place. If the child was born out of state and you are unaware if their child was tested or what the results were, you can consult www.infanthearing.org to obtain contact information for that state.

Does your child have a medical condition associated with hearing loss?

There are over 300 syndromes associated with hearing loss. This is a list those that are more common. All children with these diagnoses should be followed closely by a pediatric audiologist.

- Achondroplasia
- Alport
- Apert
- Branchio-Oto-Renal Syndrome
- Charcot-marie-Tooth
- CHARGE Syndrome
- Crouzen or Cornelia de Lange
- Fetal Alcohol Syndrome
- Goldenhar Syndrome
- Hunter Syndrome
- Mitochondrial Conditions
- Neurofibromatosis
- Pendred
- Oculo-Auriculo-Vertebral Dysplasia
- Stickler Syndrome
- Treacher Collins
- Trisomy 13 or 18
- Trisomy 21 (Down Syndrome)
- Turner Syndrome
- Usher Syndrome
- Waardenburg Syndrome

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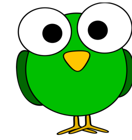

Screening for Vision Loss or Changes in Vision

Child's Name:			**ID#**		**DOB**	
Column 1			**Column 2**			
Yes	**No**		**Yes**	**No**	**NA**	
☐	☐	Do you have any concerns about your child's vision? If yes, please explain				**At 0-3 months, did/does your child:**
			☐	☐	☐	Smile at other people?
			☐	☐	☐	Look at their own hands?
☐	☐	Have you/other parent ever had a medical condition related to your eyes?	☐	☐	☐	Look at parent(s) as they enter the room?
☐	☐	Do your child's eyes appear to cross, turn in or wander?				**At 4 – 6 months, did/does your child?**
						Watch a ball drop on the floor and roll away?
☐	☐	Are your child's pupils or eyes different sizes?	☐	☐	☐	Look back and forth between 2 objects?
☐	☐	Have you noticed any rapid back and forth movement of your child's eyes?	☐	☐	☐	Notice something small like a raisin when it is 12 inches away?
			☐	☐	☐	Reach and grasp at toys?
☐	☐	Does your child press on or poke at their eye(s)?				**At 7-9 months, did/does your child?**
☐	☐	Does your child tilt or turn their head in an unusual way when looking at something?	☐	☐	☐	Look for dropped toys?
						Attempt to move toward an object that is at least 5 feet away?
☐	☐	Was your child born prematurely or on oxygen while in the hospital?	☐	☐	☐	Try to grab hair, jewelry or glasses?
☐	☐	Does your child ever bring objects very close to their face in order to see better?				Pick up or attempt to pick up a small object?
☐	☐	Does your child ever squint when in normal lighting? If yes, when?				**At 10 – 18 months, does/did your child?**
☐	☐	Does your child have a health conition associated with vision loss (see examples on next page)? Or other diagnosis or medical concerns? If yes, please explain________________	☐	☐	☐	React to facial expressions of others such as frowns or smiles?
			☐	☐	☐	Show an interest in picture books?
			☐	☐	☐	Reach in to a container and pull out objects easily?
			☐	☐	☐	Notice objects or people outside through a window?

*If you answered **"yes" to any questions in Column 1 and/or "no" to any question in Column 2,** it is recommended that you schedule a comprehensive eye exam for your child by a pediatric optometrist or ophthalmologist. A copy of this vision screening should be given to the eye care provider, as well as your child's pediatrician.*

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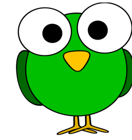

Screening for Vision Loss or Changes in Vision

Based on the results of this assessment:

☐ ***We recommend your child receives a comprehensive eye examination with a pediatric optometrist or ophthalmologist*** ***(enter FER on Evaluation Summary page)***

☐ Parents/Guardian has received ***RI Guide to Your Child's Vision*****,** which includes a list of pediatric *optometrists and ophthalmologists*

☐ ***We have learned your child is currently being followed by an*** **optometrist or** ***ophthalmologist*** ***(enter FER on Evaluation Summary page)***

Optometrist /Ophthalmologist Name: Dr.

Child's next scheduled appointment is on

☐ ***No concerns have been identified at this time. Your child should continue with recommended screenings by their pediatrician and EI will revisit this screening at, or before the annual IFSP review*** ***(enter WNL on Evaluation Summary page)***

Parents/Guardian: If applicable, remember to give your consent for Early Intervention to obtain a copy of your child's eye examination report.

There are many medical conditions that can impact a child's vision. This is a list of some that will require a child to be closely followed by a pediatric ophthalmologist.

- Strabismus
- Congenital Cateracts
- Congenital Glaucoma
- Retinal Degeneration
- Optic Atrophy
- Tuberous Sclerosis
- Marfan syndrome
- Cerebral Palsy
- Osteogenesis Imperfecta
- Galactosemic
- Hypocystinuria
- CHARGE syndrome
- Trisomy 13
- Trisomy 18
- Down Syndrome
- Albinism

The American Academy of Ophthalmology and the American Association for Pediatric Ophthalmology and Strabismus recommend the following schedule for pediatric vision screening:

Newborn. *An ophthalmologist, pediatrician, family doctor or other trained health professional should examine a newborn baby's eyes and perform a red reflex test (a basic indicator that the eyes are normal). An ophthalmologist should perform a comprehensive exam if the baby is premature or at high risk for medical problems for other reasons, has signs of abnormalities, or has a family history of serious vision disorders in childhood.*

Infant. *A second screening for eye health should be done by an ophthalmologist, pediatrician, family doctor or other trained health professional at a well-child exam between six months and the first birthday*

Preschooler. *Between the ages of 3 and 3½, a child's vision and eye alignment should be assessed by a pediatrician, family doctor, ophthalmologist, optometrist, orthoptist or person trained in vision assessment of preschool children.*

American Academy of Ophthalmology 2019
https://www.aao.org/eye-health/tips-prevention/children-eye-screening

REQUIRED FOR INITIAL ELIGIBILITY ONLY OR OPTIONALLY IF CONCERNS ARISE

Portions of this screening are adapted from: Heiting OD, Gary (2017). Your Infant's Vision Development. Retrieved from https://www.allaboutvision.com/parents/infants.htm

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Eligibility Redetermination

Child's Name:	**DOB:**	**ID#:**	**Date:**
Briefly summarize the child's present levels of development. Consider information gathered during ongoing assessment, any recent evaluations, observation and parent report. Include details on areas of strength and how the child's development and functioning is impacting their ability in each outcome area.			

Outcome 1: Positive Social Emotional Skills (Including Social Relationships):
Involves how the child relates to adults and other children, and for older children, how the child follows rules related to interacting with others. The outcome is measured based on how the child forms secure relationships with adults and children, expresses feelings, learns rules and expectations, and interacts socially.

Skills expected of a child this age (age-expected)

Skills like that of a younger child; lead to age expected (immediate-foundational)

Skills of a much younger child; earlier skills (foundational)

Other Observations

RI Early Intervention
Annual Individualized Family Service Plan Review
Eligibility Redetermination

Child's Name:	**DOB:**	**ID#:**	**Date:**

Outcome 2: Acquiring and Using Knowledge and Skills:
Involves thinking and reasoning, remembering, problem solving, using symbols and language, and understanding the physical and social world. The outcome is measured based on a child's exploration and imitation, as well as his or her understanding of object permanence, symbolic representation, numbers, classification, spatial relationships, expressive language and communication, and for older children, early literacy.

Skills expected of a child this age (age-expected)

Skills like that of a younger child; lead to age expected (immediate-foundational)

Skills of a much younger child; earlier skills (foundational)

Other Observations

Child's Name:	**DOB:**	**ID#:**	**Date:**

Outcome 3: Taking Action to Meet Needs:
Involves communicating/taking care of basic needs such as showing hunger, getting from place to place, using tools like a fork, toothbrush or crayon, and for older children, contributing to their own health and safety. The outcome is measured based on a child's ability to integrate motor skills to complete tasks, self-help skills (e.g., dressing, feeding, grooming, toileting, and household tasks), and "act on the world to get what one needs."

Skills expected of a child this age (age-expected)

Skills like that of a younger child; lead to age expected (immediate-foundational)

Skills of a much younger child; earlier skills (foundational)

Other Observations

RI Early Intervention
Annual Individualized Family Service Plan Review
Eligibility Redetermination
Child and Family Outcomes

Child's Name	**ID#**	**DOB**

Outcomes are like goals…they reflect the changes families would like to see happen for themselves and their children. They are based on family concerns and priorities and are related to the development of your child and supports and resources to support you and your family.

Recommended format for writing child outcomes is: [child] will participate in [activity/routine]in order to [what participation will look like]. We will know this has been achieved when [measurement].

Family outcomes are typically about acquisition of information, support, and resources, implementation of plans/ goals.

Outcome

Date Written **Date Reviewed**

Outcome

Date Written **Date Reviewed**

Outcome

Date Written **Date Reviewed**

Outcome

Date Written **Date Reviewed**

Outcome

Date Written ***Date Reviewed***

RI Early Intervention
Annual Individualized Family Service Plan Review
Eligibility Redetermination
Child and Family Outcomes

Child's Name	**ID#**	**DOB**

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Outcome

Date Written **Date Reviewed**

Outcome

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Outcome

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Outcome

Date Written **Date Reviewed**

Outcome

Date Written ***Date Reviewed***

RI Early Intervention
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Evaluation Summary

Child's Name **DOB** **Age** **ID** **Date**

Where was the evaluation conducted?

Was the child's behavior and participation typical?

Evaluation Team (list names/roles and include family members)**:**

Methods / Procedures Used For Evaluation/Assessment (check all that apply)**:** *OObservation* *Interview* *Checklist* *Review of medical record*

Standardized tool

Additional information about methods/procedures used:

Scores: Indicate Standard Score (SS; this is the same as Composite Score)

Results: Indicate if 2 SD or 1.5 SD, WNL (Within Normal Limits) or SIF (Significant Impact on Functioning). If result is less than 1.5 SD, indicate <1.5 SD. Significant Impact on Functioning must be described in Child Outcomes Summary Section B. For Hearing and Vision use WNL or FER (Further Evaluation Recommended).

Note: 2 SD = SS of 70 or below, 1.5 SD = SS 71-77, and SS 85-115 is considered to be within normal limits.

Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results	Developmental Area Reviewed	Score	Results
Cognitive			Gross Motor Skills			Vision	N/A	
Expressive Communication			Social Emotional			Hearing	N/A	
Receptive Communication			Adaptive Skills			Family Circumstance	N/A	
Fine Motor Skills			Health	N/A				

Eligibility Type/Reason

1. ☐ **Eligible due to Single Established Condition**

   Eligibility Diagnosis: ICD-10 Code:

2. ☐ **Eligible due to Significant Developmental Delay – 2 standard deviations in at least one area**

   Eligibility Diagnosis: ICD-10 Code:

3. ☐ **Eligible due to Significant Developmental Delay – 1.5 standard deviations in at least two areas**

   Eligibility Diagnosis: ICD-10 Code:

4. ☐ **Eligible due to Significant Developmental Delay – significant impact on child/family functioning in one or more areas**

   Eligibility Diagnosis: ICD-10 Code:

5. ☐ **Not Eligible**

Additional diagnoses that are relevant to EI services:

Diagnosis/ICD-10 Code: Diagnosis/ICD-10 Code:

Diagnosis/ICD-10 Code: Diagnosis/ICD-10 Code:

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Services

Child's Name: **DOB:** **ID #:** **Date:**

IFSP MEETING NOTICE

An IFSP meeting occurs when there are decisions to be made about starting, stopping, changing, or refusing Early Intervention services. Before holding an IFSP meeting, Early Intervention is required to provide you with written notice early enough to ensure that you, along with any other individuals you would like to have present, are able to attend. This is your notice that an annual IFSP meeting will be held today.

EI has confirmed with the parent/guardian that this meeting notice was provided early enough for the family to attend.

Services and supports are determined after IFSP outcomes are developed.

Date Added	EI Service	Provider Name	Location	*Natural Setting (Y/N)	Method	Frequency (# times per week)	Intensity (length of session in minutes)	Duration (months)	Date Ended

*** If NO, complete "Plan for Providing Services in the Natural Environment"**

Services:
- Assistive technology
- Audiology
- Family Training/Counseling
- Nursing services
- Nutrition
- Occupational therapy
- Physical therapy
- Psychology
- Social work
- Speech/language therapy
- Vision

Location Codes:
- **H** *(Home)*
- **CB** *(CenterBased)*
- **CC** *(Childcare)*
- **C** *(Community)*
- **EIGC** *(EI Group in the Community)*
- **N/A** *(Not Applicable)*

Method:
- **I** *(Individual)*
- **G** *(Group)*
- **GV** *(Group Virtual)*
- **IV** *(Individual Virtual)*

Service Coordination is provided to coordinate services on the IFSP and could consist of home visits, telephone calls, and conversation with other providers. Early Intervention can provide interpretation, translation, and transportation services for families as needed to access EI services.

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Services

Child's Name:	**DOB:**	**ID #:**	**Date:**

Other services that are in place or are needed (medical, recreational, religious, or social services outside of EI that contribute to this plan):

Program/Agency	Contact	Status

IFSP Acknowledgement

I acknowledge the following:

☐ The services listed on this IFSP were determined to meet the current needs of my child and to support the outcomes we developed as an IFSP team. This is my prior written notice for the beginning of these IFSP services and Procedural Safeguards have been provided, reviewed, and explained to me.

IFSP Consent *(check one)*

☐ I consent to Early Intervention services as written on this IFSP.

☐ I consent to Early Intervention services as written on this IFSP ***with the following changes***:

Parent/Guardian Signature:

RI Early Intervention
Annual Individualized Family Service Plan Review
Eligibility Redetermination
Plan for Providing Services in the National Environment

Child's Name:	**DOB:**	**ID#:**	**Date:**
Service/Location:			
Explain why the child's outcome(s) could not be achieved if service were provided in the child's natural environment? *(What are the barriers? How does the team know?)*			
How will the family participate in achieving this outcome? *(How will the family be coached to practice these strategies and skills in everyday routines and activities?).*			
What is needed to address this outcome within the child's typical daily routines and family activities? *(Who is responsible? What is the timetable? What is needed? How will the family be supported?).*			
Planned Review Date:			
Review Date: **Status:** ☐ **Continue** ☐ **Change** ☐ **Achieved** **Please summarize the child's progress and changes that would be helpful.**			