NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

SEP 2 8 2018

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #18-0017
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #18-0017 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2018 (Appendix I). A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of State statute and regulations are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 28, 2018 is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **18-0017**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2018**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a)(30) of the Social Security Act and 42 CFR §447.204.**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/18-09/30/18 $ 0** **b. FFY 10/01/18-09/30/19 $ 0**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A Supp 1: Attachment A (Full Page Replacements) Pages: 1-G1; 1-G2; 1-G3; 1-G4; 1-G5; 1-G6; 1-G7; 1-G8; 1-G9** **Attachment 3.1-A Supp 1: 1-G1; 1-G2; 1-G3; 1-G4; 1-G5; 1-G6; 1-G7; 1-G8; 1-G9; 1-G-10** **Attachment 4.19-B Page 10-9, 10-10**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A Supp 1: Attachment A (Full Page Replacements) Pages: 1-G1; 1-G2; 1-G3; 1-G4; 1-G5; 1-G6; 1-G7; 1-G8; 1-G9** **Attachment 3.1-A Supp 1: 1-G1; 1-G2; 1-G3; 1-G4; 1-G5; 1-G6; 1-G7; 1-G8; 1-G9;** **Attachment 4.19-B Page 10-9**	
10. SUBJECT OF AMENDMENT: **Targeted Case Management – Early Intervention** **(FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL ☐ OTHER, AS SPECIFIED:		
12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**	
13. TYPED NAME: **Donna Frescatore**		
14. TITLE: **Medicaid Director** **Department of Health**		
15. DATE SUBMITTED: SEP 2 8 2018		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

Appendix I
2018 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

ATTACHMENT A – Full Pages Being Replaced

ATTACHMENT 3.1-A SUPPLEMENT 1

Bracketed pages for full replacement:
1-G1, 1-G2, 1-G3, 1-G4, 1-G5, 1-G6, 1-G7, 1-G8, 1-G9

New York
1-G1

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: G

See attached.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached]

New York
1-G2

[A. TARGET POPULATION G

The target group consists of any categorically needy or medically needy eligibles

1. who are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome.

2. who have been referred to the municipal early intervention agency and are known to the New York State Department of Health.

3. who are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

1. a twelve month delay in one functional area, or

2. a 33% delay in one functional area or a 25% delay in each of two areas, or,

3. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standards deviations below the mean in each of two functional areas, or

4. if because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the informed clinical opinion of the multidisciplinary team. Criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of that child and family shall also be considered.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP G

Entire State]

New York
1-G3

[D. DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "G"

Case management for Target Group "G" means those initial an ongoing activities performed by case management staff related to ensuring that developmentally delayed infants and toddlers are provided access to services allowing them to:

1. resolve problems which will interfere with their independence or self-sufficiency;

2. resolve problems which will interfere with attainment or maintenance of self support or economic independence;

3. maintain themselves in the community rather than reside in, or return to an institution; or

4. prevent institutionalization from occurring.

Case management is a process which will assist Medicaid eligible infants and toddlers and their families to access necessary medical, social, psychological, educational, financial and other services in accordance with the goals contained in a written individualized family services plan (IFSP).

CASE MANAGEMENT FUNCTIONS

Case Management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management service provided.

1. Intake.

This function consists of: the initial contact to provide information concerning case management and early intervention to the parent of an eligible child or a child thought to be eligible for early intervention services at a time and place convenient to the family; exploration of the family's receptivity to the early intervention program and the case management process; determine that the recipient is a member of the targeted population; ascertain if the child and family are presently receiving case management services or other services from public or private agencies, identification of potential payers for services; and review of due process rights concerning mediation and impartial hearing.

2. Assessment.

The case manager must secure directly, or indirectly through collateral sources, with the family's permission: a determination of the nature and degree of the recipient's developmental status; must assist the family in accessing screening and evaluation services; review evaluation reports with the family; assist the family to identify their priorities, concerns, and resources; explore options and assist the family's investigation of these options; inform the family of other program and services that may be of benefit and assist]

[in making referrals; assist the recipient in obtaining interim early intervention services when it is determined that the child has an obvious, immediate need and prepare an interim family services plan.

3. Case management plan and coordination.

For purposes of early intervention, the case management plan will be known as the individualized family services plan (IFSP). Development of the IFSP is the translation of specific goals and objectives, and specific services, providers and timeframes to reach each objective. The case manager shall convene a meeting at a time and place convenient to the family with 45 days of the child's referral to early intervention agency except under exceptional documented circumstances. Participants shall include: parent(s); early intervention official; case manager; the designated contact from the evaluation team; and other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

a. A statement of the child's levels of functioning in each of the following domains: physical development; cognitive development; communication development; social or emotional development; and adaptive development.

b. A physician's order pertaining to early intervention services, which includes a diagnostic statement and purpose of treatment.

c. With parental consent, a statement of the family's strengths, priorities, concerns that relate to enhancing the development of their child.

d. A statement of the major outcomes expected to be achieved and for the child and family, including timelines, and criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes and services is necessary.

e. A statement of specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity, location and the method of delivering services.

f. A statement of the natural environments in which early intervention services will be provided

g. When early intervention services are to be delivered to a recipient in a group setting without typically developing peers, the IFSP shall document the reason(s).

h. A statement of other services, including medical services, that are not required under the early intervention program but are needed by the child and the family and the payment mechanism for these services.

i. A statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated.]

[j. The projected dates for initiation of services and the anticipated duration of these services.

k. The name of the case manager who will be responsible for the implementation of the IFSP.

l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.

m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. Implementation of the IFSP.

In implementing the service plan, the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. Reassessment and IFSP update.

Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant, or if a parent requests such a review.

6. IFSP update implementation.

The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. Crisis intervention.

Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. Monitoring and follow-up.

The case manager is responsible for:

a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;
b. assuring the family's satisfaction with the services provided;
c. collecting data and documenting the progress of the recipient in a case record;
d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);]

[e. making alternate arrangements when services have been denied or are unavailable; and

f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. Counseling and exit planning.

The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. Supervisory Review/Case Conferencing.

An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation. IFSPs and other products as well as peer review or case conferencing with other case managers.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the family and the case manager through a written assessment of the child and family's need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the child's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of **CASE MANAGEMENT FUNCTIONS**.

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child's condition or circumstances.

2. Case management plan.

A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under **CASE MANAGEMENT FUNCTIONS.**]

[3. Continuity of service.

Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child's case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family's new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services for Target Group "G":

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;

2. must not duplicate certain case management services services currently provided under the Medical Assistance Program or under any other funding sources;

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:]

[1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "G"

1. Provider qualifications

Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

a. character and competence, including fiscal viability;

b. the capacity to provide case management services;

c. availability to provide qualified personnel as defined in subsection 2 below;

d. adherence to applicable federal and state laws and regulations;

e. the capacity and willingness to ensure case managers participate in inservice training;

f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;

g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

a. a minimum of one of the following educational or case management experience credentials:

i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or

ii. one year of case management experience and an additional year ofexperience in a service setting with infants and toddlers with developmental delays or disabilities; or
]

[iii. one year of case management experience and an associates degree in a health or human service field; or

iv. a bachelors degree in a health and human services field.

b. demonstrated knowledge and understanding in the following areas:

i. infants and toddlers who are eligible for early intervention services;

ii. State and federal laws and regulations pertaining to the Early Intervention Program;

iii. principles of family centered services;

iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,

v. other pertinent information.

3. Individual case managers

Qualified personnel with appropriate licensure, certification, or registration shall apply to the State Department of Health for approval to provide case management services. In addition to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

a. current licensure, certification or registration in a discipline eligible to deliver services to children;

b. adherence to applicable federal and State laws and regulations;

c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;

d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;

e. completion of an approved Medicaid provider agreement.]

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

Target Group G: Early Intervention Services

Medicaid enrollees who are served by the New York State Early Intervention Program because they:

- are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay;
- have been referred to the NYS Early Intervention Program as defined in Public Health Law Title II-A of Article 25 and set forth in 10 NYCRR section 69-4.3 to obtain screening or a multidisciplinary evaluation to determine the need for ongoing services; and
- are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

- a twelve month delay in one functional area, or,
- a 33% delay in one functional area or 25% delay in each of the two areas, or;
- if appropriate standardized instruments are individually administered in the approval process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas, or;
- for children who have been found to have a delay only in the communication domain, a score of 2.0 standard deviations below the mean in the area of communication or, if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in relevant clinical practice guidelines.

If because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, informed clinical opinion of the multidisciplinary team may be used as one factor to establish the child's eligibility. In addition, criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of the child and family shall also be considered.

Continuing need for Early Intervention Program services may be established by a multidisciplinary evaluation based upon the following criteria:

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TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

- a delay consistent with the criteria established for initial evaluation as set forth above; or,
- a delay in one or more domains, such that the child's development is not within the normal range expected for his or her chronological age, as documented using clinical procedures, observations, assessments, and informed clinical opinion; or,
- a score of 1.0 standard deviation or greater below the mean in one or more developmental domains; or,
- the continuing presence of a diagnosed physical or mental condition with a high probability of resulting in a developmental delay.

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
____ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
____ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Consistent with Federal regulations at 34 CFR §303.23 and Section 1915 of the Social Security Act, case management services are service coordination services delivered by service coordinators in the New York State Early Intervention Program in a manner that is consistent with the requirements of 34 CFR Part 303 and 10 NYCRR subpart 69.4.

Case management (service coordination) means those initial and ongoing activities performed by Early Intervention Program case managers (service coordinators) to assist Medicaid enrolled infants and toddlers birth through age two years who have, or are suspected of having, a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, in gaining access to necessary medical, social, educational and other appropriate services. Case management (service coordination) functions associated with referral include: assisting families in identifying available service providers; securing the services determined in the

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TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assisting families with scheduling appointments; resolving problems related to implementation of the IFSP; coordinating the provision of early intervention services and medical, educational, social and other services; and, assisting families in making applications for services and entitlements.

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Under the Early Intervention Program, this function consists of the initial contact to provide information concerning case management and early intervention to the parent of a Medicaid enrolled child, who is thought to be eligible for early intervention services, at a time and place convenient to the family. The case manager (service coordinator) assesses and documents the medical, educational, social and other service needs of the child, including if the child and family are presently receiving case management services or other services from public or private agencies, and assists the family in identifying the family's priorities, concerns and resources related to the child. The case manager secures (directly, or indirectly through collateral sources, with the family's permission), a determination of the nature and degree of the child's developmental status; assists the parent in arranging for the screening or evaluation after the parent selects an evaluator; coordinates the performance of evaluations and assessments; and, reviews evaluation reports with the family to assist the parent(s) in understanding the results of screenings or evaluations. The case manager assists with the periodic reassessment of the child's needs on an ongoing basis and assists the family in preparing for required six month reviews and annual evaluations of the child's and family's individualized family service plan (IFSP).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.

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Infants, Toddlers and Families in the New York State Early Intervention Program

For the purposes of the Early Intervention Program, the care plan is the Individualized Family Service Plan (IFSP). The local early intervention official, case manager, parent, and evaluator or designated contact from the evaluation team jointly develop an IFSP for a child who has been determined eligible for early intervention services. Agreed upon early intervention services are included in the child's IFSP and are delivered in conformity with the IFSP.

An IFSP must be in writing and include: a statement, based on objective criteria, of the child's present levels of functioning in each of the following areas: physical development, including vision and hearing; cognitive development, communication development, social or emotional development and adaptive development. The IFSP identifies the needs related to the child's diagnosed condition, disability or developmental delay, and, with parental consent, incorporates the family's description of its resources, priorities, and concerns related to enhancing the child's development. The IFSP includes a statement of the specific services to be provided to the child to address the child's needs, including the frequency, intensity, length, duration, location, method and timeframe for delivering services, as well as a statement of the measurable outcomes expected to be achieved for the child and the family.

The IFSP is reviewed at six month intervals and evaluated annually to determine the degree to which progress toward achieving the outcomes is being made, and whether or not there is a need to amend the IFSP to modify or revise the services being provided or anticipated outcomes. Upon request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals to make appropriate adjustments in the IFSP and service arrangements with providers.

Case management functions related to the IFSP include: facilitating and participating in the development and review of IFSPs; implementing the service plan in the IFSP; facilitating IFSP periodic review and revision; and implementation of any adjustments in IFSP services.

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

In implementing the IFSP, the case manager must assist the child and family, as needed, to secure the medical, social educational or other services determined in the plan to be appropriate. Case management (service coordination) functions associated with referral include: assisting families in identifying available service providers; securing

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TARGETED CASE MANAGEMENT SERVICES
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the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assisting families with scheduling appointments; resolving problems related to implementation of the IFSP; coordinating the provision of early intervention services and medical, educational, social and other services; and assisting families in making applications for services and entitlements.

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. **[Specify the type of monitoring and justify the frequency of monitoring.]**

Monitoring and Follow Up (Ongoing Service Coordination)

Monitoring and follow up includes activities and contacts that are necessary to ensure that the services are being furnished in accordance with the child's plan of care (IFSP). Follow up may be with the individual, family members, providers or other individuals or entities and conducted as frequently as necessary. The case manager (service coordinator) must assure that the child obtains, on an ongoing basis, the services in the IFSP by maintaining contact, as necessary, with direct service providers and with the child and family to ensure that services identified in the IFSP are being appropriately delivered on a timely basis. Case managers (service coordinators) may assist both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP. Case managers (service coordinators) assist in determining whether there are changes in the needs or status of the child, and, if so, they must assist in making necessary adjustments in the care plan with the IFSP team and revising service arrangements with providers.

Transition Planning

Transition planning includes facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases. The case manager (service coordinator) must facilitate the transition of each child exiting the Early Intervention Program. If the child is thought to be potentially eligible for preschool special education services, the

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case manager (service coordinator) must inform the parent about notification to the Committee on Preschool Special Education (CPSE) and the opportunity to object to the notification. With parental consent, the case manager (service coordinator) will transfer evaluations, assessments, IFSPs, and other appropriate records to the CPSE/and or other programs that may provide services to the child after early intervention eligibility ends.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Early intervention case managers (service coordinators) may be located within either a public or private agency or may be individual qualified personnel approved by the State to deliver case management services.

All early intervention case managers (service coordinators) shall meet the following qualifications:

1. a minimum of one of the following educational or case management (service coordination) experience credentials:

   - two years of experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
   - one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
   - one year of case management experience and an Associate's degree in a health or human service field; or
   - a Bachelor's degree in a health or human service field.

2. demonstrated knowledge and understanding in the following areas:

   - infants and toddlers who may be eligible for early intervention services;
   - state and federal laws and regulations pertaining to the Early Intervention Program;
   - principles of family centered services;

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- the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and,
- other pertinent information.

Case managers must participate in an introductory training session sponsored or approved by the Department of Health in the first three months and by no later than one year of direct or contractual employment as an early intervention case manager.

Case management agencies and individual qualified personnel who are billing providers must conform to the following criteria to become a provider of case management services in the New York State Early Intervention Program:

- meet character and competence and other program standards established by the Early Intervention Program;
- be approved for participation in the Program;
- enter into an agreement with the Department of Health;
- enroll in the Medicaid Program and sign a Medicaid provider agreement with the New York State Department of Health, if the agency or individual provider is directly claiming to Medicaid;
- adhere to federal and State laws and regulations governing the participation of providers in the Medicaid program;
- adhere to federal and State laws, regulations and standards related to the delivery of Early Intervention services, including case management standards;
- comply with New York State requirements for annual compliance audits.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Social Security Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area in which they reside.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

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Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__X__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Providers of case management services are limited to those individuals who meet character and competence, statutory and regulatory standards, and other program standards established by the Early Intervention Program and are approved for participation in the Program to ensure that they are capable of providing appropriate services to individuals with developmental disabilities or with chronic mental illness.

Authority of Section 1915(g)(1) of the Act is invoked to limit providers of early intervention case management (service coordination) services without regard to the requirement of Section 1902(a)(10)(B) of the Act, or;

☒ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid a fixed rate based on services provided. The rate is based on the case management activities conducted as per program regulations. The provider does not receive payment if they fail to perform the minimum activities defined in regulation. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

A separate case record is established for each child receiving case management services that documents case management services provided. Providers maintain case records that documents the following for each child receiving case management services: the name of the child; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received; whether goals specified in the care plan have been achieved; whether the child's family has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

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Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Case management services must not:

- duplicate certain case management services currently provided under the Medical Assistance Program or any other funding source;
- be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority.

While the activities of case management secure access to and arrangements for services for the Target Group, reimbursement for case management services does not include:

- Medicaid eligibility determinations and redeterminations;
- Medicaid preadmission screening;
- prior authorization for Medicaid services;
- required Medicaid utilization;
- administrative functions that are purely IDEA functions such as scheduling IFSP team meetings, and providing the perquisite prior written notice;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program administration;
- activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
- services that are an integral or inseparable part of other Medicaid services;
- institutional discharge planning; or,
- outreach services that are designed to locate individuals who are potentially Medicaid eligible.

TYPE OF SERVICE:

Case Management Services
Target Group G:

Medicaid eligible clients who are served by the New York State Department of Health's Early Intervention Program and who:

1. are infants and toddlers from birth through two years who have or are suspected to have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;

2. have been referred to the municipal early intervention agency; and

3. are in need of ongoing and comprehensive rather [that] than incidental case management services.

METHOD OF REIMBURSEMENT:

Reimbursement for necessary case management services provided to the client and to the family in support of the primary client under the New York State Early Intervention Program shall be [at hourly rates] two separate fixed rates for Initial Service Coordination and one monthly fixed rate for Ongoing Service Coordination established by the New York State Department of Health and approved by the Director of the Budget. Initial Service Coordination followed by no IFSP meeting will have a minimum base of two hours with no cap. Initial Service Coordination followed by an IFSP meeting will have a minimum base of three hours with no cap. Ongoing Service Coordination will have a minimum base of 1.25 hours per child per month. In the instance that the minimum base rate is lower than the regional average, the regional average will be used for the calculation of all three rates. [Providers will be allowed to bill in quarter hour units.] The newly established rate methodology will apply only to initial IFSPs and amended IFSPs developed on or after written notice of such rate methodology has been provided to Early Intervention Officials by the Department of Health.

Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and [capitol] capital costs. The rates also adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in 86-2.10(c)(5) of Attachment 4.19-A of the State Plan. Please see Fee Schedules below.

METHOD OF REIMBURSEMENT (continued):

Early Intervention Fee Schedule (Effective July 1, 2018)

Service Type	Region	Fee	Unit of Service or Frequency
Initial Service Coordination with No IFSP	Albany	135	One-time basis
Initial Service Coordination with No IFSP	Binghamton	124	One-time basis
Initial Service Coordination with No IFSP	Central Rural	118	One-time basis
Initial Service Coordination with No IFSP	Elmira	118	One-time basis
Initial Service Coordination with No IFSP	Erie	116	One-time basis
Initial Service Coordination with No IFSP	Glens Falls	109	One-time basis
Initial Service Coordination with No IFSP	Long Island	141	One-time basis
Initial Service Coordination with No IFSP	North Rural	118	One-time basis
Initial Service Coordination with No IFSP	New York City	382	One-time basis
Initial Service Coordination with No IFSP	Orange	141	One-time basis
Initial Service Coordination with No IFSP	Poughkeepsie	134	One-time basis
Initial Service Coordination with No IFSP	Rochester	118	One-time basis
Initial Service Coordination with No IFSP	Syracuse	144	One-time basis
Initial Service Coordination with No IFSP	Utica	136	One-time basis
Initial Service Coordination with No IFSP	Westchester	356	One-time basis
Initial Service Coordination with No IFSP	Western Rural	118	One-time basis
Initial Service Coordination with IFSP	Albany	173	One-time basis
Initial Service Coordination with IFSP	Binghamton	186	One-time basis
Initial Service Coordination with IFSP	Central Rural	173	One-time basis
Initial Service Coordination with IFSP	Elmira	176	One-time basis
Initial Service Coordination with IFSP	Erie	173	One-time basis
Initial Service Coordination with IFSP	Glens Falls	164	One-time basis
Initial Service Coordination with IFSP	Long Island	211	One-time basis
Initial Service Coordination with IFSP	North Rural	176	One-time basis
Initial Service Coordination with IFSP	New York City	554	One-time basis
Initial Service Coordination with IFSP	Orange	211	One-time basis
Initial Service Coordination with IFSP	Poughkeepsie	202	One-time basis
Initial Service Coordination with IFSP	Rochester	176	One-time basis
Initial Service Coordination with IFSP	Syracuse	176	One-time basis
Initial Service Coordination with IFSP	Utica	176	One-time basis
Initial Service Coordination with IFSP	Westchester	424	One-time basis
Initial Service Coordination with IFSP	Western Rural	176	One-time basis
Ongoing Service Coordination	Albany	72	Monthly
Ongoing Service Coordination	Binghamton	77	Monthly
Ongoing Service Coordination	Central Rural	72	Monthly
Ongoing Service Coordination	Elmira	74	Monthly
Ongoing Service Coordination	Erie	72	Monthly
Ongoing Service Coordination	Glens Falls	68	Monthly
Ongoing Service Coordination	Long Island	88	Monthly
Ongoing Service Coordination	North Rural	74	Monthly
Ongoing Service Coordination	New York City	138	Monthly
Ongoing Service Coordination	Orange	102	Monthly
Ongoing Service Coordination	Poughkeepsie	127	Monthly
Ongoing Service Coordination	Rochester	74	Monthly
Ongoing Service Coordination	Syracuse	74	Monthly
Ongoing Service Coordination	Utica	74	Monthly
Ongoing Service Coordination	Westchester	118	Monthly
Ongoing Service Coordination	Western Rural	74	Monthly

Appendix II
2018 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #18-0017

This State Plan Amendment proposes to update the language for Target Group G, Medicaid enrolled clients who are served by the New York State Early Intervention Program and who are infants or toddlers from birth through age two years having or suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay; have been referred to the NYS Early Intervention Program as defined in Public Health Law Title II-A of Article 25 and set forth in 10 NYCRR section 69.3 to obtain screening or a multidisciplinary evaluation to determine the need for ongoing services; and are in need of ongoing and comprehensive rather than incidental case management. The language addresses Medicaid's responsibility regarding developing Individualized Family Service Plans and includes language that documents how providers will maintain records for individuals receiving case management. In addition, the State Plan Amendment proposes to change the payment methodology for service coordination services from an hourly rate billed in fifteen minute increments to fixed rates for initial case management (service coordination) and per member per month rates for ongoing case management (service coordination) services to be established by the New York State Department of Health and approved by the Division of Budget.

Appendix III
2018 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

PUBLIC HEALTH LAW
ARTICLE 25. MATERNAL AND CHILD HEALTH
TITLE II-A. EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS WITH DISABILITIES AND THEIR FAMILIES

§ 2541. Definitions

7. "Early intervention services" means developmental services that:
(a) are provided under public supervision;
(b) are selected in collaboration with the parents;
(c) are designed to meet a child's developmental needs in any one or more of the following areas:
(i) physical development, including vision and hearing,
(ii) cognitive development,
(iii) communication development,
(iv) social or emotional development, or
(v) adaptive development;
(d) meet the coordinated standards and procedures;
(e) are provided by qualified personnel;
(f) are provided in conformity with an IFSP;
(g) are, to the maximum extent appropriate, provided in natural environments, including the home and community settings where children without disabilities would participate;
(h) include, as appropriate:
(i) family training, counseling, home visits and parent support groups,
(ii) special instruction,
(iii) speech pathology and audiology,
(iv) occupational therapy,
(v) physical therapy,
(vi) psychological services,
(vii) case management services, hereafter referred to as service coordination services,
(viii) medical services for diagnostic or evaluation purposes, subject to reasonable prior approval requirements for exceptionally expensive services, as prescribed by the commissioner,
(ix) early identification, screening, and assessment services,
(x) health services necessary to enable the infant or toddler to benefit from the other early intervention services,
(xi) nursing services,
(xii) nutrition services,
(xiii) social work services,
(xiv) vision services,
(xv) assistive technology devices and assistive technology services,
(xvi) transportation and related costs that are necessary to enable a child and the child's family to receive early intervention services, and
(xvii) other appropriate services approved by the commissioner.
(i) are cost-effective.

§ 2543. Service coordinators

1. Upon referral to the early intervention official of a child thought to be an eligible child by a parent or professional, the early intervention official shall promptly designate an initial service coordinator, selecting whenever appropriate a service coordinator who has an established relationship with the child or family, and shall promptly notify the parent of such designation.

2. The initial service coordinator shall promptly arrange a contact with the parent after such designation, provided that such contact must be in a time, place and manner reasonably convenient for the parent and consistent with the timeliness requirements of this title.

3. The parent of the eligible child shall provide and the early intervention official shall collect such information and or documentation as is necessary and sufficient to determine the eligible child's third party payor coverage and to seek payment from all third party payors including the medical assistance program and other governmental agency payors.

§ 2545. Individualized family services plans ("IFSP")

2. (i) the name of the service coordinator selected by the parent who will be responsible for the implementation of the IFSP and coordination with other agencies and persons;

9. A parent may, at any time during or after development of the IFSP, select a service coordinator who will become responsible for implementing the IFSP and who may be different from the initial service coordinator.

10. [Eff April 1, 2013] The service coordinator shall ensure that the IFSP, including any amendments thereto, is implemented in a timely manner but not later than thirty days after the projected dates for initiation of the services as set forth in the plan.

§ 2550. Responsibilities of lead agency

1. The lead agency is responsible for the general administration and supervision of programs and activities receiving assistance under this title, and the monitoring of programs and activities used by the state to carry out this title, whether or not such programs or activities are receiving assistance made available under this title, to ensure that the state complies with the provisions of this title.

2. In meeting the requirements of subdivision one of this section, the lead agency shall adopt and use proper methods of administering the early intervention program, including:

(a) establishing standards for evaluators, service coordinators and providers of early intervention services;

(b) approving, and periodically re-approving evaluators, service coordinators and providers of early intervention services who meet department standards; provided however that the department may require that approved evaluators, service coordinators and providers of early intervention services enter into agreements with the department in order to conduct evaluations or render service coordination or early intervention services in the early intervention program. Such agreements shall set forth the terms and conditions of participation in the program. If the department requires that such providers enter into agreements with the department for participation in the program, "approval" or "approved" as used in this title shall mean a provider who is approved by the department in accordance with department regulations and has entered into an agreement with the department for the provision of evaluations, service coordination or early intervention services. The department shall use best efforts to ensure provider capacity in the early intervention program.

(c) monitoring of agencies, institutions and organizations under this title and agencies, institutions and organizations providing early intervention services which are under the jurisdiction of a state early intervention service agency;

(d) enforcing any obligations imposed on those agencies under this title or Part H of the federal individuals with disabilities education act and its regulations;

(e) providing training and technical assistance to those agencies, institutions and organizations, including initial and ongoing training and technical assistance to municipalities to help enable them to identify, locate and evaluate eligible children, develop IFSPs, ensure the provision of appropriate early intervention services, promote the development of new services, where there is a demonstrated need for such services and afford procedural safeguards to infants and toddlers and their families;

(f) correcting deficiencies that are identified through monitoring; and

(g) in monitoring early intervention services, the commissioner shall provide municipalities with the results of any review of early intervention services undertaken and shall provide the municipalities with the opportunity to comment thereon.

§ 2559-b. Regulations

The commissioner may adopt regulations necessary to carry out the provisions of this title. In promulgating such regulations, the commissioner shall incorporate coordinated standards and procedures, where applicable, and shall consider the regulations, guidelines and operating procedures of other state agencies that administer or supervise the administration of services to infants, toddlers and preschool children to ensure that families, service providers and municipalities are not unnecessarily required to meet differing eligibility, reporting or procedural requirements.

SubPart 69-4 - Early Intervention Program

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Title II-A of Article 25

Section 69-4.1 - Definitions

Section 69-4.1 Definitions.

(a) Approve means any type of approval process used by state early intervention service agencies to approve providers of services, including licensure or certification.

(b) Assessment means initial and ongoing procedures used to identify:

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

(2) 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) Child Find System means all policies and procedures established by the state early intervention service agencies to: (1) ensure that at-risk and eligible children are identified, located, and referred to the early intervention official or public health officer as designated by the municipality; (2) determine the extent to which children are receiving needed services; and (3) ensure coordination among the state agencies' major efforts to identify at-risk and eligible children.

(d) Completed mediation means:

(1) the parties have participated in mediation and reached an agreement;

(2) the parties have participated in mediation but have been unable to reach an agreement during mediation or the parent requests an impartial hearing;

(3) a parent's request for mediation has not been accommodated according to the time frame set forth in section 69-4.17(g)(12); or,

(4) the early intervention official declines to participate in mediation.

(e) Days means calendar days.

(f) Department means the New York State Department of Health.

(g) Designated County Official means the official designated by the municipality as responsible for receipt of referrals of children suspected of having or at-risk for developmental delays or disabilities.

(h) Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age adjusted for prematurity in one or more of the following areas of development: cognitive, physical (including vision, hearing, oral motor feeding and swallowing disorders), communication, social/emotional, or adaptive development and meets the level of delay set forth in section 69-4.23 of this subpart.

(i) Disability means a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

(j) Dominant or native Language, when used with respect to an individual who is limited English proficient, means the language or mode of communication normally used by that individual, or in the case of the child, the language normally used by the parent of an eligible or potentially eligible child, except that:

(1) For evaluations and assessments conducted pursuant to section 69-4.8 of this Subpart, dominant or native language means the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation and assessment.

(2) When used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, dominant or native language means the mode of communication that is normally used by the individual.

(k) Early intervention official means an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official.

(l) Early intervention services means:

(1) services that are:

(i) designed to meet the developmental needs of children eligible under this program and the needs of the family related to enhancing the child's development in accordance with the functional outcomes specified in the individualized family service plan, in one or more of the following areas of development, including:

(a) physical;

(b) cognitive;

(c) communication;

(d) social or emotional; or

(e) adaptive;

(ii) selected in collaboration with the parent;

(iii) in compliance with state standards;

(iv) provided:

(a) under public supervision;

(b) by qualified personnel;

(c) in conformity with an individualized family service plan and to the maximum extent appropriate, provided in natural environments; and,

(d) at no cost to the family; and

(v) are cost effective.

(2) Early intervention services include:

(i) Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities. This does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device.

(ii) Assistive technology service means a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include:

(a) the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;

(b) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;

(c) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(d) coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(e) training or technical assistance for a child with disabilities or, if appropriate, that child's family; and,

(f) training or technical assistance for professionals, (including individuals providing early intervention services) or other individuals who provide services to, or are otherwise substantially involved in, the major life functions of individuals with disabilities.

(iii) Applied behavior analysis(ABA) means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. These include contextual factors such as establishing operations, antecedent stimuli, positive reinforcers, and other consequences that are used to produce the desired behavior change.

(iv) Audiology, including:

(a) identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques;

(b) determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;

(c) referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;

(d) provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;

(e) provision of services for prevention of hearing loss; and

(f) determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

(v) Family training, counseling, home visits and parent support groups, including services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of a child eligible under this part in understanding the special needs of the child and enhancing the child's development.

(vi) Medical services only for diagnostic or evaluation purposes means services provided by a licensed physician to determine a child's developmental status and need for early intervention services subject to reasonable prior approval requirements for exceptionally expensive services as prescribed by the Commissioner.

(vii) Nursing services, including:

(a) the assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;

(b) provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and

(c) administration of medications, treatments, and regimens prescribed by a licensed physician.

(viii) Nutrition services, including:

(a) conducting individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and, food habits and food preferences;

(b) developing and monitoring appropriate plans to address the nutritional needs of eligible children; and

(c) making referrals to appropriate community resources to carry out nutrition goals.

(ix) Occupational therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

(a) identification, assessment, and intervention;

(b) adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

(c) prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

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

(a) screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;

(b) obtaining, interpreting, and integrating information appropriate to program planning, to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and

(c) providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

(xi) Psychological services, including:

(a) administering psychological and developmental tests, and other assessment procedures;

(b) interpreting assessment results;

(c) obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development; and

(d) planning and managing a program of psychological services, including psychological

counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

(xii) Service Coordination, including assistance and services provided by a service coordinator to enable an eligible child and the child's family to receive the rights, procedural safeguards and services that are authorized to be provided under the Early Intervention Program.

(xiii) Sign language and cued language services include teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.

(xiv) Social work services, including:

(a) making home visits to evaluate a child's living conditions and patterns of parent-child interaction;

(b) preparing a social/emotional developmental assessment of the child within the family context;

(c) providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents;

(d) working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and

(e) identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

(xv) Special instruction, including:

(a) the design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;

(b) curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan;

(c) providing families and any primary caregivers (e.g., child care providers) with information, skills, and support related to enhancing the skill development of the child; and

(d) working with the child to enhance the child's development.

(xvi) Speech-language pathology, including:

(a) identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;

(b) referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and

(c) provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

(xvii) Vision Services, including:

(a) evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities;

(b) referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and

(c) communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

(xviii) Health Services means services necessary to enable a child to benefit from the other early intervention services during the time that the child is receiving other early intervention services. The term includes:

(a) such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and

(b) consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other early intervention services.

(c) The term health services does not include the following:

(1) services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus);

(2) services that are purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose);

(3) devices necessary to control or treat a medical condition;

(4) medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children; or

(5) services that are related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant.

(i) Nothing in this Subpart shall limit the right of an infant or toddler with a disability with a

surgically implanted device (e.g., cochlear implant) to receive the early intervention services that are identified in the child's IFSP as being needed to meet the child's developmental outcomes.

(ii) Nothing in this Subpart shall prevent the provider from routinely checking that either the hearing aid or the external components of a surgically implanted device (e.g., cochlear implant) of an infant or toddler with a disability are functioning properly.

(xix) Transportation and related costs includes the cost of travel (e.g., mileage or travel by taxi, common carrier, or other means) and other costs (e.g., tolls and parking expenses) that are necessary to enable an eligible child and the child's family to receive early intervention services.

(m) Eligible child means any infant or toddler from birth through age two years who has a disability, except as provided in paragraph (1) of this subdivision.

(1) Any eligible child who has been determined to be eligible for program services under section forty-four hundred ten of the education law and who:

(i) turns three years of age on or before August 31st, shall, if requested by the parent, be eligible to continue receiving early intervention services until September 1 of that calendar year; or,

(ii) turns three years of age on or after September 1, shall, if requested by the parent and if already receiving early intervention services, be eligible to continue receiving early intervention services until January 2 of the next calendar year; except,

(iii) if the infant or toddler is receiving preschool special education services under Section 4410 of the State Education Law, he or she shall not be an eligible child.

(2) Eligibility for early intervention services shall end on the day before the child's third birthday for any child who is found ineligible for services under Section 4410 of the Education Law, or for whom an eligibility determination for such services has not been made prior to the child's third birthday.

(3) The term "eligible child" shall also include any infant or toddler with a disability who is:

(i) an Indian child that resides on a reservation geographically located in the State;

(ii) a homeless child as defined in section 725 of 42 U.S.C. 11434a, the McKinney-Vento Homeless Assistance Act; or,

(iii) who is a ward of the State.

(n) Evaluation means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for the Early Intervention Program, including determining the status of the child in each of the following areas of development: cognitive, physical, communication, social or emotional, and adaptive development.

(o) Evaluator means a team of two or more professionals approved pursuant to section 69-4.8 of

this subpart to conduct screenings and evaluations.

(p) Family assessment means the process of information gathering and identification of family priorities, resources and concerns, which the family decides are relevant to their ability to enhance their child's development.

(q) Family Concerns means those areas that parent identifies as needs, issues, or problems which they wish to have addressed within the Individualized Family Service Plan.

(r) Family Priorities means those areas which the parent selects as essential targets for early intervention services to be delivered to their child and family unit.

(s) Family Resources means the strengths, abilities, and formal and informal supports that can be mobilized to address family concerns, needs or desired outcomes.

(t) Hearing Officer means the person duly designated for the purpose of conducting or participating in a hearing pursuant to the Public Health Law, including an administrative officer or an administrative law judge assigned by the Department to the hearing.

(u) Hearing record means:

(1) all notices, pleadings, and motions;

(2) evidence presented during the hearing;

(3) questions and offers of proof, objections thereto, and rulings thereon;

(4) any statements of matters officially noticed by the hearing officer; and

(5) any findings of fact, conclusions of law, decision, determination, opinion, order or report made by the impartial hearing officer.

(v) Include means that the items named are not all of the possible items that are covered whether like or unlike the ones named.

(w) Individualized Family Service Plan (IFSP) means a written plan for providing early intervention services to a child eligible for the Early Intervention Program and the child's family. The plan must:

(1) be developed jointly by the family, appropriate qualified personnel involved in the provision of early intervention services, and the early intervention official;

(2) be based on the evaluation and assessment described in section 69-4.8 of this subpart;

(3) include matters as specified in section 69-4.11 of this subpart; and

(4) be implemented as soon as possible once written parental consent for the early intervention

services in the IFSP is obtained.

(x) Informed Clinical Opinion means the best use of quantitative and qualitative information by qualified personnel regarding a child, and family if applicable. Such information includes, if applicable, the child's functional status, rate of change in development, and prognosis.

(y) Informed consent means:

(1) the parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's dominant language or other mode of communication;

(2) the parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records if any that will be released and to whom; and,

(3) the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

(z) Initial service coordinator means the service coordinator designated by the early intervention official upon receipt of a referral of a child thought to be eligible for early intervention services, who functions as the service coordinator who participates in the formulation of the Individualized Family Service Plan.

(aa) Interim individualized family service plan means a temporary plan developed with parental consent for a child with a known developmental delay or disability who has apparent immediate needs to enable early intervention service delivery between initial identification of the child's needs and the completion of the multidisciplinary evaluation.

(ab) Mediation means a voluntary, non-adversarial process by which the parent of a child and the early intervention official or designee are assisted in the resolution of a dispute.

(ac) Medical/biological risk means early developmental and health events suggestive of medical needs or biological insults to the developing central nervous system which, either singly or collectively, increase the probability of later disability.

(ad) Multidisciplinary means the involvement of two or more professionals from different disciplines, in the provision of integrated and coordinated services, including evaluation and assessment services and development of the Individualized Family Service Plan.

(ae) Municipality means a county outside of the City of New York, or the City of New York in the case of a county contained within the city of New York.

(af) Natural environment means settings that are natural or normal for the child's age peers who have no disability, including the home, a relative's home when care is delivered by the relative, child care setting, or other community setting in which children without disabilities participate.

(ag) Ongoing service coordinator means the service coordinator designated in the Individualized

Family Service Plan.

(ah) Parent means a parent by birth or adoption, or person in parental relation to the child. With respect to a child who is a ward of the State, or a child who is not a ward of the state but whose parents by birth or adoption are unknown or unavailable and the child has no person in parental relation, the term "parent" means a person who has been appointed as a surrogate parent for the child in accordance with section 69-4.16 of this subpart. This term does not include the State if the child is a ward of the State.

(ai) Person in parental relation means:

(1) the child's legal guardian;

(2) the child's standby guardian after their authority becomes effective pursuant to section 1726 of the Surrogate's Court Procedure Act;

(3) the child's custodian; a person shall be regarded as the custodian of a child if he or she has assumed the charge and care of the child because the parents or legally appointed guardian of the minor have died, are imprisoned, are mentally ill, or have been committed to an institution, or because they have abandoned or deserted such child or are living outside the state or their whereabouts are unknown; or,

(4) persons acting in the place of a parent, such as a grandparent or stepparent with whom the child lives, as well as persons who are legally responsible for the child's welfare,

(5) except, this term does not apply to a child who is a ward of the State, and does not include a foster parent.

(aj) Provider means an agency or individual approved in accordance with section 69-4.5 of this subpart to deliver service coordination, evaluations, and/or early intervention services. (1) "Agency" means an entity which employs qualified personnel, and may contract with individual providers or other agencies which are approved by the Department, for the provision of early intervention program evaluations, service coordination, and/or early intervention services, (2) "Individual" shall mean a person who holds a state-approved or recognized certificate, license, or registration in one of the disciplines set forth in subdivision (ak) of this section and is under contract with either a municipality or an agency provider.

(ak) Qualified personnel are those individuals who are approved as required by this Subpart and under contract with a municipality or agency provider, or employed by agency providers who deliver services to the extent authorized by their licensure, certification or registration to eligible children and have appropriate licensure, certification, or registration in the area in which they are providing services, including:

(1) audiologists;

(2) occupational therapy assistants;

(3) licensed practical nurses, registered nurses and nurse practitioners;

(4) low vision specialists;

(5) orientation and mobility specialists;

(6) vision rehabilitation therapists;

(7) occupational therapists;

(8) optometrists:

(9) physical therapists;

(10) physical therapy assistants;

(11) pediatricians and other physicians;

(12) physician assistants;

(13) psychologists;

(14) registered dieticians and certified dieticians/nutritionists;

(15) school psychologists;

(16) clinical and master social workers;

(17) special education teachers and teachers of students with disabilities, birth to grade two;

(18) speech and language pathologists;

(19) teachers of the blind and partially sighted, teachers of the blind and visually handicapped, and teachers of the blind and visually impaired;

(20) teachers of the deaf and hearing impaired and teachers of the deaf and hard of hearing;

(21) teachers of the speech and hearing handicapped and teachers of speech and language disabilities; and, (22) other categories of personnel as designated by the Commissioner.

(al) Record means any information recorded in anyway, maintained by an early intervention official, designee, or approved evaluator, service provider or service coordinator. A record shall include any file, evaluation, report, study, letter, telegram, minutes of meetings, memorandum, summary, interoffice or intraoffice communication, memorandum reflecting an oral conversation, a handwritten or other note, chart, graph, data sheet, film, videotape, slide, sound recording, disc, tape and information stored in microfilm or microfiche or in computer readable form.

(am) Screening means a process involving those instruments, procedures, family information and observations, and clinical observations used by an approved evaluator to assess a child's developmental status to indicate what type of evaluation, if any, is warranted.

(an) Ward of the state means a child whose custody and guardianship have been transferred to the local social services official pursuant to a voluntary surrender by the child's parent or by a family court or surrogate's court in conjunction with the termination of the parental rights of the child's parent.

(ao) Personally identifiable information shall mean the same as "personally identifiable information" as defined in 34 CFR 99.3 of the Family Educational Rights and Privacy Act (FERPA), except that the term "student" and "school" as used in FERPA shall mean "child" and "early intervention service provider," respectively, as used in this Subpart, and includes:

(1) the name of the child, the parent or other family member;

(2) the address of the child, the parent or other family member;

(3) a personal identifier, such as the social security number of the child, parent or other family member;

(4) a list of personal characteristics or other information that would make it possible to identify the child, the parent or other family member with reasonable certainty.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.2 - Early intervention official's or public health officer's role in the Child Find System

69-4.2 Early intervention official's or public health officer's role in the Child Find System.

(a) The early intervention official shall:

(1) make all reasonable efforts to identify and locate eligible children within their municipality;

(2) coordinate efforts to identify, locate and track children conducted by other agencies responsible for services to infants and toddlers and their families;

(3) provide for identification, tracking and screening of children at risk of developmental delay, using available resources and such other resources as the Commissioner shall commit to this purpose.

(i) The municipality shall designate either the early intervention official or the public health officer to receive all early intervention referrals. If the Public Health Officer is designated to receive referrals, and is not the early intervention official, he or she shall promptly transmit the referral of children suspected of having a developmental delay to the early intervention official.

(b) If a child is referred to the early intervention program fewer than 45 days before the child's third birthday and is potentially eligible for services under section 4410 of the Education Law, the early intervention official, with parental consent, shall refer the child to the committee on preschool special education (CPSE) of the local school district in which the child resides and, is not required to conduct an evaluation, assessment, or initial IFSP meeting for the child.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.3 - Referrals

69-4.3 Referrals.

(a) The following primary referral sources shall, within two working days of identifying an infant or toddler who is less than three years of age and suspected of having a disability or at risk of having a disability, refer such infant or toddler to the official designated by the municipality, unless the child has already been referred or unless the parent objects: all individuals who are qualified personnel; all approved evaluators, service coordinators, and providers of early intervention services; hospitals; child health care providers; day care programs; local health units; local school districts; local social service districts including public agencies and staff in the child welfare system; public health facilities; early childhood direction centers; domestic violence shelters and agencies; homeless family shelters; and, operators of any clinic approved under Article 28 of Public Health Law, Article 16 of the Mental Hygiene Law, or Article 31 of the Mental Hygiene Law.

(1) A primary referral source who has identified an infant or toddler suspected of having a disability shall:

(i) Provide a general explanation of the services that are available under the Early Intervention Program and the benefits to the child's development and to the family of accessing those services,

(ii) Inform the parent that, unless the parent objects, their child will be referred to the early intervention official for purposes of a free, multidisciplinary evaluation to determine eligibility for services,

(iii) Whenever feasible, inform the parent about such referral in their dominant language or other mode of communication, and

(iv) Ensure the confidentiality of all information transmitted at the time of referral.

(2) A primary referral source who has identified an infant or toddler at risk of a disability shall:

(i) Provide a general explanation of the developmental screening, home visiting, and tracking services that are available to the family, including municipal child find programs and the benefits to the child's development and to the family of accessing those services;

(ii) Inform the parent that, unless the parent objects, their child will be referred to the designated county official for the purposes of developmental screening, home visiting, and tracking services, which may include enrollment in municipal child find programs;

(iii) Whenever feasible, inform the parent about such referral in their dominant language or other mode of communication; and,

(iv) Ensure the confidentiality of all information transmitted at the time of referral.

(3) When a parent objects to the referral, the primary referral source shall:

(i) Maintain written documentation of the parent's objection to the referral and follow-up actions taken by the primary referral source,

(ii) Provide the parent with the name and telephone number of the early intervention official if the child is suspected of having a disability or Infant-Child Health Assessment Program if the child is at-risk.

(iii) Within two months, make reasonable efforts to follow-up with the parent, and if appropriate, refer the child unless the parent objects.

(b) Information transmitted in a referral from a primary referral source, for an infant or toddler suspected of having a disability or at risk of developing a disability, shall consist of only the following information, unless written consent is obtained from a parent to the transmittal of further information to the early intervention official:

(1) the child's name, sex, race, ethnicity, and birth date;

(2) the name, address and telephone number of the parent and if known, both parents, including, if applicable, the person in parental relation to the child;

(3) when necessary and applicable, the name and telephone number of another person through whom the parent may be contacted;

(4) if the child is being referred because he or she is at risk of developing a disability, the referral shall include an indication that the child is not suspected of having a disability, but is at risk of

developing a disability in the future; and,

(5) name and telephone number of the primary referral source.

(c) Referrals may be made at any time by parents via telephone, facsimile, the Department's secure web site, in writing or in person.

(d) Referrals of children suspected of having a disability, which includes a developmental delay and/or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, shall be based on:

(1) the results of a developmental screening or diagnostic procedure(s); direct experience, observation, and perception of the child's developmental progress;

(2) information provided by a parent which is indicative of the presence of a developmental delay or disability;

(3) or a request by a parent that such referral be made.

(e) Diagnosed physical and mental conditions with a high probability of developmental delay include:

(1) chromosomal abnormalities associated with developmental delay (e.g., Down Syndrome);

(2) syndromes and conditions associated with delays in development (e.g., fetal alcohol syndrome);

(3) neuromuscular disorder (e.g., any disorder known to affect the central nervous system, including cerebral palsy, spina bifida, microcephaly or macrocephaly);

(4) clinical evidence of central nervous system (CNS) abnormality following bacterial/viral infection of the brain or head/spinal trauma;

(5) hearing impairment (a diagnosed hearing loss that cannot be corrected with treatment or surgery);

(6) visual impairment (a diagnosed visual impairment that cannot be corrected with treatment (including glasses or contact lenses) or surgery);

(7) diagnosed psychiatric conditions, such as reactive attachment disorder of infancy and early childhood; (symptoms include persistent failure to initiate or respond to primary caregivers; fearfulness and hypervigilance that does not respond to comforting by caregivers; absence of visual tracking); and,

(8) emotional/behavioral disorder (the infant or toddler exhibits atypical emotional or behavioral conditions, such as delay or abnormality in achieving expected emotional milestones such as pleasurable interest in adults and peers; ability to communicate emotional needs; self-injurious/persistent stereotypical behaviors).

(f) Referrals of children at risk of having a disability shall be made based on the following medical/biological risk factors:

(1) Medical/biological neonatal risk criteria, including:

(i) birth weight less than 1501 grams;

(ii) gestational age less than 33 weeks;

(iii) central nervous system insult or abnormality (including neonatal seizures, intracranial hemorrhage, need for ventilator support for more than 48 hours, birth trauma);

(iv) congenital malformations;

(v) asphyxia (Apgar score of three or less at five minutes);

(vi) abnormalities in muscle tone, such as hyper- or hypotonicity;

(vii) hyperbilirubinemia (> 20mg/dl);

(viii) hypoglycemia (serum glucose under 20 mg/dl)

(ix) growth deficiency/nutritional problems (e.g., small for gestational age; significant feeding problem);

(x) presence of Inborn Metabolic Disorder (IMD);

(xi) perinatally- or Congenitally transmitted infection (e.g., HIV, hepatitis B, syphilis);

(xii) 10 or more days hospitalization in a Neonatal Intensive Care Unit (NICU);

(xiii) maternal prenatal alcohol abuse;

(xiv) maternal prenatal abuse of illicit substances;

(xv) prenatal exposure to therapeutic drugs with known potential developmental implications (e.g.,psychotropic medications, anticonvulsant, antineoplastic);

(xvi) maternal PKU;

(xvii) risk of hearing loss based on family history, including syndromal presentation, or failure of initial newborn infant hearing screening and the child is in need of follow-up screening;

(xviii) risk of vision impairment, including family history of conditions causing blindness or severe vision impairment; and, (ix)presence of a genetic syndrome that may confer increased risk for developmental delay, except for those syndromes such as Down syndrome which require referral of the child as suspected of having a disability in accordance with section 69-4.3(d) and (e) of this

subpart.

(2) Medical/biological post-neonatal and early childhood risk criteria, including:

(i) parental or caregiver concern about developmental status;

(ii) serious illness or traumatic injury with implications for central nervous system development and requiring hospitalization in a pediatric intensive care unit for ten or more days;

(iii) elevated venous blood lead levels (at or above 15 mcg/dl);

(iv) growth deficiency/nutritional problems (e.g.,significant organic or inorganic failure-to-thrive, significant iron-deficiency anemia);

(v) chronicity of serous otitis media (continuous for a minimum of three months);

(vi) HIV infection;

(vii) indicated case of child abuse or maltreatment.

(g) The following risk criteria may be considered by the primary referral source in the decision to make a referral:

(1) no prenatal care;

(2) parental developmental disability or diagnosed serious and persistent mental illness;

(3) parental substance abuse, including alcohol or illicit drug abuse;

(4) no well child care by 6 months of age or significant delay in immunizations; and/or,

(5) other risk criteria as identified by the primary referral source.

(h) When the child is in the care and custody or custody and guardianship of the local social services district, the early intervention official shall notify the local social services commissioner or designee that the child has been referred.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.4 - Qualifications of service

coordinators

69-4.4 Qualifications of service coordinators.

(a) All early intervention service coordinators shall meet the following qualifications:

(1) a minimum of one of the following educational or service coordination experience credentials:

(i) two years experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or,

(ii) one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or,

(iii) one year of service coordination experience and an Associates degree in a health or human service field; or

(iv) a bachelors degree in a health or human service field.

(2) demonstrated knowledge and understanding in the following areas:

(i) infants and toddlers who may be eligible for early intervention services;

(ii) State and federal laws and regulations pertaining to the Early Intervention Program;

(iii) principles of family centered services;

(iv) the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and,

(v) other pertinent information.

(b) Service coordinators shall participate in the introductory service coordination training session sponsored or approved by the Department of Health,in the first three months and by no later than one year of direct or contractual employment as an early intervention service coordinator, provided that training sessions are offered and accessible in locations with reasonable proximity to their place of employment at least three times annually.

(1) Employees of incorporated entities, sole proprietoriships, partnerships, and state operated facilities approved to deliver service coordination services must submit documentation of participation in the introductory service coordination training agency which provided approval to deliver service coordination services]to their employers for (2) Individual service coordinators must submit documentation of their participation in introductory service coordination training to the Department of Health for retention with their approved application to deliver service coordination services.

(3) Failure to participate in the introductory service coordination training sponsored or approved by the Department of Health may result in the disqualification as a provider of service coordination services in accordance with procedures set forth in Section 69-4.17(i).

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.5 - Approval of service coordinators, evaluators and service providers

69-4.5 Approval of service coordinators, evaluators and service providers.

(a) Individuals and agencies shall apply to the Department for approval to provide evaluations, service coordination services, or early intervention services. The Department may reapprove providers, but no more frequently than every five years from the date of approval or subsequent reapproval. Upon receipt of notification from the Department, an agency or individual shall apply for reapproval if the agency or individual wishes to continue providing services in the early intervention program. The Department shall consider applications for approval and reapproval utilizing the criteria set forth in subdivision (4) of this section.

(1) All agencies approved to provide evaluations, service coordination services or early intervention services shall be enrolled as providers in the medical assistance program in accordance with the procedures for such enrollment established by the Department, and shall provide documentation of the provider's enrolled status upon the Department's request.

(2) Approved agency providers shall submit on a periodic basis consolidated fiscal reports to the Department upon request. Approved individual providers shall submit information on revenues and expenses upon request of and on a form developed by the Department.

(3) On or before September 1, 2010, all approved providers shall be in compliance with the criteria set forth in paragraph (4) of this subdivision.

(4) Approval and reapproval of individuals and agencies shall be based on the following criteria:

(i) character and competence of the individual, or for agency providers, the owners, officers, including the chief executive officer and chief financial officer, members, shareholders who own ten percent or more of the voting shares in the agency, directors or sponsors, the program director and other key employees, and the board of directors of a not-for-profit entity as determined by the Department;

(ii) documented fiscal viability of the agency;

(iii) completion of an approved Medicaid provider agreement and reassignment of Medicaid benefits to the municipality;

(iv) for individual providers, proof of current certificate, license, or registration in one of the disciplines set forth in subdivision (ak) of section 69-4.1 and documentation of a minimum of 1,600 clock hours prior to the date of application to the Department for approval, delivering such service to children under five years of age in an early intervention, clinical pediatric, early childhood education program, which may include relevant experience obtained as part of a supervised educational program and/or clinical internship as a prerequisite for professional licensure, certification, or registration, and provided that such experience must have included direct experience in delivering services to children with disabilities and their families:

(v) for agency providers, identification of all employees who will provide early intervention program services, and where applicable, the employees' licenses, registrations, certifications, national provider identification numbers and expiration dates and such other information as may be required by the Department;

(vi) for agency providers, identification of all state-approved agency and individual contractors who will be utilized to provide services and where applicable, the persons' licenses, registrations, certifications, national provider identification numbers and expiration dates and other information as may be required by the Department;

(vii) for agency providers, a quality assurance plan that is approved by the Department for each type of service offered by the agency, including evaluations and service coordination.

(viii) for agency providers, documentation that the agency has in its employment, or in accordance with this paragraph, will have in its employment, the following personnel:

(a) a professional employed on a full time basis who shall serve as the program director for the agency whose duties may include early intervention program service delivery in addition to administration and oversight responsibilities. The program director shall have a minimum of two years of full-time equivalent experience in an early intervention, clinical pediatric, or early childhood education program serving children ages birth to five years of age, provided that:

(1) such experience shall have included direct experience in delivering services to children with disabilities and their families; and

(2) at least one year of such experience shall have been in the delivery of services to children less than three years of age and their families.

(b) a minimum of two qualified personnel or service coordinators who meet qualifications established in section 69-4.4 of this subpart, in addition to the early intervention program director, each of whom provides evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours each per week.

(c) a professional or professionals who hold a license, certification, or registration in the type of service offered by the agency whose responsibilities include monitoring and overseeing

implementation of the quality assurance plan for that service as developed by the agency in accordance with subparagraph (vii) of paragraph (3) of this subdivision.

(d) for purposes of this subdivision, if the agency applying for initial approval has not, at the time of application, employed the personnel required in this paragraph, the agency may verify that it will employ such personnel within three months of approval and receive a conditional three months of approval. At the end of the three-month period, the agency shall submit documentation of the employment of such personnel in accordance with said requirements. If the agency does not provide sufficient documentation at the end of the three month period that it meets the requirements of this subparagraph, the agency's approval shall be void ab initio and the agency shall not be authorized to provide services in the early intervention program.

(e) an agency applying for reapproval shall, at the time of application, submit documentation that it has in its employment the personnel required in this paragraph;

(ix) adherence to, and for purposes of reapproval, evidence of demonstrated compliance with all applicable federal and state laws, regulations, standards and guidelines;

(x) delivery of services on a twelve-month basis and flexibility in the hours of service delivery, including weekend and evening hours in accordance with eligible childrens' IFSPs;

(xi) agreement to participate and, for purposes of reapproval, evidence of participation in continuing professional and clinical education relevant to early intervention services, including service and clinical issues unique to children less than three years of age, and in-service training on state and local policies and procedures of the early intervention program, including Department-sponsored training;

(xii) adherence to, and for purposes of reapproval, demonstrated compliance with the confidentiality requirements applicable to the early intervention program as set forth in federal and state law and regulations;

(xiii) provision of copies of all organizational documents requested by the Department and documentation of licensure or approval granted to the individual or agency by other regulatory agencies;

(xiv) for the purposes of reapproval, documentation that corrective actions required by the Department have been implemented and non-compliance corrected to the satisfaction of the Department;

(xv) provision of such additional pertinent information or documents necessary for approval or reapproval, as requested by the Department.

(5) In addition to the criteria set forth above, for reapproval of an agency or individual, the Department may also consider:

(i) any actions taken against the provider's license, certification, or registration, any criminal convictions, or any actions taken pursuant to 69-4.24 of this subpart;

(ii) the results of any investigations performed by the Department pursuant to 69-4.17(i);

(iii) the results of monitoring reviews, complaint investigations and fiscal audits performed by the Department, municipalities or either of their agents; and,

(iv) other information and documents pertinent to the provider's character and competence.

(6) Commencing on and after January 1, 2013, individuals shall not be approved to deliver both service coordination and evaluations in the early intervention program. Individuals approved prior to January 1, 2013 to deliver both service coordination and evaluations shall notify the department regarding which of these services the individual wishes to continue providing after January 1, 2013, and approval to deliver the service not selected by the individual in accordance with this paragraph shall terminate on January 1, 2013.

(b) Agencies shall apply to the Department for approval to use applied behavior analysis (ABA) aides to assist in the provision of ABA services in accordance with section 69-4.25 of this Subpart. In addition to the criteria set forth in subdivision (a)(4) of this section, the Department shall also consider the following in determining whether to grant such approval:

(1) submission of written policies and procedures as described in section 69-4.25(a)(6) that are approved by the Department and include, but are not limited to the following:

(i) A plan to ensure that all employees and subcontractors who will be delivering ABA services receive initial and ongoing training in content areas approved by the Department and directly related to ABA.

(ii) A description of the methods by which the agency will verify that employed ABA aides will meet the criteria established in section 69-4.25(e) and verify that ABA aides will be employed and supervised in accordance with section 69-4.25.

(iii) Documentation that team meetings will be required and convened by supervisory personnel for all employees and subcontractors delivering ABA services, in accordance with section 69-4.25.

(iv) A description of the methods by which the agency will ensure the quality and effectiveness of ABA services and the health and safety of eligible children.

(2) A table of organization, including employed supervisor(s), employed ABA aides, and employed and subcontracted qualified personnel who will provide ABA services to eligible children, including the planned ratio of children to employed supervisors and employed ABA aides.

(c) An agency's approval to provide services in the early intervention program shall terminate upon the transfer, assignment, or other disposition of ten percent or more of an interest or voting rights in the approved agency. If there is a transfer, assignment, or other disposition of less than ten percent of an interest or voting rights in the approved agency, but the transfer, assignment, or other disposition together with all prior transfers, assignments, or other dispositions within the last five years would, in the aggregate, involve ten percent or more of an interest in the approved agency, the agency's approval to provide services in the early intervention program shall terminate upon

such transfer, assignment, or disposition. If the agency's approval terminates as set forth in this subdivision, the agency must apply for approval in accordance with this section to provide services in the early intervention program.

(1) An agency subject to the provision of this subdivision must apply to the Department for approval at least ninety days prior to the intended effective date of the transfer, assignment or disposition if it wishes to provide services in the program after such transfer, assignment or disposition.

(2) If the agency submitted an application for approval at least ninety days prior to the intended transfer, assignment or disposition of an interest or voting rights in the agency, and the Department has not made a determination on the application prior to such transfer, assignment or disposition, the agency shall be authorized to continue providing services in the program until such time as it is notified of the Department's determination.

(d) Providers approved and reapproved to deliver early intervention evaluations, service coordination services and early intervention program services shall meet with or otherwise communicate with parents and other service providers, including participation in case conferencing and consultation. Agencies shall further require that its employees comply with the provisions of this section and require compliance with this subdivision in its contracts with individual providers.

(e)(1) Approved providers shall not disseminate, or cause to be disseminated on their behalf, marketing materials that are false, deceptive, or misleading. Upon the Department's request, providers shall periodically submit copies of marketing materials for review. Marketing materials that do not comply with the provisions of this subdivision may be a basis for action against the provider's approval in accordance with the provisions of section 69-4.24 of this subpart. The Department shall develop standards on appropriate marketing materials and shall require that marketing materials that seek to promote or advertise early intervention program evaluations or services adequately inform parents or guardians of potentially eligible or at-risk children less than three years of age about the early intervention program. Marketing materials that seek to promote or advertise early intervention program evaluations or services shall include the following statements or their equivalent:

(i) Clear identification that the early intervention program and early intervention services available through the early intervention program are for children less than three years of age who have or are suspected of having a developmental delay and/or disability.

(ii) A statement that the early intervention program is a public program funded by New York State and county governments.

(iii) A statement that all children must be referred to the municipality to access early intervention program services, and including the municipal agency's telephone number.

(iv) Clear identification of the provider referenced in the marketing and advertising materials, and an accurate statement that the provider is approved as a provider of early intervention program services and under contract with the municipality to deliver early intervention program services.

(v) A statement that all services provided under the early intervention program are provided at no out-of-pocket cost to parents, but that health insurance may be accessed for reimbursement for early intervention services provided to eligible children and their families.

(vi) A statement that eligibility for the early intervention program can be determined only by State-approved evaluators under contract with the municipality.

(vii) A statement that if a child is found eligible for the early intervention program, all needed early intervention services are identified in collaboration with the parent and must be authorized by the municipality.

(viii) A statement that the municipality will arrange for service providers, considering the individual needs of the child and family, to deliver services authorized by the municipality.

(ix) A statement that when early intervention services are delivered in child care settings or community locations that require a fee, the parent is responsible for paying any associated costs with such access to child care or community locations.

(2) Service coordinators, evaluators and approved providers, and any individual or entity which performs paid or unpaid marketing activities related to early intervention program services on their behalf, shall not engage in any marketing and advertising practices that offer incentives, or could be construed or appear to offer incentives of any kind to the parents or relatives of an eligible or potentially eligible child, or to the service coordinator, evaluator, or other approved providers authorized to deliver services to an eligible or potentially eligible child, that attempts to or would appear to influence selection of a service coordinator, evaluator or provider of services.

(3) Approved agency providers shall not offer incentives or appear to offer incentives to its employees or subcontractors in the form of payment, performance evaluations, or other awards or benefits that are based on the number of referrals and/or services authorized under the early intervention program.

(f) Approved individuals shall notify the Department within two business days if his or her license is suspended, revoked, limited or annulled, regardless of whether the suspension or limitation is stayed. Approved individuals and agencies shall notify the Department within two days if a contract the provider holds with a municipality or agency provider is terminated for any reason. Agency providers shall ensure that services are delivered by those authorized to do so and shall employ or contract with individuals who are licensed, registered or certified in compliance with applicable provisions of law, in one of the disciplines set forth in subdivision (ak) of section 69-4.1.

(g) Approved providers shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and marital status;

(h) All applicants shall receive written notice of their approval or reapproval to deliver service coordination services, evaluations, and/or early intervention program services from the Department.

(1) The notice shall inform the applicant that a contract with a municipality or with an approved agency under contract with a municipality is necessary to provide services under the early intervention program and to be reimbursed for service coordination services, evaluations, early intervention program services, and to be included on the list of approved agency and individual providers.

(2) The Department shall notify early intervention officials for municipalities in the catchment areas in which the applicant proposes to deliver service coordination services, evaluations, and/or early intervention program services shall receive written notice of the applicant's approval.

(i) The State Education Department shall notify the Department of its approval of any applicant as a provider of service coordination services, evaluations, and/or early intervention program services within five working days.

(j) Approved providers shall notify the Department in writing of any changes made subsequent to approval or reapproval of professional license, certificate, or registration; or for agency providers, transfers, assignments, or other dispositions of less than ten percent of an interest or voting rights of the agency; identification; address and location; and catchment area.

(k) An approved agency or individual provider who intends to cease providing service coordination services, evaluations or early intervention services, or in the case of an agency, intends to cease ownership, possession or operation of the agency, or chooses to voluntarily terminate status as an approved service coordination, evaluation and/or service provider agency, shall:

(1) submit to the Department and early intervention official written notice of such intention and a plan for transition of children not less than 90 days prior to the intended effective date of such action; and,

(2) collaborate with municipalities and the Department to ensure a smooth transition of eligible children and their families to other approved providers.

(l) Municipalities shall provide the Department with such information or documentation as requested and in a content, format and frequency determined by the Department.

(m) Agency providers shall periodically, upon request of the Department, provide the Department with information on its state-approved agency and individual employees and contractors utilized by the agency in the provision of early intervention program services. Information to be provided includes the provider's name, license, registration or certification, national provider identification number and expiration dates, and other such information as may be required by the Department.

Effective Date:
Tuesday, January 1, 2013
Doc Status:
Complete

Section 69-4.6 - Standards for initial and

ongoing service coordinators

69-4.6 Standards for initial and ongoing service coordinators.

(a) All agencies and individuals approved to provide early intervention service coordination shall fulfill those functions and activities necessary to assist and enable an eligible infant and toddler and parent to receive the rights, procedural safeguards and services that are authorized to be provided under State and federal law, including other services not required under the Early Intervention Program, but for which the family may be eligible.

(1) Each eligible infant and toddler and their family shall be provided with one service coordinator who shall be 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/or assistance they need.

(b) Service coordination shall be an active ongoing process that involves:

(1) assisting parents of eligible infants and toddlers in gaining access to the early intervention services and other services identified in the individualized family service plan, including making referrals to providers for needed early intervention services and other services identified in the IFSP, and scheduling appointments for infants and toddlers with disabilities and their families;

(2) ensuring the individualized family service plan outcomes and strategies reflect the family's priorities, concerns and resources, and that changes are made as the family's priorities concerns and resources change;

(3) coordinating the provision of early intervention services and other services (such as educational, social, and medical services for other than diagnostic and evaluation purposes) that the infant or toddler and the family needs or is receiving;

(4) facilitating the timely delivery of early intervention services; as soon as possible after written parental consent for the services in the IFSP is obtained and,

(5) continuously seeking the appropriate services and situations necessary to benefit the development of the child for the duration of the child's eligibility.

(c) Specific service coordination activities shall 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) conducting referral and other activities to assist families in identifying available early intervention program service providers;

(4) coordinating, facilitating, and monitoring the delivery of early intervention services to ensure that the services are provided and in a timely manner;

(5) conducting follow-up activities to determine that appropriate early intervention services are being provided and in a timely manner;

(6) informing families of their rights and procedural safeguards;

(7) informing families of the availability of advocacy services;

(8) coordinating with medical and health care providers, including a referral to appropriate primary health care providers as needed;

(9) coordinating the funding sources for services required under this Subpart; and

(10) facilitating the development of a transition plan to preschool services if appropriate or to other available supports and services.

(d) Initial and ongoing service coordinators shall obtain, and parents shall supply, any information and documentation necessary to establish, and update periodically upon the request of the early intervention official, an eligible child's third party payor coverage, and the nature and extent of such coverage, including coverage through the medical assistance program, other state governmental insurance or benefit program, and/or other plan of insurance, and promptly transmit such information and documentation to the early intervention official.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.7 - Initial service coordinators

69-4.7 Initial service coordinators.

(a) Upon referral to the early intervention official of a child thought to be an eligible child, the early intervention official shall promptly designate an initial service coordinator, selecting whenever appropriate a service coordinator who has an established relationship with the child or family and shall promptly notify the parent of such designation in writing.

(1) Upon receipt of the referral, the early intervention official shall make reasonable efforts to promptly forward a copy of the Early Intervention Program parents' handbook to the parent by mail or other suitable means.

(2) For children in the care and custody or custody and guardianship of the local social services commissioner, the early intervention official shall notify the local commissioner of social services or designee of the designation of an initial service coordinator.

(b) The initial service coordinator shall promptly arrange a contact with the parent in a time, place and manner reasonably convenient for the parent and consistent with applicable timeliness requirements.

(c) The initial service coordinator shall inform the parent of their rights and entitlement under the Early Intervention Program and shall document the information provided in the child's record.

(1) At the initial contact with the parent, the initial service coordinator shall ensure the parent has a copy of the Early Intervention Program parents' handbook, review the handbook, provide an overview of the early intervention system and services, discuss the role of the initial service coordinator, and review the parent's rights, responsibilities and entitlements under the program.

(d) The initial service coordinator shall ascertain if the child and family are presently receiving case management services or other services from public or private agencies. If so, the initial service coordinator shall discuss options for collaboration with the parent and obtain consent for the release of information for the purpose of collaboration with other case management services.

(e) All information provided to the parent shall be in the parent's dominant language or other mode of communication unless clearly not feasible to do so.

(f) All information obtained from the parent shall be confidential and may only be disclosed upon written consent, unless otherwise required or permitted to be disclosed by law.

(g) The initial service coordinator shall inform the family that services must be at no cost to parents and use of Medicaid and/or third party insurance for payment of services is required under the Early Intervention Program.

(1) the service coordinator shall inform the parent that any deductible or co- payments will be paid by the municipality;

(2) the service coordinator shall inform the parent that use of third party insurance for payment of early intervention services will not be applied against lifetime or annual limits specified in their insurance policy, if such policy is subject to New York State law and regulation; and,

(3) that the municipality will not obtain payment from their insurer if the insurer is not prohibited from and will apply payment for early intervention services to the annual and lifetime limits specified in their insurance policy.

(h) The initial service coordinator must obtain, and parents must provide, information about the

status of the family's third party insurance coverage and Medicaid status and promptly notify the early intervention official of such status, including:

(1) Medicaid enrollment status and identification number, if any;

(2) type of health insurance policy or health benefits plan, name of insurer or plan administrator, and policy or plan identification number;

(3) type of coverage extended to the family by the policy; and,

(4) such additional information necessary for reimbursement.

(i) The service coordinator shall assist the parent in identifying and applying for benefit programs for which the family may be eligible, including:

(1) the Medical Assistance Program;

(2) Supplemental Social Security Income Program;

(3) Physically Handicapped Children's Program;

(4) Child Health Plus; and,

(5) Social Security Disability Income.

(j) The initial service coordinator shall review all options for evaluation and screening with the parent from the list of approved evaluators including location, types of evaluations performed, and settings for evaluations (e.g., home vs. evaluation agency). Upon selection of an evaluator by the parent, the initial service coordinator shall ascertain from the parent any needs the parent may have in accessing the evaluation.

(k) The initial service coordinator shall at the parent's request assist the parent in arrangement of the evaluation after the parent selects from the list of approved evaluators.

(l) If the parent has accessed an approved evaluator prior to contact by the initial service coordinator, the initial service coordinator shall contact the parent to assure that the parent has received information concerning alternative approved evaluators and ascertain from the parent any needs the parent may have in accessing the evaluation.

(m) Upon receipt of the results of the evaluation, the initial service coordinator may with the approval of the early intervention official and with parental consent, require additional diagnostic information regarding the condition of the child, provided that such information is not unnecessarily duplicative or invasive to the child according to guidelines of the Department of Health.

(1) Prior to obtaining written consent for additional diagnostic information, the initial service coordinator shall provide the parent with a written explanation which shall include:

(i) diagnostic information requested;

(ii) reasons for obtaining the information, and use of the information;

(iii) location of diagnostic testing;

(iv) source of payment and that no costs shall be incurred by the parent;

(v) a statement that the information shall not be used to refute eligibility; and,

(vi) a statement that the meeting to formulate the Individualized Family Service Plan shall be held within the 45 day time limit.

(2) The initial service coordinator shall assist the parent in accessing the diagnostic testing as needed and desired by the parent.

(3) The initial service coordinator shall facilitate the parent understanding of the results of the diagnostic information, and with parent consent, incorporate this diagnostic information into the planning and formulation of the Individualized Family Service Plan.

(n) Upon the determination of a child as ineligible for early intervention services, the initial service coordinator shall inform the parent of the right to due process procedures as set forth in this Subpart.

(1) The initial service coordinator shall inform the parent of other services which the parent(s) may choose to access and for which the child may be eligible and offer assistance with appropriate referrals.

(o) Upon determination of the child's eligibility for the early intervention program, the initial service coordinator shall discuss the Individualized Family Service Plan process with the parent and shall inform the parent:

(1) of the required participants in the Individualized Family Service Plan meeting, and the parent's option to invite other parties;

(2) that the initial service coordinator may invite other participants, provided that the service coordinator obtains the parent's consent and explains the purpose of this person's participation;

(3) that inclusion of family assessment information is optional;

(4) that their priorities, concerns and resources shall play a major role in the establishment of outcomes and strategies among the parent, evaluator, service coordinator and early intervention official;

(5) of the opportunity to select an ongoing service coordinator, who may be different from the initial service coordinator, at the Individualized Family Service Plan meeting or at any other time after the formulation of the Individualized Family Service Plan.

(6) that the final decisions about the services to be provided to the child will be made by the parent and the early intervention official; and,

(7) that services can be delivered in a range of settings such as an approved provider's facility, as well as a variety of natural environments, including the child's home, child care site or other community settings.

(p) The initial service coordinator shall assist the parent in preparing for the meeting to develop the individualized family service plan, including facilitating their understanding of the child's multidisciplinary evaluation and identifying their resources, priorities, and concerns related to their child's development.

(1) The initial service coordinator shall discuss with the parent the options for early intervention services and facilitate the parent's investigation of various options as requested by the parent.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.8 - Evaluators/screening, evaluation and assessment responsibilities

69-4.8 Evaluators/screening, evaluation and assessment responsibilities

(a) Evaluations and screening.

(1) If the parent selects an approved evaluator prior to the designation of an initial service coordinator, the parent or evaluator shall immediately notify the early intervention official of such selection.

(i) The evaluator may begin the evaluation no sooner than four working days of the early intervention official's receipt of written notice from the parent or evaluator, unless otherwise approved by the initial service coordinator.

(ii) The evaluator shall obtain parental consent to conduct the evaluation prior to the initiation of the evaluation.

(2) A multidisciplinary evaluation shall be performed to determine the child's initial and ongoing eligibility for early intervention services and costs shall be reimbursed in accordance with this Subpart. The evaluator shall obtain informed parental consent to perform the evaluation and screening prior to initiating the evaluation procedures.

(i) The evaluator may, with parental consent, screen a child to determine what type of evaluation, if

any, is necessary.

(a) A screening shall not be performed if the child is known to have a diagnosed condition with a high probability of developmental delay.

(ii) If available and appropriate for the child, standardized instruments with demonstrated reliability and validity and appropriate levels of sensitivity and specificity shall be used to perform the screening.

(iii) The parent shall be present during the performance of any screening procedure, unless the parent's circumstances prevent the parent's presence. The local social services commissioner or designee may be present at the screening of a child in his or her care and custody, or custody and guardianship, in lieu of a parent who elects not to participate.

(iv) Screeners shall discuss the results of the screening with the parent, facilitate the parent's understanding of the screening results and address any concerns identified by the parent.

(a) If the results of the screen indicate that an evaluation is not warranted, the evaluator and the parent may agree to conclude the evaluation process. Costs for such screening shall be reimbursed in accordance with this Subpart.

(b) If the results of the screen indicate that an evaluation is warranted, the evaluator shall discuss with the parent the implications of the results for the child's evaluation, including composition of the multidisciplinary team.

(3) The multidisciplinary evaluation team shall include two or more qualified personnel from different disciplines who are trained to utilize appropriate methods and procedures, have sufficient expertise in child development to evaluate all required developmental domains, and at least one of whom shall be a specialist in the area of the child's suspected delay or disability.

(4) The multidisciplinary evaluation and assessment of the child shall be based on informed clinical opinion, employ age-appropriate instruments and procedures, and include the following:

(i) an evaluation of the child's level of functioning in each of the following developmental domains: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development;

(a) the evaluation of the child's physical development shall include a health assessment including a physical examination, routine vision and hearing screening and, where appropriate, a neurological assessment, except when:

(1) a physical examination has occurred within sufficient recency (as determined by the child's age and commonly accepted examination schedules, such as those recommended by the American Academy of Pediatrics and/or NYS Child/Teen Health Plan), and documentation of such examination is available; and,

(2) no indications are present which suggest the need for re-examination (e.g., rapid regression in

developmental status);

(ii) with parental consent, a review of pertinent records related to the child's current health status and medical history;

(iii) a parent interview about the family's resources, priorities, and concerns related to the child's development and about the child's developmental progress. With the consent of the parent, an interview of other family members or individuals who have pertinent knowledge about the child's development may also be conducted. Information about the child's developmental progress may be gathered from the local social services commissioner, unless the parent objects, regarding children in his or her care and custody or custody and guardianship.

(iv) an assessment of the unique needs of the child in each developmental domain, including the identification of services appropriate to meet those needs. The evaluator should avoid making recommendations regarding frequency and duration of specific services until such time as the family's total priorities, concerns and resources have been assessed and the total plan for services under the IFSP is under discussion.

(v) an evaluation of the transportation needs of the child, which shall include:

(a) parental ability or inability to provide transportation;

(b) the child's special needs related to transportation; and,

(c) safety issues/parental concerns related to transportation.

(5) With written parental consent, the evaluator may use findings from other current examinations, evaluations, or assessments, and health assessments performed for the child, including those conducted prior to initiation of the multidisciplinary evaluation, provided that:

(i) such procedures were performed in a manner consistent with the procedures set forth in this subdivision;

(ii) such findings are used to augment and not replace the multidisciplinary evaluation to determine eligibility;

(iii) no indications are present which suggest the need to repeat such procedures (e.g., the strengths/needs of the child have changed sufficiently to warrant re-examination); and,

(iv) where feasible, consultation with the professional(s) who performed such procedures is sought.

(6) The multidisciplinary evaluation shall be conducted in a professional, objective manner and shall: consider the unique characteristics of the child; employ appropriate instruments and procedures; include informed clinical opinion and observations; and use several sources and types of information about the child, including parent perceptions and observations about their child's development.

(i) Evaluators shall, in conjunction with informed clinical opinion, utilize a standardized instrument or instruments approved by the Department to be used when conducting multidisciplinary evaluations. The evaluator shall provide written justification in the evaluation report why such instrument or instruments are not appropriate or if an instrument is not available for the child, if the evaluator does not utilize an instrument approved by the Department's as part of the multidisciplinary evaluation of a child.

(ii) The evaluation procedures, including clinical observation, shall be conducted in an environment appropriate to the unique needs of the child and conducive to ensuring accuracy of results, with consideration given to the preference of the parent. Such settings may include structured (e.g., clinic or office), unstructured (e.g., play room), and natural settings (e.g., the child's home).

(7) The child's parent shall have the opportunity to be present and participate in the performance of evaluation and assessments, unless the parent's circumstances prevent the parent's presence.

(8) The parent shall have the opportunity to engage in the family assessment process with the evaluation team.

(i) Family assessments shall be family-directed and designed to determine the resources, priorities, and concerns of the family related to enhancement of the child's development. Family assessments shall be voluntary on the part of the family.

(a) If the family assessment is carried out, the assessment must:

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

(2) be based on information provided by the family through a personal interview;

(3) incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development; and,

(4) be completed within a sufficient timeframe to enable convening of the individualized family service plan meeting within forty-five days from the date of referral.

(9) Results of the child's evaluation and assessment shall be fully shared with the parent following the completion of evaluation and assessments, in a manner understandable to the parent.

(i) The evaluation team shall prepare an evaluation report and written summary and submit the summary and the report, to the following individuals as soon as practicable subsequent to the evaluation and within a sufficient timeframe to enable convening of the Individual Family Service Plan meeting within 45 days of the date that the early intervention official received the referral: the parent, early intervention official, and initial service coordinator; and with parental consent, the child's primary health care provider and the local social services commissioner or designee for those children in the care and custody or custody and guardianship of the local social services commissioner.

(ii) Components of the evaluation report and summary shall include identification of the persons

performing the evaluation and assessment, a description of the assessment process and conditions, the child's response, the family's belief about whether the child's response was optimal, measures and/or scores that were used, and an explanation of these measures and/or scores.

(iii) The evaluation report and summary shall include a statement of the child's eligibility, including diagnosed condition with a high probability of delay, if any, and/or developmental delay in accordance with section 69-4.23(a) of this Subpart. Such statement shall describe the child's developmental status including objective and qualitative criteria in sufficient detail to demonstrate how the child meets the eligibility criteria for the program in accordance with criteria set forth in 69-4.23 of this subpart.

(iv) The parent shall have the opportunity to discuss the evaluation results, with the evaluators or designated contact, including any concerns they may have about the evaluation process; and to receive assistance in understanding these results, and ensure the evaluation has addressed their concerns and observations about their child.

(v) To the extent feasible and within the parent's preference and consent regarding disclosure to the interpreter, and within confidentiality requirements, the written and oral summary shall be provided in the dominant language or other mode of communication of the parent.

(10) If a parent requests a second evaluation or component of the evaluation at public expense, the early intervention official shall authorize a second evaluation or component, if he/she deems it necessary and appropriate, and shall document the cause. Costs for such evaluation authorized by the early intervention official shall be reimbursed in accordance with this Subpart.

(11) If a child is determined ineligible for services, including determinations that second evaluations or components of evaluations are not necessary or appropriate, the parent may exercise his or her right to mediation or a hearing. However, the parent may not initiate an action regarding ineligibility for Early Intervention services until all evaluations and assessments are completed and a determination of ineligibility has been made.

(12) With parental consent, certain evaluation and assessment procedures may be performed or repeated and costs may be reimbursed as a supplemental evaluation in accordance with section 69-4.30(c)(2)(ii), if deemed necessary and appropriate by the early intervention official, in conjunction with the required annual evaluation of the Individualized Family Service Plan, or more frequently under the following conditions:

(i) an observable change in the child's developmental status indicates the need for modification of the Individualized Family Service Plan or a change in eligibility status; and,

(ii) the parent, early intervention official or service coordinator, or service provider(s) requests a re-assessment at the six month review of the Individualized Family Service Plan.

(13) After a child's initial multidisciplinary evaluation, any supplemental evaluations must be stated in the child's Individualized Family Service Plan, and must include the type of supplemental evaluation, and the date and evaluator if known.

(14) Nondiscriminatory evaluation and assessment procedures shall be employed in all aspects of the evaluation and assessment process.

(i) Responsiveness to the cultural background of the family shall be a primary consideration in all aspects of evaluation and assessment.

(a) Tests and other evaluation materials and procedures shall be administered in the dominant language or other mode of communication of the child, unless it is clearly not feasible to do so.

(ii) No single procedure or instrument may be used as the sole criteria or indicator of eligibility.

(15) An evaluation or assessment shall not include a reference to any specific provider of early intervention services.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.9 - Standards for the provision of services

69-4.9 Standards for the provision of services.
(a) For purposes of this section, early intervention providers includes all approved agencies and individuals and early intervention program services means service coordination, evaluations, and early intervention services.

(b) On or before September 1, 2010 and thereafter, all approved providers shall comply with the criteria set forth in paragraph (4) of section 69-4.5(a).

(c) Each municipality shall ensure that the early intervention program services contained in Individualized Family Service Plans are provided to eligible children and their families who reside in such municipality and may contract with approved providers of early intervention program services for such purpose. Municipalities shall make reasonable efforts to ensure that early intervention program services contracted for are delivered in a manner that protects the health and safety of eligible children, in accordance with this subpart and with standards and procedures on health, safety, and sanitation developed by the Department for the Early Intervention Program.

(1) If an early intervention official reasonably believes that the early intervention provider is out of compliance with this subpart and/or with the Department's standards and procedures on health, safety, and sanitation, or otherwise posing an imminent risk of danger to children, parents, or staff, the municipality shall take immediate action to ensure the health and safety of such persons.

(2) Upon the taking of such action by the municipality, the early intervention official shall immediately notify the Department, for purposes of the initiation of an investigation which may

result in the suspension, limitation or revocation of the early intervention service provider in accordance with procedures set forth in Section 69-4.24 of this Subpart.

(i) The Department shall notify all early intervention officials in the catchment area of the provider that an investigation has been initiated.

(d) All early intervention providers shall ensure that early intervention program services are delivered in a manner that protects the health and safety of eligible children. Early intervention providers shall:

(1) comply with standards for health, safety, and sanitation issued by the Department for the early intervention program, and for early intervention providers who are otherwise required to be approved by another state agency to deliver health or human services, complying with health, safety and sanitation standards issued by such other agency.

(2) ensure that only those individuals who are qualified in accordance with section 69-4.1(ak) or 69-4.4, as applicable, deliver such services to eligible children and their families.

(3) protect the health, safety, and welfare of eligible children during delivery of early intervention services, including with respect to and as applicable:

(i) direct supervision of and interaction with children during the delivery of services;

(ii) infection control;

(iii) handling of food;

(iv) illness;

(v) equipment, materials, or other items used during service delivery; and

(vi) delivery of services in physical environments that protects the health and safety of children during service delivery.

(e) If the provider delivers services in a physical site or setting which is rented, leased, owned, or otherwise managed or operated by the provider, including a provider's home or private office, the provider shall maintain such physical site or setting in a manner that ensures a safe environment for eligible children and their families in accordance with this subpart, applicable State and local codes, including municipal fire codes, and standards for health, safety, and sanitation issued by the Department for the Early Intervention Program. Providers subject to this paragraph shall ensure that the physical site or setting where services are delivered protects the health and safety of early intervention program children with respect to:

(1) sanitation;

(2) handling of medications and food;

(3) illness, injury, or emergencies, including allergic reactions; and,

(4) its outdoor environment.

(f) The department and early intervention officials shall make reasonable efforts to ensure that early intervention program services delivered to eligible infants and toddlers:

(1) are family-centered, including parents in all aspects of their child's services and in decisions concerning the provisions of services;

(2) use a child development emphasis in intervention strategies, incorporating quality child development practices with necessary adaptations to enhance the eligible child's development;

(3) use an individualized approach for both children and their families, including consideration and respect for cultural, lifestyle, ethnic, and other individual and family characteristics; and

(4) use a team approach that is multidisciplinary, interdisciplinary, or transdisciplinary, including the expertise of all appropriate qualified personnel.

(g) Providers of early intervention program services shall:

(1) provide early intervention program services to an eligible child and family as authorized by the early intervention official and in conformance with the child's and family's individualized family service plan.

(2) provide timely notification of any changes in the provider's ability to deliver early intervention program services to the child and family in conformance with the individualized family service plan.

(i) Providers shall make reasonable efforts to notify the child's parent within a reasonable period prior to the date and time on which a service is to be delivered, of any temporary inability to deliver such service due to circumstances such as illness, emergencies,hazardous weather, or other circumstances which impede the provider's ability to deliver the service.

(ii) Providers shall notify the child's parent and service coordinator at least five (5) days prior to any scheduled absences due to vacation, professional activities, or other circumstances, including the dates for which the provider will be unable to deliver services to the child and family in conformance with the individualized family service plan and the date on which services will be resumed by such provider.

(a) Missed visits may be rescheduled and delivered to the child and family by such provider, as clinically appropriate, agreed upon by the parent and in conformance with the child's and family's IFSP.

(iii) Providers shall notify the child's service coordinator and early intervention official of the intent to permanently cease the delivery of early intervention program services to an individual child and the child's family, for any reason, at least thirty days prior to the date on which the provider intends

to cease providing services.

(3) Consult with parents, other service providers (including primary health care providers; family day care homes, and day care centers), and representatives of appropriate community agencies to ensure the effective provision of services.

(4) Provide support, education, and guidance to parents and other caretakers (including other family members, family day care, and day care centers) regarding the provision of those services.

(5) Participate in the multidisciplinary team's assessment of a child and the child's family and in the development of integrated goals and outcomes for the Individualized Family Service Plan.

(6) Maintain and make available to the municipality and the Department upon request, complete financial records and clinical documentation related to the provision of early intervention services including such information and documentation as necessary to support municipal billing to third party payors (including the medical assistance program) and the State, and to permit a full fiscal audit by appropriate State and municipal authorities.

(7) Maintain records in accordance with section 69-4.17(a) of this subpart that document the performance of activities required to be completed by the provider on behalf of an eligible child and the child's family.

(h) To the maximum extent appropriate to the needs of the child, early intervention services shall be provided in natural environments.

(i) The use of aversive intervention in any form is strictly prohibited when providing early intervention program services to an eligible child. For purposes of this section, aversive intervention means an intervention that is intended to induce pain or discomfort to a child for the purpose of modifying or changing a child's behavior or eliminating or reducing maladaptive behaviors, including but not limited to the following:

(1) contingent application of noxious, painful, intrusive stimuli or activities;

(2) any form of noxious, painful, or intrusive spray (including water or other mists), inhalant, or tastes;

(3) contingent food programs that include the denial or delay of the provision of meals or intentionally altering staple food or drink to make it distasteful;

(4) movement limitation used as punishment, including but not limited to helmets and mechanical restraint devices;

(5) physical restraints;

(6) blindfolds; and,

(7) white noise helmets and electric shock.

(8) Aversives do not include such interventions as voice control, limited to loud, firm commands; time-limited ignoring of a specific behavior; positive reinforcers such as small amounts of food used as a reward for successful completion of a clinical task or token fines as part of a token economy system; brief physical prompts to interrupt or prevent a specific behavior; or interventions prescribed by a physician for the treatment or protection of the child.

(9) Nothing in this subsection shall preclude the use of behavior management techniques to prevent a child who is undergoing episodic behavioral or emotional disturbance from seriously injuring him/herself or others. Emergency physical interventions may be used to prevent a child from seriously injuring him/herself or others. Such interventions, which shall not include mechanical restraints, shall be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed to prevent or minimize injury and shall only be used for as long as the duration of the incident. Emergency physical interventions shall not be used as a punishment or as a substitute for systematic behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior. Staff who may be called upon to implement emergency physical interventions shall be provided with appropriate training in safe and effective physical restraint procedures. Emergency physical interventions shall be included in a behavior management plan that is developed by qualified personnel with appropriate expertise and documented in the child's record to address persistent, ongoing behavior which is injurious to the child or others.

(i) The behavior management plan shall be in writing and signed by the parent.

(ii) The plan shall be developed in concert with the child's family and providers of early intervention services and with parent consent and other clinical experts as needed.

(iii) The child shall be at significant physical risk (injury, malnutrition, or other physical harm).

(iv) A medical evaluation shall be conducted to address medical conditions.

(v) The plan shall be a result of a thorough assessment of cause or behavioral functions.

(vi) The plan shall include positive strategies to reduce or prevent the occurrence of the behavior including building replacement behaviors, when planned physical restraint is involved.

(vii) The plan shall be based on positive reinforcement approaches, where contingent food programs are involved.

(viii) The plan shall be implemented by appropriately trained individuals.

(ix) The parent shall have the right to revoke approval of the plan at any time, and request that a new behavior management plan be developed in accordance with the requirements of this subsection.

Effective Date:
Thursday, June 3, 2010
Doc Status:

Complete

Section 69-4.10 - Service model options

69-4.10 Service model options.

(a) The Department of Health, state early intervention service agencies, and early intervention officials shall make reasonable efforts to ensure the full range of early intervention service options are available to eligible children and their families.

(1) The following models of early intervention service delivery shall be available:

(i) Home and community based individual/collateral visits: the provision by appropriate qualified personnel of early intervention services to the child and/or parent or other designated caregiver at the child's home or any other natural environment in which children under three years of age are typically found (including day care centers and family day care homes).

(ii) Facility-based individual/collateral visits: the provision by appropriate qualified personnel of early intervention services to the child and/or parent or other designated caregiver at an approved early intervention provider's site.

(iii) Parent-child groups: a group comprised of parents or caregivers, children, and a minimum of one appropriate qualified provider of early intervention services at an early intervention provider's site or a community- based site (e.g. day care center, family day care, or other community settings).

(iv) Group developmental intervention: the provision of early intervention services by appropriate qualified personnel to a group of eligible children at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found (this group may also include children without disabilities).

(v) Family/caregiver support group: the provision of early intervention services to a group of parents, caregivers (foster parents, day care staff, etc.) and/or siblings of eligible children for the purposes of:

(a) enhancing their capacity to care for and/or enhance the development of the eligible child;

(b) providing support, education, and guidance to such individuals relative to the child's unique developmental needs.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.11 - Individualized Family Service Plan

69-4.11 Individualized Family Service Plan.

(a) Individualized Family Service Plan (IFSP) Participation.

(1) If the evaluator determines that the infant or toddler is an eligible child, the early intervention official shall convene a meeting of the IFSP team within 45 days of the receipt of the child's referral, to develop the initial IFSP, provided however that such timeline does not apply for any period when:

(i) the child or parent is unavailable to complete the initial evaluation and assessment of the child and family or is unavailable for the initial IFSP meeting due to exceptional family circumstances that are documented in the child's early intervention records and the multidisciplinary evaluation, and the initial evaluation and assessment and the initial IFSP meeting are completed as soon as possible after the exceptional family circumstances no longer exist; or

(ii) the parent has not provided timely consent for the initial evaluation and assessment of the child despite documented repeated attempts by the evaluator to obtain parental consent, and the initial evaluation and assessment and the initial IFSP meeting are completed as soon as possible after parental consent has been obtained for the initial evaluation and assessment of the child.

(2) The meeting shall consist of the following individuals:

(i) the parent;

(ii) the early intervention official; (a) if the early intervention official is unable to attend the meeting, arrangements may be made for his or her participation via conference call;

(iii) the evaluator;

(a) if the evaluator is unable to attend the meeting, arrangements must be made for the evaluator's involvement in the meeting, by participating in a telephone conference call, having a knowledgeable authorized representative attend the meeting, or making pertinent records available at the meeting;

(iv) the initial service coordinator; and

(v) any other persons, such as the child's primary health care provider, or child care provider, who the parent or the initial service coordinator, with the parent's consent, invite.

(3) The following individuals may also participate in the meeting as appropriate:

(i) an advocate or person outside of the family, if the parent requests that person to participate;

(ii) persons who may be providing services to the child or family;

(iii) the local services commissioner for children in the care and custody or custody and guardianship of such commissioner.

(4) The IFSP meeting must be conducted:

(i) in settings and at times that are convenient to the parent; and

(ii) in the dominant language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

(5) 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. (i) The notice to the child's parent of the IFSP meeting shall also inform the parent of the following: (a) parents are required to furnish their social security numbers and the social security number of their child to the early intervention official, in accordance with subdivision four of section 2552 of the Public Health Law, for purposes of administration of the Early Intervention Program; (b)parents shall provide their social security numbers and the social security number for their child at the time of the IFSP meeting; and, (c)social security numbers of the child and parent will be maintained in a confidential manner, will be used solely for the purpose of administration of the Early Intervention Program, and will not be re-disclosed to any party other than the Department.

(6) The early intervention official, initial service coordinator, parent, and evaluator or designated contact from the evaluation team shall jointly develop an IFSP for a parent who requests services.

(7) If the IFSP team members, including the early intervention official and the parent, agree on the initial or subsequent IFSPs, the IFSP shall be deemed final and the ongoing service coordinator shall be authorized to implement the plan.

(i) The early intervention official shall request, and the parent shall supply, the parent's social security number and the social security number for their child at the time of the IFSP meeting; provided, however that if the parent refuses to furnish such information to the early intervention official, early intervention services contained within the IFSP must still be provided and such refusal by the parent shall be documented in the child's record.

(ii)(a) For children referred to the early intervention program on or after January 1, 2013, or for children referred to the early intervention program prior to January 1, 2013 for whom an additional evaluation or partial evaluation is requested on or after January 1, 2013 for the purpose of adding a new service, neither the evaluator which conducts an evaluation of a child, an approved agency which employs or contracts with the evaluator, nor a relative or business associate of the evaluator, shall provide early intervention services to such child unless authorized by the commissioner, after consultation with the early intervention official, due to special circumstances related to the evaluator's qualifications or availability or other extraordinary circumstances in which there is a clear showing that the child will not be able to access needed services absent such authorization.

(1) For purposes of this paragraph, the following terms shall have the following meanings:

(i) "business associate" shall mean a person joined or united with one or more individuals in a business or enterprise; and

(ii) "relative" shall mean any person living in the same household as an individual or the individual's spouse, child, stepchild, stepparent, or any person who is a direct descendant of that individual's grandparents or the spouse of such descendant.

(b) Any request for such authorization shall be made by the child's service coordinator, which shall fully document the basis for the request in a manner and format prescribed by the commissioner. Requests for authorization shall be made no later than twenty days after the child's IFSP meeting; provided, however, that any request for authorization shall not delay the timely delivery of early intervention services authorized in the child's IFSP. The commissioner shall issue a determination upon such a request within ten calendar days after the request is received.

(c) If the commissioner finds there is a shortage of evaluators or approved providers in certain disciplines in a particular region of the state, the commissioner may issue a standing authorization, on such terms or conditions as he or she deems appropriate, which shall remain in effect in such region until such time as the commissioner determines that such shortage no longer exists.

(d) A service coordinator shall not assign as a service provider, a business associate of the service coordinator, a relative of such service coordinator or an agency provider which employs or contracts with such relative, who is not otherwise prohibited from serving as the provider for a child pursuant to subparagraph (a) of this paragraph, unless such relationship is disclosed to the parent and the parent does not object to the assignment.

(8) The contents of the IFSP must be fully explained to the parent and informed written consent from the parent must be obtained prior to the provision of early intervention services described in the plan. If the parent does not provide consent with respect to a particular early intervention service, or withdraws consent after first providing it, that service may not be provided. The early intervention services to which parental consent is obtained must be provided.

(9) If the IFSP team members, including the early intervention official and the parent, do not agree on an IFSP, the service coordinator shall implement the sections of the proposed IFSP that are not in dispute, and the parent may exercise his or her due process rights to resolve the dispute.

(10) The IFSP shall be in writing and include the following:

(i) a statement, based on objective criteria, of the child's present levels of functioning in each of the following domains: physical development, including vision and hearing; cognitive development; communication development; social or emotional development; and adaptive development;

(ii) a physician's or nurse practitioner's order pertaining to early intervention services which require such an order and which includes a diagnostic statement and purpose of treatment;

(iii) with parental consent, a statement of the family's strengths, priorities and concerns that relate to enhancing the development of the child;

(iv) a statement of the measurable results or measurable outcomes expected to be achieved for the child and the family (including pre-literacy and language and numeracy skills, as developmentally appropriate for the child), including timelines, and the criteria and procedures that will be used both to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services is necessary;

(v) a statement of specific early intervention services based on peer-reviewed research, to the extent practicable, including transportation and the mode thereof, necessary to meet the unique strengths and needs of the child and the family, including the frequency, intensity, length, duration, location and the method of delivering services. If ABA services using ABA aides are to be provided to the child, the IFSP shall specify the number of hours of intervention to be delivered by such aides in accordance with section 69-4.25 of this subpart. For purposes of this subparagraph frequency, intensity, length, duration, location and method shall be defined as follows:

(a) frequency shall mean the number of days or sessions the service will be provided;

(b) intensity shall mean whether the service is provided on an individual or group basis in accordance with the service model option in section 69-4.10 and reimbursed in accordance with 69-4.30 of this subpart;

(c) length shall mean the number of minutes of actual time spent delivering services during each session;

(d) duration shall mean the start date and end date the service is to be provided;

(e) location shall mean the actual place or places where the service will be delivered;

(f) method shall mean how a service is provided; and,

(vi) a statement of the natural environments in which early intervention services shall appropriately be provided, including, if applicable, a justification of the extent, if any, to which early intervention services will not be provided in a natural environment;

(a) The determination of the appropriate setting for providing early intervention services to an infant or toddler with a disability must be:

(1) made by the participants of the IFSP meeting, including the parent;

(2) consistent with the definition of natural environment in section 69-4.1(af) of this subpart; and,

(3) based on the child's outcomes that are identified by the IFSP meeting participants.

(4) If the IFSP meeting participants together determine that a particular early intervention service is to be delivered at a location that is not the natural environment for the child or service, the IFSP shall set forth in detail the justification for not delivering the service in a natural environment.

(vii) when the child is in day care and when appropriate, a plan for qualified professionals to train

the day care provider to accommodate the needs of the child;

(viii) to the extent appropriate, a statement of other services, including medical services, that the child and family needs or is receiving through other sources, but that are neither required nor funded by the program. If such services are not currently being provided, the IFSP shall include a description of the steps the service coordinator or family may take to assist the child and family in securing those other services;

(ix) a statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated;

(x) the projected dates for initiation of services, which date must be as soon as possible but no later than 30 days after the parent provides written consent for the services in the IFSP or any subsequent amendments to the IFSP, and the anticipated duration of these services, provided however that: if the parent and other members of the IFSP team determine that one or more types of service(s) included in the IFSP must appropriately be initiated more than 30 days after the parent provides written consent for the services in the IFSP, such service(s) must be delivered no later than 30 days after the projected date of initiation of such service(s) as set forth in the IFSP.

(xi) the name of the ongoing service coordinator, who may be different from the initial service coordinator, selected by the parent who will be responsible for the implementation of the IFSP and coordination with other agencies, services and persons;

(xii) if applicable, a statement of any supplemental evaluations, including the type, and the date and evaluator if known; and

(xiii) if applicable, establishment of a transition plan with the steps and services to be taken supporting the potential transition of the toddler with a disability to services provided under section 4410 of the Education Law, or to other services, including:

(a) discussions with and education of parents regarding potential options and other matters related to the child's transition, including:

(1) if the child is potentially eligible for services under section 4410 of the Education Law, the service coordinator shall notify the Committee on Preschool Special Education (CPSE) of the local school district in which the child resides of the child's potential transition for services under section 4410 of the Education Law, unless the parent objects to such notification orally or in writing. The service coordinator shall explain to the parent the procedures by which the parent may object to notification of the CPSE of the child's potential transition and the deadline for such objection;

(2) if the child is potentially eligible for services under section 4410 of the Education Law, the parent must timely refer, or provide consent for the service coordinator to refer, the child to the CPSE of the local district in which the child resides for an evaluation to determine the child's eligibility for such services;

(3) the child's eligibility for services under section 4410 of the Education Law must be determined by the CPSE prior to the child's third birthday in order to continue receiving services in the early

intervention program after the child's third birthday. If the CPSE has not made a determination of eligibility prior to the child's third birthday, early intervention services will end the day before the child turns three years of age;

(4) the requirement for the service coordinator to convene, with the approval of the parent, a conference among the early intervention official, the parent, and the chair or designee of the CPSE no fewer than 90 days before the child's third birthday or the date on which the child is first eligible for services under section 4410 of the Education Law, and at the discretion of all parties, no more than nine months prior to the child's third birthday, to discuss any services the child may receive under the Education Law, review the child's program options and establish a transition plan; and,

(5) with parental consent, such conference may be combined with:

(i) the initial meeting of the CPSE, provided that the combined conference and meeting are convened within timeframes specified in section 69-4.20(b) of this subpart; or

(ii) the IFSP review meeting that occurs closest to the child's second birthday.

(b) procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting;

(c) with parental consent, procedures to prepare program staff or individual qualified personnel who will be providing services to the child to facilitate a smooth transition;

(d) with parental consent, the transmission of information about the child to the committee on preschool special education, to ensure continuity of services, if appropriate, including evaluation and assessment information or a copy of the Individualized Family Service Plan; and,

(e) identification of transition services and other activities that the IFSP participants determines are necessary to support the transition of the child.

(b) The IFSP shall be reviewed at six month intervals and shall be evaluated annually to determine the degree to which progress toward achieving the outcomes is being made and whether or not there is a need to amend the IFSP to modify or revise the services being provided or anticipated outcomes. Upon request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals.

(1) IFSP reviews shall be conducted by an in-person meeting or other means agreed to by the parent which may include a telephone or video conference call or record review and written correspondence.

(2) An IFSP meeting shall be conducted at least annually to evaluate the IFSP for the child and the child's family, and, as appropriate, to revise its provisions. The results of any current evaluations conducted under section 69-4.8 and any other information available from the ongoing assessment of the child and family, must be used in determining the services that are needed and will be provided.

(3) The annual meeting to evaluate the IFSP and six month reviews must include the individuals listed in section 69-4.11(a)(2) as participants.

(i) If the evaluator is unable to attend the meeting, arrangements must be made for the evaluator's involvement in the meeting, including participating in a telephone conference call; having a knowledgeable authorized representative attend the meeting; or making pertinent records available at the meeting.

(4) When a request is made to review an IFSP prior to the six month review period, for the purposes of increasing the frequency or duration of an approved service, including service coordination, the early intervention official may require an additional multidisciplinary evaluation or supplemental evaluation at public expense by an approved evaluator other than the current provider of service, with parent consent. The early intervention official may consider parent input when selecting the evaluator.

(5) If the parent does not consent to the evaluation or partial evaluation, the early intervention official may determine that an increase in frequency or duration of an approved service is not warranted and may deny such request. A parent who disagrees with the determination of the early intervention official shall have the due process rights set forth in section twenty-five hundred forty-nine of the public health law.

(c) Interim services:

(1) The initial service coordinator shall inform the parent of the availability of interim services for the child and/or family in immediate need of early intervention services.

(2) Interim early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment, if the following conditions are met:

(i) Parental consent is obtained;

(ii) The parent and the early intervention official agree to an interim IFSP that includes:

(a) the name of a service coordinator who will be responsible for implementation of the interim IFSP and coordination with other agencies and persons;

(b) a physician's or nurse practitioner's order pertaining to those early intervention services which require such an order and which includes a diagnostic statement and purpose of treatment; and,

(c) the early intervention services needed immediately by the child and the child's family, including the location, frequency, and intensity and providers of such services.

(iii) The evaluation and assessment are completed and an Individualized Family Service Plan meeting is convened within 45 days of referral to the early intervention official.

(3) The costs that an approved provider of early intervention services incurs in providing such interim services shall be approved costs to the extent they are otherwise consistent with Section

2555 of the Public Health Law.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.12 - Monitoring of approved service providers (including evaluators, service providers and service coordinators)

69-4.12 Monitoring of approved service providers (including evaluators, service providers and service coordinators).

(a) Programmatic Monitoring. For purposes of this section, approved service providers means municipalities, incorporated entities, sole proprietorships, partnerships, state-operated facilities and individual qualified personnel approved by a state early intervention service agency to deliver service coordination services, evaluations, and/or early intervention services.

(1) Approved service providers shall be monitored on an annual basis by their approving state early intervention service agency.

(i) State early intervention service agencies shall monitor approved service providers in accordance with these regulations and applicable federal law and regulations and shall report annually to the Department on monitoring activities, including the status of any corrective action plans, and technical assistance activities directed at providers of early intervention services. Monitoring procedures may include:

(a)institution of reporting requirements; and,

(b)provision of technical assistance in the development and implementation of self-assessment and internal quality control procedures; and,

(c)corrective action plans where appropriate; and (d)verification of correction of non-compliance within one year of a finding of non-compliance.

(2) Approved service providers may be monitored by municipalities with which they have entered into a contract to deliver service coordination services, evaluations, and/or early intervention services in accordance with Early Intervention Program regulations and/or terms of the municipal contract.

(3) Whenever feasible and appropriate, state early intervention service agencies and municipalities

shall jointly conduct monitoring activities.

(i) By October 1 of each year, state early intervention service agencies shall determine and inform the Department of Health of monitoring activities to be conducted during the federal fiscal year, including a site visit schedule which identifies the approved providers under their approval authority which will receive a site visit during that federal fiscal year.

(4) Monitoring activities, including site visits, may include the following components:

(i) a sample review of records, including Individualized Family Service Plans;

(ii) interviews with personnel responsible for the administration and provision of early intervention services;

(iii) review of status of licensure, certification, or registration;

(iv) review of organizational structure and staffing patterns, including supervision of personnel and participation of personnel in in-service training;

(v) a review of compliance with these regulations;

(vi) a review of internal quality assurance procedures (e.g., mechanisms for parent involvement in planning and evaluation of service delivery, exit interviews with parents, parent satisfaction questionnaires, etc);

(vii) review of information or gathering of information about parent experiences and satisfaction with service delivery;

(viii) where applicable and practicable, observation of the delivery of early intervention services and interviews with families; and,

(ix) where applicable, a review of the status of any corrective action plans for any previously identified deficiencies. (x) verification of correction of previously identified deficiencies and non-compliance.

(b) An initial site visit shall be conducted within one year of approval by a state early intervention service agency of a newly incorporated service entity or other incorporated service entity which has not been previously involved in the delivery of services to eligible children and their families. Such site visits shall be conducted by the approving state early intervention agency.

(c) Fiscal auditing. For purposes of this section, approved service providers means incorporated entities, sole proprietorships, partnerships, state-operated facilities and individual qualified personnel approved by a state early intervention service agency to deliver service coordination services, evaluations, and/or early intervention services.

(1) Each municipality may conduct an audit of approved service providers under contract to deliver service coordination services, evaluations, and/or early intervention services. The municipality

shall submit the results of any such audit to the Commissioner for review and, if warranted, adjustments in state aid reimbursement, as well as for recovery by the municipality of its share of any disallowances identified in such audit.

(i) All audits will be based upon these and other applicable regulations and generally accepted accounting principles.

(ii) Audits may include a comprehensive review of all financial records and related documentation.

(2) The early intervention official shall have the ability to perform, or cause to be performed, a fiscal audit of approved service providers under contract with the municipality and located in another municipality, provided that: (i) prior to initiation of such audit, the early intervention official ascertains that neither the state nor the municipality where services are being delivered has performed or intends to perform such an audit within 6 months;

(ii) a full fiscal audit is performed;

(iii) where appropriate, the auditing is performed in conjunction with the approving state early intervention service agency to avoid unnecessary duplication of auditing procedures;

(iv) results of the audit shall be made available upon request of any other municipality making payments under the Early Intervention Program to the approved evaluator, service provider or service coordinator.

(v) No other municipality may conduct an additional audit for the time period specified above.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.13 - Local early intervention coordinating councils

69-4.13 Local early intervention coordinating councils.

(a) A local early intervention coordinating council shall be established in each municipality and shall consist of the following members appointed by the early intervention official:

(1) at least four parents of children with disabilities age birth through twelve years of age;

(2) at least three public or private providers of early intervention services;

(3) at least one child care provider or representative of child care providers;

(4) the chief executive officers or their designees of the municipalities' departments of social services, health and mental hygiene; and, a representative from the local developmental disabilities services office; and

(5) a representative from one or more committees on preschool special education of local school districts in the municipality.

(b) If membership requirements cannot be reasonably met, the early intervention official may submit a written request to the Commissioner for a waiver of such requirements.

(c) The local early intervention coordinating council shall meet, in open forum accessible to the general public preferably quarterly, but in no event less than every six months. The early intervention official shall ensure appropriate public notice of the meeting, which shall include its purpose, date, time, and location. The notice shall be within a sufficient time period prior to the meeting to enable public participation.

(d) The local early intervention coordinating councils shall advise their early intervention officials regarding:

(1) the planning for, delivery and evaluation of the early intervention services for eligible children and their families, including methods to identify and address gaps in services;

(2) the identification of service delivery reforms necessary to promote the availability of early intervention services within natural environments;

(3) the coordination of public and private agencies;

(4) such other matters relating to early intervention policies and procedures within the municipality as are brought to its attention by parents, providers, public agencies, or others.

(e) The council will report annually to the early intervention official on the adequacy of the early intervention system to ensure the availability of family centered, coordinated services; and interface with other existing planning bodies that serve like populations.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.14 - Reporting

69-4.14 Reporting.

(a) Early intervention officials shall report to the Department of Health such data as the Department may require.

(1) The early intervention official, in conjunction with the local early intervention coordinating council, shall annually and upon request submit a report to the department and the Early Intervention Coordinating Council on the status of the program within the municipality including gaps in services and methods to address these gaps.

(b) Approved early intervention evaluators, service providers, and service coordinators will provide to early intervention officials all the data necessary to complete the reports referenced in (a) in a timely manner.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.15 - Children in care

69-4.15 Children in care.

(a) Definitions. The following terms shall have the following meanings:

(1) "Foster child" shall mean a child in the care, custody or guardianship of a commissioner of a local social services district.

(2) "Homeless child" shall mean a child placed in a hotel, motel, shelter, or other temporary housing arrangement by a social services district because of the unavailability of permanent housing.

(3) "Municipality of current location" shall mean a municipality in which a child lives which is different from the municipality in which a child or such child's family lived at the time a social services district assumed responsibility for the placement of such child or family or at the time the child was admitted for care or treatment in a facility licensed or operated by a state agency other than the Department of Health.

(4) "Municipality of residence" shall mean the municipality in which a child or such child's family lived at the time the local social services district assumed responsibility or custody for such child or family or at the time the child was admitted for care or treatment in a facility licensed or operated by a state agency other than the Department of Health.

(5) "Child in residential care" shall mean an infant or toddler living in a residential facility licensed or operated by a state agency. For the purposes of subdivisions (b),(c) and (d) of this section, a child in residential care shall be deemed a homeless child.

(b) Evaluation and IFSP responsibility. The municipality of current location of a foster child or homeless child shall be responsible for the evaluation and IFSP procedures prescribed for an infant or toddler suspected of having a disability. For reimbursement purposes, the municipality of current

location shall identify to the Commissioner of Health each eligible foster child or homeless child. The municipality of current location of such child shall also transmit a copy of the IFSP and cost of service of such child to the municipality of residence.

(c) Contract and payment responsibility. The municipality of current location shall be the municipality of record for an eligible foster child or homeless child, provided that the state shall reimburse one hundred percent of the approved costs paid by such municipality which shall be offset by the local contribution.

(d) Local contribution. The municipality of residence shall be financially responsible for the local contribution in the amount of fifty percent of the approved costs.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.16 - Parents, persons in parental relation and surrogate parents

69-4.16 Parents, persons in parental relation and surrogate parents.

(a) The early intervention official shall make every effort to protect the right of parents, which includes persons in a parental relation, to make decisions about a child's receipt of early intervention services.

(b) Where the parent's availability to the child is limited due to life circumstances, including residing far from their child or the parent is residing in an institution, or the child's placement in the care and custody of the local social services commissioner, the early intervention official shall, as appropriate, facilitate the parent's involvement in early intervention services.

(c) The early intervention official shall be responsible for the determination of the need for a surrogate parent for eligible or potentially eligible children and make reasonable efforts, including contacting persons who might have information concerning the parent, or visit and/or send letters via regular and certified mail to addresses at which the parent may have lived, to discover the whereabouts of a parent before appointing a surrogate.

(1) The early intervention official shall establish agreements with local social service districts, Family Court and other relevant public agencies regarding procedures which will be used to identify eligible or potentially eligible children in need of surrogate parents.

(2) Upon receipt of a referral of an eligible or potentially eligible child who is in the care and custody or custody and guardianship of the local commissioner of social services, the early intervention official, in consultation with the local commissioner of social services or designee,

shall determine the availability of the parent.

(3) In the event that the child is a ward of the State, or in the care and custody of the local social services commissioner, but his or her parents by birth or adoption are unavailable and the child has no person in parental relation, the early intervention official shall consult with the local commissioner of social services with care and custody or custody and guardianship of the child to promptly appoint a surrogate parent.

(d) The early intervention official shall appoint a qualified surrogate parent for any eligible or potentially eligible child when the child is a ward of the state, or when the child is not a ward of the state but his or her parents by birth or adoption are unavailable, after reasonable efforts to facilitate their participation and the child has no person in parental relation.

(e) The early intervention official shall allow an available birth parent or adoptive parent to voluntarily appoint a surrogate parent upon written consent.

(f) The early intervention official shall select a surrogate parent who is qualified and willing to serve in such capacity and who:

(1) has no interest that conflicts with the interests of the child;

(2) has knowledge and skills that ensure adequate representation of the child;

(3) if available and appropriate, is a relative who has an ongoing relationship with the child or a foster parent with whom the child resides;

(4) is not an employee of any agency involved in the provision of early intervention or other services to the child, provided however that a person who otherwise qualifies to be a surrogate parent is not considered an employee solely because he or she is paid by a public agency to serve as a surrogate parent; and,

(5) has been selected, for any child who is a ward of the state or for any child whose parent is unavailable and who is in the care and custody of the local social services commissioner, in consultation with the local commissioner of social services or designee.

(g) The early intervention official shall afford the surrogate parent the same rights and responsibilities as accorded to the parent by the Early Intervention Program and shall represent the child in all matters related to:

(1) screening, evaluation, and assessment of the child;

(2) development and implementation of the Individualized Family Service Plan, including annual evaluations and periodic reviews;

(3) the ongoing provision of early intervention services;

(4) the right to request mediation or an impartial hearing in the event of a dispute; and,

(5) any other rights established in the Early Intervention Program.

(h) The surrogate parent shall maintain the confidentiality of all information regarding the child, including written records.

(i) A person appointed to serve as a surrogate parent shall be removed by the early intervention official in the event:

(1) the surrogate parent is no longer willing or available to participate in that capacity;

(2) the surrogate parent fails to fulfill his or her duties;

(3) the child is no longer a ward of the state; or,

(4) a parent becomes available.

(j) The surrogate parent may request a hearing to challenge a determination by an early intervention official to remove the surrogate parent for failure to fulfill the duties of a surrogate parent. Upon request by the former surrogate parent, a hearing shall be conducted under the provisions of Part 51 of Title 10. (k) In the event that the surrogate parent is removed and the child continues to require the assistance of a surrogate parent, the early intervention official shall appoint a surrogate parent within no more than 10 working days of the removal.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.17 - Procedural safeguards

69-4.17 Procedural safeguards.

(a) The early intervention official shall make reasonable efforts to ensure that the parent is fully informed in their dominant language of and understand the rights and entitlement afforded them under the Early Intervention Program, including the right to:

(1) elect or decline to have the child screened and/or evaluated to determine eligibility for early intervention services and to participate in the voluntary family assessment process;

(2) elect or decline to participate in the Early Intervention Program without jeopardizing their right to future participation in the Early Intervention Program;

(3) accept or decline any early intervention service without jeopardizing other early intervention services;

(4) confidentiality of personally identifiable information;

(5) review and correct records;

(6) be notified by the early intervention official within a reasonable time prior to a proposal or refusal to initiate or change the identification, evaluation, or delivery of appropriate early intervention services to the child and family unit;

(7) participate in and invite the participation of others in all decision-making meetings regarding a proposal, or refusal, to initiate or change the identification, evaluation, or delivery of services to the child and family unit;

(8) use due process procedures to resolve complaints;

(9) use an attorney or advocate in any and all dealings with the State early intervention program;

(10) receive an explanation of the use of and impact on insurance, including protection against co-payments and safeguards for lifetime and annual caps as provided in State law; and,

(11) When the initial service coordinator or the early intervention official has not made contact with the parent prior to the evaluation, the approved evaluator shall review with the parent their rights under the program and document the review in the evaluation summary.

(b) Notice.

(1) Written notice must be given by the early intervention official to the parent of an eligible child ten working days before the early intervention official proposes or refuses to initiate or change the identification, evaluation, service setting, or the provision of appropriate early intervention services to the child and the child's family.

(i) The notice must be sufficient in detail to inform the parent about:

(a) The action that is being proposed or refused;

(b) The reasons for taking such action; and

(c) All procedural safeguards available under the Early Intervention Program.

(ii) The notice must be:

(a) Written in language understandable to the general public, and

(b) Provided in the dominant language of the parents, unless it is clearly not feasible to do so.

(iii) If the dominant language or other mode of communication of the parent is not a written language, the early intervention official shall take steps to ensure that:

(a) The notice is translated orally or by other means to the parent in the parent's dominant language or other mode of communication;

(b) The parent understands the notice; and

(c) There is written evidence that the requirements of this paragraph have been met.

(iv) If a parent is deaf or blind, or has no written language, the mode of communication must be that normally used by the parent (such as sign language, braille, or oral communication).

(2) The early intervention official shall make reasonable efforts to ensure the parent receives written notification about the right to due process and the method by which mediation and an impartial hearing can be requested at the following times:

(i) upon denial of eligibility;

(ii) upon disagreement between the early intervention official and the parent on an initial or subsequent IFSP or proposed amendment to an existing IFSP; and,

(iii) upon request from the parent for such information.

(c) Confidentiality.

(1) Personally identifiable data, information, or records pertaining to an eligible child shall not be disclosed by any officer or employee of the Department of Health, state early intervention service agencies, municipalities, evaluators, service providers or service coordinators, to any person other than the parent of such child, except in accordance with Title 34 of the Code of Federal Rules Part 99, sections 300.560 through 300.576 (with the modification specified in section 303.5(b) of Title 34 of the Code of Federal Regulations) and Part 303 of Title 34 of the Code of Federal Regulations (Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 - available from the Early Intervention Program, Room 208 Corning Tower Building, Empire State Plaza, Albany, New York 12237-0618), to preserve the confidentiality of records pertaining to children participating in the early intervention program.

(2) Each municipality, evaluator, service provider and service coordinator shall adopt procedures comparable to those set forth in part 99 and sections 300.560 through 300.576 (with the modifications specified in section 303.5(b)) of Title 34 of the Code of Federal Regulations (Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 - available from the Early Intervention Program, Room 208 Corning Tower Building, Empire State Plaza, Albany, New York 12237-0026) to preserve the confidentiality of records pertaining to eligible children participating in the Early Intervention Program.

(3) Early intervention officials, all providers approved to deliver early intervention services and all personnel involved in mediation and impartial hearing procedures shall:

(i) implement and maintain policies and procedures to assure the protection of confidential personally identifiable information, which may include existing policies and procedures where

appropriate and applicable;

(ii) submit assurances that all employees, including independent contractors, consultants, and volunteers with access to personally identifiable information are informed of and are required to adhere to all confidentiality requirements of personally identifiable information;,

(iii) adhere to all legal requirements that protect records containing sensitive information (e.g., such as sexual or physical abuse, treatment for mental illness or mental health problems, HIV status, communicable disease status, the child's parentage, etc.); and,

(iv) identify the person or person(s) with designated responsibility for guaranteeing the confidentiality of personally identifiable information.

(4) Early intervention officials shall ensure the confidentiality of all information maintained in an electronic format except as required or permitted by state or federal law.

(5) The early intervention official shall provide for the confidential exchange of information among parent, evaluators, service providers and service coordinators, including policies and procedures which enable the parent to voluntarily give written consent for general release of information.

(i) The parent shall be informed of the right to refuse to sign a general release and offered the opportunity to sign a more selective release which specifies by name or category those individuals to whom information may be disclosed or from whom it may be sought.

(ii) The parent's authorization for general release shall be revokable at any time and the parent shall be informed of the right to revoke such authorization. Such information shall be included on any such release form.

(6) The early intervention official shall make reasonable efforts to ensure notification of the parent when maintenance of personally identifiable information is no longer necessary for the purposes of the early intervention program.

(i) At the request of the parent, the early intervention official shall ensure all personally identifiable information is removed from the record and destroyed. However, a permanent record of the child and the family's name and address and the types and dates of services received may be maintained without time limitation.

(d) Access to records.

(1) The early intervention official and approved evaluators, service providers, and service coordinators shall ensure the parent is afforded the opportunity to review and inspect all the records pertaining to the child and the child's family that are collected, maintained, or used for the purposes of the Early Intervention Program, unless the parent is otherwise prohibited such access under State or federal law. The opportunity to review and inspect the record includes the right to:

(i) understandable explanations about and/or interpretations of the record upon the parent's request;

(ii) obtain a copy of the record within ten working days of the receipt of the request by the early intervention official or approved evaluator, service provider, or service coordinator;

(iii) obtain a copy of the record within five working days if the request is made as part of a mediation or impartial hearing.

(iv) have a representative of the parent view the record.

(2) For children in the care and custody or custody and guardianship of the local social services district, the local commissioner of social services or designee shall be accorded access to the records collected, maintained or used for the purposes of the Early Intervention Program.

(3) An agency may presume that the parent has authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority under applicable State law governing such matters as guardianship, separation, and divorce.

(4) The early intervention official or evaluator, service provider or service coordinator may charge a reasonable fee not to exceed 10 cents per page for the first copy and 25 cents per page for any additional copies of the record , provided that the fee does not prevent the parent from exercising the right to inspect and review records and providing that no fees shall be charged to parents to obtain copies of any evaluation or assessment documents to which parents are specifically entitled under other sections of this subpart, except an evaluator or service provider may charge for copies permitted under Public Health Law section 18.

(5) Parents shall not be charged fees for the search and retrieval of the record.

(6) Where any part of the record contains information on more than one child, the parent shall only have the opportunity to review and inspect the portion of the record which pertains to their child.

(7) Each early intervention official, evaluator, service provider and service coordinator shall keep a record of parties obtaining access to records gathered, maintained, or used for purposes of the Early Intervention Program (except access by parents and authorized employees of the municipality or approved evaluator, service provider, or service coordinator) including the name of the party, the date access was given, and the purpose for which the party is authorized to use the records.

(e) Amending the record.

(1) The early intervention official, evaluator, service provider and service coordinator shall ensure the parent the right to present objections and request amendments to the contents of the record because the parent believes the information is inaccurate, misleading, or violates the privacy or other rights of the child.

(2) The parent may at any time present objections pertaining to the contents of the record to the early intervention official, evaluator, service provider or service coordinator, and request that amendments be made.

(3) The early intervention official, evaluator, service provider or service coordinator shall respond

to the parent objection and request for amendments of the record within 10 working days.

(i) If the early intervention official, evaluator, service provider or service coordinator concurs with the parent's request, the service coordinator shall ensure the contents of the record are amended as requested and notify the parent of the amendment in writing or via a verbal explanation in their dominant language unless clearly not feasible to do so.

(ii) If the early intervention official, evaluator, service provider or service coordinator does not concur with the parent's request to amend the record, the early intervention official shall notify the parent in writing of the decision and inform the parent of the right to an administrative hearing.

(4) An administrative hearing to amend the record must meet, at a minimum, the following requirements:

(i) the municipality shall hold the hearing within a reasonable time after it has received the request for the hearing from the parent;

(ii) the municipality shall give the parent notice of the date, time, and place, reasonably in advance of the hearing;

(iii) the hearing may be conducted by any individual designated by the municipality, who does not have direct interest in the outcome of the hearing;

(iv) the municipality shall give the parent a full and fair opportunity to present evidence relevant to the issues. The parent may, at their own expense, be assisted or represented by one or more individuals of his or her own choice, including an attorney;

(v) the municipality shall make a decision in writing within a reasonable period of time after the hearing; and,

(vi) the decision must be based solely on the evidence presented at the hearing, and must include a summary of the evidence and reasons for the decision.

(vii) If, as a result of the hearing, the municipality determines that the record contains information that is inaccurate, misleading, or violates the privacy rights of the child or family, the municipality shall order the amendment of the record as requested by the parent.

(viii) If the record is ordered to be amended, the early intervention official shall ensure the record is amended and notify the parent in writing of the amendment.

(ix) If, as a result of the hearing, the municipality determines that the contents of the record are not inaccurate or misleading or do not violate the privacy rights of the child and family, the municipality shall order that the parent be notified in writing of such decision and informed of the right to place a statement in the record reflective of their views. The municipality shall ensure that such parental statement is incorporated, maintained, and disseminated as part of the record.

(f) Availability of due process.

(1) The parent of an eligible or potentially eligible child shall have the right to access mediation and/or an impartial hearing at no cost for the resolution of individual child complaints regarding eligibility determinations or the provision of early intervention services.

(2) The Department of Health shall establish, implement, and maintain impartial hearing and mediation processes for the resolution of individual complaints regarding the identification, evaluation, assessment, eligibility determinations, and development, review and implementation of the individualized family services plan (IFSP).

(i) The Department of Health shall assure the availability of hearing officers who are trained and knowledgeable of the federal and State law and regulations pertaining to the Early Intervention Program and the conduct of administrative hearing procedures.

(3) The failure of the parent to participate in mediation proceedings for the resolution of a complaint or dispute shall not constitute a failure to exhaust administrative remedies and shall not prevent the parent from accessing an impartial hearing.

(g) Mediation procedures.

(1) The Department shall ensure that a statewide mediation system shall be available to ensure parent and early intervention officials may voluntarily access a non-adversarial process for the resolution of complaints regarding the provision of early intervention services.

(2) Mediation services for the resolution of disputes regarding eligibility determination or early intervention service delivery shall be available from community dispute resolution centers upon the written request of the parent and/or early intervention official and the mutual agreement of the parent and the early intervention official to participate in mediation.

(3) The early intervention official shall ensure the parent, upon the request for mediation services by the parent or the early intervention official, is informed of:

(i) the voluntary nature of mediation;

(ii) the parent's right to withdraw at any time from mediation and request an impartial hearing; and,

(iii) the right to be accompanied by supportive persons and/or an attorney.

(4) The parent's request to the early intervention official for mediation services may be made in a written format selected by the parent.

(5) The early intervention official's request that the parent agree to participate in mediation services shall be made in writing in the dominant language of the parent(s), if feasible, and in a manner understandable to the parent.

(6) If the early intervention official requests mediation, the early intervention official shall obtain the express written consent of the parent to transmit personally identifiable information to the community dispute resolution center.

(7) Within two working days of receipt of a request by the early intervention official for mediation by the parent, the early intervention official shall notify the appropriate community dispute resolution center in writing of the request for mediation. The parent and service coordinator shall simultaneously be sent a copy of such notification, which shall include:

(i) the names, addresses, and telephone numbers of the parties to participate in the mediation;

(ii) the need for interpretive services, if any; and,

(iii) the nature of the dispute(s) which has resulted in the request for mediation.

(8) Immediately upon receipt of a request for mediation, the community dispute resolution center shall contact the parent and early intervention official to discuss at a minimum the following:

(i) the mediation process;

(ii) a convenient site and time for the mediation; and

(iii) the need for interpretative services or alternative communication services, if any.

(9) The community dispute resolution center shall, upon a determination of the mutual agreement of the parent and early intervention official to participate in mediation, make appropriate arrangements for and convene the mediation proceedings within two weeks of the receipt of the request by the early intervention official, unless an extension is requested or consented to in writing by the parent.

(i) The mediation proceedings shall be convened at a date, time, and location convenient to the parent.

(10) The mediator and community dispute resolution center shall maintain the confidentiality of all personally identifiable information as required by state or federal law or regulations.

(11) The parent and the early intervention official may represent themselves during the mediation proceedings.

(i) The parent and the early intervention official shall have the right to invite others to accompany them at the mediation proceeding.

(12) The parent and/or the early intervention official may be accompanied by an attorney at the mediation proceeding, provided that advanced notice is given to the other party of the intention to be accompanied by an attorney.

(13) The mediation process shall be completed within 30 calendar days of the receipt of the request for mediation by the community dispute resolution center.

(i) When mediation has resulted in successful negotiation of a partial or full agreement on areas in dispute between the parent and the early intervention official, the mediator shall document the

terms of the negotiated agreement, including a list of unresolved issues, in writing and obtain the signatures of the parent and the early intervention official on the written agreement.

(ii) The mediator shall, whenever feasible, provide the written agreement in the dominant language of the parent or other alternative mode of communication.

(iii) The mediator shall forward a copy of such agreement to the community dispute resolution center, which shall ensure that the parent, early intervention official, and service coordinator receive a copy of the written agreement.

(iv) The service coordinator shall ensure that the terms of services agreed to in the written agreement are incorporated into the Individualized Family Service Plan within 5 working days of the receipt of the written agreement.

(v) When the mediation has not resulted in the negotiation of a resolution, the early intervention official shall ensure the parent is informed of the right to and procedures for requesting and obtaining an impartial hearing.

(vi) In any due process proceedings subsequent to the mediation process, only requests for mediation and mediation agreements may be available for presentation as evidence.

(14) Mediation records shall be maintained by the community dispute resolution center for a period of at least six years.

(h) Impartial Hearing Procedures for Individual Child Complaints

(1) The parent shall have the right to an impartial hearing which ensures the fair and prompt resolution of individual child disputes or complaints.

(i) A request for an impartial hearing must be made in writing and signed by a parent and submitted to the Commissioner of Health or designee.

(2) Upon the receipt of a request for an impartial hearing, the Commissioner of Health or designee shall inquire of the early intervention official whether or not mediation has been requested or completed, and provide the parent and respondents with a notice of hearing. If any party is represented by counsel, notice also shall be served upon the attorney representing the party.

(i) The notice of hearing shall, at a minimum:

(a) specify the date, time, and place of the hearing, which shall be convenient to the parent;

(b) briefly state the issues which are to be the subject of the impartial hearing, if known;

(c) explain the manner in which the impartial hearing will be conducted;

(d) describe the circumstances under which attorney's fees shall be reimbursed;

(e) advise the parent of the right to be represented by counsel and to be accompanied by any person of their choice;

(f) advise the parent of the right to interpreter for the deaf services;

(g) advise the parent of the right to testify, present evidence, and produce and cross-examine witnesses;

(h) advise the parent of the right to appeal the decision of the hearing officer;

(i) inform the parent that early intervention services that are not in dispute shall be continued pending the decision of the hearing officer and any appeal of such decision; and,

(j) inform the parent of the availability and procedures for requesting mediation.

(ii) If the municipality intends to be represented by counsel,the early intervention official shall notify the parent within five working days of receipt of the notice of an impartial hearing request, and the hearing shall be held no sooner than five working days from the receipt of the notice.

(a) The service coordinator shall ensure the parent is informed about legal services and advocacy organizations available to assist them in the impartial hearing process.

(3) All notices and papers connected with a hearing, other than the notice of hearing and statement of charges, if any, may be served by ordinary mail and may be deemed complete three days after mailing.

(4) Upon receipt of a request for an impartial hearing, a hearing officer shall be assigned.

(i) The hearing officer shall complete the impartial hearing and render a decision within 30 days of the filing of a written request by the parent.

(ii) No hearing officer shall preside who has any bias with respect to the matter involved in the proceeding. Any party may file with the Department a request, together with a supporting affidavit, that a hearing officer be removed on the basis of personal bias or for other good cause. (iii) A hearing officer shall be disqualified for bias. For purposes of this subpart, bias shall exist only when there is an expectation of pecuniary or other personal benefit from a particular outcome of the case; when the individual is an employee of any agency or other entity involved in the provision of early intervention services or care of the child; or, when there is a substantial likelihood that the outcome of the case will be affected by a person's prior knowledge of the case, prior acquaintance with the parties, witnesses, representatives, or other participants in the hearing, or other predisposition with regard to the case. The appearance of impropriety shall not constitute bias and shall not be a grounds for disqualification. Hearing officers are presumed to be free from bias.

(iv) A hearing officer may disqualify himself/herself for bias on his/her own motion. A party seeking disqualification for bias has the burden of demonstrating bias. The party seeking disqualification shall submit to the hearing officer an affidavit pursuant to State Administrative Procedures Act section 303 setting forth the facts establishing bias. Mere allegations of bias shall

be insufficient to establish bias.

(v) The hearing officer shall rule on the request for disqualification.

(vi) Upon the refusal of the impartial hearing officer to voluntarily withdraw from the case, the party filing the request shall have the right to appeal this decision to a court of competent jurisdiction. Any such appeal shall not interrupt the hearing proceedings unless the parties consent to an adjournment pending the outcome of such appeal or otherwise ordered by a court.

(5) The hearing officer shall conduct the impartial hearing in a fair and impartial manner and shall have the power to:

(i) rule upon requests by parties to the hearing, including all requests for adjournments;

(ii) administer oaths and affirmations and issue subpoenas requiring the attendance and testimony of witnesses and the production of books, records and other evidence pertinent to the impartial hearing;

(iii) admit or exclude evidence;

(iv) limit the number of times any witness may testify, repetitious examination or cross-examination, and the amount of corroborative or duplicative testimony;

(v) hear arguments on facts or law;

(vi) order that opening statements be made by the parties to the impartial hearing;

(vii) order the parties to appear for a pre-hearing conference to consider matters which may simplify the issue or expedite the hearing, and which may ensure that the parties understand the procedures governing the hearing;

(viii) ensure that a written or electronic verbatim record of the proceedings is maintained and made available to the parties; and,

(ix) perform such other acts as may be necessary for the maintenance of order and efficient conduct of the impartial hearing, unless otherwise prohibited by law or regulation.

(6) A parent involved in an impartial hearing has the right to obtain a written or electronic verbatim transcription of the proceeding.

(7) The procedures used to conduct the impartial hearing proceeding shall provide the parties with a fair and prompt resolution of any dispute.

(i) The parties to the impartial hearing may be represented by legal counsel or individuals with special knowledge or training with respect to children eligible for early intervention services and may be accompanied by other persons of their choice.

(ii) The parent shall have the right to determine whether or not the child who is the subject of the impartial hearing shall attend the hearing.

(iii) The impartial hearing shall be closed to the public unless the parent requests an open hearing. Upon such request, the hearing officer shall make a determination regarding whether the hearing will be opened to the public.

(iv) The parties to the impartial hearing, and their respective counsel or representative, if any, shall have an opportunity to present evidence and to question all witnesses at the hearing.

(v) All evidence including documents and a listing of witnesses shall be disclosed to the opposing party at least five working days before the hearing.

(a) The parent has the right to prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five days before the proceeding.

(vi) The local social services commissioner or designee shall be afforded notice and a right to be heard at any mediation process and/or impartial hearing for any child in his or her care and custody or custody and guardianship.

(vii) Each witness shall be sworn or given an affirmation by the impartial hearing officer.

(viii) The hearing officer shall consider all relevant evidence and shall include as part of the record all records, documents and memoranda submitted into evidence. The formal rules of evidence do not apply; provided, however that any request for mediation and mediation agreement entered into by the parties may be included as evidence.

(ix) The parties may enter into a stipulation to resolve the matters in dispute at any time prior to the issuance of a decision by the impartial hearing officer.

(a) The parties shall inform the hearing officer of such stipulation.

(b) Upon such notice, the hearing officer shall terminate the proceedings and provide notice to the Department of Health of the termination.

(x) The hearing officer may issue a consent order upon such stipulation by the parties. Such consent order shall have the same force and effect and shall be implemented in the same manner as an order issued by the hearing officer.

(xi) Upon conclusion of the proceedings, the hearing officer shall render a written decision within 30 days of the request for the hearing, which shall include:

(a) The findings of fact and conclusions of law.

(b) A determination regarding the matters in dispute.

(c) An order of implementation of the determination; and,

(d) the right to appeal the decision to a court of competent jurisdiction.

(xii) The decision of the hearing officer shall be final, provided that any party may seek judicial review by a court of competent jurisdiction.

(xiii) Where a decision is not rendered within 30 days, the hearing officer may issue interim orders which shall ensure that the child and family receive appropriate early intervention services to the extent feasible and consistent with the services requested by the parent.

(xiv) Where the hearing officer determines that delay in rendering a written decision may result in harm to the child's health or welfare, the hearing officer may provide for an expedited hearing, including an interim verbal decision where necessary, to be followed by a written decision.

(xv) A copy of the written decision shall be mailed to the parties of the hearing, the service coordinator for the child and family, the Commissioner of Health or designee, the local social services commissioner or designee for children in his or her care and custody or custody and guardianship and any other state early intervention service agency affected by such decision.

(xvi) The early intervention official or service coordinator shall modify the Individualized Family Service Plan no later than five working days after receipt of the written or oral decision, whichever is issued sooner.

(xvii) The records and decisions by hearings officers shall be maintained for at least six years.

(i) Availability of complaint procedures.

(1) All complaints alleging violations of laws, rules and regulations by a state early intervention service agency, early intervention official, or provider approved to deliver early intervention services shall be submitted by a parent, representative of the parent or any other individual or entity to the Department of Health for investigation and resolution. For the purpose of this section, "provider" refers to evaluators, service providers and service coordinators.

(i) Complaints shall be submitted in writing to the department.

(ii) The complaint shall allege a violation of laws, rules or regulations that occurred not more than one year prior to the date that the complaint is received.

(iii) The party filing the complaint must forward a copy of the complaint to the early intervention official, any provider who is the subject of the complaint, and to the service coordinator of the child named in the complaint, at the same time the party files the complaint with the Department.

(iv) The complaint shall include:

(*a*) a statement that the Department, municipality, or provider has violated a requirement of Part C, Title 34 of the Code of Federal Regulations, Title II-A of Article 25 of the Public Health Law; or Subpart 69-4: Early Intervention Program regulations;

(*b*) the facts on which the complaint is based; and

(*c*) the signature and contact information for the complainant.

(v) If alleging violations with respect to a specific child, the complaint shall also include:

(*a*) the name, date of birth, and address of the residence of the child;

(*b*) the name of the provider(s), service coordinator, and municipality serving the child;

(*c*) a description of the nature of the problem associated with the child, including facts relating to the problem; and

(*d*) a proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

(2) All investigations shall be completed within 60 calendar days of the receipt of the complaint by the Department of Health.

(3) Upon receipt of a complaint the complainant shall be informed of the following:

(i) the procedures governing the investigation;

(ii) the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

(iii) the opportunity for a parent who has filed a complaint to voluntarily engage in mediation, in accordance with section 69-4.17(g) of this Subpart;

(iv) the right of the complainant to receive a written decision that addresses each allegation in the complaint, contains findings of fact and conclusions, and describes the reasons for the final decision; and,

(v) that the subject of the complaint shall have the opportunity to respond to the complaint.

(4) The Department may permit an extension of the time limit of the issuance of a written decision under paragraph (2) of subdivision (i) of this section only if:

(i) exceptional circumstances exist with respect to a particular complaint; or

(ii) the parent (or individual or organization) and the Department, municipality, or provider involved agree to extend the time to engage in mediation pursuant to subparagraph (i)(3)(iii) of this section.

(5) The investigation of any complaint shall include:

(i) the opportunity for the subject of the complaint to respond to the complaint;

(ii) an on-site investigation, if the Department determines it is necessary;

(iii) provision for an interview of the complainant; any person named in the allegation; and, any person who is likely to have relevant information pertaining to the allegation; and,

(iv) provision for the receipt of any documentation which may confirm or deny the substance of the allegation.

(6) Upon completion of an investigation a determination shall be made by the Department as to whether the allegation is substantiated and the complainant and subject of the investigation shall be notified in writing of such determination.

(i) Upon completion of an investigation resulting in substantiation of one or more allegations, the Department may require corrective action be taken by the subject of the investigation and, where the subject is an approved individual or agency, may take such other actions, including but not limited to actions in accordance with subdivision 69-4.24 of this subpart.

(ii) Written notification shall include:

(a) the findings and determination of the merit of each allegation; and,

(b) where applicable, corrective actions to be taken which may include participation in technical assistance or other actions prescribed by the Department.

(iii) Corrective action plans developed by the subject of an investigation shall be submitted for approval to the Department.

(a) At a minimum, the corrective action plan shall specify the date by which the plan shall be implemented and procedures for implementation.

(7) If a written complaint is received and it is the subject of an impartial hearing, or it contains multiple issues of which one or more are part of such a hearing, the Department shall set aside any part of the complaint that is being addressed in the impartial hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the impartial hearing shall be resolved using the time limit and procedures described in this section.

(8) If an issue raised in a complaint filed under this section has previously been decided in an impartial hearing involving the same parties, the impartial hearing decision shall be binding on that issue.

(9) A complaint alleging the Department, a municipality, service coordinator, or provider's failure to implement an impartial hearing decision shall be resolved by the Department.

(10) Nothing herein regarding the filing of complaints shall prohibit the Department or any party, including a parent, representative of the parent, or any other individual or entity, from communicating with the Department orally or in writing, from responding to requests for assistance in resolving any concerns or problems related to the delivery of early intervention services;

provided, however, that such parties shall be informed by the Department of the availability of complaint procedures.

(j) Pendency

(1) During the pendency of any mediation, impartial hearing, or appeal, the early intervention official shall ensure the following services for the child and family are implemented:

(i) the services provided pursuant to the Individualized Family Service Plan previously in effect; or

(ii) if the early intervention official and the parent do not agree on the IFSP, the sections of the proposed IFSP that are not in dispute.

(2) The early intervention official of a municipality to which a child and family has moved shall ensure that the services identified in the previous Individualized Family Service Plan of the former municipality shall continue to be provided to the extent feasible until a new Individualized Family Service Plan has been developed or that the parent and early intervention official otherwise agree to a modification of such former plan.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.18 - Respite services

69-4.18 Respite services.

(a) As appropriate, respite services and models for respite services may be discussed with the parent at the individualized family service plan meeting

(b) The provision of respite services for an eligible child and family shall be determined in the context of IFSP development, based on the individual needs of the child and family, and with consideration given to the following criteria:

(1) severity of child's disability and needs;

(2) potential risk of out-of-home placement for the child if respite services are not provided;

(3) lack of access to informal support systems (e.g., extended family, supportive friends, community supports, etc.);

(4) lack of access to other sources of respite (e.g., Family Support Services under the auspices of the Office of Mental Retardation and Developmental Disabilities and respite provided through

other State early intervention service agencies), due to barriers such as waiting lists, remote/inaccessible location of services, etc.

(5) presence of factors known to increase family stress (e.g., family size, presence of another child or family member with a disability, etc.); and,

(6) the perceived and expressed level of need for respite services by parent.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.19 - Transportation

69-4.19 Transportation.

(a) The municipality shall ensure that transportation is available beginning the first day of service as agreed upon in the individualized family service plan when transportation is necessary to enable the child and the child's family to receive early intervention services.

(1) Transportation may be provided directly, by contract, or through reimbursement of the parent at a mileage rate authorized by the municipality for the use of a private vehicle or for other reasonable transportation costs, including public transportation, tolls, and parking fees.

(b) In developing the IFSP, consideration shall first be given to provision of transportation by a parent of a child to early intervention services.

(c) If the parent has demonstrated an inability to provide or access transportation, the municipality in which an eligible child resides shall arrange and provide payment for suitable transportation services necessary for the child and parent participation in early intervention services contained within the Individualized Family Service Plan.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.20 - Transition planning

69-4.20 Transition planning.

(a) A transition plan shall be established in the IFSP to ensure a smooth transition for every child

exiting the Early Intervention Program.

(1) If the child may be eligible for preschool services under section 4410 of the Education Law, the service coordinator, with parental consent, shall convene a conference among the early intervention official, the parent, and the chairperson of the CPSE or designee, not fewer than 90 days, and at the discretion of all parties, not more than nine months before the child's third birthday to discuss any services the child may receive under education law.

(2) If the child is not potentially eligible for preschool services under section 4410 of Education Law, the service coordinator, with parental consent, shall make reasonable efforts to convene a conference among the early intervention official, the parent, and providers of other appropriate services for the toddler to discuss appropriate services that the child may receive, including early education, Head Start, Early Head Start, child care programs or other appropriate services.

(3) All meetings to develop the transition plan, including the transition conference, must be at a time and place mutually convenient to all participants and must meet all requirements pertaining to IFSP meetings in section 69-4.11(a)(2)-(5) of this Subpart.

(4) The transition plan established in the IFSP must be developed with the child's family and shall include procedures to prepare the child and family for changes in service delivery, including:

(i) a review of program and service options for the child from the child's third birthday through the remainder of the program year, if appropriate;

(ii) steps for the child and his or her family to exit from the Early Intervention Program;

(iii) steps and services to help the child adjust to and function in a new setting;

(iv) procedures to prepare program staff or individual qualified personnel who will be providing services to the child to facilitate a smooth transition; and

(v) transition services and other activities that the IFSP participants determine are needed by the child and family to support the transition of the child.

(b) For children thought to be eligible for services under section 4410 of the Education Law, not fewer than 90 days prior to the child's potential eligibility for services under the Education Law, Section 4410, the service coordinator shall provide written notification to the committee on preschool special education of the local school district in which an eligible child resides of the potential transition of the child.

(1) The service coordinator shall ensure the parent is informed in accordance with procedures in subdivision 69-4.11(a)(10)(xiii) of this subpart of the opportunity to object to such notification prior to providing notice to the CPSE of the child's potential transition.

(i) The parent shall be afforded at least thirty calendar days to object, either orally or in writing, to written notification to the CPSE of the child's potential transition.

(ii) If the parent objects to such notification, the notification shall not be made, and the parent's objection shall be documented in the child's record.

(iii) If the parent does not object to such notification, the service coordinator shall include the following information in the written notice to the CPSE of the child's potential transition:

(a) the child's name;

(b) the child's date of birth and date of referral to the early intervention program;

(c) the method by which the parent may be contacted, including the parent's name, address, and telephone number; and,

(d) the name and contact information for the child's service coordinator who is transmitting the notification.

(iv) if notification in subdivision (b)(1)(iii) of this section is required the service coordinator must confirm, in written documentation, the transmission of the notification to the CPSE and include such documentation in the child's and family's transition plan established under section 69-4.11(a)(10)(xiii).

(2) For children in the care and custody or custody and guardianship of the commissioner of the local social services district, the service coordinator shall notify the local commissioner of social services or designee of the child's potential transition.

(3) The service coordinator shall review information concerning the transition procedure with the parent and obtain parental consent for the transfer of appropriate evaluations, assessments, Individualized Family Service Plans, and other pertinent records.

(4) With parent consent, the service coordinator shall convene a transition conference with the parent, service coordinator, and the chairperson of the CPSE or designee, at least 90 days prior to the child's eligibility for services under Education Law, Section 4410, or no fewer than 90 days before the child's third birthday, whichever is first, provided, however, that such conference shall not be held more than nine months prior to the child's third birthday, to review program options and if appropriate, establish a transition plan.

(i) The local social services commissioner may participate in the conference for children in the care and custody or custody and guardianship of the social services commissioner.

(ii) The conference may be combined with:

(a) the initial meeting of the CPSE pertaining to the child, provided, however, that such initial meeting must convene within the required timeframes for the transition conference; or

(b) the IFSP review or annual meeting that occurs closest to the child's second birthday, provided that such meeting is convened no more than nine months before the child's third birthday.

(iii) The parent may decline a transition conference; provided, however, that the parent shall be informed that the child's eligibility for services under section 4410 of the Education Law must be determined by the child's third birthday to continue receiving early intervention services after the child's third birthday and that if a determination of eligibility for services under section 4410 of the Education Law has not been made by the CPSE prior to the child's third birthday, eligibility for early intervention services will end on the day before the child's third birthday.

(a) Declination of a transition conference by the parent shall be documented in the child's record.

(b) The service coordinator shall explain to the parent that if the parent declines a transition conference, the parent may refer the child to the CPSE for determination of eligibility for Education Law 4410 services and shall provide information on how the parent may make such referral.

(c) For children thought not to be eligible for programs under Education Law, Section 4410, the service coordinator shall assist the parent in the development of a transition plan to other appropriate early childhood and supportive services. The service coordinator shall assist the parent in identifying, locating, and accessing such services.

(d) With parental consent, the service coordinator shall notify the committee on preschool special education of those children potentially eligible for transition to the preschool special education program but whose parents have selected to continue with early intervention services for the specified period of eligibility for the Early Intervention Program.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Section 69-4.21 - Reimbursement of municipal administrative costs

69-4.21 Reimbursement of municipal administrative costs.

(a) Municipalities shall be eligible for reimbursement for administrative costs, exclusive of due process costs, incurred during the preceding year pursuant to this Title.

(b) The costs of direct early intervention services are not considered administrative costs. Administrative costs shall include personnel and operating expenses incurred for administration of the program.

Effective Date:
Wednesday, November 5, 1997
Doc Status:

Complete

Section 69-4.22 - Third-party payments

69-4.22 Third-party payments.

(a) Municipalities shall in the first instance and where applicable, seek payment from private third party insurers, prior to claiming payment from Medicaid or the Department of Health, for services delivered to eligible children and their families, provided that the municipality shall not obtain payment from a third party payor who is not prohibited from applying such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy.

(b) The municipality or its designee shall be subrogated, to the extent of expenditures by the municipality for early intervention services provided to an eligible child and parent, to any rights the child or parent may have or be entitled to from third party reimbursement.

(1) The early intervention official shall, upon notification by the initial service coordinator of the parent's eligibility for benefits from a health insurance policy or benefits plan promptly notify the health insurer or benefits plan administrator of the intent to exercise subrogation rights.

(c) All approved evaluators, service coordinators, and service providers shall forward to the early intervention official within a reasonable period all documentation and information necessary to support municipality billing of all third party payors, including the Medical Assistance Program.

(d) The municipality shall pay all co-payments and deductibles to meet any requirement of an insurance policy or health benefit plan in accessing funds applied to payment for early intervention services. These payments will be subject to the same level of state reimbursement as all other payments by the municipality for Early Intervention services.

(1) The municipality shall establish a procedure to ensure that the parent does not make a first instance payment for co-pays and deductibles. Such procedures may include an arrangement between the municipality and the provider for payment of co-payments and deductibles to the provider directly.

Effective Date:
Wednesday, November 5, 1997
Doc Status:
Complete

Section 69-4.23 - Initial and continuing eligibility criteria

69-4.23 Initial and continuing eligibility criteria.

(a) Initial eligibility for the early intervention program shall be established by a multidisciplinary evaluation conducted in accordance with section 69-4.8 of this subpart and shall be based on the following criteria:

(1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay; or,

(2) The presence of a developmental delay which affects functioning in one or more of the following domains of development: cognition, physical (including vision, hearing and oral motor feeding and swallowing disorders), communication, social-emotional, or adaptive development; and, as measured by qualified personnel using informed clinical opinion, appropriate diagnostic procedures, and/or instruments and documented as:

(i) a twelve month delay in one domain; or

(ii) a 33 percent delay in one domain or a 25 percent delay in each of two domains; or

(iii) if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one domain or a score of at least 1.5 standard deviation below the mean in each of two domains; or

(iv) notwithstanding subdivisions (i)-(iii) for children who have been found to have a delay only in the communication domain, delay shall be defined as a score of 2.0 standard deviations below the mean in the area of communication; or, if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department, including the following:

a) for children 18 months of age or older;

(i) a severe language delay as indicated by no single words by 18 months of age, a vocabulary of fewer than 30 words by 24 months of age, or no two-word combinations by 36 months of age; or

(ii) the documented presence of a clinically significant number of known predictors of continued language delay at 18-36 months of age, in each of the following areas of speech language and non-speech development:

(1) Language production;

(2) Language comprehension;

(3) Phonology;

(4) Imitation;

(5) Play;

(6) Gestures;

(7) Social Skills; and,

(8) Health and family history of language problems; or,

b) for children younger than 18 months of age, documentation that the child has attained none of the normal language milestones expected for children in the next younger age range, and none for the upper limit of the child's current chronological age range, and the presence of a preponderance of established prognostic indicators of communication delay that will not resolve without intervention, as specified in clinical practice guidelines issued by the Department.

(b) If there is an observable change in the child's developmental status that indicates a potential change in eligibility, the early intervention official may require a determination to be made of whether the child continues to be eligible for early intervention program services. The early intervention official shall not, however, require that such a determination be made sooner than six months after a child and family's initial IFSP in the program.

(1) Continuing eligibility for the early intervention program shall be established by a multidisciplinary evaluation conducted in accordance with section 69-4.8 of this subpart which includes the right for the parent to select an approved evaluator, and shall be based on the following criteria:

(i) a delay consistent with the criteria established for initial eligibility as set forth above; or,

(ii) a delay in one or more domains, such that the child's development is not within the normal range expected for his or her chronological age, as documented using clinical procedures, observations, assessments, and informed clinical opinion; or,

(iii) a score of 1.0 standard deviation or greater below the mean in one or more developmental domains; or,

(iv) the continuing presence of a diagnosed physical or mental condition with a high probability of resulting in a developmental delay.

(2) If pursuant to subdivision (b) herein, the early intervention official requests a determination of the child's continuing eligibility for the early intervention program, and the parent refuses to consent to a multidisciplinary evaluation to establish the child's continuing eligibility, continuing eligibility has not been established and the child shall no longer be eligible for early intervention program services. The early intervention official shall provide the parent with written notice ten working days before the early intervention official proposes to discharge the child from the early intervention program. The notice must be in sufficient detail to inform the parent about the action that is being proposed, the reasons for taking such action; and, all procedural safeguards available under the early intervention program, including the right of the parent to request mediation or an impartial hearing on the child's ongoing eligibility for the early intervention program.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.24 - Proceedings involving the approval of an individual or agency

69-4.24 Proceedings involving the approval of an individual or agency.

(a) An agency's or individual's approval to deliver evaluations, service coordination services and early intervention program services may be revoked, suspended, limited or annulled by the commissioner upon a finding that the agency or individual provider:

(1) has failed to comply with the provisions of title II-A of article twenty five of the public health law or rules and regulations promulgated thereunder;

(2) no longer meets one of the criteria for approval or reapproval as set forth in section 69-4.5 of this subpart;

(3) does not have current licensure, registration or certification to deliver services in the early intervention program;

(4) for agency providers, use of personnel, whether by contract or under employment, to deliver evaluations, service coordination services or early intervention program service who did not hold a license, registration or certification to provide such service;

(5) falsely represented or omitted material fact in an application submitted to the Department or, where applicable, State Education Department, for approval or re-approval;

(6) is, or ever has been, excluded or suspended as a provider under Medicaid, Medicare, or any governmental or private medical insurance program;

(7) has been the subject of one or more actions taken against the provider by another State agency which approves, licenses, certifies, or registers the applicant for any purpose;

(8) has been convicted of an offense in an administrative or criminal proceeding;

(9) has failed to provide unobstructed access to and examination of facilities, child records, or any other documents relevant to early intervention program services as requested and within the timeframes required by the Department or a municipality under contract with the provider, or an agent of any of these entities, for purpose of monitoring, auditing, or investigating the provider's participation in the Early Intervention Program;

(10) has failed to submit required corrective action plans or other information or documents

requested by the Department, or a municipality to address findings of noncompliance identified through monitoring, systems complaint investigations, audits, or other early intervention program oversight activities, or to correct non-compliance within one year of any finding of non-compliance;

(11) has failed to pay recoupment due, or to implement any actions required, on the basis of a State or municipal audit within the timeframes specified in such audit report;

(12) has failed to pay any fines or penalties assessed against the applicant or provider within timeframes specified by the Department;

(13) through action, or act of omission, has placed children, parents, or staff in danger, or otherwise violated early intervention program health and safety standards issued by the Department;

(14) has submitted improper or fraudulent claims to one or more municipalities or approved agencies under contract with a municipality for payment, including but not limited to submission of claims for services not rendered;

(b) No approval shall be revoked, suspended, limited or annulled without first providing the individual or agency an opportunity to be heard. The Department shall notify the individual or agency in writing of the proposed action and shall afford the individual or agency an opportunity to be heard.

(c) Approval may be temporarily suspended or limited prior to granting an opportunity to be heard for a period not exceeding one hundred twenty days upon written notice to the provider following a finding by the Department that the health or safety of a child, parents or staff of the agency or municipality in which the provider is under contract is in imminent risk of danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of such children, parents or staff of the agency or municipality in which the provider is under contract. Upon such a finding and notice the Department may also:

(1) prohibit or limit the assignment of children to the provider;

(2) remove or cause to be removed some or all of the children the provider currently serves; and

(3) suspend or limit or cause to be suspended or limited payment for services to the provider.

(d) The provider shall be afforded an opportunity to be heard to contest the Department's findings.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.25 - Standards for agency

providers approved to use applied behavior analysis (ABA) aides in the delivery of ABA

69-4.25 Standards for agency providers approved to use applied behavior analysis (ABA) aides in the delivery of ABA

(a) Approved agency providers of ABA services using ABA aides shall deliver ABA services to eligible children in accordance with this subpart, applicable state or federal regulations, generally recognized professional standards, and clinical practice guidelines issued by the department, and shall:

(1) Coordinate all early intervention program services included in a child's and family's IFSP, for each child who is receiving an ABA services from the provider agency. The agency shall implement a collaborative team in the approach to delivery of services among all qualified personnel and ABA aides, and require that all personnel delivering services to the child and family participate in team meetings.

(2) Assign each child to a team responsible for the implementation of the child's and family's ABA intervention program and other services authorized in the IFSP. The team shall consist of a supervisor, ABA aides, and where applicable, other qualified personnel to deliver early intervention services identified in the child's and family's IFSP.

(i) Supervisors and qualified personnel shall be strictly prohibited from delegating the performance of any service or intervention included in the scope of practice of any profession licensed, certified, or registered by the State to ABA aides.

(ii) ABA aides shall be strictly prohibited from providing services that are within the scope of any profession licensed, certified, or registered by the State.

(3) Employ supervisory personnel and ABA aides who meet the qualifications in subdivision (d) of this section to implement individual child ABA plans.

(4) Employ or contract with other appropriately qualified personnel as defined in subsection 69-4.1 (ak) of this subpart, to participate in delivery of individualized child ABA plans and/or deliver other early intervention services included in a child's and family's IFSP. The municipality shall contract with other approved providers for the provision of services not offered by the approved ABA services agency; provided, however, that the approved ABA services agency shall not be relieved of its responsibility to coordinate the delivery of all early intervention program services authorized in the child and family's IFSP.

(5) Use systematic measurement and data collection to monitor and document child progress, and where indicated, modify individual child ABA intervention strategies as needed to promote progress towards goals and generalization of learning.

(6) Maintain and implement written policies and procedures approved by the Department for the

delivery of ABA services which are in conformance with nationally recognized, evidence-based practices for the delivery of such services. Such written policies and procedures shall be:

(i) reviewed at least annually by the agency and updated as necessary to maintain conformance with evidence-based practices for delivery of ABA services; and,

(ii) available for review for monitoring purposes and upon request by the Department and/or its agent.

(7) Maintain and implement a plan to ensure the initial and ongoing training of supervisory personnel and ABA aides in content areas identified by the Department or national and state professional associations for behavior analysis as necessary for the effective delivery of behavior interventions using applied behavior analysis.

(i) Such plan must include required staff participation in training sponsored by the Department.

(b) Individuals employed to supervise and oversee individual child ABA services using ABA aides shall be:

(1) licensed or certified qualified personnel from among the following professions:

(i) psychiatrist;

(ii) psychologist and school psychologist;

(iii) licensed clinical social worker;

(iv) special education teachers and teachers of students with disabilities, birth to grade two; and,

(v) speech-language pathologists who are also board certified behavior analysts credentialed by the Behavior Analyst Certification Board.

(c) Individuals employed to supervise and oversee individual child ABA services using ABA aides shall meet the following minimum education, training, and experience requirements:

(1) Documented completion of a minimum of twenty hours of continuing education or twelve credits of matriculated or non-matriculated relevant coursework in behavioral interventions, including at a minimum the following content areas:

(i) basic principles, processes, and concepts of behavior analysis;

(ii) clinical application of ABA, including behavior assessment, selecting intervention outcomes and strategies, behavior change procedures and systems support, data collection and analyses to measure and monitor children's progress, including measurement of behavior and displaying and interpreting data; and,

(iii) ethical issues related to the delivery of behavior interventions using ABA techniques.

(2) A minimum of two years of documented full-time professional supervised work experience providing behavior interventions using ABA to infants and young children, ages birth through five years with autism spectrum disorders or other developmental disability for whom such services have been proven effective in peer-reviewed, scientific research. Such experience must include at a minimum:

(i) performance of behavior assessments;

(ii) development and evaluation of individualized, child-specific ABA services;

(iii) employing an array of scientifically validated, behavior analytic procedures, including but not limited to discrete trial intervention, modeling, incidental teaching, and other naturalistic teaching methods, activity-embedded instruction, task analysis, and chaining;

(iv) using ABA methods in one-to-one intervention, small and large group intervention, and in transitions across these situations;

(v) use of behavior change procedures and systems supports;

(vi) measurement of behavior and displaying and interpreting behavior data;

(vii) conducting functional assessments (including functional analyses) of challenging behavior and selecting the specific assessment methods that are best suited to the behavior and the context; and,

(viii) assessment, monitoring, documentation, evaluation, and modification of applied behavior analysis techniques as necessary to promote a child's progress.

(d) Supervisors of individual child ABA services using ABA aides shall be responsible for:

(1) Developing individual child ABA plans in collaboration with the child's family and, as appropriate, qualified personnel and ABA aides.

(2) Directing the implementation of individual child ABA plans and the ongoing monitoring, systematic measurement, data collection, and documentation of child progress.

(3) Modifying individual child ABA services as necessary to promote progress towards goals, generalization of learning, and where applicable, transitioning of the child from receiving services in home- and facility-based settings to receiving services and participating in other community settings.

(4) Providing assistance, training, and support as needed by parents/caregivers to assist them in follow-through specified in the child's ABA plan and to enhance child development, behavior, and functioning.

(5) Supervising ABA aides, including:

(i) A minimum of six hours per month in the first three months of employment of an ABA aide, and

a minimum of four hours per month thereafter, of direct on-site observation of each ABA aide assigned to the child; and,

(ii) A minimum of two hours per month of indirect supervision of ABA aides assigned to the child, in a group or individual format, including:

(a)weekly review and signed approval of the child's record, progress notes and data, correspondence, and evaluation of written reports;

(b)participation in telephone conferences with the behavior aide and parent;

(c)ensuring proper documentation of the intervention provided and child's response;

(d)ensuring modifications in the child's plan are followed by the ABA aide; and,

(e)other supervision and support as needed by the ABA aide to successfully implement the child's ABA plan.

(6) Convening a minimum of two team meetings per month with all qualified personnel who are delivering services to the child and ABA aides assigned to the child to review child progress, identify problems or concerns, and modify intervention strategies as necessary to enhance child development, behavior, and functioning.

(e) Individuals employed as ABA aides shall meet the following minimum qualifications:

(1) A minimum level of education, as established by meeting at least one of the following requirements:

(i) a high school diploma or its equivalent; and,

(a)two years of full-time direct, supervised work experience providing services to children with disabilities under the age of five years; or,

(b)current matriculation in a degree program in psychology, early childhood development, early childhood education, speech language pathology, special or elementary education, or in a degree program necessary for a license, registration, or certification in a profession designated as qualified personnel in section 69-4.1(ak) of this Subpart;

(ii) an Associate's or higher level degree in psychology, early childhood development, early childhood education, speech language pathology, special or elementary education, or in a discipline necessary for license, registration, or certification in a profession designated as qualified personnel in section 69-4.1(ak) of this subpart;

(iii) certification as a teaching assistant; or,

(iv) board certification as a behavior analyst or assistant behavior analyst credentialed by the Behavior Analyst Certification Board, Inc., who are not otherwise licensed, registered, or certified

by the New York State Education Department in a discipline included in the list of qualified personnel as defined in 69-4.1(ak).

(2) Prior to the provision of services to any child without direct, on-site supervision, ABA aides shall:

(i) Complete a child abuse and neglect identification and reporting workshop.

(ii) Complete a minimum of 20 hours of training or in-service in behavior interventions using ABA techniques within the past five years, including at a minimum;

(a)basic principles of behavior analysis;

(b)the application of these principles in behavior intervention, including collection of data as needed for monitoring child progress;

(c)ethical issues related to the delivery of applied behavior interventions; and,

(d)overview of autism and pervasive developmental disorder.

(3) ABA aides shall complete a minimum of ten hours of additional training or in-service annually in topics pertaining to ABA services, and autism spectrum disorders or other disabilities for whom such interventions have been proven effective.

(i) Matriculation in a degree program specified in section 69-4.25(d)(1)(i)(b) may be used to meet this training requirement.

(f) Under the supervision and direction of a supervisor in accordance with this section, ABA aides shall:

(1) assist the supervisor and qualified personnel with the implementation of individual child ABA plans;

(2) assist in the recording and collection of data needed to monitor child progress;

(3) participate in required team meetings, and

(4) complete any other activities as directed by his or her supervisor and as necessary to assist in the implementation of individual child ABA plan.

(g) Qualified personnel who are employed or under contract with agencies approved to deliver ABA services using ABA aides, and who are providing ABA services using ABA aides and/or other early intervention services included in a child's and family's IFSP shall:

(1) participate in the ongoing, systematic measurement, data collection, and documentation of the child's progress;

(2) conduct data reviews on an ongoing basis to identify modifications that may be needed to individual child ABA plans as appropriate;

(3) provide direction and support to ABA aides as needed and appropriate to assist such aides with the implementation of individual child ABA plans;

(4) train and support the child's parent and/or caregivers to assist the parent and/or caregiver in follow-through with the child; and,

(5) collaborate with other qualified personnel and ABA aides in implementing individual child ABA plans and IFSPs, including participating in team meetings convened by supervisors of ABA plans.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.26 - Content and retention of child records

69-4.26 Content and retention of child records.

(a) Municipalities shall maintain an early intervention record for each child referred to the program which documents the performance of all activities required to be completed by early intervention officials or their designees on behalf of eligible children under Article 25 of Title II-a of Public Health Law. The early intervention record shall be maintained in a confidential manner in accordance with subdivision (b) of section 69-4.17 of this subpart. The early intervention record shall include the following:

(1) the original or a copy of intake and referral documents, which must include the date the child's referral was received by the municipality;

(2) Medicaid and third party payor information required for claiming, including the date such information was obtained and updated;

(3) documentation signed by the parent acknowledging receipt of information regarding the rights afforded parents under the Early Intervention Program;

(4) copies of all required written notices to the parent, which shall set forth the date the notice was sent to the parent;

(5) original or copy of signed and dated consent from the parent for the child's and family's participation in the Early Intervention Program;

(6) documentation identifying the child's and family's initial service coordinator and the date on which the such service coordinator was assigned to the child and family;

(7) where applicable, documentation of the designation of a surrogate parent for a child, including the date assigned, the surrogate parent's name and contact information, and circumstances leading to the designation of a surrogate parent;

(8) any evaluation and diagnostic reports, including family assessments and any medical records and correspondence to/from primary care physician(s) that are part of the evaluation record and demonstrate ongoing physician involvement;

(9) the child's and family's individualized family service plan and related documentation, including required six-month reviews, annual evaluations, amendments to the plan and any progress notes and other reports and documentation used at individualized family service plan meetings;

(10) originals or copies of all correspondence to/from the municipality regarding the child and family. Municipalities shall also maintain in the child's record notations of any relevant discussions with parents, providers or others regarding the child and the child's family and their participation in the Early Intervention Program, except as otherwise prohibited by law;

(11) for children in the care and custody or custody and guardianship of the local social services commissioner, originals or copies of any correspondence with the Commissioner or designee of the local social services districts. Municipalities shall also maintain in the child's record notations of any relevant discussions with the Commissioner or designee of the local social services district regarding the child's participation in the EIP;

(12) all records pertaining to any due process proceedings, except as otherwise prohibited by law, related to the child's and family's participation in the Early Intervention Program;

(13) original or copies of all correspondence with the local school district regarding the child's transition from the Early Intervention Program to services under section 4410 of the Education Law. Municipalities must also maintain in the child's record notations of all actions taken to ensure a smooth transition for the child from the Early Intervention Program to services under section 4410 of Education Law;

(14) reasons for a municipalities closure of a child's case in the Early Intervention Program and date of the closure;

(15) documentation necessary to support municipal claims to third party payors, including the medical assistance program, and to the Department for reimbursement of early intervention services. Such documentation shall include at a minimum: recipient identification; units of service and specific type of service provided; date(s) and session start and end times for the service rendered; ICD diagnostic code for the conditions or reasons for which care was provided; the name, address, and license, registration, certification, or where applicable, national provider identification number, of the individual that rendered the service and the name and identifying information of the billing provider.

(16) any other documentation and records pertaining to municipal actions and responsibilities pertaining to the child's and family's participation in the Early Intervention Program.

(b) Agency and individual providers shall maintain Early Intervention Program records for each eligible child for whom the provider is authorized to deliver service coordination services, evaluations, and early intervention services. The early intervention record shall be maintained in a confidential manner in accordance with subdivision (c) of section 69-4.17 of this subpart and shall document the performance of activities required to be completed by the provider on behalf of the child and family, including:

(1) written correspondence with or regarding the child/family and documentation of any relevant discussion with parents, other providers, or municipalities regarding the child and family;

(2) signed and dated parental consents relevant to delivery of services to the child and/or family;

(3) signed and dated consents related to the disclosure and/or exchange of information with other parties regarding services provided and/or the child's and family's participation in the Early Intervention Program;

(4) copies of any written notice(s) sent to the parent by the provider, which shall contain the date of such notice;

(5) the child's and family's individualized family service plan and related documentation, including required six-month reviews, annual evaluations, amendments to the plan and periodic progress notes and other reports and documentation used at individualized family service plan meetings;

(6) documentation of all authorizations by the municipality to provide early intervention services to the child and/or the child's family;

(7) documentation of accidents and incidents that have been reported to the early intervention official;

(8) written orders or recommendations from specific medical professionals when required for the services being provided to the child;

(9) reports pertaining to the child and/or family, including evaluation reports, ongoing assessments related to the services provided, and relevant professional and medical reports produced by or transmitted to the provider with parental consent;

(10) periodic progress notes shall be made by the provider and included in the child's record summarizing the effectiveness of the service and the progress being made toward outcomes included in the child's and family's individualized family service plan;

(11) where applicable, originals or copies of all written correspondence to/from the provider regarding discontinuation of services to the child and reasons why early intervention services were discontinued;

(12) documentation necessary for submission and substantiation of early intervention claims for payment by the municipality, including recipient identification (name, sex, and age of child); unit and specific type of service provided; date(s) of service; signature of parent or caregiver verifying the service was delivered; ICD diagnostic code for the condition or reasons for which care is provided; where applicable, the appropriate procedure code(s) for the service(s) provided; and, the name, address, and license, registration, certification, or where applicable, national provider identification number, of the professional delivering the service; and,

(13) any other documentation relevant to activities performed and services rendered related to the child's and family's participation in the Early Intervention Program.

(c) Individual providers who directly render services to a child and family, as a contractor to a municipality or approved agency, shall maintain original signed and dated session notes, following each child and family contact, which shall include the recipient's name, date of service, type of service provided, time the provider began delivering therapy to child and end time, brief description of the recipient's progress made during the session as related to the outcome contained in the individualized family service plan, name, title, and signature of the person rendering the service, and date the session note was created, and signature of the parent or caregiver which documents that the service was received by the child on the date and during the period of time as recorded by the provider.

(i) Qualified personnel who are licensed, registered, or certified under state education law and who deliver early intervention services shall, in addition to the provisions of this subpart, retain records in accordance with the laws and regulations that apply to their professions.

(ii) A municipality or provider agency in contract with individual providers may request or require submission of copies of such providers' session notes for municipal or provider agency records.

(iii) Original early intervention records generated by qualified personnel who are employees of a municipality or provider agency shall be retained by the respective municipality or provider agency.

(iv) Qualified personnel shall supply original session notes upon the request of a municipality, the Department, or provider agency for programmatic monitoring and fiscal audit purposes.

(d) Agency and individual providers of initial and/or ongoing service coordination services shall document all activities related to the performance of their duties as set forth in sections 69-4.6 and 69-4.7 of this subpart, including recipient's name; date of service; a description of the specific service coordination activity performed; name, date of contact, and purpose of contact for providers or others contacted on behalf of the child and family as necessary to implement the IFSP; start and end time for each contact; and, name, title and signature of the service coordinator, as applicable.

(e) Early intervention records pertaining to a child and family shall be retained by all municipalities and agency and individual providers for a minimum of six years from the date that care, services, or supplies were provided to the child and family.

(i) Individual early intervention providers who are licensed, registered, or certified under state

education law must retain child and family records for the period of time set forth in the laws and regulation that apply to their profession.

(ii) All municipalities, except New York City, shall retain early intervention program records, including but not limited to case record and screening, assessment, and referral records as follows:

(a)individual case records shall be retained until the child reaches the age of 21; and,

(b)screening, assessment, and referral records not found in individual case records must be retained for seven (7) years.

Effective Date:
Thursday, June 3, 2010
Doc Status:
Complete

Section 69-4.27 Reserved

Section 69-4.28 Reserved

Section 69-4.29 Reserved

Section 69-4.30 - Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers

69-4.30 Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers.

(a) The commissioner shall annually determine the rates for approved early intervention services and evaluations provided to eligible children, subject to the approval of the director of the budget. For payments made pursuant to this section for early intervention services to Medicaid patients, reimbursement shall be based upon a uniform payment schedule with discrete prices as set forth in subdivision (d) of this section. To be eligible to receive reimbursement pursuant to this section, providers must be approved to provide early intervention services pursuant to Article 25 of the Public Health Law.

(b) For purposes of this section, a billable visit shall mean a face to face contact for the provision of authorized early intervention services between a provider of early intervention services and the

individual(s) receiving such services, except for service coordination as described in subdivision (c) (3) of this section. Duration shall mean the time spent by a provider of early intervention services providing direct care or client contact. Activities such as case recording, training and conferences, supervisory conferences, team meetings and administrative work are not separately billable activities.

(c) Reimbursement shall be available at prices established pursuant to this section for the following early intervention program services:

(1) Screening as defined in section 69-4.1(ll) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. A provider shall submit one claim for a screening regardless of the number of visits required to perform and complete a screening. Reimbursement may be provided for up to two screenings of a child suspected of having a developmental delay in any twelve month period without prior approval of the Early Intervention Official. The Early Intervention Official shall approve any additional screenings provided to a child within the twelve month period. Reimbursement shall not be provided for screenings performed after a child has been found eligible for early intervention services.

(2) Multidisciplinary evaluation as defined in section 69-4.1(m) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. Reimbursable evaluations shall include core evaluations and supplemental evaluations. A provider shall submit one claim for a core or supplemental evaluation regardless of the number of visits required to perform and complete the evaluation.

(i) A core evaluation shall include a developmental assessment, a review of pertinent records and a parent interview as specified in section 69-4.8(a)(4) of this Subpart, and may include a family assessment.

(a) A developmental assessment shall mean procedures conducted by qualified personnel with sufficient expertise in early childhood development who are trained in the use of professionally acceptable methods and procedures to evaluate each of the developmental domains: physical development, cognitive development, communication development, social or emotional development and adaptive development.

(b) A family assessment shall mean a voluntary, family-directed assessment conducted by qualified personnel who are trained in the use of professionally acceptable methods and procedures to assist the family in identifying their concerns, priorities and resources related to the development of the child.

(ii) Supplemental evaluations shall include supplemental physician or non-physician evaluations and shall be provided upon the recommendation of the multi- disciplinary team conducting the core evaluation and agreement of the child's parent. A supplemental evaluation may also be provided in conjunction with the core evaluation by a specialist trained in the area of the child's suspected delay or disability who is present during the core evaluation as required by section 69-4.8(a)(3) of this Subpart and who provides an in-depth assessment of the child's strengths and needs in such area. Supplemental evaluations provided subsequent to the child's Individualized Family Service Plan (IFSP) must be required by and performed in accordance with the IFSP as specified in section 69-

4.8(a)(13) of this Subpart.

(a) Supplemental physician evaluation shall mean an evaluation by a physician licensed pursuant to article 131 of the Education Law for the purpose of providing specific medical information regarding physical or mental conditions that may impact on the growth and development of the child and completing the required evaluation of the child's physical development as specified in section 69- 4.8(a)(4)(i)(a) of this Subpart, or assessing specific needs in one or more of the developmental domains in accordance with section 69-4.8(a)(4)(iv) of this Subpart.

(b) Supplemental non-physician evaluation shall mean an additional evaluation for assessing the child's specific needs in one or more of the developmental domains in accordance with section 69-4.8(a)(4)(iv) of this Subpart. Information obtained from this evaluation shall provide direction as to the specific early intervention services that may be required for the child. Supplemental non-physician evaluations may be conducted only by qualified personnel as defined in section 69-4.1(jj) of this Subpart.

(iii)(a) A multidisciplinary evaluation consisting of a core evaluation and up to four supplemental evaluations (which may include any combination of physician and non-physician evaluations) may be reimbursed within a 12 month period without prior approval of the Early Intervention Official to develop and implement the initial IFSP and subsequent annual IFSPs. The Early Intervention Official shall approve and notify the department of any additional core or supplemental evaluations provided to a child within a twelve month period. If additional core or supplemental evaluations are necessary, such notice shall be provided on a monthly basis on forms provided by the department. Additional core or supplemental evaluations provided subsequent to the child's initial IFSP must be required by and performed in accordance with the IFSP as specified in section 69-4.8(a)(13) of this Subpart.

(b) Certain evaluation and assessment procedures may be repeated if deemed necessary and appropriate by the Early Intervention Official in conjunction with the required annual evaluation of the child's IFSP or more frequently in accordance with section 69-4.8(a)(12) of this Subpart. If additional evaluation or assessment procedures are necessary, the Early Intervention Official shall approve up to one more core evaluation and two supplemental evaluations prior to the next annual IFSP. Such additional evaluations must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8(a)(13) of this Subpart. Any additional evaluations within that period shall be based on the indicators specified in section 69-4.8(a)(12), approved by the Early Intervention Official and the Commissioner of Health of the New York State Department of Health and required by and performed in accordance with the child's IFSP.

(3) Service coordination as defined in section 69-4.1(l)(2)(xii) of this Subpart. Service coordination shall be provided by appropriate qualified personnel and billed in 15 minute units that reflect the time spent providing services in accordance with sections 69-4.6 and 69-4.7 of this Subpart, or billed under a capitation or other rate methodology as may be established by the Commissioner subject to the approval of the Director of the Budget and as specified in prior written notice provided by the Commissioner to Early Intervention Officials. Such written notice shall specify that any newly established rate methodology shall apply only to initial IFSPs and IFSP amendments made on or after the effective date of such written notice by the Commissioner. The rate methodology may be established on a per month, per week, and/or service component basis for

providing service coordination services. When units of time are billed, the first unit shall reflect the initial five to fifteen minutes of service provided and each unit thereafter shall reflect up to an additional fifteen minutes of service provided. Except for child/family interviews to make assessments and plans, contacts for service coordination need not be face-to-face encounters; they may include contacts with service providers or a child's parent, caregiver, daycare worker or other similar collateral contacts, in fulfillment of the child's IFSP.

(4) Assistive technology as defined in section 69-4.1(k)(2)(ii) of this Subpart;

(5) Home and community-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or parent(s) or other designated caregiver at the child's home or other natural setting in which children under three years of age are typically found (including day care centers, other than those located at the same premises as the early intervention provider, and family day care homes). Reimbursable home and community-based individual/collateral visits shall include basic and extended visits.

(i) A basic visit is less than one hour in duration. Up to three (3) such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(ii) An extended visit is one hour or more in duration. Up to three (3) such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(iii) Notwithstanding subparagraphs (i) and (ii) of this paragraph, no more than three (3) basic and extended visits combined per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(iv) A provider shall not bill for a basic and extended visit provided on the same day by appropriate qualified personnel within the same discipline without prior approval of the Early Intervention Official.

(6) Office/facility-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or parent(s) or other designated caregiver at an approved early intervention provider's site (including day care centers located at the same premises as the early intervention provider). Up to one (1) visit per discipline and no more than three (3) office/facility-based visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(7) Parent-child group visit. This shall mean the provision of early intervention services in a group comprised of parent(s) or other designated caregivers and eligible children, and a minimum of one appropriate professional qualified to provide early intervention services at an early intervention provider's site or a community-based site (e.g. day care center, family day care, or other community settings). Up to one (1) visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(8) Basic group developmental intervention visit. This shall mean the provision of early

intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(ii) For purposes of subparagraph (i) of this paragraph and subparagraphs (i) of paragraphs (9) through (11) of this subdivision, a group developmental intervention visit shall include a basic visit as described in this paragraph, an enhanced visit as described in paragraph (9) of this subdivision, a basic with one-to-one aide visit as described in paragraph (10) of this subdivision, or an enhanced with one-to-one aide visit as described in paragraph (11) of this subdivision.

(9) Enhanced group developmental intervention visit. This shall mean a group developmental intervention visit as defined in paragraph (8) of this subdivision provided to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(10) Basic group developmental intervention with one-to-one aide visit. This shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, with attendance at the group developmental intervention session by an additional aide or appropriate qualified personnel. This visit must be provided at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(11) Enhanced group developmental intervention with one-to-one aide visit. This shall mean a group developmental intervention with one-to-one aide visit as defined in paragraph (10) of this subdivision provided to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(12) Family/caregiver support group visit. This shall mean the provision of early intervention services by appropriate qualified personnel to a group of parents or other designated caregivers (such as foster parents, day care staff) and/or siblings of eligible children for the purposes of:

(i) enhancing their capacity to care for and/or enhance the development of the eligible child; and/or

(ii) provide support, education, and guidance to such individuals relative to the child's unique developmental needs. Up to two (2) visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official (for example, one (1) for parents or other designated caregivers and one (1) for sibling(s) in a given day).

(13) ABA services. This shall mean services delivered by an ABA aide employed by and under the supervision of an agency provider approved in accordance with 69-4.25 of this subpart to deliver ABA services in accordance with requirements set forth in section 69-4.25 of this subpart. The price established pursuant to this section shall include direct and indirect supervisory time, team meetings and training. ABA services shall be billed by the day and in increments of 60 minutes up to and in accordance with the hours of service as specified the child's IFSP.

(14) The Early Intervention Official shall approve and notify the department of any visits provided in addition to those described in paragraphs (5) through (12) as may be required by and provided in accordance with the child's IFSP. If such additional visits are necessary, such notice shall be provided on a monthly basis on forms provided by the department.

(d) The prices established pursuant to this section shall provide full reimbursement for the following:

(1) physician services, nursing services, therapist services, technician services, nutrition services, psychosocial services, service coordination, and other related professional and paraprofessional expenses directly incurred by the approved provider;

(2) space occupancy, except as provided in subdivision (f) of this section, and plant overhead costs;

(3) all supplies directly related to the provision of early intervention services, except as provided in subdivision (g) of this section; and

(4) administrative, personnel, business office, data processing, recordkeeping, housekeeping, and other related provider overhead expenses.

(e) The price for each service shall be adjusted for regional differences in wage levels to reflect differences in labor costs for personnel providing direct care and support staff and shall include consideration of absentee data and child to professional to paraprofessional ratios.

(f) Assistive Technology Devices - Reimbursement for approved assistive technology devices shall be at reasonable and customary charges approved by the Commissioner or her designee.

Effective Date:
Wednesday, November 30, 2016
Doc Status:
Complete
Statutory Authority:
Public Health Law Section 2559-b

Appendix IV
2018 Title XIX State Plan
Third Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Division of Criminal Justice Services
Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Law Enforcement Agency Accreditation Council to be held on:

Date: Monday, April 2, 2018
Time: 1:00 p.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact*: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Division of Criminal Justice Services
Municipal Police Training Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Municipal Police Training Council to be held on:

Date: Friday, March 30, 2018 (tentative)
Time: 9:30 a.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact*: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2018, this initiative proposes to eliminate the supplemental medical assistance payments of $6 million annually made to providers of emergency medical transportation.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $6 million.

Effective on or after April 1, 2018, the professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be updated to $10.08, to align with current costs.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2018/2019 is $795,531.

Effective on and after October 1, 2018, Medicaid will cover ABAs. ABAs are State Education Department (SED) licensed practitioners who provide intensive treatment for persons diagnosed with autism spectrum disorder using applied behavioral analysis treatment modalities. These services and practitioners are currently covered by Early Intervention (EI), Child Health Plus (CHIP), and all major commercial payers. The Medicaid Program does not currently recognize or reimburse ABA's, which results in a break in coverage for those children who age out of the EI program.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $12.1 million.

Effective on and after July 1, 2018, the physical therapy cap under both fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per member in a 12-month period. The following populations are exempt from the 40-visit limitation: children (0-21 years of age); individuals with developmental disabilities; Medicare/Medicaid dually eligible individuals when the service is

covered by Medicare; and individuals with a traumatic brain injury. Revision of the physical therapy cap will provide members an opportunity to obtain additional rehabilitation therapy to treat low back pain as well as other physical conditions which will help reduce the need for opioid treatment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $4.6 million.

Effective on and after April 1, 2018, Medicaid will begin covering Centers for Disease Control (CDC) certified National Diabetes Prevention Program (NDPP). The NDPP is a CDC recognized educational and support program designed to assist at-risk individuals from developing Type 2 diabetes. The program focuses on lifestyle interventions and the long-term effects of diet and exercise. These intense interventions demonstrate a greater influence on the reduction in diabetes risk, return to normoglycemia, and weight loss than less intense programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.03 million.

Effective on or after April 1, 2018, the Early Intervention Program reimbursement methodology for the targeted case management (service coordination) services will be revised from an hourly rate billed in fifteen-minute units to two separate categories of fixed rates for initial case management services and one per member per month fixed rate for ongoing case management services. These rates are being revised to create administrative efficiencies for billing providers and adjust for administrative activities assumed by providers in direct billing to third party payers through a state fiscal agent established April 1, 2013. These revisions will make the State Plan content and format consistent with Medicaid requirements for case management.

Initial service coordination services not followed by an Individualized Family Service Plan meeting will have a minimum base of two hours with no cap; those followed by an Individualized Family Service Plan meeting will have a minimum base of three hours with no cap. Ongoing service coordination services will have a minimum base of 1.25 hours per month. Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capital costs, and regional cost differences.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendments.

Effective on or after April 1, 2018, this proposal is to establish a ten percent rate increase to the Hospice Residence rates, set a benchmark rate and include specialty rates in the weighted average rate calculation. The proposal would increase Medicaid Hospice Residence rates to help cover current costs and avoid closure of Hospice Residence programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.7 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

For state fiscal year beginning April 1, 2018 through March 31, 2019, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Effective on or after April 1, 2018, The Department of Health proposes to amend the Public Health Law § 3001, create new Public Health Law § § 2805-z and 3001-a, and amend the Social Services Law § 365-a to permit health care providers to collaborate on community paramedicine programs that allow emergency medical personnel to provide care within their certification, training and experience in residential settings.

The annual increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $2.3 million.

Institutional Services

Effective on or after April 1, 2018, the commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one-percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one-percent reduction in capital expenditures beginning with State fiscal year 2018/2019.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $13.4 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2018, payments to hospitals that meet the criteria as an enhanced safety net hospital, the criteria is as follows: In any of the previous three calendar years has had not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $40 million.

Long Term Care Services

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in $2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $3 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at $70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of $70 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $140,000,000.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

- Strong Memorial Hospital

The aggregate payment amounts total up to $4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $4,370,030 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Appendix V
2018 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #18-0017

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**
   - **(iii) the total amounts transferred or certified by each entity;**
   - **(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
   - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

   Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

   The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There are no new provider taxes associated with this service and none have been modified.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Response: Early intervention Targeted Case Management/Service Coordination services are covered as rehabilitation services and are, therefore, not held to UPL requirements.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the State Plan for Early Intervention Targeted Case Management/Service Coordination Services is a prospective methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z)**

would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.