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| Massachusetts Department of Public Health |
| Early Intervention Operational Standards |
| July 2013 updated February 2020 |

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# I. INTRODUCTION

The Massachusetts Department of Public Health (MDPH) is the designated lead agency for Part C of the Individuals with Disabilities Education Act of 2004. Operational Standards are developed based on Part C of Public Law 108-446, 34 CFR Part 303 Early Intervention Program for Infants and Toddlers with Disabilities, and on Massachusetts General Law, Chapter 111G. Massachusetts Early Intervention services are provided within the Commonwealth. The Massachusetts DPH works collaboratively with families, Early Intervention providers and other community partners to measure and report on Federal Child and Family Outcomes.

The Department of Public Health in Massachusetts serves a culturally and socioeconomically diverse population of infants and toddlers with disabilities and their families, including those children at risk of developmental delays. Massachusetts is strongly committed to equal access and treatment for all infants and toddlers and their families who are referred to, and served in, the Part C program, as well as to the Early Intervention service providers and the general public. Massachusetts is advised by and works with its State Interagency Coordinating Council to identify and address any barriers to service for these designated populations. Massachusetts ensures that Part C programs are a part of a statewide system of Early Intervention services, and provides an environment free from discrimination and harassment based upon gender, race, national origin, color, disability or age.

The Massachusetts Early Intervention system comprises community-based programs certified as Early Intervention providers by the Massachusetts Department of Public Health. Early Intervention in Massachusetts is a statewide, integrated, developmental service available to families of eligible children from birth to three years of age. Children may be eligible for Early Intervention if they have developmental difficulties due to identified disabilities or delays, or if typical development is at risk due to certain birth or environmental circumstances.

The Individualized Family Service Plan (IFSP) is developed in collaboration with families and is based on measurable results and functional outcomes determined by the family with respect to their own concerns and priorities. Services reflect the cultural, linguistic, and ethnic composition of the state and of the families enrolled. Early Intervention services focus on the family unit, utilizing family resources and daily routines to enhance the child’s growth and development. Early Intervention staff work in partnership with individuals present in the child’s natural environment. Early Intervention staff support and encourage the family’s use of and access to community-based resources that will continue to support and enhance the child’s development.

These Operational Standards are developed to describe requirements of community Early Intervention programs and are used as criteria by the Massachusetts Department of Public Health for ongoing monitoring, for contract performance review and for Early Intervention program certification. All Massachusetts DPH-certified Early Intervention programs incorporate into their practice the following core values:

## Respect

Recognizing that each group of people has its own unique culture, and honoring the values and ways of each family’s neighborhood, community, extended family, and individual unit.

## Individualization

Tailoring supports and services with each family to its own unique needs and circumstances.

## Family-Centeredness

Basing decisions with each family on its own values, priorities, and routines.

## Community

Realizing that each family exists in the context of a greater community, and fostering those communities as resources for supports and services.

## Team Collaboration

Working as equal partners with each family and with the people and service systems in a family’s life.

## Life-Long Learning

Viewing Early Intervention supports and services as a first step on a journey for each child, family, and provider.

# II. DEFINITIONS

**assistive technology—**An assistive technology deviceis any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an infant or toddler with a disability. The term does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (*e.g.,* mapping), maintenance, or replacement of that device.

**caregiver—**As used in these standards, a caregiver is a person in whose care an infant or toddler may be temporarily placed, including, but not limited to, non-custodial relatives, baby-sitters, childcare providers, and nannies.

**child—**As used in these standards, the term *child* may be used interchangeably but means an infant and/or toddler under the age of three.

**Child Find/public awareness—**Child Find is a series of activities in the community that raise public awareness regarding Early Intervention services.

**child group settings—**For all child group services, regardless of location, there must be at least one certified (full or provisional) Early Intervention Specialist to facilitate or co-facilitate the group. Child groups may be provided in Primary or Non-Primary sites as defined in these standards. Each type of site is subject to DPH approval, as defined in Section XI, E of these standards. Adult/child ratios and expectation for parent participation for child groups are as follows:

1. **Primary sites**, where the Early Intervention program is responsible for enrolling infants or toddlers, planning curriculum, and ensuring that the physical facility meets the current Early Intervention Operational Standards criteria. Space can be owned, leased, rented, or borrowed.
2. Infants and toddlers under 18 months of age must be accompanied by a parent or caregiver (as defined in these standards) for any activity at a primary site. Parents/caregivers must remain on site but are not required to remain in the group with the infant or toddler. When parents/caregivers are not in the group, the adult/child ratio must be at least one Early Intervention staff person (can include teaching assistants, interns, and volunteers) for every two infants and/or toddlers under 18 months.
3. Toddlers 18 months of age and over: When parents/caregivers are not present in the group, the adult/child ratio must be at least one Early Intervention staff person (can include teaching assistants, interns, and volunteers) for every three toddlers over 18 months.
4. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community infants or toddlers are expected to attend the group then parents/caregivers of Early Intervention enrolled infants or toddlers are also expected to attend. Attendance sheets must be maintained for all participants.

2. **Non-primary sites**,

1. Where the Early Intervention program and a community program are jointly responsible for enrolling children and/or planning curriculum. Physical facility must be EEC licensed or parent(s)/caregivers must remain on site but are not required to remain in the groups with the children.Adult/child ratiosare the same as for Primary sites, above.
2. Where the Early Intervention program joins an already existing activity in the community. Physical facility must be EEC licensed or the infant or toddler be accompanied by parent(s)/caregivers at all times*.*

**consent—***consen*t, as used in these standards, means the following:

1. The parent has been fully informed of all information relevant to the activity for which consent is sought, is in the parent's native language unless clearly not feasible to do so, and shall otherwise be done in the manner best understood by the parent;
2. The parent understands and agrees in writing, including electronic signature, 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;
3. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time; and
4. If a parent does revoke consent, that revocation is not retroactive and will not negate the action that occurred before consent was revoked.

**day—**As used in these standards, *day* means calendar day unless otherwise specified.

**due process—**Due Process refers to the policies and procedures established to ensure the rights of families with infants and toddlers eligible for Early Intervention through procedural safeguards and options for the timely, impartial resolution of disputes.

**Early Intervention program—**An Early Intervention program is one that is certified by the Massachusetts Department of Public Health as a community Early Intervention program.

**Early Intervention services (See also Section VIII) —**Early Intervention services are:

1. developmental services designed to meet the needs of each eligible infant or toddler and the needs of the family related to enhancing the infant or toddler’s development in the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development;
2. determined in collaboration with the family in accordance with the Individualized Family Service Plan (IFSP);
3. provided by qualified personnel as defined by these standards;
4. subject to the Early Intervention Operational Standards, DPH contracting, and Part C requirements; and
5. available to all eligible infants and toddlers including Indian infants and toddlers, homeless infants and toddlers, and infants and toddlers who are wards of the state.

**Early Intervention Specialist—**An individual who meets the criteria specified in Section V, B of these standards and is certified by the Massachusetts Department of Public Health prior to working in a professional capacity within the Early Intervention system. The certification may be provisional, provisional with advanced standing, or full.

**Early Intervention record—**An Early Intervention record is any record directly related to the infant or toddler and parents inclusive of all records created by the Early Intervention program as well as those records directly related to the infant or toddler and parents collected, maintained, or stored as part of the Early Intervention record. Early Intervention records are subject to the confidentiality provisions specified in Part C of the IDEA and applicable regulations of the Family Educational Rights and Privacy Act (FERPA).

**eligible infants and toddlers—**Infants and toddlersfrom birth to age three, living in Massachusetts, who through a multidisciplinary team evaluation by a certified Early Intervention program are deemed eligible to receive Early Intervention services based on the eligibility criteria set by the Massachusetts Department of Public Health. Eligible infants and toddlers may receive Early Intervention services as long as they meet eligibility criteria up to, but not on, their third birthday.

**eligibility evaluation—**An activity carried out by a multidisciplinary team of certified Early Intervention Specialists to determine an infant or toddler’s initial or continuing eligibility for Early Intervention services.

**Individualized Family Service Plan (IFSP)—**The written plan for providing Early Intervention services to an eligible infant or toddler and the infant or toddler’s family in accordance with federal regulations and with the Massachusetts Department of Public Health Early Intervention Operational Standards.

**informed clinical opinion—**Informed clinical opinion makes use of qualitative and quantitative information gathered by certified Early Intervention professionals in the evaluation and assessment process in order to form a determination regarding the infant or toddler’s current developmental status and the potential eligibility for early intervention.

**Local Education Agency (LEA)—**As used in these standards,Local Educational Agency (LEA) refers to the public school district or entity in which the child resides, and is recognized, approved or authorized by the Department of Elementary and Secondary Education (DESE) to provide special education supports and services to eligible children beginning at age three (3).

**low-incidence condition—**Low incidence refers to a diagnosis of blindness, vision loss (not corrected by medical intervention), deafness, hearing loss, deaf/ blindness, or Autism Spectrum Disorder.

**measurable outcomes/results—**A measurable outcome or result is a benefit experienced as a *result* of services and supports provided for an infant or toddler and family.

**functional outcomes/results—**Refers to the behaviors, knowledge, and skills that are meaningful to infants or toddlers in their everyday lives. The outcomes refer to actions that infants or toddlers need to have in order to function successfully across a variety of settings.

**child outcomes/results—**Child outcomes are measured in the three areas of child functioning (positive social emotional skills, acquisition and use of knowledge and skills, and use of appropriate behaviors) necessary for each child to be an active and successful participant at home, in the community, and in other settings, such as a child care program or preschool.

**family outcomes/results—**show the impact of Early Intervention services on the family: how the services have helped the family know their rights, effectively communicate their child’s needs, and help their child develop and grow.

**multidisciplinary team—**A team consisting of two or more certified Early Intervention Specialists of different disciplines, as defined in Section V of these standards.

**native language—**

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

**natural settings—**Settings that are typical for a same-age infant or toddler without a disability. Natural settings may include the child’s home, childcare centers, family childcare homes, and other community settings.

**parent**[[1]](#footnote-1)**—** As used in these standards, *parent* means

1. a biological or adoptive parent of the infant or toddler;
2. a foster parent;
3. a guardian generally authorized to act as the infant or toddler’s parent or make early intervention, educational, health, or developmental decisions for the infant or toddler;
4. another person acting in the place of a biological or adoptive parent (including a grandparent, step-parent, or relative with whom the infant or toddler lives who is legally responsible for the infant or toddler’s welfare); or
5. a surrogate parent, but does not include any parent whose authority to make educational decisions has been terminated under state law.

An Early Intervention service provider or a service provider from a public child welfare agency (DCF) may **not** act as a parent for the purposes of Part C services.

**Parent Contact—**A parent whose infant or toddler is currently enrolled in an Early Intervention program. This parent volunteers to work with the Parent Leadership Project to receive information and share it with other families and staff in his/her Early Intervention program. The Parent Contact also shares program news and information regarding family involvement with the Parent Leadership Project.

**Parent Liaison—**A family member of a child who is currently receiving or who has received Early Intervention services and is employed by the Early Intervention program. The role of the Parent Liaison is to foster family involvement in program activities and to share the family perspective with Early Intervention staff members.

**personally identifiable information—**Information that includes:

1. the name of the infant or toddler, the infant or toddler’s parent, or other family member;
2. the address of the infant or toddler, or the infant or toddler’s parents;
3. a personal identifier, such as the infant’s or toddler’s or parent’s social security number.
4. other indirect identifiers such as the infant or toddler’s date of birth, place of birth and mother’s maiden name; or
5. a list of personal characteristics or other information that alone or in combination would make it possible for a reasonable person in the community, who does not have personal knowledge of the child or parents, to identify the infant or toddler with reasonable certainty.

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

**procedural safeguards—**The policies and procedures established to ensure that providers inform families of their rights to written notice, use of native language, informed consent, records, and confidentiality, and their options for the impartial timely resolution of disputes associated with the provision of Early Intervention services.

**service coordination—**The activities carried out by a certified Early Intervention Specialist assigned as a service coordinator to:

1. assist and enable an eligible infant or toddler and the infant or toddler’s family to receive IFSP services in a timely manner;
2. coordinate all Early Intervention services including evaluations and assessments;
3. facilitate and participate in the development, reviews, and evaluation of the IFSP
4. facilitate the development of a transition plan;
5. ensure families are aware of all rights and procedural safeguards available within the Early Intervention system;
6. provide information on available resources; and
7. support families as needed to access resources.

Please see additional language related to the role of the service coordinator in Section VIII, C.

**Specialty Service Provider (SSP)—** A clinician with specialized skills or knowledge to work with infants or toddlers with *low incidence conditions* (Autism Spectrum Disorder (ASD), Blindness/Vision Loss, Deaf and Hard of Hearing)and their families.

**specialty services—**Specialty Services are available for children enrolled in EI programs who have been diagnosed with *low incidence conditions*.

**State Education Agency (SEA)—**as used in these standards, the State Education Agency is the Department of Elementary and Secondary Education.

**strategies—**The specific activities that support the family’s capacity to meet the desired outcomes throughout the infant or toddler’s typical daily routine.

**surrogate parent—**A surrogate parent is an individual assigned by the Massachusetts Department of Public Health to represent the rights of an eligible infant or toddler when:

1. the Department or Early Intervention Provider, after reasonable efforts, is unable to identify or locate the parent, guardian, or person acting as parent of the infant or toddler; or
2. the infant or toddler is in the legal custody of the Department of Children and Families and the natural parent’s rights to participate in educational decision making have been terminated. In this case, a foster parent will be designated as surrogate unless this person indicates he/she is unwilling or unable to serve as surrogate.[[2]](#footnote-2)

**timely services—**IFSP services that begin within 30 days from written parental consent.

**Transition Planning Conference (TPC)—**A transition planning conference is a designated opportunity for Early Intervention staff to meet with parents and other community providers that a parent would like to have participate to develop or review a transition plan.

**ward of the state—**An infant or toddler in foster care, a ward of the state, or an infant or toddler in the custody of the Department of Children and Families (DCF). The exception to this definition would be an infant or toddler in the custody of DCF who has a foster parent approved to act as a parent under these definitions.

# III. ELIGIBILITY FOR EARLY INTERVENTION SERVICES

## A. Determination of Eligibility

Massachusetts Department of Public Health Certified Early Intervention programs determineeligibility through an evaluation conducted by a multidisciplinary team that includes:

* Administering a DPH-approved developmental inventory tool in all 5 developmental domains. The Battelle Developmental Inventory, 2nd Edition (“BDI-2”) is the tool approved for determining eligibility by delay..
* A review of family and child characteristics that may have an impact on the child’s development; and
* A review of pertinent medical records that may include a condition on the Massachusetts Early Intervention Diagnosed Conditions List or identify child/family eligibility factors.
* Conducting functional assessment with families to gather information

Parents must receive prior written notice (PWN) before an evaluation that determines a child’s eligibility. Families should be informed about the process of determining eligibility in a way that they can understand. Families should also have an active role in all information gathering and decision making in the eligibility and IFSP processes.

A parent must provide consent to proceed to evaluation. Consent means that the parent is agreeing, in writing, to the administration of the BDI-2 in all 5 domains, providing information and having the EI program review records or information from other sources, as stated above. (Note: obtaining records or information from outside sources requires separate consent).

Based on federal regulations, all of these components must be completed to determine eligibility of a child and family. If the program cannot complete the activities listed to establish eligibility, the child will not be eligible to receive EI services. Early Intervention staff conducting an evaluation to determine eligibility will use their informed clinical opinion throughout the evaluation and assessment process in the scoring and interpretation of the eligibility tool. Informed clinical opinion may be used if the child does not meet the current definition of established condition or developmental delay when qualitative concerns can be documented. Informed clinical opinion may be used as an independent basis to establish eligibility when other instruments do not substantiate eligibility; however, in no event may informed clinical opinion be used to negate the results of the evaluation instrument used to establish eligibility.

## B. Categories and Criteria of Eligibility

There are four categories of eligibility:

1. Infants and Toddlers with an Established Condition or Conditions,

2. Infants and Toddlers with Established Developmental Delay or Delays,

3. Infants and Toddlers at Risk for Developmental Delay(s), and

4. Clinical Judgment.

### 1. Infants and Toddlers with Established Condition(s)

This category includes infants and toddlers whose early development is influenced by diagnosed medical conditions of known etiology bearing relatively well-known expectations for developmental delay**.** Approved diagnoses are found on the current Massachusetts Early Intervention Diagnosed Conditions List (Appendix A of these standards). Infants and toddlers with a diagnosis found on the Diagnosed Conditions List are eligible for Early Intervention Services for one year and may be eligible up until, but not on their third birthday. A child’s medical record or other records may be used to establish eligibility (without conducting an evaluation of the child) if the records indicate that a child has an established condition found on the Diagnosed Conditions List (Appendix A).

**Criteria**

The infant or toddler has,:

* A diagnosed neurological, metabolic, or genetic disorder, chromosomal anomaly, medical or other disabling condition with documented expectation of developmental delay, **or**
* vision loss not corrected by medical intervention or prosthesis, **or**
* permanent hearing loss of any degree.

An Established Condition can be added to the child’s record at any time and to update the eligibility timeframe.

### 2. Infants and Toddlers with Established Developmental Delay(s)

This category includes infants and toddlers who, during the infancy period, or more commonly in the second year of life, begin to manifest developmental delays, often of unknown etiology.

**Criteria**

The infant or toddler’s development is at least 1.5 standard deviations below the mean, as measured by the *Battelle Developmental Inventory* – 2nd Ed. (BDI-2), in one or more areas of development, including:

* physical development (includes gross and fine motor),
* cognitive development,
* communication development (includes expressive andreceptive),
* social or emotional development, or
* adaptive development.

Infants and toddlers eligible by Established Developmental Delay will be eligible for one year (12 months) from their last evaluation/assessment to determine eligibility up until, but not on their third birthday.

### 3. Infants and Toddlers at Risk for Developmental Delay(s)

This category includes:

1. infants and toddlers with a history of prenatal, perinatal, neonatal, or early life events suggestive of biological insults to the developing central nervous system which, either singularly or collectively, increase the probability of later atypical development, and

2. infants and toddlers who are biologically sound but whose early life experience, including maternal and family care, health care, nutrition, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that they impart high probability for delayed development. Infants and toddlers eligible in the Risk for Developmental Delay category will be eligible for one year (12 months) from their last evaluation/assessment to determine eligibility up until, but not on their third birthday.

**Criteria**

Four or more of the following eligibility factors are present at the time of initial and subsequent eligibility evaluations:

**CHILD ELIGIBILITY FACTORS**

Note 1:Eligibility factors 1-3 apply only to infants and toddlers who are under 18 months chronological age at the time of the evaluation for eligibility.

Note 2: Birth or medical records are available in the Early Intervention record to substantiate factors 1-8. Identification of eligibility factors 9–12 should be determined by parent perception and written documentation for eligibility factors 9–12 is kept in the Early Intervention record.

1. Birth weight is **less**  than 1500 grams, 3.3. lbs .
2. Gestational age is **fewer** than 32 weeks. Developmental evaluation for eligibility will be based on chronological age, not on adjusted age.
3. NICU admission is **more** than 5 days.
4. Total hospital stay is **more** than 25 days in 6 month period, excluding the initial birth admission to a NICU.Diagnosis of Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA) is made at birth
5. A child’s weight for age *or* weight for height is *less than* the 5th percentile *or greater than* the 95th percentile according to a growth chart adopted by the National Center for Health Statistics

***Or***

A child’s weight for age has dropped *2 or more* major percentiles in 3 months, if under 12 months of age, or *2 or more* major percentiles in 6 months if between 12 and 36 months.

A major centile is defined as the major percentiles (5, 10, 25, 50, 75, 90, 95) on the Physical Growth Chart adopted by the National Center for Health Statistics. The above two measurements should be based on the appropriate growth chart approved by the National Center for Health Statistics.

1. Blood lead levels measures at 5 µg/dl (micrograms per deciliter) or more. An infant or toddler meets this criteria with a **venous** (not finger stick) blood lead level of 5 µg/dl (micrograms per deciliter) or more. This factor is based on the most recent laboratory results at the time of eligibility determination.
2. Child has chronic feeding difficulties. An infant or toddler meets this risk factor if any of the following conditions exist over an extended period of time:

* stressful or extremely conflicted feedings,
* refusal or inability to eat resulting in stressful or extremely conflicted parent/child interactions during feeding times, or
* Failure to progress with feeding skills.

Evidence of these conditions should be documented in the Early Intervention record and appropriate outcomes and treatment strategies addressed as determined by the family. Note: If an infant or toddler has been diagnosed as Failure-to-Thrive, he/she is eligible under the category of Established Condition.

1. Insecure attachment/interactional difficulties. An infant or toddler meets this criteria if he/she appears to have **inadequate, atypical or disturbed social relationships, depression, or indiscriminate aggressive behavior** and/or thefamily identifies or describes the behaviors atypical for the child’s chronological age as a concern. Note: In most cases, insecure attachment in infants and toddlers is evidenced by behavior such as persistent failure to initiate or respond to social interactions, fearfulness that does not respond to comforting by caregivers, and indiscriminate sociability.
2. Suspected central nervous system abnormality. Suspected CNS abnormalities may include but are not limited to the following:

* Infection: meningitis, encephalitis, maternal infection during pregnancy (TORCH infections: toxoplasmosis, other [syphilis and HIV], rubella, CMV, herpes);
* Trauma: intracranial hemorrhage, subdural hematoma, epidural hematoma;
* Metabolic: Profound and persistent hypoglycemia, seizures associated with electrolyte imbalance, profound and persistent neonatal hyperbilirubinemia greater than 20 mg/dl [milligrams per deciliter], acidosis;
* Asphyxia: prolonged or recurring apnea, ALTE [apparent life threatening event], suffocation, hypoxia, meconium aspiration, near-drowning;
* In utero drug exposure: nicotine, ethanol, THC, cocaine, amphetamine, phenytoin, barbiturates, and other.

This category may also include the following clinical findings:

* Abnormal muscle tone;
* Persistence of multiple signs of less than optimal sensory and motor patterns, including under-reaction or over-reaction to auditory, visual, or tactile input.
* Under reaction or over reaction to auditory, visual or tactile input
* Atypical developmental patterns of mobility, oral motor, gross and fine motor, cognitive, and/or adaptive development.

***Or***

An alcohol- or other drug-affected infant is one in which there is any detectable physical, developmental, cognitive, or emotional delay or harm that is associated with parental action involving substance use or abuse.

A *series* of traumas or losses, directly experienced by the child that may impact on the care and development of the child.**FAMILY ELIGIBILITY FACTORS**

NOTE #1 – Regarding children in the care of someone other than the infant’s or toddler’s birth/biological parent: If the DCF (Department of Children and Families) goal is for the reunification of the parent and child, the following eligibility factors apply based on the birth/biological parent. The Early Intervention program should work closely with both the birth and foster families of the infant or toddler, whenever possible. If there is no goal for reunification with the child’s birth/ biological parents, the eligibility factors are to be based on the primary caregivers.

NOTE #2 – Determination of eligibility factors under parent characteristics should be based on parent perception.

NOTE #3 – Maternal characteristics apply as eligiblity factors to fathers if the father is the primary caregiver.

NOTE #4 – Written documentation of parent eligibility factors is kept in the Early Intervention record.

1. Maternal age of less than 17 years at child’s birth or there is a maternal history of 3 or more births before age 20.
2. Maternal education of 10 years or less. A mother meets this eligibility factor if she has completed 10 years or less of formal education at the time of the eligibility evaluation.
3. Parental chronic illness or disability affecting care-giving ability. This risk factor applies if a parent has a diagnosed chronic illness or a sensory, mental, or developmental disability and agrees that may interfere with or adversely affect the infant or toddler’s development or have an impact on care-giving abilities. Examples of this eligibility factor may be affective disorders, schizophrenia, sensory limitations, including visual or hearing limitations, and cognitive limitations.
4. Parent lacking social supports. Family is geographically or socially isolated and acknowledges that they are in need of emotional support and services. Family lacking adequate food or clothing.. This risk factor applies if the lack of food, clothing, or a stable housing arrangement causes life stress for the family.
5. Homelessness. An infant and/or toddler and his/her parentswill be considered homeless if:

* The family lacks a fixed, regular, and adequate nighttime residence, or
* The family is sharing the home of other persons due to loss of housing, economic hardship, or a similar reason, or
* The family is living in a motel, hotel, camp ground, or emergency or transitional shelter, or the infant/ toddler is abandoned in a hospital or is awaiting foster care placement, or
* The family is living in a public or private place not designed for or ordinarily used as a regular sleeping accommodation including, but not limited to cars, parks, public spaces, substandard housing, or bus or train stations, or
* The family is considered to be migratory workers and is living in any of the situations described above.

1. Open or confirmed protective service investigation, including a child currently in foster care. *This eligibility factor applies if the family:*

* has an open protective service file with the Department of Children and Families, or
* is in the period of investigation for child abuse or neglect, or
* has had its file closed by DCF in the last 3 months.

1. Substance abuse.. A family meets this eligibility criterion if substance abuse is having or may have had an adverse effect on the child's development or the parent(s) caregiving ability.Domestic Violence/Emotional/Physical or Sexual Abuse.

A family meets this eligibility criterion if there is a current, or a history in the family of any of the below:

* Domestic Violence
* Emotional Abuse
* Physical Abuse
* Sexual Abuse

which is likely to interfere with or adversely affect the child’s development or the parent’s care giving ability.

### 4. Clinical Judgment

**Criteria**

The infant or toddler has questionable quality of developmental skills andfunctioning based on the informed clinical opinion of a multidisciplinary team.

Achildfound eligible in the category of clinical judgment mayreceive services for up to 6 months. For services to continue after this period, eligibility must be determined based on Established Condition, Established Delay, or Infant and Toddler/Parent Risk Factors.

Programs are required to adhere to the following procedures when utilizing the eligibility category of Clinical Judgment:

1. Document the qualitative or quantitative concerns that are atypical.

2. Provide the family with written notice of the evaluation/assessment results.

## C. Finding of Ineligibility

If, based on the evaluation, the infant or toddler does not meet the eligibility criteria, the parent will be provided with the following to meet the requirements of written notice:

1. the written narrative of the evaluation reflecting the finding that the infant or toddler does not meet eligibility criteria,
2. a copy of the family rights notice, and
3. an explanation of the parent’s right to dispute the eligibility determination by requesting a due process hearing, mediation or filing a formal administrative complaint.

# IV. CATCHMENT AREA

## A. Local Catchment Area

An Early Intervention program serves all cities and towns within its catchment area as defined by the Department of Public Health. Early Intervention services are provided within the Commonwealth of Massachusetts. A child may only be enrolled in one Early Intervention program. The Early Intervention program that serves the city or town considered as the child’s primary residence is designated as the program responsible for developing and implementing and IFSP to an eligible child and family.

## B. Options for Families

If there is more than one Early Intervention program in a catchment area, parents must be informed of the other EI programs in the catchment area and of their right to choose which program prior to EI services occurring. Parents are informed that investigating other programs may prolong the time it takes to complete the IFSP process. This discussion is documented in the infant or toddler’s Early Intervention record.

## C. Out-of-Catchment Services

Programs are responsible for providing individualized services to families as outlined in the IFSP. Occasionally this means that services may be provided outside of the catchment area in which the family resides. The Early Intervention program may decline to enroll families and/or provide services to families who reside outside the program’s defined catchment area. Should an out of catchment Early Intervention program choose to enroll or provide services, the full range of services, with the exception of transportation, must be available.

Families of eligible children who volitionally maintain a temporary residence (not subject to the definition of a homeless child and youth under the McKinney-Vento Homeless Act) outside of the catchment area may inquire about accessing services from the Early Intervention program that serves the city or town of the family’s temporary domicile. The Early Intervention program (which is not the Early Intervention program that serves the child’s primary residence) may, at its discretion, honor or deny the family’s request. The Early Intervention program may provide information regarding community resources to the family.

## D. Homeless Infants and Toddlers and Their Parents

An infant and/or toddler and his/her parentswill be considered homeless if:

1. The family lacks a fixed, regular, and adequate nighttime residence;
2. The family is sharing the home of other persons due to loss of housing, economic hardship, or a similar reason;
3. The family is living in a motel, hotel, camp ground, or emergency or transitional shelter, or the infant/ toddler is abandoned in a hospital or is awaiting foster care placement;
4. The family is living in a public or private place not designed for or ordinarily used as a regular sleeping accommodation including, but not limited to cars, parks, public spaces, substandard housing, or bus or train stations; or
5. The family is considered to be migratory workers and is living in any of the situations described above.

Given the instability families experiencing homelessness may face, Early Intervention programs are encouraged to consider procedures to address the timely identification and provision of IFSP services for eligible infants and toddlers who are homeless. The Early Intervention program responsible for providing services to the community of the child’s temporary residence during the period the family is considered homeless will be responsible for the development and implementation of the IFSP.

# V. SERVICE PROVIDERS AND ROLES

## A. Professional Certification

All professional staff members who will be providing direct service to children and families, employed directly or indirectly by an Early Intervention program (including salaried, contract/fee-for-services, or consultant/subcontract), are certified as Early Intervention Specialists by the Massachusetts Department of Public Health. Required documentation is submitted to the Department of Public Health for all newly hired and returning staff at least two weeks before the date of hire. Early Intervention staff members may not bill for any Early Intervention service until Certification status is approved. Approval date by DPH is the date that the individual is able to bill for EI services in the MA EI system.

All staff new to the field of Early Intervention in Massachusetts, who work 20 hours or more per week in one or more Massachusetts Early Intervention programs, are required to attend and participate in a two-day orientation training offered by the Early Intervention Training Center at the Department of Public Health. It is recommended that all staff new to the Massachusetts system participate in this training, completing both days by the end of their first year of employment.

Primary program administrators, usually Program Director or Program Coordinator, must meet the credentialing requirements for one of the disciplines listed in Section B below. The primary program administrator is required to meet the Department of Public Health Early Intervention Program Director certification requirements. Further description may be found in Section XII, Program Administration, of these standards.

Certification for Early Intervention Specialists:

1. **Provisional certification** is granted by the Department of Public Health to potential direct service staff who meet entry level requirements.
2. **Provisional certification with advanced standing (PCAS)** is granted by the Department of Public Health to graduates of DPH-approved higher education programs in Early Intervention after satisfactory review of completed application
3. Application for **full certification** must be completed by the end of 3 years of employment for those working 20 hours or more per week at one or more MDPH-certified Early Intervention program(s).
4. Requirements for staff with provisional certification:
5. A portfolio documenting competencies as an Early Intervention Specialist must be submitted within three years of employment for those working 20 hours or more per week at one or more MDPH-certified Early Intervention program(s). Those working fewer than 20 hours per week are also encouraged to apply for full certification.
6. Therapy Assistants are exempt from the requirement of full certification.
7. Requirements for staff with provisional certification with advanced standing:
8. Completion of 1,440 hours of supervised employment in a MDPH-certified Early Intervention program. (Depending on program of study, some applicants may be required to complete 1,540 hours.)
9. Submission of the appropriate application for full certification.
10. Documentation of completion of two-day orientation to MA Early Intervention offered by DPH.

## B. Early Intervention Credentials

MDPH-certified Early Intervention programs must demonstrate a commitment to respond to the diversity of families in their communities. The following are the minimum credentials for entry-level provisional certification as an Early Intervention Specialist:

1. As Developmental Specialist:
2. A bachelor’s degree from an accredited institution with a major or concentration in infants and toddlers (includes Early Intervention and early childhood education).
3. A bachelor’s degree from an accredited institution with a major or concentration in child development or child studies.
4. A bachelor’s degree from an accredited institution with a major or concentration in education or special education.
5. A bachelor’s degree from an accredited institution or a Masters Degree in Speech/language pathology or Audiology and currently in clinical fellowship prior to being granted a CCC.

For all categories of Developmental Specialist, transcripts of degree work or subsequent transcripts must reflect successful completion of at least 4 approved 3-credit courses that focus on infants, toddlers, and/or families. Additionally, at least 300 hours of practicum or work experience with young children (under the age of 5) is required and documented on a résumé. Additional experience with infants, toddlers and/or families is preferred.

1. *In Nursing:* Current licensure as a Registered Nurse by the Massachusetts Board of Registration in Nursing.
2. *In Occupational Therapy*: Current licensure as an Occupational Therapist by the Massachusetts Board of Registration of Allied Health Professions.
3. *In Physical Therapy*: Current licensure as a Physical Therapist by the Massachusetts Board of Registration of Allied Health Professions.
4. *In Social Work*: Current licensure as a Licensed Certified Social Worker (LCSW) or as a Licensed Independent Clinical Social Worker (LICSW) by the Massachusetts Board of Registration of Social Workers.
5. *In Mental Health*: A minimum of a master’s degree from an accredited recognized educational institution in
6. counseling psychology, clinical psychology, developmental psychology, or educational psychology

**or**

1. Current licensure as a Licensed Mental Health Counselor (LMHC) or as a Licensed Marriage and Family Therapist (LMFT) by the Massachusetts Board of Allied Mental Health and Human Services Professionals

**or**

1. A minimum of a Master’s degree from an accredited recognized educational institution in Mental Health Counseling, Marriage and Family Therapy, or a Related Field

**and** “license eligible” for LMFT or LMHC with official written verification by the applicant’s accredited educational institution.

1. *In Speech and Language Pathology:* (a) Current licensure by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology and a Certificate of Clinical Competence (CCC) granted by the American Speech, Language and Hearing Association, or (b)
2. *Specialty Provider*: -Early Intervention Programs may hire staff to provide Specialty Services to children with specific *low incidence conditions*. These individuals must meet applicable state requirements for the profession or discipline in which the person is providing Early Intervention services.
3. *Therapy Assistant:* Current licensure from the Massachusetts Board of Registration in Allied Health Professions as an Occupational Therapy Assistant (OTA) or Physical Therapy Assistant (PTA); or from the Massachusetts Board of Registration in Speech Language Pathology and Audiology as a Speech Language Pathology Assistant (SLPA). The scope of participation of a Therapy Assistant includes work with children and families, under close supervision and in accordance with the appropriate Board of Registration for specific disciplines. The role of the Therapy Assistant is to support the provision of IFSP services. Refer to the Board of Registration for supervision, documentation, billing, and scope of practice rules and regulations. Therapy Assistants are not required to attain Full Certification as Early Intervention Specialists because of the limitations on scope of practice regulated by their Professional Boards.
4. *Music Therapist* *(a) Current licensure as a Registered Dietician/Nutritionist by the Massachusetts Board of Registration/Division of Professional Licensure*
5. *Registered Dietician/Nutritionist*  *(a) Current licensure as a Registered Dietician/Nutritionist by the Massachusetts Board of Registration/Division of Professional Licensure*

The above disciplines may not be an inclusive list of personnel with specific expertise to meet the unique developmental needs of infants and toddlers. However, any staff considered for employment in a professional capacity to provide IFSP services must meet the minimum credentials for entry level provisional certification as an Early Intervention Specialist listed above.

# VI. ENTRY INTO PROGRAM

## Public Awareness and Child Find

As part of a comprehensive system of Child Find, each Early Intervention program will be responsible for engaging in public awareness activities that focus on the early identification of potentially eligible infants and toddlers, including Indian infants and toddlers, infants and toddlers who are homeless, in foster care, or wards of the state ,and infants and toddlers under the age of three who are directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. (Please see Appendix B – DPH/DCF Referral Policy.) Programs are encouraged to broadly distribute information about the availability of Early Intervention services, about the central directory available through Family TIES, and about the process for referral.

Public awareness and child find activities may include, but are not limited to, participation in community collaborations, health fairs, early education and care coalitions or the dissemination of information related to Early Intervention services to primary referral sources, pediatricians and family health practitioners, neonatal intensive care units (NICUs), community health centers, hospitals, child care resource and referral centers, and/or local child welfare (including domestic violence programs) and protection agencies.

## Referral

1. The date of the referral to an EI program is the date in which the program receives the referral. Referrals should be made by referral sources as soon as possible, but no later than seven (7) days after a child has been identified as potentially eligible for Early Intervention services. Early Intervention programs accept referrals from all sources. If a parent has not been informed of the referral, the Early Intervention program will encourage the referral source to notify the parent. A face-to-face or telephone response to the parent from the Early Intervention program is made within 14 calendar days following the initial referral. Attempts to contact a parent of a child referred are documented in the record. An infant or toddler may be re-referred at any time prior to his/her third birthday.
2. Following referral, the Early Intervention program will begin pre-assessment planning. Pre-assessment planning is the opportunity to gather some information from parents, family, and other caregivers about the infant or toddler, and about the resources, priorities, and concerns of the family. This information is used to plan the assessment environment and logistics, which include determining who needs to be involved in the assessment based on the infant or toddler’s area of need, and the family’s preference concerning involvement in the assessment, so that the most accurate picture of the infant or toddler can be obtained during the assessment. If the child is found eligible for Early Intervention services, an IFSP meeting is convened.
3. The initial contact with the family provides an opportunity for discussion with family members regarding potential participation in Early Intervention. An overview of Early Intervention is given to the family.
   * If the initial contact is a face-to-face contact and if the program obtains any information related to potential eligibility, written parental consent (including electronic signature) for the eligibility evaluation is obtained
   * Often the child’s medical and developmental histories are discussed.
   * Parents are provided with a copy of the Massachusetts Department of Public Health Notice of Family Rights and Procedural Safeguards.The program will make an effort to ensure that the parent understands the notice and that the parent has been given the opportunity to discuss the contents of the notice and to have questions answered. There is written evidence, which may include parent signature, that these requirements have been met. The procedural safeguards afforded to children and families under Part C and these standards apply from the time a child and family are referred for Early Intervention services.

## Eligibility Evaluation

1. Eligibility evaluations are performed by staff certified as Early Intervention Specialists by the Department of Public Health. An evaluation to determine eligibility for Early Intervention services is available to all infants and toddlers from birth until 45 days before a toddler’s third birthday, consistent with Section IX, Transition and Discharge, of these standards. The Early Intervention program will retain the option to complete an evaluation to determine eligibility (with parental consent) or refer the child directly for Part B services if the toddler is referred within 45 days of his/her third birthday.
2. Written prior notice is provided, and written parental consent is obtained, prior to an eligibility evaluation.
3. A review of available records related to the infant or toddler’s current health status and medical history is completed as part of the evaluation/assessment.
4. An evaluation of the infant or toddler’s development is to be made by a multidisciplinary team (two or more certified Early Intervention Specialists representing different disciplines) using a DPH-approved developmental evaluation tool, the teams’ informed clinical opinion and utilizing non-discriminatory practices. The evaluation must include the child’s functioning in each developmental domain::
5. cognitive development,
6. physical development (gross and fine motor), including vision, hearing, and health status,
7. communication development, including expressive and receptive language development,
8. social and emotional and personal development, and
9. adaptive development/self-help.

If a parent chooses to not provide consent for all developmental domains, the process of determining eligibility cannot be made.

1. Eligibility evaluation further consists of a determination of parent and infant/toddler eligiblity factors to document eligibility as described in Section III, B, 3, of these Standards. An assessment of family resources, priorities, and concerns is family-directed and designed to determine ways to enhance the development of the child. Any assessment of a family’s need for support or services is voluntary in nature, and based on information provided by the family through personal interviews conducted by personnel trained in appropriate methods and procedures. If the family chooses not to share this information, they must be informed that their decision may impact eligibility.
2. The eligibility evaluation process is culturally and linguistically appropriate for the infant/toddler and family. Unless clearly not feasible to do so, child evaluations and assessments must be conducted in the native language of the infant/toddler. The disciplines represented on the multidisciplinary evaluation team are determined, to the extent possible, by the developmental areas of concern for the infant/ toddler.
3. Early Intervention staff conducting an evaluation to determine eligibility will use their informed clinical opinion when conducting evaluations and assessments. Informed clinical opinion may be used as an independent basis to establish eligibility when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of the evaluation instrument (*Battelle Developmental Inventory – 2*) used to establish eligibility.
4. Parents are provided with written notice of the outcome of all eligibility evaluations.

## Assessment

1. Assessment consists of the ongoing procedures used by appropriately qualified personnel throughout the period of a child’s eligibility for services to identify (1) the child’s unique strengths and needs 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 child.
2. If eligibility is based on an established condition or child and family eligibility factors, an assessment must be completed to determine the child’s unique strengths and needs in order to determine the Early Intervention services appropriate to meet those needs. Such an assessment will include a review of the results of any evaluation(s) or records; observation of the child; and the identification of needs with respect to physical development, cognitive development, communication development, social or emotional development, or adaptive development. Assessment procedures are culturally and linguistically appropriate for the infant/ toddler and the family.
3. Family directed assessments are voluntary and conducted with the concurrence of each family member as a means to identify the family’s concerns, priorities, and resources, and the services and supports necessary to enhance the capacity to meet the developmental needs of the infant/toddler. Family directed assessments, if based in part on an assessment tool, include an interview and are completed in the family’s native language unless clearly not feasible to do so.
4. The assessment emphasizes the collaborative process among Early Intervention personnel, the family, and other agencies and providers. Logistics should be primarily responsive to family and child needs and preferences regarding time, place, and other such factors. Families will be given prior written notice of assessments, and consent is obtained prior to assessment.

## Timelines and Documentation

1. Early Intervention programs will document efforts to do the following:
2. Contact families after the referral.
3. Obtain consent. A parent’s refusal of an evaluation to determine eligibility is documented in the record.
4. Complete the evaluation and assessment. In the event that an infant/toddler is not available to complete the evaluation and assessment subsequent to the referral (for example, due to family reasons of availability or because he/she is hospitalized), the reasons for the delay in completing the evaluation/assessment will also be documented. The evaluation/assessment is to be completed as soon as possible after the infant/toddler becomes available for the evaluation to determine eligibility subject to parental consent.
5. The evaluation and assessment and IFSP meeting must occur within 45 days from referral unless the exceptions listed in section D.1. c. above exist.

# VII. INDIVIDUALIZED FAMILY SERVICE PLAN DEVELOPMENT

**A. Individualized Family Service Plan (IFSP)**

An Individualized Family Service Plan (IFSP) is a working document that outlines the Early Intervention outcomes and services to be provided with the child and family. It is produced collaboratively by a multidisciplinary team of EI providers, parents, and any others the parents may wish to include. Based on a multidisciplinary eligibility evaluation, functional assessments, and any information provided by the family, the plan includes the services deemed necessary by the team to enhance the development of an eligible child to meet IFSP outcomes and the capacity of the family to meet their child’s needs. All certified Early Intervention programs must use the current universal IFSP form approved by the Massachusetts Department of Public Health.

**B. IFSP MEETINGS**

1. **Meeting to develop the initial IFSP:** An IFSP Meeting will be held within 45 days of referral for an eligible child to develop the child’s initial (first) IFSP. An initial IFSP will be considered compliant with the 45 day timeline when the components 1-6 (and 7 as appropriate to the child’s age and/or situation) as listed in section VII.D of these standards have been discussed, documented and completed as part of the IFSP meeting.
2. **Annual IFSP Meeting:** Annually, an IFSP meeting is held to review and revise, as appropriate the entire IFSP based on information from updated evaluations, functional and/or family assessments and the review, modifications or addition of outcomes
3. **6 Month/Periodic IFSP Review Meetings** A complete review of the IFSP for a child and the child’s family must also be conducted every six (6) months, or more frequently, if conditions warrant or if the family requests a meeting to review the IFSP. The purpose of the 6-month review (and periodic reviews if requested more than every 6 months) is to determine the degree to which progress is being made toward achieving the measurable results or outcomes identified in the IFSP, and if modifications or revisions of the measurable results, outcomes, or Early Intervention services are necessary.

**C. IFSP MEETINGS PARTICIPANTS**

There must be multidisciplinary representation of the Early Intervention team at the initial and annual development of the IFSP as well as the required complete review (s). These meetings must include the service coordinator, parent, and, at a minimum, one other staff member who represents a discipline different from that of the service coordinator.

Prior written notice of the  IFSP Meeting to develop the initial IFSP, annual IFSP meeting, and any 6 month/Periodic IFSP review must be provided to all participants early enough to allow attendance and each of the following shall be provided with a reasonable opportunity to participate:

1. the parent or parents of the child (or person legally designated in this function),

2. the individual designated to be the service coordinator,

3. another person or persons directly involved in conducting the eligibility evaluation and assessment representing a discipline different from that of the service coordinator, and

4. other family or team members as requested by the parent if feasible to do so.

5. An advocate or other non–family member, if the parent requests that the person participate. \*

6. Persons who will be providing services to the child and/or family.\*

\* If a person who wishes to be involved in the IFSP planning meeting is unable to attend, arrangements are made for the person’s involvement through other means, including:

* 1. participating in a telephone conference call,
  2. having a knowledgeable designee attend the meeting, or
  3. Making pertinent records available at the meeting.

**D. IFSP COMPONENTS**

The required components of the IFSP include:

1. A statement of the child’s present level of cognitive development, physical development (gross and fine motor, including vision, hearing, and health status), communication development (including expressive and receptive language development), social and emotional development, and adaptive development.
2. To the extent appropriate, identification of medical and other community services and resources that the child needs but that are not required or funded under Part C of IDEA (Individuals with Disabilities Education Act) or M.G.L. 111G. The IFSP should also identify the steps that the service coordinator or family may take to secure those services. A statement of the family’s strengths, concerns, priorities and resources related to enhancing the development of the child, if the family desires to have such statement included.
3. A statement of measurable results or measurable functional outcomes identified by the family that are expected to be achieved for the child and family. The results or outcomes include the criteria, procedures, and timelines used to determine (1) the degree to which progress toward achieving the results or outcomes is being made, and (2) whether modifications or revisions of the outcomes or services are necessary.
4. A statement of the Early Intervention services, based on peer reviewed research (to the extent practical) necessary to meet the unique needs of the child and family to achieve the measurable results or measurable functional outcomes, including start date and service type/method (individual or group services), including transportation, location (where occurring), service frequency (how often), length (how long per session), duration (how long the service is projected to be needed), and service provider (name and discipline).
5. A statement of the natural settings in which Early Intervention will be provided, including justification of the extent to which the services will not be provided in a natural environment. Individualized clinical justification on the IFSP for services that do not occur in a natural setting (as determined by the parent and IFSP team) based on the child’s unique needs, family routines, and identified measurable results or outcomes must include the following: An explanation of why the IFSP team determined that the outcomes could not be achieved in the child’s natural settings; an explanation of how the services provided in this setting will support measurable results or outcomes and the child’s ability to function in his/her natural environment; and a plan with a timeline for providing Early Intervention services in a natural setting in order to achieve the outcomes identified on the IFSP.
6. **Identification of a service coordinator:** The IFSP will specify the name of the service coordinator who is responsible for ensuring the coordination and implementation of the IFSP including transition services, procedural safeguards and coordination with other agencies and services. The service coordinator should be from the profession most relevant to the child’s or family’s needs or is otherwise qualified to carry out these responsibilities.
7. **IFSP Transition Plan development**: A transition plan is developed as part of the IFSP for all children when it is anticipated they will transition out their EI program. Transition plans are guided by family interest and individualized to address the reasons for the child’s anticipated discharge from a program due to age, a finding that the child is no longer eligible, or transfer to another EI program. The transition plan will include the steps and services to support a smooth transition of the child including:

* support available to parents
* steps and services necessary to support the adjustment of the child and family to changes in services
* discussion with parents, and training of parents if requested, covering future placements or other matters related to transition;
* documentation of a Transition Planning Conference (TPC)or documentation why the TPC did not occur
* documentation of notification to the Local Education Agency (LEA) and State Education Agency (SEA) if the child is potentially eligible for special education or related services;not fewer than 90 days and at the discretion of the parties, up to 9 months before the child’s third birthday
* identification of the persons responsible for ensuring the transition activities
* information to be sent to receiving community providers with parental consent; and

## For a child potentially eligible for special education, the development of a transition plan follows the steps outlined on the transition pages of the Universal IFSP, Section IX of these Standards and in the “Interagency Agreement between the Massachusetts Department of Public Health and the Massachusetts Department of Elementary and Secondary Education, Addressing Transitions from Early Intervention Programs to Early Childhood Special Education Services.” See Appendix C of these standards.

## E. THE IFSP LANGUAGE

The IFSP is written in the family’s native or chosen language or other mode of communication unless it is clearly not feasible to do so.An English translation of the child’s developmental profile and the service delivery plan is available at the program site for coordination and program-monitoring purposes.

**F**. **Parental Consent**

The contents of the IFSP are fully explained to the child’s family and informed written consent from the parents is obtained prior to the provision of Early Intervention services listed in the plan. If the parents do not provide consent with respect to a particular Early Intervention service or withdraw consent after first providing it, that service may not be provided. **This action will not jeopardize the provision of other Early Intervention services for which the parent has provided consent. Parents retain the ultimate decision as to whether they, their child, or other family members will accept or decline any or all listed IFSP service(s).** The Early Intervention services for which parental consent is obtained must be provided within 30 days of parental consent.

Parents must be provided with a copy of their family’s IFSP, including each revision as soon as possible.

**G**. **Interim IFSPs**

An interim IFSP may be developed for an eligible infant or toddler prior to the completion of evaluation and assessment if it is determined by the team that the immediate implementation of services is necessary to meet IFSP results or outcomes. Evaluation and assessments that are required components of an IFSP must be completed within 45 days of the referral.

The interim IFSP must include:

1. the identification of the service coordinator responsible for the implementation of the interim IFSP and the coordination of services or supports from other community agencies, and
2. the IFSP services necessary to meet the identified measurable results or outcomes.

**H.** Accountability

Early Intervention Specialists providing direct services are responsible for making good faith efforts to assist an infant or toddler toward achieving the outcomes identified in his/her IFSP. However, Part C of the IDEA does not require that an Early Intervention Specialist be held accountable if an infant or toddler does not achieve the projected gains toward meeting IFSP results or outcomes.

# VIII. EARLY INTERVENTION SERVICES

## A. Services

Children and families receive individualized services in accordance with the functional outcomes identified in the IFSP. Intervention is designed to include the child, parent or designated caregiver, and staff member(s). Parent participation in service delivery is strongly encouraged in meeting the developmental needs of the child. If family circumstances preclude such participation, this is documented in the child’s record and alternative methods to share information and strategies with the parent are developed. Subject to the Early Intervention service types listed in Section D below, and the requirements that Early Intervention services be provided by appropriately qualified staff consistent with the certification requirement specified in Section V, “Service Providers and Roles,” Early Intervention services may include:

* assistive technology devices and services but does not include a medical device that is surgically implanted, including cochlear implants or the optimization (e.g. mapping), maintenance, or replacement of the device. Eye glasses, hearing aids and/or prosthetic limbs are generally considered personal or daily use items,
* audiology services,
* family training, counseling, and home visits, to assist the family with understanding the special needs of the child and enhancing the child’s development,
* health services,
* medical services for diagnostic or evaluation purposes to determine a child’s developmental status and need for Early Intervention only,
* nursing services,
* nutrition services,
* occupational therapy,
* physical therapy,
* psychological services,
* service coordination,
* sign language and cued speech,
* social work services,
* special instruction,
* speech and language therapy services,
* transportation services, and
* vision services.

## B. Natural settings

Services are provided in the natural settings for the child, as determined through the IFSP process. Natural settings may include the child’s home, childcare centers, family childcare homes, and other community settings.

## C. Service Coordination

The service coordinator is determined during the IFSP process. Service coordination activities (services) provided by the service coordinator include:

1. Explaining the IFSP process, including due process and procedural safeguards;
2. Facilitating and participating in the development, review, and evaluation of the IFSP;
3. Conducting activities which ensure the timelyand consistent delivery of IFSP (Part C) services;
4. Making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families;
5. Conducting referrals and other activities to assist families in identifying available Early Intervention service providers;
6. Coordinating and monitoring eligibility evaluations, ongoing assessments by qualified personnel, and service delivery;
7. Coordinating funding sources for services required under Part C ;
8. Providing information on available resources and supporting families, as needed, to access resources;
9. Educating and/or supporting the family in advocating for their rights and needs;
10. Informing the family of the availability of advocacy services;
11. Coordinating services with medical and health providers, with written parental consent;
12. Facilitating the development of a transition plan; and
13. Making recommendations and referrals to meet the individual needs of the child and family as appropriate and with written parental consent.

## D. Early Intervention Service Types

1. **Home Visit.**  A face-to-face meeting at the eligible infant’s or toddler’s home or a natural setting outside of the Early Intervention program’s primary site with at least the
2. eligible infant or toddler and parent, **OR**
3. eligible infant or toddler’s parent (see definition of parent in these standards), **OR**
4. eligible infant or toddler and caregiver and a certified Early Intervention Specialist for the purpose of furthering the infant or toddler’s developmental progress and/or IFSP outcomes.
5. **Center Individual Visit.** A face-to-face (professional to infant or toddler and/or parent(s)) visit provided at the Early Intervention site or at another service site or private clinic with which the Early Intervention Program has contracted to provide Early Intervention services. A Center Individual Visit is provided by a certified Early Intervention Specialist for the purpose of furthering the infant or toddler’s developmental progress and/or IFSP outcomes. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting.
6. Center Individual Visit during an Early Intervention-only group:

A face-to-face (professional to infant or toddler and/or parent(s)) visit provided during an **Early Intervention–only Group**, identified on the IFSP as a Center Individual Visit provided as part of an Early Intervention–only Group. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting.

1. Center Individual Visit during a community group:

A face-to-face (professional to infant or toddler and/or parent(s)) visit provided during a community-based infant or toddler group service and identified on the IFSP as a Center Individual Visit occurring within a Community Group setting. This service does not require clinical justification as it does not occur in a segregated setting.

**3. Child Group.**  The group is designed to provide developmental opportunities for infants or toddlers birth to three years of age. The purpose of the group is to enhance each infant or toddler’s development, and to provide opportunities for young children to come together in locations where they typically spend time. Child group supports the concept that Early Intervention Services are most effective when provided within the family’s everyday routines and activities.

There are two types of Child Groups**: (a) Community Group** and **(b) EI-Only Group**. Each type of group must follow the ratios outlined in the definition of Child Group Settings.

**a. Community Group.** A group of two or more infants or toddlers who are participating in group services as a part of an Individualized Family Service Plan and peers who are not eligible for Early Intervention services. This group should be specified on the IFSP as a “Community Group.”

**b. Early Intervention–Only Group.** A group of two or more infants or toddlers where the only participants are infants or toddlers and families eligible for Early Intervention. When an infant or toddler participates in an Early Intervention–Only Group, the infant or toddler’s IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward attaining outcomes in natural settings. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. This group should be specified on the IFSP as “Early Intervention–Only Group.”

**4. Parent Group.**  A face-to-face meeting of a group of eligible infants and toddlers’ parents with a certified Early Intervention Specialist for the purpose of support and guidance. A Parent Group is provided for a regularly scheduled period. Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent Groups. These sessions are based on a specific curriculum and have an evaluation component, kept on file at the program.

**5.** **Sibling Group.**  A group for siblings of the eligible infant or toddler may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of having a sibling with developmental needs.

**6. Assessment.** The ongoing procedures used by appropriately qualified personnel throughout the infant or toddler’s eligibility to identify (1) the infant or toddler’s unique strengths and 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 the infant or toddler. Eligibility evaluations (See Section VI, B of these standards) may take place as part of an assessment. When evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the infant or toddler are determined by a multidisciplinary team. This event is referred to as an eligibility evaluation and assessment.

**7. Co-treatment visit.** A co-treatment visit is either a home visit or a center-based individual visit with two or more Early Intervention Specialists. Co-treatment visits are for the purpose of consultation about and coordination of treatment planning and implementation.

# IX. TRANSITION AND DISCHARGE

For the purpose of these standards, *transition* is the process by which a child and family are assisted in preparing for discharge from, or transfer within, the Massachusetts Early Intervention system. Transitions will be guided by the Memorandum of Understanding (MOU) on Early Childhood Transitions and the Department of Public Health and Department of Elementary and Secondary Education Interagency Agreement related to transition (appendix D) for coordination and collaboration of services for young children and their families. The Memorandum of Understanding recognizes the roles and responsibilities of individual programs (Part B and C programs, Head Start, and Department of Early Education and Care licensed programs) to adhere to respective standards and/or regulations. The Memorandum of Understanding does not supersede these standards or regulations, but works within them, emphasizing collaborative state and community-level activities to ensure smooth transitions for young children and families.

Transition activities extend beyond each child’s IFSP. Ongoing collaborative relationships between Early Intervention Programs and community providers (LEAs, Head Start programs, childcare providers, etc.) enhance the capacity of communities to offer varied and comprehensive options for families with young children.

A transition from Early Intervention will occur for every child receiving Early Intervention services. Therefore, planning for transition occurs jointly with families as part of the development of each IFSP and IFSP review. Each IFSP will have a transition plan that must include the steps and services to be taken to support the transition of the child and family from early intervention. For children potentially eligible for special education supports and services at age 3, the transition plan aligns with the requirements and timelines of the Individuals with Disabilities Education Act of 2004 (IDEA) for preschool services under Part B of the Act, to the extent that those services are appropriate.

## Development of a Transition Plan

A transition plan reflects the individualized activities necessary to ensure smooth transitions for children moving to other programs and/or because they are no longer eligible for Early Intervention services. The plan will identify timelines and the person(s) responsible for ensuring that transition activities occur.

Each infant or toddler exiting Early Intervention services will have a transition plan developed as part of his/her IFSP. The transition preparation and transition plan sections of the IFSP are developed with the concurrence of the family, and must be completed not fewer than 90 days, and at the discretion of the parties, up to 9 months before the infant or toddler’s third birthday, or as soon as possible when a parent indicates a desire to transfer services to another program or to withdraw consent for service. However, activities and support related to fulfilling the plan often continue until a child’s third birthday or discharge from the program.

The IFSP transition plan is complete when the activities (steps) or services that the IFSP team determines necessary to support the smooth transition of the child out of Early Intervention (Part C) services to preschool services under Part B, and/or other appropriate community services, are documented in the transition section of the IFSP. Family interests guide transition plans.

B. Transition Planning for Children Within the Massachusetts Early Intervention   
 System

When a family initiates a transition to another Early Intervention program, the transferring program will send minimally personally identifiable information to the receiving program as soon as possible or within 7 days unless the parent has indicated their refusal to have this information released. Minimally personally identifiable information is defined as the child’s name and date of birth, the parent’s name, and the phone number and address of the child’s family. **Additional information that would help support the transition requires consent from the family. ~~The full historical record is visible to the new program in the EI system once the parent has given consent to share as part of the transfer process.~~**

If a parent declines a referral for ongoing Early Intervention services, family interest in other community resources, supports, and/or opportunities should guide transition planning.

The date that minimally personally identifiable information is sent to the receiving program will constitute the date of referral and will be documented in the appropriate transition section of the IFSP.

The transferring EI program will develop a transition plan with the family that reflects the activities necessary to facilitate a smooth transition to the receiving EI program. This may include the transmission of pertinent records (including, but not limited to, selected information related to eligibility, dates and hours of assessment used, evaluations, assessments, and IFSPs) in order to avoid duplication of evaluations or assessments and support the continuity of Early Intervention services. Parental consent for the disclosure of records must be obtained. The transferring program will document when the transition plan has been carried out or the reasons that the transition plan was not completed in the transition section of the IFSP prior to discharging the child from the program.

The receiving EI program will convene an IFSP meeting as soon as possible, but within 45 days from referral, at a time and location mutually agreed upon with the family. Prior written notice of the IFSP meeting will be sent with sufficient time to allow participation of invited parties. If the family agrees, staff from the transferring EI program are encouraged to participate in the initial IFSP meeting with the receiving program either directly or via alternative methods (such as participating by teleconference, making pertinent records available, etc).

## C. Transition Planning for Children Who Do Not Continue to Meet Eligibility Criteria

Transition plans, with concurrence of the family, are developed when a child no longer meets the eligibility criteria set by the Department of Public Health as determined by the informed clinical opinion of a multidisciplinary team’s eligibility evaluation. The child and family will have up to 45 days from the date the parent(s) is/are provided with prior written notice that the child is no longer eligible to develop and implement a transition plan. A copy of the Family Rights notice is provided and reviewed with parents along with the written evaluation narrative(s) and/or other documentation which forms the basis for the multidisciplinary team’s determination that the child is no longer eligible for EI services. Parents are provided with an explanation of the parent’s right to dispute the eligibility determination by requesting a due process hearing or mediation or filing a formal administrative complaint.

The transition plan is guided by family interests and may include the identification of community options, parent training, informational resources, opportunities for parent networking, and/or early learning experiences.

The IFSP transition plan is complete when the activities (steps) or services that the IFSP team determines are necessary to support the smooth transition of the child out of Early Intervention services to preschool services under Part B and/or other appropriate community services are documented on the appropriate sections of the IFSP. These steps include:

1. Documentation of the discussions with and training of parents, as appropriate, regarding future placements and other matters related to the child's transition.
2. Steps and services to prepare the child for changes in service delivery, including steps to support the child’s adjustment, functioning, and participation in a new setting.
3. If the child is potentially eligible for preschool special education or related services through Part B, confirmation that minimally personally identifiable information was transmitted to the Lea and DPH ~~consistent with the opt out provision specified in this policy~~. With parental consent, the Early Intervention program will transmit additional information about the child to the local educational or other receiving agency, including the most recent evaluation, assessments, and IFSP, to ensure continuity of services.
4. With concurrence of the family, a reasonable effort by the Early Intervention program to convene a transition planning conference for the child exiting Early Intervention services. A transition planning conference is a designated opportunity to meet with parents and other community providers that a parent would like to have participate to develop or review a transition plan. The program will document if a parent declines a transition planning conference.
5. The purpose of the transition planning conference with parent(s) and other community partners the parent wishes to include is to:
6. review the child’s services and development;
7. discuss possible options for supports and services once the child exits Early Intervention; and
8. establish or review transition activities.
9. For toddlers potentially eligible for Part B services and in accordance with the IDEA, a transition planning conference to be held not fewer than 90 days or, at the discretion of the parties, up to 9 months before the child’s third birthday. With the approval of the family, a representative of the LEA will participate in the transition planning conference convened by the Early Intervention program if the child is potentially eligible for Part B services. Program staff should work toward coordinating the transition planning conference at a mutually agreeable time for both parent(s) and a representative from the LEA and/or other community programs. The Early Intervention program is responsible to notify the LEA of the transition planning conference.

With written parental consent, pertinent records that may assist in the transition (evaluations/assessments, IFSP) are sent to community providers.

## D. Transition Planning for Children Potentially Eligible for Part B Services at Age 3:

In Massachusetts, a child will be considered “potentially eligible” for Part B services if the child *meets the criteria for one or more of the following disabilities or impairments:*[[3]](#footnote-5)

1. *Autism.* A developmental disability significantly affecting verbal and nonverbal communication and social interaction. The term shall have the meaning given it in federal law at 34 CFR §300.8(c) (1).
2. *Developmental Delay.* The learning capacity of a young child (3–9 years old) is significantly limited, impaired, or delayed as exhibited by difficulties in one or more of the following areas: receptive and/or expressive language; cognitive abilities; physical functioning; social, emotional, or adaptive functioning; and/or self-help skills.
3. *Sensory Impairment.* The term shall include the following:

*Hearing Impairment or Deaf.* The capacity to hear, with amplification, is limited, impaired, or absent and this results in one or more of the following: reduced performance in hearing-acuity tasks; difficulty with oral communication; and/or difficulty in understanding auditorally presented information in the education environment. The term includes students who are deaf and students who are hard of hearing.

*Vision Impairment or Blind.* The capacity to see, after correction, is limited, impaired, or absent and this results in one or more of the following: reduced performance in visual-acuity tasks; difficulty with written communication; and/or difficulty with understanding information presented visually in the education environment. The term includes students who are blind and students with limited vision.

*Deafblind.* Concomitant hearing and visual impairments, the combination of which causes severe communication and other developmental and educational needs.

1. *Neurological Impairment.* The capacity of the nervous system is limited or impaired with difficulties exhibited in one or more of the following areas: the use of memory, the control and use of cognitive functioning, sensory and motor skills, speech, language, organizational skills, information processing, affect, social skills, or basic life functions. The term includes students who have received a traumatic brain injury.
2. *Emotional Impairment.* As defined under federal law at 34 CFR §300.8(c)(4), the student exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. The determination of disability shall not be made solely because the student's behavior violates the school's discipline code, because the student is involved with a state court or social service agency, or because the student is socially maladjusted, unless the IEP Team determines that the student has a serious emotional disturbance.
3. *Communication Impairment.* The capacity to use expressive and/or receptive language is significantly limited, impaired, or delayed and this is exhibited by difficulties in one or more of the following areas: speech, such as articulation and/or voice; and conveying, understanding, or using spoken, written, or symbolic language. The term may include a student with impaired articulation, stuttering, language impairment, or voice impairment if such impairment adversely affects the student's educational performance.
4. *Physical Impairment.* The physical capacity to move, coordinate actions, or perform physical activities is significantly limited, impaired, or delayed and this is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions. The term shall include severe orthopedic impairments or impairments caused by congenital anomaly, cerebral palsy, amputations, and fractures, if such impairment adversely affects a student's educational performance.
5. *Health Impairment.* A chronic or acute health problem such that the physiological capacity to function is significantly limited or impaired and results in one or more of the following: limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli resulting in limited alertness with respect to the educational environment. The term shall include health impairments due to asthma, attention deficit disorder or attention deficit with hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia, if such health impairment adversely affects a student's educational performance.

If a child is identified as potentially eligible for Part B Special Education preschool and/or related services at age three, the Early Intervention program will develop jointly with parents a transition plan not fewer than 90 days and, at the discretion of the parties, up to 9 months before the child’s third birthday.

The IFSP transition plan is complete when the activities (steps) or services that the IFSP team determines are necessary to support the smooth transition of the child out of Early Intervention (Part C) services to preschool services under Part B and/or other appropriate community services are documented on the appropriate pages of the IFSP. These steps include:

1. Documentation of the discussions with and training of parents, as appropriate, regarding future placements and other matters related to the child's transition, including potential placement options for the period from the toddler’s third birthday through the remainder of the school year.
2. Steps and services to prepare the child for changes in service delivery, including steps to support the child’s adjustment, functioning, and participation in a new setting.
3. ~~Confirmation that minimally personally identifiable information was transmitted to the LEA and DPH consistent with the out provision specified in this policy~~. With parental consent, the Early Intervention program will send additional information about the child to the local educational or other receiving agency, including the most recent evaluation, assessments, and IFSP to ensure continuity of services.
4. With concurrence of the family, a transition planning conference, held not fewer than 90 days or, at the discretion of the parties, up to 9 months before the child’s third birthday. With the approval of the family, a representative of the LEA will participate in the transition planning conference convened by the Early Intervention program. The program staff should work toward coordinating the transition planning conference at a mutually agreeable time for both parent(s) and a representative from the LEA and/or other community programs. The Early Intervention program is responsible to notify the LEA of the transition planning conference. The program will document if a parent declines a transition planning conference on the appropriate sections of the IFSP.

a. The purpose of the conference is to:

1. review the child’s services and development,
2. discuss possible options including potential placement options for the period from the toddler’s third birthday through the remainder of the school year, and
3. establish or review transition activities.

b. With written parental consent, information related to the child that may assist in the transition (evaluations/assessments, IFSP) is identified and sent to the LEA. The transmission of pertinent records (for example, information such as evaluations, assessments, or IFSPs) that would assist in avoiding duplication of evaluations, support the process for determining Part B eligibility, contribute to the development of an Individualized Education Program (IEP), and facilitate the continuity of services when the child turns three, is strongly encouraged.

1. Upon invitation of the parent and as feasible, Early Intervention staff will attend the child’s Individual Education Plan (IEP) Meeting.

## E. Opt-Out Policy State Education Agency (SEA) and Local Education Agency (LEA) Notification

Parents of children who are potentially eligible for Part B services are informed that IDEA allows for the disclosure of minimally personally identifiable information without parental consent to the Local Education Agency (LEA) and State Education Agency (SEA). The purpose of the disclosure is to notify the LEA and SEA of the child’s potential eligibility for special education and/or related services. Minimally personally identifiable information is defined as the child’s name and date of birth and parents’ name, address, and telephone number. If a parent chooses to refer his/her child to the LEA for an evaluation to determine eligibility for special education or related services, the parent will be informed that the SEA will be provided with minimally personally identifiable information.

~~The parent shall be informed of their option to opt out of the LEA and SEA notification if they choose not to refer their child for Part B services. Parents have 30 days from the date they are informed of this option to indicate their desire to opt out or allow the disclosure of minimally personally identifiable information. The date that the opt-out discussion occurs with the family will be documented in the child’s record. If the family does not opt out within 30 days, the Early Intervention program will send minimally personally identifiable information to the LEA and the DPH.~~~~The date the LEA and DPH are notified, or the date the family chooses to opt out, will be documented in the child’s record.~~

~~If a parent has not chosen to opt out, notification to the LEA and DPH must occur not fewer than 90 days before and, at the discretion of the parent(s), up to 9 months before the child’s third birthday. The date of notification of the child’s potential eligibility for special education will serve as the referral date and is documented in the transition plan of the IFSP. Early Intervention Programs are strongly encouraged to refer potentially eligible toddlers to the LEA and DPH when the toddler is 30 months old.~~ Notification to the LEA must occur not fewer than 90 days before and, at the discretion of the parent(s), up to 9 months before the child’s third birthday. The date of notification of the child’s potential eligibility for special education will serve as the referral date and is documented in the transition section of the IFSP. Early Intervention Programs are strongly encouraged to refer potentially eligible toddlers to the LEA when the toddler is 30 months old.

### F. Late Referrals to Early Intervention When a Child Is Potentially Eligible for Part B Services

If a toddler is determined eligible for Early Intervention services at least 45 days before, and within 90 days of, his/her third birthday, the EIP will notify the LEA and DPH as soon as possible of the child’s potential eligibility for Part B services ~~unless a parent chooses to opt out.~~

If a toddler is referred fewer than 45 days before his/her third birthday, and is determined to be potentially eligible for Part B services, the Early Intervention program may exercise the option to complete an evaluation to determine eligibility (with parental consent) and if the child is eligible, develop an IFSP; or may obtain parental consent to refer the child directly for Part B services.

Transition planning occurs as feasible given when a child is referred to Early Intervention. If a toddler is determined eligible for Early Intervention services at least 45 days before, and within 90 days of, his/her third birthday, with concurrence of the family, transition planning should occur. The IFSP transition plan is complete when the activities (steps) or services that the IFSP team determines are necessary to support the smooth transition of the child out of Early Intervention (Part C) services to preschool services under Part B, and/or other appropriate community services, are documented on the appropriate pages of the IFSP. These steps include:

1. Documentation of the discussions with and training of parents, as appropriate, regarding future placements and other matters related to the child’s transition, including potential placement options for the period from the toddler’s third birthday through the remainder of the school year.
2. Steps and services to prepare the child for changes in service delivery, including steps to support the child’s adjustment, functioning, and participation in a new setting.
3. Confirmation that minimally personally identifiable information was transmitted to the LEA and DPH. With parental consent, the Early Intervention program will transmit additional information about the child to the local educational or other receiving agency, including the most recent evaluation, assessments, and IFSP to ensure continuity of services.
4. With concurrence of the parent(s), a transition planning conference is held not fewer than 90 days, or as soon as possible before, the child’s third birthday. With the approval of the parent(s), a representative of the LEA will participate in the transition planning conference convened by the Early Intervention program. The program staff should work toward coordinating the transition planning conference at a mutually agreeable time for both parent(s) and a representative from the LEA and/or other community programs. The Early Intervention program is responsible to notify the LEA of the transition planning conference. The program will document if a parent declines a transition planning conference on the appropriate pages of the IFSP.

The purpose of the conference is to:

1. review the child’s services and development,
2. discuss possible options including potential placement options for the period from the toddler’s third birthday through the remainder of the school year, and
3. establish or review transition activities.

With written parental consent, information related to the child that may assist in the transition (evaluations/assessments, IFSP) is sent to the LEA. The transmission of pertinent records (for example, information such as evaluations, assessments, or IFSPs) which would assist in avoiding duplication of evaluations, support the process for determining Part B eligibility, contribute to the development of an Individualized Education Program (IEP) and facilitate the continuity of services when the child turns three is strongly encouraged.

Upon invitation of the parent and as feasible, Early Intervention staff will attend the child’s Individualized Education Program (IEP) meeting.

## Transition Planning for Children Exiting Early Intervention to Community Settings at Age 3:

With concurrence of the family, children who are not being referred to the LEA (either by parental choice or because the child does not present as a child potentially eligible for Part B services) must still have a transition plan developed as part of their IFSP. Specific activities related to transition will be documented in the appropriate sections of the IFSP. Timelines and the person(s) responsible for transition activities are identified as part of the plan.

The transition plan is guided by family interests and may include the identification of community options, parent training, informational resources, opportunities for parent networking, and/or early learning experiences.

The IFSP transition plan is complete when the activities (steps) or services that the IFSP team determines are necessary to support the smooth transition of the child out of Early Intervention (Part C) services to appropriate community services are documented on the appropriate pages of the IFSP. These steps include:

1. Documentation of the discussions with and training of parents, as appropriate, regarding future placements and other matters related to the child's transition.
2. Steps and services to prepare the child for changes in service delivery, including steps to support the child’s adjustment, functioning, and participation in a new setting.
3. With concurrence of the family, a reasonable effort by the Early Intervention program to convene a transition planning conference for the child exiting Early Intervention (Part C) services not fewer than 90 days, and at the discretion of the parties, up to 9 months before the child’s third birthday. A transition planning conference is a designated opportunity to meet with parents and other community providers that parent would like to have participate to develop or review a transition plan. The program will document if a parent declines a transition planning conference.

* The purpose of the transition planning conference with parent(s) and other community partners the parent wishes to include is to is to:

1. review the child’s services and development,
2. discuss possible options for supports and services once the child exits Early Intervention, and
3. establish or review transition activities.

* With written parental consent, pertinent records are selected that may assist in the transition (evaluations/assessments, IFSP) and be sent to community providers.

## Concurrent Transition Planning Conference and IFSP Meetings or IFSP Review Meetings

If a transition planning conference occurs as part of an initial or annual IFSP meeting or IFSP review meeting, the program must ensure that:

Prior written notice of the IFSP meeting is provided early enough to participants to allow attendance. At each initial and subsequent IFSP meeting, following an eligibility evaluation, each of the following shall be provided with a reasonable opportunity to participate:

* 1. The parent or parents of the child (or person legally designated in this function),
  2. The individual designated to be the service coordinator,
  3. Other person or persons directly involved in conducting the eligibility evaluation and assessment,
  4. Other family or team members as requested by the parent if feasible to do so,\*
  5. An advocate or other non–family member, if the parent requests that the person participate,\* and
  6. Persons who will be providing services to the child and/or family.\*

\* If a person who wishes to be involved in the IFSP planning meeting is unable to attend, arrangements are made for the person’s involvement through other means, including:

* + 1. participating in a telephone conference call,
    2. having a knowledgeable designee attend the meeting, or
    3. making pertinent records available at the meeting.

## Criteria for Program Discharge:

The program will discharge a child and family from Early Intervention services when:

1. The child reaches his/her third birthday;
2. The child and family no longer meet eligibility criteria;
3. The parent withdraws consent for all services (This is documented in the child’s record);
4. The child has moved out of the program’s catchment area;
5. The parent chooses to receive services from another Early Intervention program within the catchment area; or
6. The child dies. (The program may provide support to the family during the initial grieving process, with a request for reimbursement from the Department of Public Health.)

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# X. FAMILY PARTICIPATION

Early Intervention in Massachusetts is a family-centered system. Early Intervention services are provided in a collaborative manner with families and Early Intervention service providers working as partners. Family members are encouraged to be active participants in every component of the Early Intervention service system. On an individual level, family members are involved in determining and participating in services for their child and family. On the program level, families are encouraged to advise and participate in the development and monitoring of policies, procedures, and practices. Family members may choose to participate in these advisory functions as a group or as individuals.

To ensure comprehensive family participation, all members of the Early Intervention service team share responsibility for providing an environment in which such participation can occur. Early Intervention programs provide multiple and varied opportunities for family participation. This enhances the collaborative nature of service delivery and ensures that service providers can respond to the diverse needs and interests of the families.

In order to support family participation throughout the Early Intervention system, a program shall be able to demonstrate its efforts in the following activities:

1. Providing families with information on ways to access the MDPH Early Intervention Operational Standards, which include the core values (see Section I of these standards) and a range of individualized options, service delivery, and supports.
2. Sharing information about services, supports, and opportunities with all families on an ongoing basis.
3. Seeking input from a diverse and representative number of families and incorporating the mechanisms of input into its policy and procedure/operations manual as part of its administrative organizational plan.
4. Providing families with information about and access to programmatic procedures.
5. Responding to written suggestions offered by families within 7 days. Families who have difficulty in producing written suggestions may request assistance from the program. Families and program staff will work together to develop an action plan to address concerns.
6. Including a diverse and representative number of families in any ongoing program development initiatives, such as best practices guidelines, modifications/updates to the policies and procedures, etc.
7. Developing mechanisms to share information about the Early Intervention statewide system and opportunities for family participation including but not limited to the following:

* making the Early Intervention Parent Leadership Project website available to families (www.eiplp.org),providing information about how to access the *Parent* *Perspective* newsletter,
* inviting a parent to accompany Early Intervention staff to an ICC (Int*eragen*c*y Coordinat*ing Council) related activity,
* sponsoring a parent to attend the annual MEIC (Massachusetts Early Intervention Consortium) Conference,
* informing families of statewide trainings, and
* encouraging family participation on working committees.

To assist in the above efforts, the program shall:

1. Designate a Staff or Parent Liaison (an Early Intervention staff member) to facilitate the involvement of a diverse and representative number of families and serve as a link between the staff and families;
2. Identify and support a parent currently receiving Early Intervention services to be the contact person for the Early Intervention Parent Leadership Project; this Parent Contact will share information with the Early Intervention Parent Leadership Project and may share information with program staff and families enrolled in the program; and
3. Cover reasonable administrative expenses such as copying and distribution of information requested by families.

Both the designated Early Intervention staff member and the current Parent Contact will be identified on the program’s DPH Annual Report. In addition, the program will notify the Early Intervention Parent Leadership Project Director by calling 1-877-353-4757.

Parent Leadership Project Staff are available to attend Early Intervention staff meetings or parent meetings if requested to provide technical assistance in the area of family involvement.

## Family Involvement Activities

Family members enrolled in Early Intervention programs may choose to participate in a variety of family involvement activities or join together in a formal group, called a PAC (Parent Advisory Council), in order to meet the diverse needs and interests of families in the program.

The program will ensure that families are informed that they have the option to form a PAC if one is not already established. Information, support, and technical assistance are available to programs and families through the Early Intervention Parent Leadership Project (EIPLP).

The program has the responsibility to support a PAC or other family involvement activities by:

1. ensuring information regarding activities is communicated to all enrolled families;
2. encouraging activities that are responsive to the cultural and linguistic diversity of the program;
3. designating an Early Intervention staff member who will be a link between the staff and the PAC;
4. covering reasonable administrative expenses;
5. covering copying and postage expenses for family involvement activities or a PAC/program newsletter, if published;
6. assisting family members to problem solve ways to overcome barriers to family involvement; and
7. assisting with the management of any funds raised.

# XI. HEALTH AND SAFETY

The following Health and Safety standards are based on the Health and Safety regulations of the Department of Early Education and Care and on *Caring For Our Children: National Health and Safety Performance Standards: Guidelines for Out-Of-Home Care*, developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care. *Caring For Our Children* can be accessed and fully utilized on line at <http://nrc.uchsc.edu/CFOC/>. For additional information/resources on health and safety, please visit the Massachusetts Department of Public Health website at [www.mass.gov/dph/](http://www.mass.gov/dph/).

**Note:** The entire Health and Safety section has been formatted as a checklist and can be used as a stand-alone section for facility checks and general supervision monitoring. The following are requirements for all certified Early Intervention programs:

## MDPH Early Intervention program certification

The program holds current Early Intervention Program Certificate, displayed.

## Health Care Consultant

The Early Intervention program has either a physician or registered nurse with pediatric or family health   
training and/or experience, as the program’s health care consultant.  
 The consultant assists in the development of the program’s health care policy, and   
 approves and reviews the policy at least every two years.   
 approves the first aid training for the staff.  
 is available for consultation as needed, and   
 approves any changes in the health care policy.   
 The health care consultant’s name and contact information are readily available.

## Health Care Policies

The program has written health care policies and procedures that protect the health and safety of children,  
 staff, and families.   
 All staff members are trained in such procedures.   
 Appropriate policies and procedures are made available to families upon request. The written health care   
policy includes but is not limited to the following plans and/or procedures:

1. Written Health Care Policy

a. The program does not admit a child or staff member who has a diagnosed communicable disease (which cannot be contained by Universal Precautions) during the time when it is communicable.

b. The program notifies all parents and participants when any communicable disease, including those reportable to the Department of Public Health such as measles, mumps, and chicken pox, has been introduced to the group.

c. The program monitors the environment daily to immediately remove or repair any hazard that may cause injury.

d. The program keeps all toxic substances, poisonous plants, medications, sharp objects, matches, and other hazardous objects in a secured place out of reach of children.

e. Program health records include each child’s annual physical and immunization records. (See *Caring For Our Children*).

All children enrolled in Early Intervention are up to date on immunizations according to the recommendation of the Massachusetts Department of Public Health, unless the child’s parent has stated in writing that vaccination or immunization conflicts with his/her sincere religious beliefs or if the child’s physician has stated in writing that the vaccination or immunization is medically contraindicated.

All children enrolled in Early Intervention are screened for lead at least once between the ages of nine and twelve months and annually thereafter until the age of thirty-six months. For all children enrolled in Early Intervention prior to nine months of age, a statement signed by a physician that the infant has been screened for lead is obtained by the Early Intervention program by the time the infant reaches one year of age.

All Early Intervention–enrolled children attending community-based Early Intervention activities have awritten statement from a physician which indicates that the child has had a complete physical examination (which includes screening for lead poisoning and current immunizations) within one year prior to admission, or obtains one within one month of admission or obtains written verification from the child’s parent(s) that they object to such anexamination on the ground that it conflicts with their sincere religious beliefs.

2. A plan for the management of infectious diseases. The plan includes:

a. criteria regarding signs or symptoms of illness that will determine whether a child or staff member will be excluded from activities;

b. policies for when a child or staff member who has been excluded from activities may return;

c. policies regarding the care of mildly ill children in attendance at a non-home-based activity, including special precautions to be required for the following types of infectious diseases until the child can be taken home or suitably cared for elsewhere:

(a) gastro-intestinal infections,   
(b) respiratory infections, and   
(c) skin or direct-contact infections.

d. procedures for notifying parents when any communicable disease, such as measles or salmonella, has been introduced to the group.

3. A plan for infection control. Procedures are written to include:

a. directions for proper hand-washing techniques,

b. instructions on the care of toys and equipment.

4. A plan for the control of diseases spread by blood products and body fluids. Procedures are written to include:

a. universal precautions, including the requirement that staff use single-use latex-free gloves when they are in contact with body fluids and that contaminated materials are cleaned or disposed of properly,

b. annual training in blood-borne diseases including hepatitis B and C and HIV,

c. an exposure control plan, and

d. a hepatitis B vaccine series offered to staff at the time of hire.

5. A plan for the provision of the reasonable safety of staff while providing services, including a communication policy and/or procedures for staff providing center- or community-based services.

a. When providing services in the home environment may pose a risk to staff health or safety, the program will work with families to address the concern(s). Justification must be documented in the IFSP if services cannot be provided in the natural setting due to health and/or safety concerns including but not limited to exposure to communicable diseases, aggressive pets, secondhand smoke, and/or the presence of potentially abusive/violent visitors or family members.

6. A plan for addressing secondhand smoke exposure. Procedures are written to include the following:

a. training for staff in the health risks for children who are exposed to secondhand smoke,

b. provision of free secondhand smoke information and quit-smoking resources to families,

c. during the first face-to-face meeting, asking all families about children’s exposure to secondhand smoke and about parent/caregiver tobacco use status, and

d. recommended strategies for staff on addressing secondhand smoke exposure with families.

7. A procedure for reporting suspected child abuse or neglect to the Department of Children and Families. The procedure includes assurances that:

a. As mandated reporters, all staff will immediately report suspected child abuse or neglect to the Department of Children and Families pursuant to M.G.L. c. 119 51A, and to the program’s director or designee;

b. The program director or designee will notify the Department of Public Health, Early Intervention Services, immediately after filing a 51A report, or learning that a 51A report has been filed alleging abuse or neglect of a child by a member of the Early Intervention program’s staff; and

c. The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect that include but are not limited to ensuring that an allegedly abusive or neglectful staff member does not work directly with children until the Department of Children and Families’ investigation is completed or for such time as the Department of Public Health requires.

8. General Policies/Procedures

a. The program develops a Behavior Management Policy and trains all staff in its use.

b. The program has written procedures in place to be followed by Early Intervention staff to communicate with parents on a regular basis.

c. The program has written procedures to be followed in case of illness or emergency. These procedures include:   
 method of transportation,   
 notification of parents,  
 procedures when parent(s) cannot be reached.

In addition, programs shall obtain:

(1) an emergency phone contact for every child whose caregiver is not present,

(2) an emergency contact for caregivers who are present,

(3) written parental consents for emergency first aid and transportation to a specific hospital in emergencies, and

(4) written parental consent specifying by name any person authorized to take the child from the program or receive the child at the end of an activity.

d. The Program has written procedures for injury prevention and management of medical emergencies during field trips.

e. The Program maintains daily attendance records for Early Intervention–enrolled and community children that indicate each child’s attendance, arrival, and departure times.

f. The program posts a current activity schedule in each classroom.

g. Early Intervention staff obtain or have access to information from parents regarding:

(1) the child’s daily schedule, developmental history, sleeping and play habits, favorite toys, and accustomed mode of reassurance and comfort,

(2) procedures for toilet training of the child, if appropriate, and

(3) the child’s eating schedule and eating preferences, where appropriate, including handling, preparation, and feeding for unique dietary needs,

9. The program provides a copy of the Health and Safety section of these standards to all newly hired staff and to all staff at annual staff trainings on health and safety issues.

a. The program provides updated information to staff regarding communicable diseases, preventive health policies, and environmental health risks.

## Staff Requirements

1. Within the first six months of hire, all direct care staff members obtain and maintain current certification in CPR that specifically addresses infants and toddlers.   
 The CPR curriculum includes the management of a blocked airway and rescue breathing.

2. Within the first six months of hire, all direct care staff members obtain and maintain current certification in pediatric first aid.

3. At the time of hire and/or prior to the initiation of any direct contact with families, new staff, regularly scheduled volunteers, and student interns must present to the program director evidence of:

a. A physical examination, including a statement of physical limitations in working with children, completed within one year prior to employment.   
 The physical examination is valid for two years from the examination date and will be repeated every two years thereafter.

b. Immunity for measles, mumps, and rubella in accordance with MDPH regulations. (See [www.mass.gov/dph](http://www.mass.gov/dph) ). Such evidence is not required of any person who states in writing that vaccination or immunization conflicts with his/her sincere religious beliefs, or if it is medically contra-indicated.

c. Negative Mantoux TB test or a clear chest x-ray in accordance with current Department of Public Health regulations.

4. There is a CORI check on each of the Early Intervention provider’s employees with the potential for unsupervised contact with children, which is documented in the employee’s file. Such check shall be in accordance with current requirements in regulations of the Executive Office of Health and Human Services, 101 CMR 15.00: Criminal Offender Record Checks. The Department shall be permitted access to such documentation, and a copy of the documentation upon request, to ascertain the contractor’s compliance with the CORI requirements.

a. The Early Intervention provider is also responsible for ensuring that subcontractors conduct a documented CORI check for each employee with the potential for unsupervised contact with children, in accordance with the EOHHS CORI regulations, 101 CMR 15.00. The contractor shall ensure compliance through a subcontract or MOU that requires the subcontractor to perform and document in the employee’s file such a CORI check.

b. The Early Intervention provider conducts periodic audits to ensure compliance with CORI requirements, in accordance with any guidelines established by the Department.

c. The Early Intervention provider complies with all state and federal requirements regarding employee background record checks.

## Primary Sites

Early Intervention services, not including those services provided in children’s homes, are provided in settings that are safe, thatsupport the optimal development of infants and toddlers, and that are conducive to community collaboration. Such settings are welcoming to young children and their families, and are often part of a naturally occurring family routine. It is critical that settings where young children spend time be carefully evaluated to ensure the health and safety of children, staff, and families participating in Early Intervention activities. **Primary sites require written approval by DPH.** The following are requirements for primary sites:

1. Documentation and Safety Features:

a*.* The current DPH Early Intervention program certification is posted.

b. The program holds the Department of Early Education and Care (EEC) license or written documentation of exemption. It is the program’s responsibility to notify EEC of any changes to their status that would require licensure. The Early Intervention Program must have documentation of facility approval from the Department of Public Health.

c. The program holds a current Building Certificate of Inspection.

If the program offers any services (i.e. toddler group, center individual visit with the child) at the primary site without caregivers present, the Building Certificate of Inspection:

(1) is specific to those rooms used for services, and

(2) specifies “Codes I-4 Usage” (indicating children under 2 years, 9 months) and “E Usage” (children 2 years, 9 months and over) or states “infants and toddlers.”

d. The program holds documentation that the site is lead free.

(1) For a facility built prior to 1978, the program provides evidence of a lead paint inspection from the local board of health, or the Massachusetts Department ofPublic Health, or a private lead paint inspection service, and compliance with 105 CMR 460.000 (Department of Public Health Prevention and Control of Lead Poisoning regulations).

(2) For a facility built after 1978, the program provides documentation of the construction date.

(3) The program removes andcovers any chipping, flaking, or otherwise loose paint or plaster.

e. The program holds documentation that the site is accessible as defined in the Americans with Disabilities Act (ADA). The site must be accessible in all areas (including bathrooms) to children, staff, and caregivers.

f. The program holds documentation that the site is asbestos safe.

g. Fully functioning smoke detectors and carbon monoxide detectors are present.

h. Fire extinguishers are present and are  
 accessible,   
 charged, and   
 out of reach of children.

i. Automatic sprinkler system is present (not required).

j. There is a staff person certified in first aid and CPR on site whenever children are present.

2. Telephone/Intercom System

There is a telephone/intercom system readily available for emergencies. The following information is immediately visible at each telephone:

a. name and telephone number of the health care consultant,

b. 911 for fire, police, and ambulance services,

c. Poison Control Center number, and

d. telephone number and address of the program, including the location of the program within the facility.

3. Written Emergency Preparedness Plans

a. The program develops specific written preparedness plans and procedures to deal with fire, natural disasters, and loss of power, heat, or water.

b. Evacuation procedures are posted next to each exit.

c. The program has a policy and procedures for regularly scheduled evacuation drills.

d. The program documents the date, time, and effectiveness of each drill.

e. There is documentation that each staff person (with the exception of a staff member working fewer than ten hours per week) has participated annually in at least one evacuation drill.

4. Indoor Space

Indoor space *used by children and/or parents/caregivers* meets the following requirements:

a. The program shall have a minimum of 40 square feet of **activity space** per child, exclusive of hallways, lockers, wash and toilet rooms, isolation rooms, kitchens, closets, offices, or areas regularly used for other purposes.

b. There is a comfortable, non-intrusive space where parents and visitors can observe play groups.

c. Each room has a minimum of two means of egress.

d. The exits from each room are clearly marked and clear of obstructions.

e. Floors of rooms used by children are clean, dry, smooth, and free from cracks, splinters, sharp or protruding objects, and other safety hazards.

f. Ceilings and walls are maintained in good repair, and are clean and free from sharp or protruding objects and other safety hazards.

g. All steam and hot water pipes and radiators are protected by permanent screens, guards, insulation, orother suitable device

h. All electrical outlets are covered with or include a safety device when not in use. Ifthe covering is a shock stop, it shall be of adequate size to prevent a choking hazard.

i. The space is well ventilated and free of mold and mildew.

j. Room temperature is maintained at a draft-free temperature of not less than sixty-five (65) degrees when outside temperature is from zero degrees to 65 degrees Fahrenheit; and at not more than eighty (80) degrees when the outside temperature is 80 degrees Fahrenheit or above.  EI staff must take appropriate measures to protect children from health risks associated with excessive heat.

k. There is designated space, separate from children’s play or rest areas, for administrative duties and staff or parent conferences.

l. There is sufficient space accessible to children for each child to store clothing and other personal items.

m. The interior of the building is clean and maintained free from rodents and/or insects.   
 The program employs integrated pest management as necessary, and   
 notifies families in advance of any pest management that is planned.

n. The program provides suitable guards across the insides of any windows that are accessible to children and present a hazard.   
 The program provides suitable guards across the outside of basement windows abutting outdoor play areas.

o. Guards are placed at the top and bottom of stairwells opening into areas used by children. **Pressure gates may not be used at the top of stairs.**

p. Routine, major housekeeping activities, such as vacuuming and washing floors and windows, are not being carried on in any room while it is occupied by children.   
 All disinfecting, potentially hazardous, and cleaning materials are stored away from children.

q. The kitchen is maintained in a sanitary condition and garbage receptacles used in the kitchen are emptied and cleaned daily.

r. The program provides a barrier, such as a door or gate, that prevents unsupervised children’s access to the kitchen.

s. All toileting and diapering areas are away from food-handling areas.

t. The program does not permit smoking in the Early Intervention site.

u. The program does not permit hot liquids in the presence of children.

5. Toileting, Diapering, and Hand Washing

The program has written procedures for regular toileting and diapering of children and for disposal/cleaning of  
 soiled clothing, diapers, and linens.

a. The program maintains at least one toilet and washbasin in one or more well-ventilated bathrooms.

b. Hand washing procedures are posted (for example, “Hand Washing Procedure” in *Caring for Our Children*).

c. A diapering plan is posted (for example, “Diaper Change Procedure” in *Caring For Our Children*).

d. There is a disposable diapering surface.

e. There is a covered, lined trash container for soiled diapers.

f. When adult toilets and washbasins are used, theprogram provides non-tippable stairs to permit access by those children who are able to use them. In addition to toilets, portable “potty chairs” may be used in the bathroom or other separate room for children unable to use toilets.

g. Potty chairs, if used, are cleaned and disinfected after each use.

h. If cloth diapers are used, a flush sink or toilet for rinsing diapers and a hand-washing facility are provided convenient to the diaper changing area.

i. Special handrails or other aids shall be provided if required by special-needs children.

j. The program provides both hot and cold running water in washbasins and for water used by children.

k. Thereis a temperature control to maintain a hot water temperature at no more than one hundred twenty (120) degrees Fahrenheit.

6. Food/Snacks

Food provided at the site is nutritionally and/or developmentally appropriate for children.

a. The program stores, prepares, and serves all food and beverages in a manner that ensures that it is freefrom spoilage and safe for human consumption.   
 The program provides refrigeration and storage for food at not less than 32°F or more than 45°F for food requiring refrigeration.   
 The program stores all food in clean, covered containers.   
 The program disposes of milk, formula, or food unfinished by a child.   
 The program posts a weekly snack menu. (Not required if snacks are provided by individual parents for their own child).

b. The program provides tables and chairs for use by children while eating, which are of a type, size, and design appropriate to the ages and needs of the children.   
 When feeding tables or highchairs are used, they are designed to prevent children from falling or slipping.   
 The program washes and disinfects the tables or highchair trays used by the children for eating before and after each meal.   
 The eating area is clean, well-lit, and well-ventilated.

c. The program provides eating and drinking utensils that are appropriate to the age and developmental needs of the children.   
 Eating and drinking utensils are free from defects, cracks, and chips.   
 Disposable cups and plates may be used, but if plastic silverware is used, it shall be heavy duty and dishwasher safe.   
 All reusable eating and drinking utensils are thoroughly washed and sanitized before reuse.

d. The program provides a source of sanitary drinking water located in, or convenient to, rooms occupied by children.

7. Equipment

a. The program uses only equipment, materials, furnishings, toys, and games that are developmentally appropriate.   
 They are sound, safely constructed, flame retardant, easily cleaned, and free from lead paint, protruding nails, rust, and other hazards.

b. The program keeps all equipment, materials, furnishings, toys, and games clean and in safe workable condition.

c. Equipment is sturdy, stable, and non-tippable.

d. Water play containers and toys are sanitized daily.

e. Some materials and equipment are visible and readilyaccessible to the children, and   
 are arranged so that children may select, remove, and replace the materials either independently or with minimum assistance.

f. There is adequate storage for playgroup materials and equipment.

g. The program provides equipment and materials that reflect the racial and ethnic composition of the children enrolled.

8. First Aid Supplies

a. The program maintains adequate first aid supplies

b. The program has a procedure for the use, storage, and transportation of first aid supplies (See *Caring For Our Children*, “First Aid Kits”). A portable first aid kit must accompany staff on all field trips.

9. Injury Reporting

The program has a written injury-reporting policy that includes, but is not limited to:

a. An injury report that includes the name of child, date, time, and location of accident or injury, description of injury and how it occurred, name(s) of witness(es), and name(s) of person(s) who administered first aid or required medical care;

b. The written policy for informing parents, in writing, within 24 hours, of any first aid administered to their child and immediately informing them of any injury or illness that requires care other than first aid;

c. The assurance that the injury report shall be maintained in the child’s record; and

d. The maintenance of a central log or file of all injuries that occur during program hours and the policy for periodically monitoring the safety record of the program to identify problem areas.

10. Care of Mildly Ill Children at the Program Site

The program has a procedure for the care of mildly ill children at the site.   
 The plan shall include, but not be limited to, meeting individual needs for food, drink, rest, play materials, and comfort in an appropriate space separate from other children.

Staff who are assigned to care for mildly ill children are trained in the following areas:

a. General practices and procedures for the care and comforting of mildly ill children,

b. Recognition and documentation of symptoms of illness, and

c. Taking a child’s temperature.

11. Administration of Medication

The program has a written plan for administration of medication. The program may accept written parental authorization for specific non-prescription medications, prescription medications, vitamin supplements, and topical medications to be administered.

a. Topical medications such as petroleum jelly, diaperrash ointments, and anti-bacterial ointments that are applied to wounds, rashes, or broken skin are stored in the original container, labeled with the child’s name, and used only for that individual child.

b. Topical medications such as sunscreen, bug spray, and other ointments that are not applied to open wounds, rashes, or broken skin may be generally administered to children with written parental authorization.

12. Written Medical Care Plans

The program’s health care consultant develops with the family a written Medical Care Plan for meeting an individual child’s specific health care needs, including the procedure for identifying children with allergies and protecting children from exposure to foods, chemicals, or other materials to which they are allergic.

13. Outdoor Space Used by Children

**NOTE**: The outdoor play area is not a requirement when children are in attendance at the program site less than 4 hours per day.

a. The outdoor play area shall have a minimum of 75 square feet per child.

b. Outdoor play areas are accessible.

c. Children are not exposed to secondhand smoke while in the outdoor play area.

d. Children in the outdoor play area have access to both direct sunlight and shade.

e. The average width of such a play area is not less than eight feet.

f. The outdoor play area is free from hazards including but not limited to: a busy street, poisonous plants, water hazards, debris, and broken glass.   
 Any such hazard is fenced by a sturdy, permanently installed barrier that is at least four feet high or otherwise protected.

g. If the outdoor play area is located on a roof, it is protected by a non-climbable barrier at least seven feet high.

h. The outdoor play area is not covered with a dangerously harsh or abrasive material.

i. Pea gravel and wood chip nuggets are not used.

j. The ground area and fall zones under swings, slides, and climbing structures are covered with an adequate depth of an impact-absorbing material.

14. Animals

Before adults and children are exposed to any animal, staff shall consider the effect on their health and safety, with special attention to people with compromised immune systems and other vulnerabilities. **Under no circumstances should children come into contact with reptiles at the Early Intervention program.** (See Public Health Fact Sheet: “Salmonellosis from Pet Reptiles and Amphibians,” www.mass.gov/dph.

15. Transportation

a. Early Intervention Staff members are familiar with DPH Transportation Standards.

b. Transportation drop-off point is:

off street with loading/unloading zone, **OR**

on street with enforced designated parking space for handicapped loading/unloading.

c. There is adequate, interior protected, secure storage space for car seats.

d. The car seat storage space is readily accessible to drivers.

e. The drop-off point is within view of program staff, or   
 there is a system for drivers to communicate (i.e., buzzer).

f. Staff meet transportation vehicles at the drop-off point.

g. Transportation concerns are promptly reported.

# XII. PROGRAM ADMINISTRATION

A. Early Intervention programs must have a primary program administrator. A primary program administrator may be a program director or program coordinator and must meet the credentialing requirements for one of the disciplines listed in Section V of these standards. If the administrative responsibilities are shared within an agency, a written administrative plan is developed, designating specific roles and responsibilities to named individuals. The primary program administrator is required to meet the DPH requirementsfor Early Intervention Program Director Certification.

B. Each Early Intervention program has an organizational plan and written policies addressing processes and procedures that are readily available.

1. A written administrative organizational plan designates the person/persons responsible for:

1. administrative oversight,
2. program development,
3. budget development and oversight,
4. program evaluation, including a plan to ensure the validity and integrity of billing to public and private insurance and the DPH,
5. staff development,
6. hiring, review, and termination of staff,
7. clinical program supervision,
8. linkage to vendor agency,
9. linkage to lead agency,
10. designation of administrative coverage during hours of operation,
11. facilitation of family involvement. and linkage between staff and parents,
12. approval and assistance in developing health care policies for the program (either a physician or registered nurse),
13. coordination of transportation issues and the processing of transportation forms and reports, and
14. policies addressing staff rights and responsibilities.

2. Early Intervention programs will make positive efforts to hire and advance qualified staff in various roles (professional, supportive, and administrative) to provide services that reflect the diversity of enrolled children, their families, and the community served. Personnel records for each staff member are maintained, which include but are not limited to:

* 1. employee’s résumé or job application,
  2. documentation that the employee has met the credentialing requirements,
  3. documentation of completed CORI evaluation and all required background record checks,
  4. documentation of any and all other state requirements related to staffing (for example, Office of Inspector General),
  5. health records as required in Section XI of these standards,
  6. documentation of requiredtraining to meet core competencies, and
  7. documentation of Early Intervention certification status.

3. The following written procedures are available to any interested party upon request:

1. Child Find and public awareness,
2. referral,
3. determination of eligibility (evaluation),
4. assessment,
5. IFSP development,
6. service delivery modes,
7. transition,
8. discharge,
9. maintenance, management, and destruction of client records in accordance with the procedural safeguards found in Section XIII of these standards,
10. release of record with written parental consent, and
11. guidelines for referral to specialty providers and services.

4. The record kept on each child contains the following:

1. access sheet for recording those authorized persons who have reviewed a record;
2. signed parental consent forms;
3. documentation to support the child’s eligibility;
4. medical information necessary to support the child’s eligibility or to support the development of the IFSP;
5. reports from other agencies and professionals, as applicable;
6. results of evaluations and assessments;
7. complete IFSPs; and
8. documentation of allcontacts related to the provision of Part C services with child and family including date, service type, duration and content of contact, and the name and discipline of the staff person completing the EI service.

C. Programs will have a designated person available by phone during regularbusiness hours.

D. Each Early Intervention program has a core team

The core team has a minimum of three members, each of whom must work at least 30 hours per week.The core team comprises a Developmental Specialist (DSa through DSc) and two other professionals representing different disciplines as defined in Section V, B, 2–7 of these standards. The primary program administrator and Therapy Assistants are not considered part of the core team.

If at any time following the initial program certification, the staffing of the program does not meet the requirements for a core team, the program director will notify the Department of Public Health in writing of the absence of a core team. The program will be given sixty days from the first day of noncompliance to regain compliance of this requirement. Families enrolled in the program will be notified in writing of the absence of a core team forthe timeframe this situation exists and of the options available to them for comprehensive Early Intervention services. Families will also be given a copy of Family Rights in Early Intervention at this time. A copy of the written notice to families will be submitted to the Department of Public Health for review before distribution and a copy of the notification will be filed in each child’s record. If a core team is not in place at the end of the sixty-day period, a program certification review will take place.

Early Intervention programs are grounded in child development and serve young children and their families within the context of understanding the full spectrum of child development. Therefore, the Developmental Specialist serves a critical function within the Early Intervention core team. Early Intervention programs must employ at least one Developmental Specialist (DSa, DSb, or DSc) [who works at least 30 hours per week] for the first 75 enrolled children. For each additional 75 enrolled children, an additional 30 hours per week of Developmental Specialist (DSa, DSb, or DSc) time is required. These additional hours of Developmental Specialist time may be a combination of part-time staff.

E. Early Intervention programs are expected to enter data required by the Department of Public Health within the timelines established.

1. Referrals should be entered on the day that the referral is received at the program. This includes all referrals received by the program.
2. All other required data must be entered in a timely manner.

F. Each program conducts an annual self-evaluation. Programs encourage families to participate in the self-evaluation, which should include areas such as:

1. feedback on staff performance,
2. evaluation of program services,
3. review of IFSP process,
4. review of transition procedures,
5. approaches to family participation,
6. review of health and safety procedures,
7. review of interagency agreements and service contracts, and
8. review to ensure the integrity and validity of billing.

G. Each program develops a written procedure for the internal resolution of disputes.

1. Any family with a complaint must be informed again (as they were at the first face-to-face visit) of procedural safeguards and family rights.

2. Families must also be informed of their option to speak to Department of Public Health personnel and/or file a formal written complaint.

3. At the time of the family’s complaint, a copy of the Family Rights and Early Intervention Services brochure is given to the family.

4. Due process procedures for families enrolled in Early Intervention are outlined in Section XIII of these standards.

H. The Department of Public Health Encourages public participation.

The Department of Public Health assures that at least 60 days prior to the submission of its annual application for funding from the federal Department of Education, it will publish and widely disseminate notice to stakeholders of any policies, procedures, descriptions, methods, certifications, assurances, and other information required of the application.

The notice will be published in a manner that ensures circulation throughout the state for at least a 60-day period, with an opportunity for public comment on the application for at least 30 days during that period.

Any current and proposed changes of policies, procedures, descriptions, methods, certifications, assurances, and other information required of the application will be made available electronically or in paper format upon request to any of the following:

* + parents,
  + Interagency Coordinating Council members,
  + state and local community providers and the general public, and
  + Parent Training and Information Center(s).

The Department will provide notice of the scheduled hearing(s) at least 30 days before the hearings are conducted in order to enable public participation. Early Intervention programs are encouraged to make the notice available to local community providers and enrolled families. Any new policy or procedure, including any revision to an existing policy or procedure, will be part of the public hearing.

The Department will provide and accept comment from the general public, including individuals with disabilities, parents of infants and toddlers with disabilities, Early Intervention providers, and members of the Interagency Coordinating Council, for at least 30 days on any new policy or procedure (including any revision to an existing policy or procedure) needed to comply with Part C of the IDEA. Early Intervention programs are encouraged to support families who wish to provide comment by providing a copy of the public hearing notice, linking families with the Parent Leadership Project, or providing parents with contact information for the Department of Public Health Part C Coordinator or designated staff.

# XIII. PROCEDURAL SAFEGUARDS AND DUE PROCESS PROCEDURES

The Massachusetts Department of Public Health ensures procedural safeguards to all families that are in effect from the time a child is referred to the program. The following procedural safeguards are established to ensure that providers inform families of their rights concerning written notice, use of native language, informed consent, records, and confidentiality, and their options for the impartial timely resolution of disputes associated with the confidentiality, disclosure, access to, or amending of records, or the provision of Early Intervention services.

Procedural safeguards are designed to protect the interests of infants and toddlers receiving Early Intervention services and ensure parents are the key decision-makers for their child.

## Prior Written Notice

Families are provided written notice within a reasonable timeframe before an Early Intervention provider proposes to initiate or refuse an activity that relates to the identification, evaluation, or change in IFSP service; the provision of appropriate Early Intervention services; disclosure of personally identifiable information requiring consent; or accessing public or private reimbursement for service.

Early Intervention programs are required to use the forms and notices (paper or electronic) provided by DPH when requesting consent or providing notice for the following activities unless approval has been granted by DPH for the program to use a different form:

* evaluation/assessment to determine eligibility,
* convening an IFSP meeting for the purpose of developing an initial, subsequent or review of an IFSP, and
* providing IFSP services (Universal IFSP).

1. Any proposed activity that involves a proposed change to the infant or toddler’s IFSP services (for which consent has been obtained), or any refusal by the Early Intervention provider to include or amend an IFSP service proposed by a parent or IFSP team member requires written notice. The notice provides sufficient detail to inform the parent about:
2. the action(s) being proposed or refused and what will happen with respect to actions which the parent objects to or requests;
3. the reasons for taking the action(s); the need for informed consent, and the right to refuse consent;
4. when applicable, the right to request a mediation or due process hearing or file a complaint, and to receive services not in dispute;
5. the right to consent to some services, evaluations, and assessments and reject others, without jeopardizing other services under this part;
6. all other procedural safeguards available; and
7. any cost or use of insurance associated with the proposed action.

The notice must be:

1. written in language understandable to the general public, and
2. provided in the native language of the parents, unless it is clearly not feasible to do so.
3. If the native language (as defined in Section II of these standards) or other mode of communication is not written language, the service coordinator must:
4. translate the notice in a manner acceptable and understood by the parent,
5. document that the notice has been translated in a manner acceptable and understood by the parent, and
6. provide the parent an opportunity to discuss the contents of the notice and have questions answered.
7. Inclusive of all procedural safeguards available to parents including how to file a complaint or request a due process hearing or mediation.
8. Written Notice: Massachusetts Family Rights Notice

The “Massachusetts Early Intervention and You” family rights notice of procedural safeguards must be provided to families:

1. prior to any determination of eligibility,
2. prior to the development of an initial or subsequent IFSPs,
3. prior to a meeting to review the IFSP,
4. when a copy is requested by a parent,
5. upon disagreement between members of the IFSP team and the parent(s) on an initial or subsequent IFSP or a proposed amendment to an existing IFSP, and
6. when a parent files an informal complaint at the program level, a formal administrative complaint, or request for mediation or due process hearing.

Service coordinators will provide an explanation to any aspect of the notice or of how the safeguards   
 relate to the activity proposed or refused by the Early Intervention program

The “Massachusetts Early Intervention and You” family rights notice of procedural safeguards explains the procedures to:

1. receive notice of the opportunity to participate in any meeting where it is expected that a decision will be made about Early Intervention services for a child or family;
2. receive notice before a provider proposes or refuses to initiate or change an identification, placement, evaluation, assessment or service, in accordance with this section;
3. grant or refuse consent;
4. appeal a disputed matter concerning an evaluation, identification, placement, assessment or the process of IFSP development (in accordance with the section on Complaint Resolution);
5. file a formal administrative complaint about non-compliance issues or any violation of Part C;
6. ensure confidentiality of personally identifiable information, in accordance with the definition of personally identifiable information;
7. review or amend records, in accordance with Section F, Parent Access, and G, Amending The Record;
8. use a lawyer, advocate, or other representative in any matter pertaining to Early Intervention services;
9. receive an explanation of the use of and effect upon insurance;
10. appeal a decision of a hearing officer to an appropriate state or federal court; and
11. access other appropriate procedural safeguards available under Part C.

## Written Notice

The parent shall be given a readily understandable written notice a reasonable time before a provider proposes or refuses to initiate or change the identification, evaluation, or placement of a child or the provision of Early Intervention services to the child or family.

1. The notice shall be in the parent's native language, unless clearly not feasible, or otherwise in the manner best understood by the parent.
2. If the parent's native language or other mode of communication is not written language, the program shall ensure that the notice is translated orally or by another means in the parent's native language, unless clearly not feasible to do so, or otherwise in a manner best understood by the parent.
3. If the parent is deaf or blind, or has no written language or mode of communication, the notice shall be provided in the language/mode of communication normally used by the parent, unless clearly not feasible to do so, or otherwise in a manner best understood by the parent.
4. The provider will ensure that:
5. the parent understands the notice to the maximum extent feasible,
6. there is written evidence that these requirements have been met, and
7. the parent is given an opportunity to discuss the contents of the notice and have questions answered.

## Consent

**Parental consent** shall mean that:

1. The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent’s native language unless clearly not feasible to do so, and shall otherwise be informed in the manner best understood by the parent;
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

the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time. The parent shall have an opportunity to discuss the explanation and to have questions answered. If the explanation is not in the parent’s native language, the parent shall be provided, whenever feasible, with a list of interpreters in that language.

1. Consent must be obtained:
2. before conducting an evaluation or assessment, or a reassessment or re-evaluation to determine eligibility; prior to any assessment involving family members, informed consent shall be obtained,
3. at the time the initial IFSP and any subsequent IFSP are developed, or any revisions are made to an IFSP,
4. before a change is made in identification, placement, evaluation, or assessment, or a change is made in IFSP services in terms of frequency, location, duration or service provider,
5. prior to accessing public or private insurance, and
6. prior to disclosing personally identifiable information (unless otherwise permitted under state or federal law).

## Parent’s Right to Decline Service

Early Intervention services are voluntary. Parents may determine whether they, their child, or other family members will accept or decline any Early Intervention service. Parents may also decline such a service after first accepting it, without jeopardizing other Early Intervention services.

1. If a parent does not give consent, the program must make an effort to ensure:
2. that the parent is fully aware of the nature of the evaluation, assessment, or services that would be available, and
3. that the parent understands the child will not be able to receive an evaluation, assessment, or services without consent.

Early Intervention programs may not use a due process hearing to challenge a parent’s right to refuse consent for evaluations and assessments to determine eligibility, or to refuse any aspect of the infant or toddler’s Early Intervention services. A parent may withdraw his/her consent for Early Intervention services after initially providing it without jeopardizing other Early Intervention services.

**2. Parent:** As used in these standards, “parent” means

1. a biological or adoptive parent of the infant/toddler,
2. a foster parent,
3. a guardian generally authorized to act as the infant or toddler’s parent or make Early Intervention, educational, health, or developmental decisions for the infant/ toddler,
4. another person acting in the place of a biological or adoptive parent (including a grandparent, step-parent, or relative with whom the infant/ toddler lives) who is legally responsible for the infant or toddler’s welfare, or
5. a surrogate parent, but does not include any parent whose authority to make educational decisions has been terminated under state law.

An Early Intervention service provider or a service provider from a public child welfare agency (DCF) may not act as a parent for the purposes of Part C services

**Exceptions**: An adoptive or biological parent may exercise his/her option to provide or refuse consent for Early Intervention services (“parent acting as a parent”) if more than one of the above persons in Section 2, a–e meets the definition of parent, unless the biological or adoptive parent does not have the legal authority to make educational or Early Intervention decisions for the infant/toddler. A judicial decree or court order may identify a specific person (or persons) to act as a “parent” for purposes of decisions related to the infant or toddler’s Early Intervention services. The person authorized by the court order or decree will be recognized as the “parent” in terms of decision making authority, unless that person is an employee of the Early Intervention program or public agency (such as DCF) which provides services to the child.

1. **Surrogate Parent:** A surrogate parent is an individual assigned by the Massachusetts Department of Public Health or through a judicial order to represent the rights of an eligible infant or toddler in the following circumstances: (1) when the Department or Early Intervention provider, after reasonable efforts, is unable to identify or locate the parent, guardian, or person acting as parent of the infant/toddler; or (2) when the infant/toddler is in the legal custody of a State agency and the natural parent’s rights to participate in educational decision making have been terminated. In this case, a foster parent will be designated as surrogate unless he/she indicates or demonstrates an unwillingness or inability to serve as surrogate.
2. In the event that the provider is unable to identify a suitable surrogate for a child in state custody, the Department shall appoint a surrogate within 30 days.
3. The Department will attempt to appoint an effective advocate, with a preference given to a person with an understanding of the child and family’s cultural, religious, and linguistic background.
4. The Department shall ensure that the person selected as a surrogate parent has knowledge and skills that ensure adequate representation of the child; he/she will be knowledgeable and trained in the developmental needs, service options, and legal rights of children eligible for Early Intervention services, shall be impartial, shall have no interest that conflicts with the child's interests, and shall not be an employee of the Department the Department of Children and Families, or an Early Intervention provider; however, such person may be paid by the Department for serving as a surrogate.
5. Even when there is a surrogate appointed, if reunification of the child and the natural parent is the goal of the DCF service plan, the provider shall make every effort to have the biological parent participate in decision making about the provision of services, unless the natural parent’s rights to participate have been terminated by judicial process.
6. The Early Intervention program will consult with the state agency (typically the Department of Children and Families) that has been assigned custody of the child. The surrogate shall have the same rights as a parent under these standards, including the right to consent, revoke, or withhold consent and to represent the infant or toddler in all matters pertaining to evaluation, assessment, IFSP development, the provision of Early Intervention services, and any other rights established under this part.

## Records

1. A record is any information, regardless of location, recorded in any way, maintained by an agency or Early Intervention service provider or any party acting on behalf of the agency or Early Intervention service provider.
2. A record concerning a particular child includes any file, evaluation, report, study, letter, telegram, minutes of meetings, memorandum, summary, intra-office communication, notes, charts, graphs, data sheets, films, videotapes, slides, sound recordings, discs, tapes, and information stored in microfilm or microfiche or in computer readable form.
3. All safeguards related to records, including access, amendments, and confidentiality are applicable from the time the infant/toddler is referred, regardless whether or not the infant/toddler is eligible for Early Intervention services. These safeguards apply to all providers of Early Intervention services, including subcontractors of certified Early Intervention providers, but do not apply to primary referral sources or public agencies such as MassHealth or private entities (such as private health insurance) that act solely as a funding source for Early Intervention services.

## Parent Access

1. The Department of Public Health and the provider shall presume that the parent has the authority to review and inspect any and all Early Intervention records related to their child unless the Department or provider has been advised that the parent does not have this authority under state law.
2. The Department or provider shall, within five days of request, give the parent a list of the types and locations of records collected, maintained, or used by the Department or provider.
3. The parent shall be afforded the opportunity to inspect and review any such record relating to evaluations, assessments, eligibility determination, development, implementation of IFSP, due process hearing, individual complaints dealing with the child, and any other area involving records about the child/family. This includes all records collected and maintained by the provider. The provider should notify all parties asked to submit records for a child’s file that they are open to the parent.
4. The right to review a record includes the right to an explanation or interpretation of the record, the right to have a representative of the parent view the record, and the right to request that the agency provide a copy of the records containing the information.
5. An initial copy of the record is provided at no cost to the parent. subsequent ies of
6. Programs must provide, at no cost to parents a copy of each evaluation, assessment, and IFSP as soon as possible after each IFSP meeting.
7. An agency or service provider shall comply without unnecessary delay and no later than 10 days after receiving the request.
8. Where records are requested in connection with a meeting regarding the IFSP or a formal hearing, the agency or service provider shall comply at least five days before the meeting or hearing.
9. If a record contains information on more than one child, the parent has a right to inspect only those portions of the record pertaining to his or her child.

## Amending the Record

1. If a parent feels that the information in Early Intervention records that is collected, maintained, or used is inaccurate, irrelevant, or misleading, or violates the privacy or other rights of the child or parent, he/she may request that the participating agency that maintains the records amend the information.
2. The holder of the record shall respond within 30 days. If the holder of the record finds that the objection is valid, it shall amend the contents of the records and duly notify the parent in writing. If the holder refuses to amend the record, it shall notify the parent in writing of the decision, the right to a hearing, and the right to place a statement in the record reflecting the parent’s views, which would be maintained and disseminated with the rest of the record.
3. In responding to a parent’s objection, the holder of the record may not amend the contents of a record that was submitted to the child’s file by a source outside of the provider agency. The provider may agree to amend the record by placing a statement in the record reflecting the parent’s (and/or the provider’s) views and direct the parent to contact the originator of the record to request that a corrected copy be placed in the file.
4. A parent, upon request, must be granted a hearing to challenge information contained in an Early Intervention educational record.
5. Such a hearing shall be conducted under procedures in section 99.22 of the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99).
6. If the hearing officer finds that the challenged information is inaccurate, misleading, or irrelevant, or violates the privacy or other rights of the child or family, the record shall be amended and the parent so notified in writing.
7. If the hearing officer finds that the information is not inaccurate, misleading, or irrelevant, or not a violation of the privacy or other rights of the child and family, the parent shall be informed of the right to place in the record a statement of the parent’s views. This statement shall be maintained by the agency for as long as the contested part of the record is maintained, and disseminated with the record.

## Confidentiality

1. The Department of Public Health and providers shall ensure the protection of confidential personally identifiable information at collection, storage, disclosure, and destruction stages.
2. All records and information pertaining to a child or family shall be confidential, commencing with the referral of the infant/toddler. All holders of personally identifying information shall comply with the confidentiality provisions of M.G.L. c. 66A and related regulations. All records must contain an access sheet that keeps record of parties obtaining access to the record. This sheet must list the name of the party requesting access, and the date and purpose of access.
3. Records and personally identifying information shall not be disclosed, even to prospective providers of services, without the parent’s written informed consent unless permitted by state or federal law. Personally identifiable information shall not be used for purposes other than meeting the requirements of these standards without parental consent. Beyond these exceptions, any additional release of information will not occur without parental consent.
4. Exceptions to the confidentiality requirements include:
5. inspection by health personnel in response to a health or safety emergency;
6. inspection by state and federal agencies for purposes of audit, evaluation for compliance with legal and contractual requirements, and certification;

notification of the Local Education Authority (LEA) and State Education Authority (SEA) if the child is potentially eligible for Part B services

1. compliance with a lawfully issued subpoena. The program will notify the parent of the receipt of the subpoena to allow the parent the ability to seek a protective order in a court of competent jurisdiction. If the parent cannot provide a protective order within the timeframe noted in the subpoena for the disclosure, the program must comply with the disclosure.
2. The Department and each provider shall appoint an employee responsible for ensuring confidentiality. The Department and each provider shall maintain a current list of employees with access to personally identifiable information and shall provide these employees with training concerning the state’s policies and procedures. Supervision and monitoring procedures will ensure that all providers meet confidentiality requirements.
3. If the Department or provider maintains personally identifying Early Intervention information not subject to the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99), it shall protect that information pursuant to the confidentiality provisions of 5 USC 522A and related regulations.

Upon a child’s discharge from Early Intervention services, the provider shall notify the parent that personally identifiable information is no longer needed to provide services to the child or family. At the request of the parent, such information may after seven years be destroyed or redacted in such a manner that the record is no longer personally identifiable. The Department of Public Health will maintain a permanent record of the child and family’s name, address, and phone number, and dates of enrollment.

1. The Department and program shall meet any additional confidentiality requirement with the following modifications:
2. Any reference to the "State Education Agency" means the Department of Public Health.
3. Any reference to "special education," "related services," "free appropriate public education," "free public education," or "education" means the provision of Early Intervention services.
4. Any reference to "local education agencies" and "intermediate educational units" means certified Early Intervention programs.
5. Any reference to "Identification, Location, and Evaluation of the Child with Disabilities" means "Comprehensive Child Find System."
6. Any reference to "Confidentiality of Personally Identifying Information" means "Confidentiality of Information."
7. Any reference to "education records" means the type of records covered under the definition of education records in Part 99 of the Family Educational Rights and Privacy Act of 1974 (FERPA) or “early intervention record” under Part C of the IDEA.
8. Any reference to "participating agency" when used in reference to a local educational agency or an intermediate educational agency, means a local service provider.
9. Any reference to "destruction" means physical destruction or removal of personal identification from information.

## Lead Agency Procedures for Complaint Resolution

The Department of Public Health offers parents of children enrolled in Massachusetts Early Intervention programs and other interested parties, options for the resolution of complaints and/or disputes. The following procedural safeguards reflect the federal regulations of Part C of IDEA and provide parents a means of filing a complaint or requesting to resolve a disagreement through due process in a timely, impartial, and consistent manner. In resolving a complaint in which it finds failure to provide appropriate services, the Department will address:

1. how to remediate the denial of those services, including, as appropriate, the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child’s family; and
2. appropriate future provision of services for all infants and toddlers with disabilities and their families.

1. Massachusetts Department of Public Health shall be responsible for adopting written procedures to:

1. investigate any complaint that it receives (including individual child complaints and those that are systemic in nature); and
2. resolve the complaint if the agency determines that a violation has occurred. This includes a complaint filed by an organization or individual from another state indicating that any public agency or private service provider is violating a requirement of the regulations as stipulated by Part C of the Individuals with Disabilities Education Act (IDEA).

2. All such complaints and requests for mediation and/or due process hearings shall be filed with the Department. As needed or requested, the Department shall assist the parent in drafting and filing the complaint. The complaint must include:

1. A statement that the Department or Early Intervention program has violated a requirement of Part C of the IDEA or the Early Intervention Operational Standards;
2. The facts on which the complaint is based;
3. Signature and contact information of the complainant;
4. If alleged violation relates to a specific infant or toddler,
5. the name and address of the infant or toddler,
6. the name of the Early Intervention program, and
7. a description of the nature of the problem or violation, including the facts relating to the alleged violation or problem; and
8. A proposed resolution to the violation or problem, to the extent known and available to the party at the time the complaint is filed. The complaint must allege a violation that occurred not more than one year prior to the date that the complaint is filed.

3. The complaint must be filed with the Early Intervention program at the same time the complaint is filed with the Department of Public Health.

1. Information on the availability of this type of administrative complaint resolution process shall be widely disseminated to parents and other interested individuals, including parent training centers, protection and advocacy agencies, and other appropriate entities.
2. Formal Administrative Complaints

1. The Department shall include in its complaint procedures a time limit of 60 calendar days after a complaint is filed to:

1. carry out an independent on-site investigation, if the Department determines that such an investigation is necessary;
2. give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;
3. provide the agency or Early Intervention service provider an opportunity to respond to the complaint, including at a minimum:

* at the discretion of the Department, a proposal to resolve the complaint,
* an opportunity for the parent and the Department or Early Intervention program or agency to engage in mediation;

1. review all relevant information and make an independent determination as to whether there has been a violation of a requirement of Part C of IDEA;
2. issue a written decision to the complainant that addresses each allegation in the complaint and contains findings of fact, conclusions, and the reason for the lead agency’s final decision. The Department’s procedures may permit an extension of the time limit of 60 days only if exceptional circumstances exist with respect to a particular complaint or if the Department or Early Intervention program and the parent agree to extend the complaint in order to engage in mediation;
3. include procedures for effective implementation of the Department’s final decision, if needed, including

* technical assistance activities,
* negotiations,
* corrective actions to achieve compliance.

2. If a written complaint is received that is also the subject of a due process hearing under Sec. 303.430, or contains multiple issues, of which one or more are part of that hearing, the Department will set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action will be resolved within the 60-calendar-day timeline using the complaint procedures previously described.

3. If an issue is raised in a complaint filed under this section that has previously been decided in a due process hearing involving the same parties,

1. The hearing decision is binding, and
2. The Department must inform the complainant to that effect.

4. The Department will resolve a complaint alleging a public agency’s or private service provider’s failure to implement a due process decision.

## Requests for Due Process Hearings and Mediations

A parent or Early Intervention provider may file a request for a due process hearing and/or mediation under this subsection on any issue in dispute concerning identification, evaluation, assessment, determination of eligibility, the process of developing the IFSP, and the appropriateness of the Early Intervention services to be provided. A parent or provider may also seek resolution of a dispute by filing a complaint if the dispute is related to a violation of Part C or the Early Intervention Operational Standards.

* A request for a due process hearing or mediation shall be in writing. As needed or requested, the Department shall assist the parent in drafting and filing the hearing or mediation request.
* All requests for a due process hearing or mediation must be filed with the Department of Public Health.

1. The parent must send a copy of the complaint to the Early Intervention program at the same time a copy is sent to the Department. The complaint must include:

1. A description of the issue(s) to be resolved relating to the proposed or refused initiation or change, including the facts relating to the dispute,
2. Signature and contact information of the complainant,
3. If there is an alleged violation in relation to a specific infant or toddler,

* the name and address of the infant/toddler. In the case of a homeless infant or toddler, available contact information for the child to the extent known,
* the name of the Early Intervention program,
* a description of the nature of the problem or violation including the facts relating to the alleged violation or problem, and

d. A proposed resolution to the violation or problem, to the extent known and available to the party at the time the complaint is filed.

2. Within five (5) days of receiving a request for a due process hearing or mediation, the Department shall notify the parent of free or low-cost legal and advocacy services, and of the right to be advised by an individual with special knowledge of Early Intervention services; of the option of mediation, including a description of the mediation process and its voluntary nature; and of the alternative of having the Department investigate the complaint if the dispute is related to a violation of Part C or the Early Intervention Operational Standards. The Department shall also send the parent a copy of the notice of rights specified in this section.

3. During the pending process of appeal or mediation, the child and family shall be entitled to those services that are currently being provided or, if initial services, are not in dispute. If there is a dispute between agencies or providers as to payment for Early Intervention services provided under the IFSP, the Department shall ensure the provision of services without charge until the dispute is resolved.

## Mediation Process

Whenever a hearing is requested, parties must be offered the choice to resolve their disputes through a mediation process. Mediation may also be offered and accessed at any time to resolve a dispute. If mediation is requested, the Department shall promptly appoint a qualified and impartial mediator who is trained in effective mediation techniques. The mediator shall promptly schedule a meeting to be held within 14 days, unless otherwise requested by the parent, at a mutually convenient time and place.

1. The Department will send the parent(s) a list of free or low-cost attorneys and advocates who may be available to assist parents through the process.
2. The Department will ensure that the mediation process:
3. is voluntary on the part of the parties,
4. is not used to deny or delay a parent’s right to a due process hearing or any other rights afforded under Part C of the IDEA, and
5. is conducted by a qualified and impartial mediator.
6. The Department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of Early Intervention services. Mediators will be assigned randomly.

**Impartiality of Mediators**: An individual who serves in the role of a mediator

1. may not be an employee of the Department of Public Health or an Early Intervention program involved in the provision of Early Intervention services for the infant or toddler, and
2. may not have a personal or professional interest that conflicts with his/her own objectivity.

A person who is qualified and serves as a mediator is not an employee of the Department of Public Health but may be paid by the Department of Public Health to serve in the role of a mediator.

1. The Department shall bear the cost of the mediation process.
2. Each session in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties.
3. A parent may proceed with the hearing process while engaged in mediation. A parent may also request mediation at any time in the hearing process.
4. Discussions that occurred during mediation are confidential and may not be used as evidence in any subsequent due process hearing or civil proceedings of any federal or state court of a state receiving Part C funds. The parties to the mediation process may be required to sign a confidentiality pledge prior to the commencement of the process.
5. An agreement reached by the parties to the dispute in the mediation process must be set forth in a written legally binding mediation agreement.
6. The mediation agreement is signed by the parent or both parents and a representative of the Early Intervention program or agency who has the authority to bind such an agreement.
7. The signed written agreement is binding and enforceable in a court of competent jurisdiction or U.S. district court.

## Procedures to Address the Requests for Due Process Hearing

1. All requests for due process hearings must be filed with the Department.
2. Parents may file a request for a due process hearing not more than 2 years from the date that the parent or Early Intervention provider knew or should have known of the violation. The two-year timeline does not apply if the parent was prevented from filing a due process complaint due to:
3. a misrepresentation by the agency that it had resolved the problem that formed the basis of the complaint, or
4. the failure of the Early Intervention provider or lead agency to provide the parent with the information necessary to file the request.
5. The parent must send a copy of the complaint to the Early Intervention program at the same time a copy is sent to the Department. As needed or requested, the Department shall assist the parent in drafting and filing the complaint. The complaint must include:
6. A description of the issue(s) to be resolved relating to the proposed or refused initiation or change, including the facts relating to the dispute,
7. Signature and contact information of the complainant,
8. If there is an alleged violation in relation to a specific infant or toddler,
9. the name and address of the infant or toddler. In the case of a homeless infant or toddler, available contact information for the child to the extent known,
10. the name of the Early Intervention program,
11. a description of the nature of the problem or violation including the facts relating to the alleged violation or problem.

4. The party who is named in the request for hearing must provide a response to the dispute to the hearing officer within 5 days.

5. Upon receipt of a request for due process hearing under this section, the Department shall promptly appoint an impartial hearing officer who shall be knowledgeable about the provisions of Part C and the needs of and services available to eligible children. Such hearing officer shall be impartial.

* 1. **Impartiality of Hearing officers**: An individual who serves in the role of a hearing officer
* may not be an employee of the Department of Public Health or an Early Intervention program involved in the provision of Early Intervention services for the infant or toddler; and
* may not have a personal or professional interest that conflicts with his or her own objectivity.

b. A person who is otherwise qualified as a hearing officer is not an employee of the Department of Public Health but may be paid by the Department of Public Health to serve in the role of a hearing officer.

c. A hearing officer’s decision about whether an infant or toddler was appropriately identified, evaluated, and placed, or was provided with appropriate Early Intervention services, must be based on substantive grounds. A hearing officer may make a determination that an infant or toddler was not appropriately identified, evaluated, or placed, or provided appropriate Early Intervention services based on procedural violations only if the procedural violations:

1. impeded the child’s right to be identified, evaluated, and placed or to receive appropriate Early Intervention services,
2. impeded the parent’s right to participate in the decision-making process related to the identification, evaluation, or placement, of the child or the provision of appropriate Early Intervention services, or
3. caused a deprivation of educational or developmental benefit.

A hearing officer may order a provider to comply with the procedural requirement associated with any aspect of IDEA or these Operational Standards.

6. If a parent initiates a request for a due process hearing, the Department will inform the parent of the availability of mediation. The Department will send the parent(s) a list of free or low-cost attorneys and advocates who may be available to assist parents through the process.

7. The hearing officer shall: promptly arrange for a hearing at a time and a place that is reasonably convenient for the parents and duly notify the parties; listen to the presentation of the relevant viewpoints about the issue(s) in dispute; examine all information relevant to the issues; seek to reach a timely resolution of the complaint; provide a record of the proceedings; and mail a written decision to each of the parties.

8. The pre-trial and hearing process shall be governed by the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.00, unless otherwise noted and shall include the right to present evidence, and confront, cross-examine, and compel the attendance of witnesses. In addition, the parent shall have the right to:

1. have the child and family be accompanied and advised by their own legal counsel and by other individuals with special knowledge or training with respect to Early Intervention services,
2. present evidence and confront, cross-examine and compel the attendance of witness,
3. have the hearing closed to the public, unless otherwise requested by the parents,
4. prohibit the introduction of evidence not disclosed at least five days prior to the proceeding, unless agreed to by the parties,
5. have the child who is the subject of the hearing present,
6. be provided with an interpreter whenever feasible at no charge, if required for proper adjudication of the matter,
7. be provided with an electronic, or if unavailable, a written verbatim transcription of the proceeding at no cost to the parent, and
8. obtain written findings of fact and a written decision at no cost to the parent.
9. Each party must disclose (to the other party) all evaluations completed and associated recommendations.
10. The party requesting the hearing may not raise any issue(s) that were not raised in the due process complaint unless otherwise agreed to by the opposing party.
11. A decision shall be rendered within 30 days of receipt of the request for a hearing. A hearing officer may grant a specific exemption beyond 30 days at the request of either party.
12. Not later than 30 days after the receipt of a parent's complaint, unless an extension has been granted by the hearing officer, the parties shall be notified in writing of the decision, the reasons for the decision, all relevant findings of fact and conclusions of law, and the right to appeal the decision in state or federal court.
13. The Department will maintain a central file of decisions, which shall be a public record with the exception of personally identifying information.
14. The hearing officer’s decision shall be promptly implemented.
15. Any party aggrieved by the finding and decisions of the hearing officer has the right to bring a civil action in state or federal court within 90 days from the date of the decision of the hearing officer.

## Status of Child During Proceedings

1. During the pendency of any administrative or judicial proceeding involving a request for a due process hearing, unless the public agency and parents of a child otherwise agree, the child must continue to receive the appropriate Early Intervention services in the setting identified in the IFSP for which the parent had previously provided consent.
2. If the proceeding involves an application for initial services under this section, the child must receive the agreed upon services that are not in dispute.
3. This section does not apply if a child is transitioning from Early Intervention services under this part to preschool services under Part B of the IDEA.

# XIV. REQUEST FOR PROGRAMMATIC WAIVER, AND REQUEST FOR REIMBURSEMENT FOR SERVICES

A request for a programmatic waiver from these standards or a request for reimbursement for services may be made by submitting a written request to the Massachusetts Department of Public Health.

The Massachusetts Department of Public Health retains the authority to allow or deny the request.

The following provides the current list of requests:  
  
  
• Increased assessment hours (> 10 hours per year)  
• Increased center-individual visit (>2 hours per session)  
• Increased child group (> 2.5 hours per week)  
• Increased co-treatment (> 1 session per month)  
• Increased home visit (> 2 hours per clinical visit)  
• Increased parent group (> 1.5 hours per week)  
• Over 3 services  
  
• Services after child dies

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| Massachusetts Department of Public Health |
| Appendix A:  Massachusetts Early Intervention Diagnosed Conditions List |
| July 2013 |

**Massachusetts Department of Public Health**

**Early Intervention**

**DIAGNOSED CONDITIONS LIST**

*(Effective: October 1, 2015)*

All children diagnosed with one of the following non-asterisked established conditions that have a high probability of resulting in developmental delay, are eligible for early intervention services until the child’s third birthday, unless a change in the status of a diagnosis or condition resolves with medical/surgical treatment. Those diagnoses or conditions that may improve are denoted on the list with an asterisk \* and are underlined. These conditions can be entered on only ONE evaluation and will have an eligibility timeframe of one year. The evaluation having this condition does NOT have to be the initial evaluation. No other evaluations for this child can have this same asterisked established condition

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| **SENSORY CONDITIONS** | | | | | | |
| *BLINDNESS* | | | |  | | |
| H54.0 | |  | | Blindness, both eyes (Note: 10/1/17 not valid for insurers) | | |
| H54.40 | |  | | Blindness, one eye | | |
| H47.619 | |  | | Cortical Blindness/Cortical Vision Impairment | | |
| H47.20 | |  | | Optic Nerve Atrophy | | |
| H35.179 | | \* | | Retinopathy of Prematurity | | |
| *LOW VISION* | | | | | | |
| H54.2 | |  | | Low vision, both eyes (Note: 10/1/17 not valid for insurers)  *(20/70 best acuity with correction)* | | |
| H54.52 | | \* | | Low vision, left eye, normal vision right eye  (Note: 10/1/17 not valid for insurers) | | |
| H54.51 | | \* | | Low vision, right eye, normal vision left eye  (Note: 10/1/17 not valid for insurers) | | |
| *HEARING LOSS (permanent)* | | | | | | |
| H91.93 | |  | | Hearing impairment, bilateral | | |
| H91.92 | |  | | Hearing impairment, left ear | | |
| H91.91 | |  | | Hearing impairment, right ear | | |
| H90.3 | |  | | Neural hearing loss/auditory neuropathy | | |
| **CANCERS** | | | | | | |
| C80.1 | |  | | Cancer, Other *(not included on this list)* | | |
| C95.90 | |  | | Leukemia | | |
| C82.50 | |  | | Lymphoma | | |
| C71.9 | |  | | Malignant neoplasm of brain | | |
| C64.9 | |  | | Malignant neoplasm of kidney | | |
| C41.9 | |  | | Osteosarcoma | | |
| C49.3 | |  | | Rhabdomyosarcoma | | |
| **CARDIAC CONDITIONS** | | | | | | |
| Q21.2 | |  | | Atrioventricular canal defect | | |
| I42.9 | |  | | Cardiomyopathy | | |
| Q25.1 | |  | | Coarctation of the aorta | | |
| I27.0 | |  | | Hypertension, pulmonary | | |
| Q23.4 | |  | | Hypoplastic left heart syndrome | | |
| Q24.9 | |  | | Major cardiac anamoly, other  *(not included on this list)* | | |
| Q21.3 | |  | | Tetralogy of Fallot | | |
| Q20.3 | |  | | Transposition of great vessels | | |
| **CENTRAL NERVOUS SYSTEM DISORDERS** | | | | | | |
| Q04.0 | |  | | Aicardi syndrome | | |
| Q00.0 | |  | | Anencephaly | | |
| G11.3 | |  | | Ataxia-Telangiectasia | | |
| G37.9 | |  | | Brain Sclerosis | | |
| G12.22 | |  | | Bulbar palsy | | |
| Q04.9 | |  | | Cerebral atrophy, congenital | | |
| G80.9 | |  | | Cerebral palsy | | |
| I61.9 | |  | | Cerebrovascular accident *(CVA)* | | |
| Q04.6 | |  | | Congenital Schizencephaly | | |
| Q03.1 | |  | | Dandy-Walker malformation | | |
| G80.1 | |  | | Diplegia | | |
| G04.90 | |  | | Encephalitis | | |
| Q01.9 | |  | | Encephalocele | | |
| G93.40 | |  | | Encephalopathy | |
| G40.901 | |  | | Epilepsy | |
| **CENTRAL NERVOUS SYSTEM DISORDERS** *(Continued)* | | | | |
| G81.90 |  | | Hemiparesis/Hemiplegia | |
| Q04.2 |  | | Holoprosencephaly | |
| Q04.3 |  | | Hydranencephaly | |
| Q04.3 |  | | Hypoplasia of the brain | |
| G40.401 |  | | Hypsarrhythmia | |
| P52.21 | \* | | Intraventricular hemorrhage *(grade 3)* | |
| P52.22 | \* | | Intraventricular hemorrhage *(grade 4)* | |
| E75.25 |  | | Leukodystrophy/Canavan disease | |
| Q04.3 |  | | Lissencephaly | |
| G03.9 |  | | Meningitis *with negative long-term effects* | |
| Q02 |  | | Microcephaly | |
| P96.1 | \* | | Neonatal Abstinence Syndrome | |
| Q04.3 |  | | Polymicrogyria | |
| G40.401 |  | | Spasms, infantile | |
| Q05.9 |  | | Spina bifida/Myelomenigocele | |
| P11.5 |  | | Spinal Cord Injury at birth | |
| S14.109A |  | | Spinal Cord Injury not at birth, *cervical* spinal cord | |
| S34.109A |  | | Spinal Cord Injury not at birth, *lumbar* spinal cord | |
| S34.139A |  | | Spinal Cord Injury not at birth, *sacral* spinal cord | |
| S24.109A |  | | Spinal Cord Injury not at birth, *thoracic* spinal cord | |
| Q05.9 |  | | Spinal Lipomeningocele | |
| Q85.8 |  | | Sturge-Weber disease | |
| **CHROMOSOMAL DISORDERS** | | | | |
| Q93.4 |  | | Cat Cry Syndrome *(Cri-du-Chat)* | |
| Q99.9 |  | | Chromosomal Anomaly  *(including trisomies, deletions,* d*uplications,*  *translocations,inversions, rings & isochromosome)*  *Exceptions: Klinfelter’s Syndrome, Turner Syndrome)* | |
| Q87.1 |  | | Cornelia De Lange Syndrome | |
| Q90.9 |  | | Down Syndrome | |
| Q99.2 |  | | Fragile X syndrome | |
| Q87.1 |  | | Prader-Willi Syndrome | |
| Q93.88 |  | | Smith-Magenis Syndrome | |
| **METABOLIC DISORDERS** | | | | |
| E72.9 |  | | Amino acid metabolism disorder | |
| E88.1 |  | | Congenital lipodystrophy | |
| E74.21 | \* | | Galactosemia | |
| E75.10 |  | | Gangliosidosis | |
| E74.00 |  | | Glycogen storage disease | |
| E76.1 |  | | Hunter syndrome | |
| E83.39 |  | | Hypophosphatasia | |
| E71.310 |  | | LCHAD *(Long Chain Acyl CoA Dehydrogenase*  *Deficiency)* | |
| E71.0 | \* | | Maple syrup urine disease | |
| E83.09 |  | | Menkes Syndrome | |
| E71.120 |  | | Methylmalonic acidemia | |
| E76.3 |  | | Mucopolysaccharidosis | |
| E70.0 | \* | | Phenylketonuria *(PKU)* | |
| E71.121 |  | | Propionic acidemia | |
| Q87.1 |  | | Sjogren-Larsson Syndrome | |
| E75.02 |  | | Tay-Sachs disease | |

**Massachusetts Early Intervention**

**DIAGNOSED CONDITIONS LIST**

*(Effective: October 1, 2015)*

All children diagnosed with one of the following non-asterisked established conditions that have a high probability of resulting in developmental delay, are eligible for early intervention services until the child’s third birthday, unless a change in the status of a diagnosis or condition resolves with medical/surgical treatment. Those diagnoses or conditions that may improve are denoted on the list with an asterisk \* and are underlined. These conditions can be entered on only ONE evaluation and will have an eligibility timeframe of one year. The evaluation having this condition does NOT have to be the initial evaluation. No other evaluations for this child can have this same asterisked established condition.

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| **SKELETAL DISORDERS** | | | | | | | |
| M08.00 | |  | | Arthritis, juvenile rheumatoid | | | |
| Q74.3 | |  | | Arthrogryposis | | | |
| Q87.40 | |  | | Beals Syndrome | | | |
| Q74.0 | |  | | Cleidocranial Dysostosis | | | |
| Q75.0 | |  | | Craniostenosis | | | |
| Q75.1 | |  | | Crouzon's Syndrome | | | |
| Q87.0 | |  | | Mobius sequence | | | |
| Q87.0 | |  | | Nager-de Reynier Syndrome | | | |
| Q78.0 | |  | | Osteogenesis imperfecta | | | |
| Q72.90 | |  | | Proximal Focal Fibula Deficiency  *(PFFD w/fibula hemimelia)* | | | |
| Q68.1 | | \* | | Radial Club Hand | | | |
| **OTHER DISORDERS** | | | | | | | |
| Q73.0 | |  | | Absence of limb | | | |
| Q77.4 | |  | | Achondroplasia | | | |
| P02.9 | |  | | ADAM Complex | | | |
| B20 | |  | | AIDS | | | |
| Q44.7 | |  | | Alagille Syndrome | | | |
| Q93.5 | |  | | Angelman Syndrome | | | |
| Q87.0 | |  | | Apert Syndrome | | | |
| D61.9 | |  | | Aplastic anemia | | | |
| F84.0 | |  | | Autism spectrum disorder | | | |
| Q87.3 | |  | | Beckwith-Wiedemann Syndrome | | | |
| D61.01 | |  | | Blackfan-Diamond Syndrome | | | |
| Q82.3 | |  | | Bloch-Sulzberger Syndrome | | | |
| Q92.8 | |  | | Cat Eye Syndrome | | | |
| Q89.8 | |  | | CHARGE Syndrome | | | |
| Q37.9 | | \* | | Cleft lip and palate | | | |
| Q35.9 | | \* | | Cleft palate | | | |
| Q87.1 | |  | | Cockayne Syndrome | | | |
| P35.1 | |  | | Congenital CMV - Cytomegalovirus | | | |
| Q89.4 | |  | | Conjoined twin | | | |
| E84.9 | |  | | Cystic fibrosis | | | |
| D82.1 | |  | | DiGeorge Syndrome | | | |
| Q79.6 | |  | | Ehlers-Danlos Syndrome | | | |
| D22.9 | |  | | Epidermal Nevus Syndrome | | | |
| Q81.9 | |  | | Epidermolysis Bullosa | | | |
| N04.9 | |  | | Epstein's Syndrome | | | |
| P14.0 | |  | | Erb's palsy *(Brachial Plexis injury)* | | | |
| R62.51 | | \* | | Failure to Thrive | | | |
| D61.09 | |  | | Fanconi Anemia | | | |
| P04.3 | |  | | Fetal Alcohol effects | | | |
| Q86.0 | |  | | Fetal Alcohol Syndrome | | | |
| Q79.3 | |  | | Gastroschisis | | | |
| Q87.0 | |  | | Goldenhar Syndrome | | | |
| Q67.4 | |  | | Hemifacial Microsomia | | | |
| P35.2 | |  | | Herpes, congenital | | | |
| P83.2 | |  | | Hydrops-Fetalis | | | |
| E03.1 | |  | | Hypothyroidism, congenital | | | |
| P57.9 | |  | | Kernicterus | | | |
| Q76.1 | |  | | Klippel-Feil Syndrome | | | |
| **OTHER DISORDERS** *(Continued)* | | | | | | | |
| Q74.8 |  | | Larsen Syndrome | |
| G31.82 |  | | Leigh's Disease | | | |
| K76.9 |  | | Liver disease and/or dysfunction | | | |
| Q78.5 |  | | Metaphyseal dysplasia | | | |
| G71.3 |  | | Mitochondrial myopathy | | | |
| I67.5 |  | | Moyamoya disease | | | |
| G71.0 |  | | Muscular dystrophy/Duchenne's | | | |
|  |  | | *(includes progressive muscular atrophy)* | | | |
| D46.9 |  | | Myelodysplasia | | |
| G71.11 |  | | Myotonic dystrophy | | |
| Q85.00 |  | | Neurofibromatosis | | |
| Q87.1 |  | | Noonan Syndrome | | |
| J38.00 |  | | Paralysis, vocal cords | | |
| Q87.0 | \* | | Pierre Robin Syndrome | | |
| F84.2 |  | | Rett Syndrome | | |
| P35.0 |  | | Rubella, congenital | | |
| Q87.2 |  | | Rubinstein-Taybi Syndrome | | |
| Q87.1 |  | | Russell-Silver Syndrome | | |
| T74.4XXA |  | | Shaken Baby Syndrome | | |
| E78.72 |  | | Smith-Lemli-Optiz Syndrome | | |
| Q87.3 |  | | Sotos Syndrome | | |
| Q89.8 |  | | Stickler Syndrome | | |
| Q68.0 | \* | | Torticollis, congenital | | |
| P37.1 |  | | Toxoplasmosis, congenital | | |
| S06.1X0A |  | | Traumatic Head Injury | | |
| Q75.4 |  | | Treacher Collins Syndrome | | |
| Q85.1 |  | | Tuberous Sclerosis | | |
| Q87.2 |  | | VACTER Syndrome | | |
| Q79.8 |  | | Waardenburg-Klein Syndrome | | |
| Q87.89 |  | | Williams Syndrome | | |
| D82.0 |  | | Wiskott-Aldrich Syndrome | | |

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| Massachusetts Department of Public Health |
| Appendix B:  DPH/DCF Referral Policy |
| July 2013 |

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| **DCF** | **COMMONWEALTH OF MASSACHUSETTS ~ DEPARTMENT OF CHILDREN AND FAMILIES** | |
| **Policy Name:** Early Intervention Policy | |
| **Policy #:**  2011-01 | **Approved by:** |
| **Effective Date:** March 1, 2011 |  |
| **Revision Date(s):** NA |

**EARLY INTERVENTION REFERRAL POLICY**

**Policy**

Early intervention programs provide services to families of children under 3 years of age about whom concerns of developmental delays exist due to identified disabilities or their birth or environmental circumstances. The Department of Children and Families (DCF) regards referrals to early intervention programs as an opportunity to facilitate a connection for families to services they may need to assist their children in coping with developmental delays. DCF informs the family, in writing, that the referral is being made.

**Federally Required Referrals**

The federal Child Abuse Prevention and Treatment Act, as amended June 25, 2003, requires DCF to refer to early intervention programs families in which a 51B investigation is supported on a child who is under 3 years of age. In completing this mandatory referral, DCF recognizes its obligation to maintain strict confidentiality regarding family information. For this reason, DCF provides the minimum information necessary to enable the provider to contact the family and assist them in determining whether they can benefit from early intervention services.

**Voluntary Referrals**

DCF also supports access to early intervention services for any other family with a child under the age of 3 when it appears that such services might be beneficial. Under these circumstances, DCF works with the family to determine whether the family will contact the early intervention services provider directly or whether DCF will complete a referral. Prior to completing a referral, DCF obtains written parental authorization to release information to the early intervention services provider.

**Procedures: Required Referrals**

1. **Notice to Family.** When DCF supports a 51B investigation involving a reported child under age 3 years, the Investigator orally provides to the parents the following information:

* Early intervention programs assess children under age 3 to determine whether they are experiencing developmental delays and or are at risk for developmental delays. If the early intervention provider determines the child to be eligible, the family is offered early intervention services.
* DCF is required by federal law to refer the family to an early intervention program and will be providing an early intervention services provider with the minimum information needed to contact the family. *(NOTE: If known, the Investigator also provides to the family the name and contact information for the early intervention services provider that will be contacting the parent to arrange an assessment.)*
* Early intervention services are voluntary. Parents have the right to refuse the family’s participation in the assessment and may decline any offer of services. If DCF is subsequently notified of the family’s refusal to participate when offered an assessment by the early intervention provider or to participate in service provision for which the early intervention provider found the child eligible, DCF may consider the information during any future decision-making.

Information about federally required referrals is also included in the DCF written guidebook for parents.

1. **Referral to Early Intervention Program.** DCF provides a written referral for the child to an early intervention provider that serves the geographical area in which the child resides. The referral includes the following information:

* Child’s name, date of birth, address;
* Parent names, addresses and telephone numbers; and
* When the child is in placement, name, address and telephone number of the foster/pre-adoptive parent or other provider with whom the child is residing.

A copy of the referral is sent to the parents unless DCF determines that concerns regarding danger and safety to the child or another family member prevent release of the referral information to the parents. If the child is in placement, a copy of the referral is also sent to the foster/pre-adoptive or other provider. *[NOTE: Information regarding the placement provider’s name, address and telephone number is deleted from the copy of the referral sent to the parents.]*

The referral letter is prepared by the DCF Investigator except when an emergency response is completed and supported and the decision is made to open a case or DCF services. Under these circumstances, the referral letter is prepared by the DCF Social Worker assigned to complete the assessment.

***Timeframe for Completing the Early Intervention Referral.*** The referral is normally within 5 working days of the Support decision. If a referral to the District Attorney is being completed, the referral is not sent to the early intervention provider nor is a copy mailed to the parents (or the foster/pre-adoptive parent or other provider) until after the notification regarding the investigation outcome is sent to the parents.

***If the child is the subject of more than one supported 51B investigation during a calendar month***, only one referral is sent. If the child is the subject of one or more supported 51B investigations during a subsequent month, an additional referral is completed.

***If the child about whom the 51B investigation report is supported lives out of state***, the DCF Investigator informs the parents about early intervention services and provides her/him with information about how to contact the child welfare agency in the state where the child lives for early intervention program and contact information.

In a situation where a reported child under the age of 3 has died referrals to EI should be considered for any other children in the household under age 3.

**Assessment and Service Planning**. When the family of a referred child is assigned for a DCF assessment or has an already open DCF case, the DCF Social Worker obtains a release of information, if not already obtained, from a parent, to allow for communication of results of the early intervention eligibility evaluation. She/he works with the family to determine how the early intervention program’s findings and decisions will affect DCF’s work with the family. When appropriate, and the family agrees, the DCF Social Worker and/or family invites the early intervention program to participate in service planning with the family and DCF.

1. **Follow-Up.** If DCF receives information from the early intervention program that the family has refused to participate in the assessment or has declined services, the Area Director/designee informs the child’s DCF Social Worker (when assigned) who considers the information, in consultation with her/his Supervisor (at a minimum), during decision-making regarding the child and family.

Even when participation in an early intervention assessment or services has been stipulated in the DCF Service Plan, information that the family has refused to participate or declined early intervention services CANNOT be the sole basis for filing a 51A report.

**Procedures: Voluntary Referrals**

1. **Informing the Family about Early Intervention Services.** Under circumstances other than those described above which require a referral, the DCF Social Worker or Investigator, as assigned, orally provides to the parents of a child under age 3 the following information:

* Early intervention programs assess children under age 3 to determine whether they are experiencing developmental delays or are at risk of developmental delays. Children determined eligible are offered early intervention services.
* Early intervention services are voluntary. Parents have the right to refuse the family’s participation in the assessment and may decline any offer of services.

1. **Completing the Referral. The DCF Social Worker or Investigator, as assigned, works with the family to determine whether the family will contact the early intervention services provider on their own or DCF will complete a referral.**

* Self Referral: The DCF Social Worker or Investigator, as assigned, provides to the family the name and contact information for one or more early intervention programs serving the geographical location in which the family resides.
* DCF Referral: The DCF Social Worker or Investigator, as assigned, obtains written parental authorization to release information regarding the child and family. Then she/he provides a written referral to an early intervention provider that serves the geographical area in which the child resides (copy to the family with modifications—described in dictation—if necessary to maintain the safety of the child or another family member). The referral includes:
* child’s name, date of birth, address;
* parent names, addresses and telephone numbers; and
* other information as required by the early intervention services provider.

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| Massachusetts Department of Public Health |
| Appendix C:  Interagency Agreement on Transitions |
| July 2013 |

**Interagency Agreement**

**Between**

**The Massachusetts Department of Public Health**

**And**

**The Massachusetts Department of Elementary and Secondary Education**

**Addressing**

**Transition from Early Intervention Programs (Part C)**

**to Early Childhood Special Education Services (Part B)**

WHEREAS the Massachusetts Department of Elementary and Secondary Education (ESE), organized under G.L. c. 15 and c. 69, is the designated state educational agency (SEA) under 34 CFR §§ 300.41 and 300.149, and, as such, receives federal special education funds under Part B of the Individuals with Disabilities Education Act (IDEA), 20 USC §1400 *et seq.*, including Section 619[[4]](#footnote-6) funds for preschool children;

WHEREAS the Massachusetts Department of Public Health (DPH), organized and governed by G.L. c. 17 and 111-111N, is the designated state lead agency for Early Intervention services and, as such, receives federal funds under Part C of the Individuals with Disabilities Education Act (IDEA);

WHEREAS the parties are required by 34 C.F.R. § 303.209(a)(3)(ii)A to enter into an interagency agreement to ensure a seamless transition from Part C services to Part B services for eligible children;

WHEREAS the parties recognize the existing collaborations that have evolved at the local level to promote seamless transitions;

WHEREAS community Early Intervention Programs (EIPs) and school districts are in an optimal position to recognize the developmental, educational, social/emotional, linguistic, ethnic, and cultural diversity within their communities as they relate to the process of child find, identification and implementation activities associated with early childhood transitions; and

WHEREAS the parties are committed to assisting EIPs and LEAs with developing a seamless transition process for eligible children;

NOW, THEREFORE, in consideration thereof, the parties agree as follows:

**I. JOINT RESPONSIBILITIES**

1. Utilize agency resources to provide guidance, training and/or technical assistance to support the ongoing efforts of EIPs and LEAs to develop local procedures that identify processes and procedures to support young children and their families during the transition.
2. Designate staff to serve on a cross agency committee, board, and/or council. Such group will address any concerns, data updates, and other issues regarding this agreement or the processes described within the agreement.
3. DPH will disclose data to ESE, in accordance with the specifications set out in Section IV of this agreement, for the purposes of State Performance Plan (SPP) and Annual Performance Reports (APR), and for other compliance or evaluation purposes as necessary to ensure effective transitions from Part C programs to Part B programs as required by the IDEA. The Parties agree to adhere to all requirements set forth under the IDEA and the Family Educational Rights and Privacy Act (FERPA).
4. Define a child “potentially eligible for Part B services” as a child eligible for Part C[[5]](#footnote-7) services who appears to meet the criteria for one or more of the following disabilities or impairments consistent with the definitions of 603 CMR 28.02:[[6]](#footnote-8)
   * 1. Autism
     2. Developmental Delay
     3. Intellectual Impairment
     4. Hearing Impaired or Deaf
     5. Vision Impaired or Blind
     6. Deafblind
     7. Neurological Impairment
     8. Emotional Impairment
     9. Communication Impairment
     10. Physical Impairment
     11. Health Impairment
     12. Specific Learning Disability,

or a combination of the above disabilities such that the child is considered to have multiple disabilities.

1. Collaborate to ensure requirements associated with transition, including child find, identification, evaluation, and Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) development and implementation, are met in accordance with state and federal requirements.

**II. RESPONSIBILITIES of DPH**

A. Develop policies and procedures to ensure the timely notification to school districts and SEA of toddlers potentially eligible for Part B services including referral, development of transition plans, and arranging for transition planning conferences that reflect the statutory and regulatory requirements of Part C.

B. Implement general supervision and monitoring activities to ensure compliance with the following standards by EIPs:

1. Notification of Toddlers Potentially Eligible for Part B Services

1. EIPs will notify the LEA and DPH of children currently receiving early intervention services who are potentially eligible for Part B services no later than 90 days, and, at the discretion of the parent and EIP, up to 9 months before the child’s third birthday.
2. EIPs will notify the LEA and DPH as soon as possible of children potentially eligible for Part B services who have been determined eligible for Part C services at least 45 days before, and within 90 days of, their third birthday.
3. EIPs will, with parental consent, notify the LEA and DPH of toddlers who are potentially eligible for Part B services who have been referred within 45 days of their third birthday. The EIP will not be responsible for conducting an evaluation to determine eligibility for Part C services if the child is referred 45 or fewer days before his/her third birthday, but may do so at its discretion and with parental consent.

2. Convening a Transition Planning Conference

1. The EIP, with the family’s approval, will convene a transition planning conference at least 90 days, or at the discretion of the parties, up to 9 months, before the child’s third birthday. The Special Education Administrator of the school district, or other designee of the school district, will be notified of the transition planning conference early enough to allow for participation. The purpose of the conference is to discuss any services the toddler may receive under Part B and to determine appropriate activities to prepare the child and family for smooth transition from Part C services to Part B services, if eligible.
2. If the transition planning conference occurs as part of an IFSP meeting or IFSP review meeting, the meeting/transition conference must meet all of the requirements of any IFSP meeting including providing notice to families.
3. Participants for a transition planning conference that occurs as part of an IFSP meeting or IFSP review meeting will provide for the participation of the IFSP team members typically required for any IFSP meeting plus a representative of the LEA to which the student is being referred.
4. Participants for a transition planning conference that occurs outside of an IFSP Meeting or IFSP review meeting will include a representative of the school district that received the referral, the parent or parents of the child, the EIP service coordinator, and others the parent identifies to be part of the development of the transition plan, if feasible. If a person who would otherwise participate in the transition planning conference is unable to attend the meeting, arrangements are made for the person's involvement through other means.

3. Development of a Transition Plan

Each transition plan must reflect the individualized activities, supports, and services necessary to ensure a smooth transition. The plan will identify timelines and person(s) responsible for ensuring that transition activities occur, and will include:

1. An explanation to families that transition planning activities occur for all children beginning at any time, but no later than 90 days, and at the discretion of the parent, EI program, and other participants the family would like to include, up to 9 months, before the child’s third birthday;
2. Documentation or confirmation that notification to the school district and DPH occurred;
3. Identification of steps and/or services necessary for the child or his/her family to promote a smooth transition;
4. Review the program options for the toddler for the period from the child’s third birthday through the remainder of the school year; and
5. Documentation or confirmation that information related to the child that may assist in the transition (e.g. evaluations/assessments, IFSP) is sent to the school district with written parental consent. The transmission of pertinent records which would avoid duplication of evaluations, support the process for determining Part B eligibility, contribute to the development of an IEP, and facilitate the continuity of services when the child turns three, is strongly encouraged.

C. Submit data to ESE in accordance with section IV of this agreement.

**III. RESPONSIBILITIES of ESE**

1. Implement general supervision and monitoring activities to ensure children eligible for Part B services have an IEP or, at the election of the local school district under 603 CMR § 28.06(7)(c), the format and services of an IFSP developed and implemented by the child’s third birthday. (20 USC 1412(a)(9), 34 C.F.R. §§ 300.101(b) and 300.124(b)). If the district elects to use the IFSP format, it may be used only for one additional year after the child turns three and the following must be completed:
   1. The child’s parents are provided with a detailed explanation of the differences between an IEP and an IFSP;
   2. Written informed consent is obtained from the parent if the parent chooses an IFSP;
   3. The IFSP includes an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills for a child with an IFSP who is at least three years of age; and
   4. The IFSP is developed in accordance with the IEP procedures under Part B of the IDEA (20 USC § 1414(d)(2)(B) and 34 C.F.R. § 300.323(b)).
2. Maintain a process for ESE to receive data pertaining to children potentially eligible for Part B services who will soon reach age three (3), from DPH. Such data shall consist of the elements set forth in IV A. ESE will provide DPH access to ESE’s secure web portal for the purpose of disclosure of the data to ESE according to the terms of this interagency agreement (Agreement). ESE also will provide technical assistance to DPH, as necessary, to ensure the effective and secure transmission of the data.
3. Provide administrative advisories, guidance, training, or technical assistance to inform school districts of their obligation to participate in transition planning conferences arranged by the local EIP for toddlers who may be eligible for preschool services under Part B (20 USC §1412(a)(9) and 34 C.F.R. § 300.124).
4. Provide administrative advisories, guidance, training, or technical assistance to remind school districts of their obligation to invite the family’s Early Intervention service coordinator or other Early Intervention representative to the child’s initial IEP meeting if the parent or guardian requests that he or she be invited.
5. Provide administrative advisories, guidance, training, or technical assistance to advise district representatives and inform other IEP meeting participants to consider the contents of the most recent IFSP (including the natural environments statement) when developing the initial IEP).

**IV. DATA**

1. Data Elements

Once DPH receives notification from an EIP that a child has been identified as potentially eligible for Part B services, DPH will store that information in a database designated for this purpose. DPH will then disclose the following data elements to ESE :

* 1. Child’s first name
  2. Child’s last name
  3. Child’s date of birth
  4. Primary contact person
  5. Primary contact person’s address
  6. Primary contact person’s phone number.

1. Data Submission

As often as necessary, but no less often than once per calendar month, DPH will disclose the data elements to ESE through ESE’s secure web portal. ESE will notify DPH via email within three days of receipt of the data to confirm that the file was received. If ESE determines that the file is corrupt or has any other difficulty with the file, ESE will notify DPH and request that the file be submitted again, if necessary and appropriate.

1. Access to ESE Portal and Technical Assistance

ESE will assign login credentials to authorized staff at DPH, as determined by DPH, for purposes of accessing ESE’s secure web portal. DPH staff will have full access to the parts of the web portal that are relevant to the terms of this Agreement.

In the event that DPH staff require technical assistance with the web portal, they will contact Robert Curtin at [rcurtin@doe.mass](mailto:rcurtin@doe.mass) who will respond by email or telephone, or arrange for another ESE staff person to contact DPH to provide the necessary assistance.

1. Data Security

The ESE web portal is protected by the Entrust Getaccess product to secure applications which offers commercial grade and authorization protection for web applications. An independent third party security audit and penetration test was completed two years ago to verify the safety of the site and it passed all tests. To provide even greater security and protection against advanced web threats, the security infrastructure will be upgraded over the next several months.

**V. MODIFICATION and TERMINATION of the AGREEMENT**

Either party may propose a modification of the Agreement or may terminate the agreement with written notice by email and first class mail to the individual designated in Section VI. In the event of a proposed modification, both parties must approve the changes to amend this Agreement. Termination of the Agreement shall be effective thirty (30) days after the written notice is received by the other party.

**VI. KEY CONTACTS**

The following individuals are key contacts for this Agreement and for written notice provided under Section V.

DPH: Ron Benham

Part C Director

Massachusetts Department of Public Health

250 Washington St., 5th floor

Boston, MA 02108

ron.benham@massmail.state.mass.us

ESE: Marcia Mittnacht

Part B Director

Massachusetts Department of Elementary and Secondary Education

75 Pleasant Street   
Malden, MA 02148-4906

[mmmittnacht@doe.mass.edu](mailto:mmmittnacht@doe.mass.edu)

**VII. SIGNATURES**

Signed 4/16/2013 by 
Ron Benham, IDEA Part C Director, Department of Public Health
and
Marcia Mittnacht, IDEA Part B Director, Department of Elementary and Secondary Education


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| --- |
| Massachusetts Department of Public Health |
| Appendix D:  Early Childhood Memorandum of Understanding (MOU) |
| July 2013 |

* *A Memorandum of Understanding Concerning Early Childhood Programs*
* *By and Among*
* *Massachusetts Executive Office of Education,*
* *Massachusetts Department of Early Education and Care,*
* *Massachusetts Department of Elementary and Secondary Education,*
* *Massachusetts Executive Office of Health and Human Services,*
* *Massachusetts Department of Public Health and*
* *U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, Region I and Region XII*
* PARTIES

The Massachusetts Executive Office of Education (EOE) is organized under G.L. c. 6A, §14A, and is the secretariat that includes the departments of early education and care, elementary and secondary education and higher education. Among other things, the secretary is responsible for reviewing and approving mission statements and 5-year master plans encompassing each sector of the public education system, including early education and care, elementary and secondary education and higher education.

The Massachusetts Department of Early Education and Care (EEC) is organized under G.L. c. 15D and is the state lead agency for the administration of all public and private early education and care programs and services. EEC receives funding from various sources to provide support to and services for children with disabilities, including, but not limited to, federal funding under the Child Care Development Fund (CCDF) and under Section 619 of Part B of the Individuals with Disabilities Education Act through the Massachusetts Department of Elementary and Secondary Education. EEC is within the EOE secretariat.

The Massachusetts Department of Elementary and Secondary Education (ESE) is organized under G.L. c. 15A, is the designated state educational agency and, as such, receives federal special education funds under Part B of the Individuals with Disabilities Education Act (IDEA), including Section 619 funds for preschool children. ESE is within the EOE secretariat.

The Massachusetts Executive Office of Health and Human Services (EOHHS) is established by M.G.L. c. 6A, s. 16, and serves as the principal agency of the Executive Department for the purpose of developing, coordinating, administering and managing health, welfare and human services operations.

The Massachusetts Department of Public Health (DPH) is organized and governed by M.G.L. chapters 17, 111 and 111-111N, is the designated state lead agency for Early Intervention services, and as such, receives federal funds under Part C of the Individuals with Disabilities Education Act (IDEA). DPH is within the EOHHS secretariat.

The Administration for Children and Families (ACF) was created in 1991 to consolidate U.S. Department of Health and Human Services programs supporting children and families into one organization.  Within ACF, the Head Start program, authorized under 42 USC 9801 *et seq*. and administered by the Office of Head Start, provides federal grants to local public and private non-profits and for-profit agencies to provide comprehensive child development services, such as education, health, nutrition, social and other services, to pregnant women, economically disadvantaged children birth to five years of age, and families to promote school readiness. Head Start programs engage parents in their children’s learning, help them make progress toward their education, literacy and employment goals, and place significant emphasis on the involvement of parents in the administration of local Head Start programs.

STATEMENT OF PURPOSE

The Massachusetts Executive Office of Education (EOE), the Massachusetts Department of Early Education and Care (EEC), the Massachusetts Department of Elementary and Secondary Education (ESE), the Massachusetts Executive Office of Health and Human Services (EOHHS), the Massachusetts Department of Public Health (DPH), and the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, Region 1 and XII (ACF), hereafter collectively referred to as the “parties”, enter into this Memorandum of Understanding (hereafter “the MOU”) to promote coordination and collaboration in the provision of services to eligible infants, toddlers and preschool children with disabilities and their families, as applicable, through Early Intervention and early education and care programs including Head Start, Early Head Start, Migrant and Seasonal Head Start, public school pre-schools,[[7]](#footnote-9) for children with disabilities in the Commonwealth.

The principles expressed in this Agreement will guide the parties’ coordination of activities across programs in implementing Parts B and C of the Individuals with Disabilities Education Act (IDEA)[[8]](#footnote-10), as well as EEC[[9]](#footnote-11) and Head Start statutes and regulations related to young children with disabilities[[10]](#footnote-12).

The MOU is also intended to be used as a guide for strengthening local collaboration for developing regional and/or local agreements, and for strengthening relationships among agencies and programs serving young children, with and without disabilities, and their families.

The parties agree to work toward the availability of quality, inclusive early childhood options for all young children and their families, in order to provide high-quality child development, health, and early education and care services. The parties also agree to make efforts to increase the availability of programs that offer a range of local services and supports for eligible children and their families.

The parties agree that this collaboration includes cross-system coordination of:

* child-find;
* intake;
* screening;
* referral;
* assessment/evaluation;
* development and implementation of individual child and family plans, including, but not limited to, Family Partnership Agreements (FPAs), Individualized Family Service Plans (IFSPs), and coordinated case management, as well as Individualized Educational Programs (IEPs) for children and families participating in services across multiple agencies;
* transition from one program to another; and
* training and technical assistance.

The parties recognize that their respective roles and responsibilities are governed by federal and state laws, policies and standards applicable to their respective programs. The MOU describes shared responsibilities when multiple programs are working in partnership. The MOU does not supersede federal and state laws, policies and standards applicable to the programs administered by the respective parties. Rather, the MOU is intended to assist providers to meet state and federal requirements, as well as the Massachusetts Quality Rating and Improvement System Standards, Early Learning Guidelines for Infants and Toddlers, and Guidelines for Preschool Learning Experiences, and the quality standards of other organizations as applicable, such as the Head Start Child Development and Early Learning Framework.

The parties to the agreement will work to use language that is clear, respectful and reflects the role of parents and families under the laws, policies and standards of the respective programs.**3**

PRINCIPLES

The principles below guide the work of the parties under this agreement. To the extent feasible and consistent with the laws and policies applicable to the program(s) administered by the respective parties, the parties will promote practices that are centered on eligible families’ interests and needs; systems[[11]](#footnote-13) that are accessible to families; and program resources that are inclusive of families whose children have disabilities, and are sensitive and attentive to the culture and language of individual families.[[12]](#footnote-14) The rights of parents and their children will be observed as the parties work together to coordinate and/or provide high-quality child development, health, and early education and care services.

|  |  |
| --- | --- |
| **Collaborative** | There is a coordinated and unified effort among programs and systems:   * that maximizes the array of services and supports, where appropriate, to address the breadth and depth of a child’s and family’s specific needs; and * that provide services seamlessly, even when the child and family are involved in multiple programs and systems and when they transition from one to another. |
| **Community-based** | Services, programs and resources are provided where and with whom young children and their families live, attend school and/or spend time. The system fosters the capacity of communities to support young children and their families. |
| **Confidential** | Parents have access to personal information about their children and themselves held by the parties and providers, which may not be released without parental consent except as authorized by applicable federal and state law. |
| **Continuity of care** | Systems promote consistency among caregivers. To the extent permitted by federal and state privacy and confidentiality laws, there is consistent and reliable communication among various providers with individual families and that services and supports are coordinated across programs and settings, especially when children are at risk of disrupted services related to transiency. |
| **Continuous improvement** | Resources, services and systems are continuously reviewed, adjusted and updated as needed, so that each child, family, and provider has opportunities for life-long learning. |
| **Developmentally appropriate** | The process of making decisions about the well-being and education of children is based on:   * Research on child development: knowledge of age-related human characteristics that permits general predictions within an age range about what activities, materials, interactions or experiences will be safe, healthy, stimulating, achievable, and also challenging, to children; * What is known about the strengths, interests and needs of each individual child to be able to adapt and be responsive to inevitable individual variation; * What is known about the strengths, interests, and needs of each individual child in order to design environments which both support and challenge individual learning styles; * Knowledge of social and cultural contexts in which children live so that learning experiences are meaningful, relevant, and respectful for the participating children and their families. |
| **Equitable** | Quality services and resources designed for families with young children are accessible regardless of where the family lives, their socio-economic status, disabilities, race, ethnicity, primary language, or their knowledge about how to access information. |
| **Family-centered** | Family-centered services are both a goal and a process by which families are recognized as active, equal partners in planning and participating in outcomes and services that they and/or their children need and want. Children are considered in the context of their entire family, with the family as the constant decision-making center. Services and supports are provided within each family’s achievements, unique goalsand priorities as well as those of their children. |
| **Inclusive** | Children with and without disabilities are welcomed in settings with their same-age peers and receive the supports and services that facilitate their participation in those settings. |
| **Outcomes-based** | Services and activities are focused on the results that families, in partnership with providers, would like for their children and themselves. |
| **Parents** | Children have a variety of diverse family constellations. The term “parents” recognizes and is inclusive of grandparents, foster parents or other individuals acting as a parent or serving as a child’s legal guardian. |
| **Respect for diversity** | Policies, systems, programs and staff are knowledgeable about and responsive to the diversity of families, with regard to their needs, culture, ethnicity, language, economics, and family structure. |
| **Understandable**  **and**  **User-friendly** | Services, programs and resources are easily accessible, understandable and presented in a variety of formats and languages to meet individual family needs. |
| **Whole child** | Services, programs and resources meet the needs of the whole child. Whole child is defined as each child’s cognitive, social, emotional, physical, cultural and creative dimensions. |

PROVISIONS

The following provisions are guided by the principles previously described. These provisions are strategic methods and techniques that guide systems in supporting children and their families. The parties agree:

* to inform themselves of and understand each other’s practices, standards, and requirements;
* to use all our knowledge (research and experience) and available technology to support children and families; and
* to share responsibility for improving our polices, practices, and support to local programs, as they work together to coordinate and/or provide high-quality child development, health, and early education and care services, in order to foster positive outcomes and school readiness for children.

Specific terminology and descriptions are consistent with, but are not legal interpretations of, federal or state rules, standards, regulations and laws.

***Child Development***

Through policies, training and technical assistance, the parties will support local programs and services to promote the overall development of all young children including physical, communication, social/emotional, positive behavior, cognitive, and adaptive areas, as appropriate, and to address any unique needs of children in order to foster the development of young children and their families.

***Family Involvement and Engagement***

The parties recognize that families have primary responsibility for their children and that they are their children’s first and most important teachers and best advocates. The parties will meaningfully engage parents or legal guardians as partners in their children’s education by providing them with information, resources, training, and support to facilitate their ability to make informed decisions.

The parties commit to supporting leadership roles of parents and family members to serve as trainers, consultants and advisors in training, technical assistance, system development, program design and evaluation.

***Outreach, Child Find, and Recruitment***

**Through policies, training and technical assistance, the parties will support local programs and services to:**

* understand, share, and promote public awareness about available services and resources in the community in the manner that reflects its cultural, linguistic, and structural diversity;
* use a variety of outreach methods;
* make specific efforts to reach migrant families, homeless families, and families who are traditionally underserved; and
* inform families about services and resources in their communities, including, but not limited to:
* options for developmental services and early education and care programs;
* family support services;
* sources of continuous health care (medical home), mental health services, and dental care;
* health insurance including Medicaid and EPSDT; and
* coordinated child-find activities for the identification of children who have disabilities or are at risk of disabilities.

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***Screening, Referral, Eligibility Determination***

Referrals may be made to Early Intervention (birth to three) or their Local Education Agency (30 months or older) for any child who has or may have special health or education needs and/or delays in development consistent with applicable laws and/or regulations with the understanding that referral does not guarantee eligibility for services. Referrals to other service providers may be made, with written parent consent, or as allowed by law.

**Through policies, training and technical assistance, the parties will support local programs and services to:**

* plan and carry out screening and intake (as provided by individual program requirements) in our communities, and explore new opportunities for collaboration to promote and facilitate appropriate and timely referrals that are especially critical for highly mobile families;
* provide parents with the information about the programs to which they are being referred;
* share results of screening and intake with other programs, with written parental consent;
* make referrals to needed or requested services with parental consent, or as allowed by law;
* accept self-referrals and referrals from providers;
* with parental consent, complete initial evaluation to determine eligibility based on the individual program’s requirements; and
* notify the referral source about the status of referrals and eligibility determination, with parental consent.

***Development and Implementation of FPAs, IFSPs and IEPs***

The parties recognize the essential role of parents as a team member in the development of plans related to their child and, as applicable, the family, and the parties agree to provide support to maximize opportunities for families to participate effectively in this process.

**Through policies, training and technical assistance, the parties will support local programs and services to**:

* integrate plans (e.g., IFSPs and IEPs) for children and/or families who participate in more than one program, with written consent as required by the applicable programs;
* encourage the participation of early education and care including Early Head Start, Head Start, Migrant and Seasonal Head Start, Early Intervention, local school district, and representatives from other programs in which the family is involved in the development of the specific child’s IFSP/IEP, with written consent as required by the applicable programs;
* expect school personnel, service coordinators and/or case managers to provide adequate notification of meeting date, time and location to those people the family wishes to be involved in the IFSP/IEP process;
* establish, in collaboration with families, mutually agreed upon times and processes for sharing information, including obtaining parental consent, if necessary, as well as processes for reporting progress and coordinating service delivery; and
* provide copies of FPAs, IFSPs, and IEPs, as applicable and appropriate, to staff from collaborating agencies/schools in a timely manner, with written parental consent.

***Service Coordination***

The parties recognize that each parties’ program(s) has laws, regulations and/or policies that address coordination and transition of service provision. The parties also recognize that parents play a central role in the success of coordination and transition of services.

**Through policies, training and technical assistance, the parties will support local programs and services to:**

* clearly and simply articulate applicable program requirements regarding service coordination and transition for each of our service systems;
* share information about services and resources available to children and their families and, with written parental consent, with the other providers and systems supporting the family;
* encourage all providers for a child or family, as applicable, to meet together, if requested and consented to in writing by the parent, for the purposes of coordinating and maximizing services across programs.

***Transition Planning***

The parties recognize the importance of carefully coordinated and timely transitions for children and families moving from one program to another across providers, services and/or settings. It is critical that families and staff from the sending and receiving programs be fully informed and involved in this process. Transition procedures reflect federal and state law, regulation, and standards, and the individual needs of children and families.

**Through policies, training and technical assistance, the parties will support local programs and services to coordinate transition for children and families by:**

* beginning transition planning six to nine months prior to transition;
* making referrals, as allowed by law, or with written parental consent;
* sharing information about individual program transition procedures with parents and collaborating staff;
* sharing information about program eligibility and options with parents;
* transferring records to receiving program, with written parental consent; and
* informing families of the variations between sending and receiving programs.

**The parties agree that it is best practice to also:**

* conduct orientation about the receiving program for parents and families, as appropriate;
* link transitioning parents with parents who are familiar with the transition process;
* offer opportunities for the child to experience and become comfortable with the receiving program setting;
* invite parents and families, as appropriate, to meet staff of receiving program;
* arrange meetings with parents and families, as appropriate, and staff from sending and receiving programs to address concerns and develop an effective transition plan; and
* create local transition teams that meet quarterly to plan upcoming transitions, with the parent’s agreement and consent.

***Technical Assistance***

The parties recognize that technical assistance supports and strengthens agencies and organizations to meet the specific needs of children and their families, where applicable. Technical assistance provides information, training and resources, and assists agencies and organizations in implementing and adapting specific innovations or practices.

The parties agree to support the development and implementation of a cross-system technical assistance effort that includes representatives and resources from high-quality child development, health, and early education and care services.

***Professional Development***

The parties recognize the expertise of families and staff and, due to this recognition, agree to maximize these resources with reciprocal professional development and consultation opportunities.

**The parties agree to share responsibility for:**

* planning and conducting joint professional development opportunities at the local, regional and state levels;
* disseminating information and resources regarding best practices in professional development and family consultation opportunities;
* informing partner programs, families and staff about upcoming professional development and training; and
* encouraging cross-sector training among local programs and systems.

***Dissemination and Expectations for Local Entities***

The parties agree to disseminate this MOU to local program administrators/providers and to encourage their acceptance of the letter and spirit of the MOU; and the parties agree to encourage and provide technical assistance in the development and implementation of similar agreements among local and regional entities that provide high-quality child development, health, and early education and care services.

***MOU Review***

The MOU may be revised upon written request by any party to the MOU, after obtaining written agreement by all parties to the MOU.

***Signed 10-22-2012 by
Paul Reville, Secretary, Massachusetts Executive Office of Education
Judyann Bigby, MD, Secretary, Massachusetts Executive Office of Health and Human Services
Sherri Killins, Ed.D, Commissioner, Massachusetts Department of Early Education and Care
Mitchell D. Chester, Commissioner, Massachusetts Department of Elementary and Secondary Education
John Auerbach, Commissioner, Massachusetts Department of Public Health
Louise Eldridge, Regional Program Manager, Region 1 Office of Head Start, Administration for Children and Families, US Department of Health and Human Services
Sandra Carton, Regional Program Manager, Region XII Office of Head Start, Administration for Children and Families, US Department of Health and Human
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1. Please see additional language related to *parent* in Section XIII Procedural Safeguards [↑](#footnote-ref-1)
2. Please see additional language related to “parent” in Section XIII Procedural Safeguards. [↑](#footnote-ref-2)
3. *Note: There are two (2) disability categories not included in this list. Programs should consult 603 CMR 28.02 for additional information about* Intellectual Impairment *and* Specific Learning Disability. *The criteria to determine disability in these categories do not appear consistent with the age at which children are referred for special education services. For further information, please refer to: http://www.doe.mass.edu/lawsregs/603cmr28.html?section=02#start* [↑](#footnote-ref-5)
4. Section 619 is codified at 20 USC §1419. For purposes of this Interagency Agreement the parties will refer to Section 619 of the IDEA, and not 20 USC §1419, because Section 619 is more commonly used to refer to pre-school programs and the funding that supports such programs. [↑](#footnote-ref-6)
5. See exception to a child eligible for Part C services in Section II. B(1)(a)(b) of this Agreement. [↑](#footnote-ref-7)
6. There are two disability categories included in this list, but unlikely to be used for young children. Programs should consult 603 CMR 28.02 for additional information about Intellectual Impairment and Specific Learning Disability. [↑](#footnote-ref-8)
7. Early education and care programs include a mixed system, which is defined as “any person providing early education and care including, but not limited to, public, private, non-profit and for-profit preschools, child care centers, nursery schools, preschools operating within public and private schools, Head Start programs and independent and system affiliated family child care homes.” *See* G.L.c. 15D, § 1A. [↑](#footnote-ref-9)
8. 20 USC §§1400 et seq.; 34 CFR Parts 300 (Part B) and 303 (Part C regulations). [↑](#footnote-ref-10)
9. 42 USC §§ 9858 et seq; 45 CFR Parts 98 and 99; 606 CMR 10.00 et seq. [↑](#footnote-ref-11)
10. 42 USC §§ 9801 et seq.; 45 CFR Parts 1301 to 1311 [↑](#footnote-ref-12)
11. Systems refers to the infrastructure that includes programs, services and resources available to support young children with disabilities and their families at the local and state level. [↑](#footnote-ref-13)
12. Wherever the term “family” is used in this document in connection with participation, partnership, coordination, decision-making and support, it shall mean “parent” with respect to programs funded under Part B of the Individuals with Disabilities Education Act. Part B of the IDEA provides special education supports and services to individual student based on the students’ needs, as determined at a Team meeting. *See* 603 CMR 28.05; 34 CFR §320.00 *et seq*. [↑](#footnote-ref-14)