WEST CENTRAL EARLY STEPS

OPERATIONS HANDBOOK

2024

West Central Early Steps Program
at Johns Hopkins All Children's Hospital – Department 6500006005
501 Sixth Avenue South - St. Petersburg, FL 33701
Phone (727) 767-4403 - Fax (727) 767-4715

This handbook is a guidance document specific to West Central Early Steps (WCES) for agencies and providers who work with children and families. The Early Steps Policy Handbook and Operations Guide https://floridaearlysteps.com/program-policies-and-guidance/ are the final guidance documents.

Contents

Section 1: Agency Enrollment and Responsibilities

A. To contract and enroll your agency with WCES, the following documentation must be completed, submitted to and accepted by the John's Hopkins All Children's Hospital (JHACH) Legal Team:
    a. Proof of Limited Liability Corporation or Corporation
    b. Johns Hopkins All Children's Hospital Letter of Agreement (see Attachment 3)
    c. Signed Debarment form (see Attachment 1)
    d. Signed Affidavit (see Attachment 2)
    e. Signed W9 form (see Attachment 4)
    f. Proof of enrollment in Florida State Medicaid Managed Care Plans (MMA)
    g. Agency/provider must register with PaymentWorks®, the JHACH Accounting platform

B. All agencies must attend the WCES New Provider Orientation.

C. Agency representatives and/or billing agents must attend WCES fiscal training.

D. Providers working for an agency contracted with WCES must be approved to provide services to WCES families (see Section 2 below).

E. An active list of agency/provider personnel who serve WCES families must be on file with WCES (see Attachment 5).

F. Should a provider resign or terminate employment with the agency, the WCES Professional Development and Credentialing Coordinator and Service Coordinator (SC) must be notified within 2 business days.

G. Should an agency resign or terminate their Letter of Agreement (LOA) with WCES, the Professional Development and Credentialing Coordinator and WCES Director must be notified within 2 business days.

H. Should WCES determine that an agency and/or provider has acted in a way that is considered unprofessional or unethical, WCES has the right to terminate the relationship with said agency and/or provider.

Section 2: Provider Enrollment and Ongoing Requirements

Provider Enrollment:

A. To enroll with WCES, all licensed healthcare professionals, Infant Toddler Developmental Specialist(s) (ITDS) and Early Interventionist(s) (EI) must provide documentation of the following to WCES Professional Development and Credentialing Coordinator:
    a. The WCES Enrollment Form completed by the agency owner on behalf of the individual enrolling (See Attachment 6)
    b. Completed W9 Form with signature (see Attachment 4)
    c. Current work history, documenting in a month/year timeline for the last five (5) years, with explanations of any gaps longer than 90 days (about 3 months) in employment
    d. Documentation of appropriate professional early intervention experience reflected by completing the Certificate of Work Experience Form (see Attachment 7)
        i. Non-licensed candidates with in-field degrees (childhood education, early childhood/special education, child and family development, family life specialist, communication sciences, psychology, or social work) require one year of early intervention experience

ii. Non-licensed candidates with out of field degrees require five (5) years of early intervention experience

iii. Licensed healthcare professionals without the required one year of early intervention experience must complete the Early Steps mentorship requirements and the Early Steps Mentorship Documentation Form (see Attachment 8) prior to serving Early Steps children without a mentor. Prior to pursuing mentorship, please contact the Professional Development and Credentialing Coordinator.

1. Individuals pursuing mentorship must be approved by WCES prior to initiating mentorship requirements
2. Mentors must be the same discipline as the person being mentored
3. Mentoring will be monitored at the local level with oversight through contract management reviews
4. The mentorship must be completed within one year of its initiation

e. Copy of most recent Professional License (Licensed Providers only)

f. Copy of College/University Diploma

g. Copy of College/University Transcript(s)

h. National Provider Identification (NPI) number from NPPES NPI Registry (npiregistry.cms.hhs.gov/search)

i. Council for Affordable Quality Healthcare (CAQH) Number (Licensed Professionals only)

j. Copy of current professional liability insurance coverage in the following amounts: $1,000,000 each claim and $3,000,000 per aggregate as described in JHACH Policy, "Certificate of Coverage Program" and to provide evidence of such insurance to WCES annually or upon any change in coverage. Agency coverage must name personnel covered by the policy

k. Level II Security Background Screen results obtained from ACHA

l. Documentation of the following training modules completed on the TRAIN Florida platform (please contact the Professional Development and Credentialing Coordinator to receive access to *TRAIN Florida*):

i. Infant Toddler Developmental Specialist Training Module Certificates; Non-licensed only (6 certificates total)

ii. Early Steps Orientation Training Module Certificates (3 certificates total)

iii. Child Outcome Summary Training Module Certificate (1 certificate reflecting 8 completed sessions)

B. If the required enrollment documentation is approved by the Professional Development and Credentialing Coordinator, providers will be required to attend WCES New Provider Orientation

a. Note that non-licensed providers may not attend New Provider Orientation until they have an active Medicaid number

b. After completing WCES New Provider Orientation, providers are considered fully enrolled in WCES and ready to accept referrals from WCES Service Coordinators

Ongoing Requirements:

A. It is the responsibility of the agency and/or provider to ensure the following documentation on file for WCES remains current and accurate.

a. Professional Liability Insurance Coverage (expires annually)

b. Professional License (expires every three years)

c. Level II Background Screening (expires every five years)

B. All ITDSs must renew their ITDS certification every three years from the date of their last certification. Such renewal must include:

   a. Completion of at least 24 hours of continuing education within the previous three-year period related to infant and toddler development or family engagement with caregivers of children under 36 months (about 3 years) of age. Hours of continuing education may include:

      i. Continuing Education Units (CEUs) in relevant classes and/or

      ii. In-service hours

   b. Documentation of all CEUs and/or in-service hours on the Early Steps ITDS Recertification Form and Continuing Educations Credits or In-Service Hours Form (see Attachment 9 and Attachment 10)

Section 3: Florida Embedded Practices and Interventions (FL-EPIC)

FL-EPIC is an evidence-based coaching model focused on helping caregivers embed learning opportunities during everyday routines and activities with their children. FL-EPIC ESPD promotes the statewide emphasis on teaching providers Social Emotional Development to support children in the natural environment across each learning domain. FL-EPIC ESPD provides coaching to providers to learn best practices that support caregivers to help their children increase participation in their everyday routines and in turn allows every child to make the best gains in overall development.

A. All contracted providers are obligated to adhere to Florida's Early Steps Professional Development (FL-EPIC ESPD) and its associated training framework.

B. Initial Training Development: The FL-EPIC ESPD training framework consists of an initial 12-hour provider workshop during which providers are trained in evidence-based home visiting and caregiver coaching practices. Following this initial training, providers will participate in a 6-month individualized professional development coaching cycle with an assigned provider coach. During this cycle, each provider is required to video record home or virtual visit sessions with a family and provide this video, along with additional required documentation, to the provider coach. The provider and coach will meet for one coaching session, per month, to be conducted either in-person or virtually. To support the progression of fidelity, providers are required to attend a monthly virtual or in-person professional development training. Once a provider successfully completes the first 6-month initial phase of FL-EPIC ESPD, the provider is eligible to receive reimbursement for the FL-EPIC fee (EPIC/99601), per child, per day for providing services in the natural environment.

C. Ongoing Professional Development: Upon completion of the initial coaching cycle, providers will meet with their assigned provider coach to assess their progress in achieving fidelity and determine the recommended frequency and modality of coaching for their individualized ongoing professional development plan. This transition marks the beginning of on-going coaching which continues in some form of the entirety of the provider's affiliation with Early Steps.

D. Throughout their professional development, providers engage in on-going coaching sessions to achieve an annual coaching frequency. WCES offers a variety of on-going coaching formats and frequencies to individualize to provider's needs. The purpose of on-going provider coaching sessions is to support providers in maintaining and refining their skills in accordance with FL-EPIC practices, ensuring they consistently deliver high-quality early intervention services.

E. Once initial fidelity is achieved, providers will submit an ongoing home visit video in 6 months and complete the required tasks. Upon fidelity review, if the provider maintains fidelity, the provider will move to Annual Video Submission. If the provider is no longer maintaining fidelity, coaching will be increased to a prescribed frequency of coaching, and training attendance will be determined to support the provider's continued professional development.

F. Upon completion of the FL-EPIC ESPD Workshop and training, all providers will receive a certificate as proof of their participation. ITDS providers can use the hours completed in the FL-EPIC ESPD Workshop and monthly professional development training towards their ITDS recertification. Ongoing Coaching Training hours towards ITDS certification is determined by training content and at the discretion of WCES.

G. Providers who actively participate in FL-EPIC ESPD activities are eligible to receive a Reimbursement Support Fee at a rate of $50 per hour (see Attachment 11).

H. Contracted agencies should adhere to the established guidelines and policies when seeking reimbursement for the FL-EPIC services rendered (see Attachment 12).

I. To participate in the initial phase of FL-EPIC ESPD, agency owners/leads submit provider names to the WCES FL-EPIC Team and/or providers will be chosen, at the discretion of WCES, to attend by the WCES FL-EPIC initial phase. Providers will be chosen to begin their FL-EPIC training at the LES' discretion and will be notified before their training period starts. Once offered an invitation for a cohort/cycle, providers must confirm participation or deferment with the understanding that they must participate within the next two cohorts/cycles. Providers may not defer more than once (see Attachment 13 and Attachment 14).

J. The provider's failure to participate or complete a FL-EPIC cycle or fail to demonstrate on-going participation in FL-EPIC ESPD tasks and activities as prescribed, may result in any one of the following: (1) the provider being deemed in breach or default of this contract, (2) withholding of new referrals (4) termination of this contract for cause.

SECTION 4: IFSP Service Delivery and Supports

A. Individuals with Disabilities Education Act, Part C (IDEA, Part C) requires services in the natural environment. Under Section 303.18 of IDEA, Part C, "Natural Environments" is defined as "…settings that are natural or typical for a same-aged infant or toddler without a disability, may include the home or community settings…"

B. Per Early Steps Policy, the IFSP team will:

    a. Ensure that services are necessary to meet the unique needs of the child and family to achieve the results or *outcomes identified on the IFSP*, and

    b. Help each family use available resources in a way that maximizes the child's access to services that are necessary to *achieve the outcomes identified on the IFSP*.

C. Per Early Steps Policy, the minimum frequency and intensity of supports and services necessary to achieve progress toward an identified outcome must be used as the initial point of consideration by the IFSP team.

D. The Early Steps approach to services:

    a. Primary Service Provider (PSP) Approach - A team-based family-centered approach that utilizes a capacity building method to intervene with infants and toddlers with disabilities or developmental delays. A lead provider works with other IFSP team members for the provision of direct services, co-visits or consultations, as appropriate, to meet identified outcomes. The IFSP team identifies who the PSP will be. It is appropriate for the PSP to change based on the identified needs of the IFSP team.

    b. Coaching - using an interaction style with caregivers and other team members

        i. In order to maximize the benefits of coaching, the provider(s) work directly with the caregivers during each early intervention session using techniques such as modeling, observation, problem solving, etc. It would be inconsistent with the Early Steps approach to services for a provider(s) to only interact and play with the child during sessions.

    c. Strengthening caregivers' confidence and competence in promoting child learning and development.

d. Supporting caregivers' competence in obtaining desired supports and resources.

e. Providing all services and supports within the natural learning opportunities/activities of the family.

f. Interventions that are embedded in the child's and family's daily routines, activities and places in the child's natural environment.

E. Arranging IFSP services

a. When a provider has been identified to provide a service on the IFSP, the SC will send the provider and the agency, a copy of the IFSP and the Service Initiation Form (SIR) (see Attachment 15).

b. Providers who are in-network with the child's insurance will receive priority consideration.

c. For early intervention services, speech therapy (ST), occupational therapy (OT), and physical therapy (PT), services must begin within 30 days of the authorization start date.

d. The SIR must be used to record all attempts to initiate services with the family. If services are not initiated within 30 days, the provider must document on the SIR as to the reason why.

e. Provider issues are not a justifiable reason for missing the 30 days and should be communicate with the SC immediately so steps can be taken to ensure the 30 day timeline is met.

f. Once the first visit has taken place, the provider must record the start date on the SIR and return to the SC within 5 business days.

F. Providers must only provide and bill for authorized services when the provider has IFSP documentation that is signed and dated, that specifies the authorized agency, provider, service, dates of service, and frequency. Verbal approval to provide services, does not constitute authorization, nor does automatic continuation of existing services past an end date.

G. All providers must reside in the state of Florida and be physically located in the state of Florida when providing services.

H. Medicaid Policies and procedures must be followed as stated in the most current Therapy *Services Coverage and Limitations Policy* and *Early Intervention Services Coverage and Limitations Policy* available at:

a. https://ahca.myflorida.com/medicaid/review/Specific/59G-4.085_EIS_Coverage_Policy.pdf

b. https://ahca.myflorida.com/content/download/7043/file/59G_4-320_Physical_Therapy_Services.pdf

c. https://ahca.myflorida.com/content/download/7042/file/59G_4-318_Occupational_Therapy_Services.pdf

d. https://ahca.myflorida.com/content/download/7044/file/59G_4-324_Speech_Language_Therapy_Services.pdf

I. Adding additional services and supports to the IFSP

a. If an IFSP review is requested, outside a periodic/6 month or annual review, to address new concerns/outcomes or lack of progress with current services, the PSP must submit a progress report to the SC.

b. This progress report must document the new developmental concerns and/or lack of progress toward current outcomes.

c. During the IFSP review, the team will discuss and determine if increasing current services or adding additional services or supports is needed.

d. If the team suspects ongoing therapy support from an occupational therapist (OT), physical therapist (PT) or speech language pathologist (SLP) is needed, an evaluation must first be completed by qualified personnel for that discipline (OT, PT or SLP).

e. The report from this evaluation must be sent to the SC, documenting the results from the evaluation.

f. Once the report is received by the SC, an IFSP review will be scheduled with the team to discuss the results of the evaluation, the need for ongoing therapy, and, if needed, the frequency, intensity, and location of services.

J. Consultation

a. Early Steps defines consultation as "A method of service provision in which direct service providers on the child's IFSP team meet to share content expertise in a specific area or discuss evidence-based practice related to implementing strategies to achieve outcomes on the IFSP. Consultation may be via telephone contact or face-to-face meeting."

b. The date and time of the consultation must be shared with the family prior to the meeting. When the family wants to participate in the consultation, the professionals must accommodate this request.

c. Consultation must be authorized on the IFSP.

d. All consultations must be documented on a case note or the Consultation Form (see Attachment 16) and maintained in the child's record.

K. Missed Appointments

a. If a family misses an appointment without advance notice, the provider should leave a note or a message, as applicable, for the family that explains that they will be contacting them to reschedule, remind them of their cancellation policy, and document the missed appointment/follow up activity in the provider record.

b. When a family misses a second consecutive appointment without advance notice, the provider will:

i. Contact the SC within 5 days of the second missed appointment,

ii. Work with the family's SC to re-establish services or to end services due to unsuccessful attempts to contact, and

iii. Document any missed appointments and follow-up activity in the provider's record for the child.

c. When a service provider has advanced notice of an event (child or family related issue, holiday, vacation, jury duty, etc.) and is not able to provide services at the frequency and intensity authorized on the IFSP, it is expected that the IFSP team will plan around these events in order to serve the child. The following are possible scenarios:

i. Sessions are usually scheduled on Monday and Thursday. Monday is a holiday. The Monday session is re-scheduled for Tuesday.

ii. The family is going on a two-week vacation. Prior to the family's departure, the provider discusses activities the family can use within the context of everyday routines during the vacation in order to address outcomes.

iii. The provider is called for jury duty for one week and arranges for a substitute to provide services during that week.

iv. The child will be hospitalized for one week and will have a two-week recovery time. Following hospitalization and recovery, the IFSP team reconvenes to

consider whether a modification to the frequency and intensity of the service is needed.

d. It should not be automatically assumed that increasing the frequency or intensity of services will compensate or make up for a period when no services were provided.

SECTION 5: Periodic and Annual IFSP reviews

A. Periodic/6 Month IFSP reviews

a. Per Early Steps Policy, the purpose of the periodic IFSP review for children with an established condition or developmental delays is to determine:

i. The degree to which progress toward achieving the results or outcomes identified on the IFSP is being made,

ii. Whether modification or revision of the results or outcomes or early intervention services identified on the IFSP is necessary, and

iii. Whether additional needs have been identified based on ongoing assessment/observation.

B. Provider responsibilities for the Periodic/6 Month IFSP review

a. Gather information for the Periodic/6-month IFSP review. In addition to provider observations and caregiver report, the following tools *can* be used for information gathering:

i. Hawaii Early Learning Profile (HELP® (Birth to 3)

ii. Early Learning Accomplishment Profile (E-LAP™)

iii. Ages and Stages Questionnaire(s) (ASQ)

iv. Assessment, Evaluation, and Programming System for Infants & Children (AEPS®)

v. Developmental Assessment of Young Children (DAYC)

vi. Battelle® Developmental Inventory Screener (BDI)

b. The PSP is responsible for gathering updated information from the IFSP team to complete the progress report (see Attachment 17).

c. Progress reports must be submitted to the SC, no later than 2 weeks prior to the scheduled IFSP review.

d. If the authorization period for services is set to expire in 30 days or less and an IFSP review has not been scheduled, the provider(s) can move forward with completing the progress report and submitting to the SC.

e. Providers are strongly encouraged to attend the Periodic/6 Month review.

C. Annual IFSP review

a. Per Early Steps Policy, the purpose of the annual IFSP review is to re-determine eligibility and review the IFSP to revise, change or modify its provisions and assess the continued appropriateness of the outcomes, strategies and recommended services

D. Provider responsibilities for the Annual IFSP review:

a. Assisting with eligibility re-determination by gathering updated child information using one of the tools mentioned above, caregiver report, and team observations. This information must be documented on the progress report and show continued eligibility in a way that is consistent with Florida Early Steps criteria.

b. The PSP is responsible for gathering updated information from the IFSP team to complete the Progress Report**.**

c. Progress reports must be submitted to the SC, no later than 2 weeks prior to the scheduled IFSP review.

d. If the authorization period for services is set to expire in 30 days or less and an IFSP review has not been scheduled, the provider(s) can move forward with completing the progress report and submitting to the SC.

e. Providers are required to attend annual IFSP reviews.

SECTION 6: Child Outcome Summary Requirements

A. Children who are eligible for Early Steps services will receive a rating of 1 to 7 in the following outcome areas: *Developing Positive Social – Emotional Skills*, *Acquiring and Using Skills and Knowledge, and Using Appropriate Actions to Meet Needs*. The score and supporting documentation will be entered on the Child Outcome Summary Form (see Attachment 18).

B. Children who will have an IFSP for less than 180 days, will not need an entry or exit COS form completed.

C. For children that are turning 3 and have had an IFSP for at least 180 days:

a. The PSP will be responsible for completing the exit COS form with input from all IFSP team members.

b. The exit COS form will be completed no sooner than 45 days from the 3rd birthday and no later than 30 days past the 3rd birthday.

c. The PSP is responsible for sending the completed exit COS form to the SC within 7 days of finalizing the form.

D. If a child exits Early Steps prior to the 3rd birthday and has had an IFSP for at least 180 days, an exit COS is needed, regardless of the reason for closure. For example, if a family moves without notifying the team or if a caregiver stops responding to attempted contacts, the PSP will still complete the exit COS form using information collected through ongoing progress monitoring and provider observations when the child was enrolled.

SECTION 7: AGENCY CHILD RECORD STANDARDS

A. The agency will maintain a child's record to include a copy of the IFSP, each WCES authorized session note**,** all progress monitoring data updates and reports, and other relevant documentation needed to provide services to the child and his family.

B. Early intervention sessions must be documented on a session note and must include:

a. Date with start and end time

b. Location(s)

c. Narration of activities to address IFSP outcomes

d. Family/caregiver participation in coaching activities

e. Provider and family/caregiver signatures

f. Caregiver and/or provider cancellation of session

C. The State requires retention of records for a period of six (6) years after termination of the current State contract, COQZM, unless notified by the State of Florida or Johns Hopkins All Children's Hospital, Inc. in writing to the contrary.

SECTION 8: AGENCY/PROVIDER FISCAL COMPLIANCE

A. Agencies/providers must:

a. Adhere to the understanding that Early Steps/Part C funds are always accessed as payor of last resort.

b. Adhere to the Florida Early Steps most recent written policies concerning “Financial Policies and Procedures”, “System of Payments”, and “Public and Private Insurance” cited in *Component 1* of the *Early Steps Policy Handbook and Operations Guide* (http://www.cms-kids.com/home/resources/es_policy/es_policy.html).

c. Retain all pertinent documents that determine accuracy of claims submitted, adjudicated and reimbursed which includes:

    i. therapy/early intervention session notes

    ii. IFSP/authorization records

    iii. consultation documentation

    iv. travel log,

    v. progress notes,

    vi. exit COS documentation,

    vii. Explanation of Benefits.

d. Verify the child’s insurance on a monthly basis.

e. Bill all known and available third-party resources for services, with parent/guardian consent as documented on the IFSP and *Early Steps Informed Consent for the Use of Private Insurance and Medicaid* form.

f. Submit ALL claims for cost reimbursement to WCES Fiscal Coordinators:

    i. Within 60 calendar days from date of service, or submit claims that have been submitted to a third-party payor in a timely manner and denied by the third-party payor within 60 calendar days after the service provider receives notice of denial.

    ii. In an Excel file format specified by the WCES Fiscal Coordinator via an encrypted/password protected email.

    iii. Including, valid explanation of benefits (EOB) (see Attachment 19) “Insurance Denial Reasons”). **NOTE**: **WCES in not responsible for payment when the provider did not comply with the third-party agent’s or WCES billing requirements. Acknowledgement that third-party payor’s denial of payment for failure of the service provider to follow proper billing procedures, incorrect diagnosis code, or other correctable reasons will NOT constitute grounds for payment from WCES**

g. Document and maintain each early Intervention professional’s travel on the “Natural Environment Travel Log”

    i. TRAVEL/NESF (Natural Environment Support Fee) is paid only in conjunction with an IFSP authorized and delivered Early Steps service.

h. Accept Early Steps/Part C reimbursement rate as payment in full.

    i. For further explanation, refer to: *Early Steps Service Taxonomy* ***https://floridaearlysteps.com/part-c-fee-schedule/***

i. Inform the SC if the provider identifies any changes in funding sources for services listed on the IFSP.

j. Provide a copy of the compliance audit package, as required under OMB Circular A-133, if a provider or agency is subject to OMB A-133 and receives $500,000 or greater in federal funds or state financial assistance during it's fiscal year.

Attachment 1

Debarment

CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION
CONTRACTS / SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each provider whose contract/subcontract contains federal monies or state matching funds must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. DOH cannot contract with these types of providers if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms “debarred”, “suspended”, “ineligible”, “person”, “principal”, and “voluntarily excluded”, as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will consist of federal monies, to submit a signed copy of this certification.

7. The Department of Health may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the contract manager’s file. Subcontractor’s certifications must be kept at the contractor’s business location.

CERTIFICATION

(1) The prospective provider certifies, by signing this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

_____ _____

Signature Date

Name _____ Title _____

Attachment 2

Affidavit

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL, INC.

E-VERIFY FORM UNDER SECTION 448.095, FLORIDA STATUTES

Project Name: West Central Early Steps

Obligation for State Funded Contracts:

Executive Order 11-116, which supersedes Executive Order 11-02, directs all agencies under the direction of the Governor to verify the employment eligibility of all new agency employees through the U.S. Department of Homeland Security's E-Verify system. Further, agencies are directed to include as a condition of all contracts for the provision of goods or services to the state in excess of nominal value, an express requirement that contractors utilize the U.S. Department of Homeland Security's E-Verify system to verify the employment eligibility of all new employees hired by the contractor during the contract term, and an express requirement that contractors include in such subcontracts the requirement that subcontractors performing work or providing services pursuant to the state contract utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor during the contract term.

In accordance with Executive Order 11-116, Pinellas County requires all vendors doing business with the County who are awarded state-funded contracts to verify employee eligibility using the E- verify system. It is the responsibility of the awarded vendor to insure compliance with E-verify requirements (as applicable). To enroll in E-Verify, employers should visit the E-Verify website (http:// www.uscis.gov/e-verify) and follow the instructions. The employer must, as usual, retain the I-9 Forms for inspection.

By affixing your signature below you hereby affirm that you will comply with E-Verify requirements.

Company Name:
Authorized Signature:
Print Name:
Title
Date:
Phone:

Attachment 3

Letter of Agreement

LETTER OF AGREEMENT

Johns Hopkins All Children's Hospital, Inc. **AND** _____
West Central Early Steps- Dept. 6500006005 _____
501 Sixth Avenue South _____
St. Petersburg, Florida 33701 _____

This is a mutual agreement between Johns Hopkins All Children's Hospital, Inc. ("JHACH") and _____ (the "Provider") effective on this 1st day of July, 2024 or date of signature, whichever is latest.

BACKGROUND

Johns Hopkins All Children's Hospital, Inc., a Florida not for profit corporation, is the recipient of a grant from the State of Florida, Department of Health, and Children's Medical Services (CMS) to implement and coordinate the local CMS Early Steps system known as West Central Early Steps (WCES). The purpose of Early Steps is to ensure that families and caregivers of infants and toddlers' birth to thirty-six months of age with disabilities have the opportunity to enhance the development of their children within their everyday routines, activities and places. The system provides transdisciplinary team supports, services, and service coordination in accordance with the Individualized Family Support Plan (IFSP). Individual or agency service providers must be approved by WCES prior to entering into an agreement with JHACH. Approval as a service provider for WCES and the execution of an agreement with JHACH does not guarantee client referrals.

NOW THEREFORE, in consideration of the mutual agreements and covenants contained herein after, the parties agree as follows:

A. REQUIRED DOCUMENTATION FROM PROVIDER:

1. Signed Letter of Agreement;
2. List of active Agency/Provider personnel who serve WCES families; **(Attachment 5)**
3. Current Certificate of Liability Insurance;
4. Signed Debarment Form **(Attachment 1);**
5. Signed Affidavit "JOHNS HOPKINS ALL CHILDREN'S HOSPITAL, INC. E-VERIFY FORM UNDER SECTION 448.095, FLORIDA STATUTES **(Attachment 2)**
6. Level II Background Screening Results

B. SERVICE DELIVERY:

1. To provide services in accordance with the current Florida Early Steps Policy Handbook and Operations Guide (https://floridaearlysteps.com/program-policies-and-guidance/), and WCES Operations Handbook 2024 **(Attachment HB1).**

2. To comply with all components and requirements of the current *Medicaid Early Intervention Services Coverage and Medicaid Therapy Services Limitations Handbook* which is incorporated herein by reference and can be located at: *https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies* ***OR***

   https://ahca.myflorida.com/medicaid/review/Specific/59G-4.085_EIS_Coverage_Policy.pdf
   https://ahca.myflorida.com/content/download/7043/file/59G_4-320_Physical_Therapy_Services.pdf
   https://ahca.myflorida.com/content/download/7042/file/59G_4-318_Occupational_Therapy_Services.pdf
   https://ahca.myflorida.com/content/download/7044/file/59G_4-324_Speech_Language_Therapy_Services.pdf

3. To comply, where applicable, with the Health Insurance Portability and Accountability Act (HIPAA), as well as all regulations promulgated hereunder (45 CFR Parts 160, 162 and 164*).http://www.hhs.gov/hipaa/for-professionals/privacy/index.html*

4. To supply additional information, forms or data as may be required by WCES and as deemed necessary by the Early Steps State Office (ESSO).

5. To provide services to children regardless of payor, according to Florida Medicaid and Title 42, Code of Federal Regulations, Part 447.20.5.

6. To provide and bill for authorized services only when the provider of services has IFSP documentation that is signed and dated, that specifies the authorized agency, provider, type of service, dates of service, and frequency. Verbal approval to provide services, nor automatic continuation of existing services past an end date do not constitute authorization to render services.

7. To notify WCES **immediately** should an individual provider resign or terminate employment. *(Note: If the provider has an active caseload, the WCES Fiscal Coordinator and assigned Service Coordinator(s) must be notified immediately).*

8. To comply with all aspects of Florida Embedded Practices and Intervention with Caregivers Early Steps Professional Development (FL-EPIC ESPD), including its corresponding training, service delivery, and documentation framework and ensure that all Early Steps providers participate in the required FL-EPIC ESPD in accordance with the current West Central Early Steps Operations Handbook 2024. **(Attachment HB1)**

   The Provider's agency will ensure that providers commit to a FL-EPIC ESPD training cycle of an initial 6-month period when they are selected by WCES to begin based on readiness criteria as determined by WCES. WCES will maintain a "wait list" of community providers requesting to participate in FL-EPIC. A provider may defer two FL-EPIC ESPD training cycles by submitting their deferment request in writing to the Lead Implementation Coach. Failure to complete the 3rd cycle requirement is cause for WCES to end a provider's active status, ending the providers opportunity for new referrals and to provide services.

C. FISCAL MANAGEMENT AND FISCAL RECORDKEEPING

WCES is responsible for direct service payments to Agency/Providers. Changes in fiscal requirements, processes, and funding will be communicated to the Agency/Providers by email, and/or meetings.

Agencies/Providers are required:

1. With signed parent permission, to bill all known and available third-party resources for Early Steps authorized services. To bill WCES for same services if third party payment is denied and a written explanation of benefits (EOB) is included with the billing. The written denial or EOB must include a processing date, description of the services denied, reason for denial (e.g. non-par provider), and date(s) for which services are denied.

2. To submit claims for cost reimbursement within 60 calendar days from date of service, or submit claims that have been submitted to a third-party payor in a timely manner and denied by the third-party payor within 60 calendar days after the service provider receives notice of denial.
   (Acknowledgement that third-party payor's denial of payment for failure of the service provider to follow proper billing procedures, incorrect diagnosis code, or other correctable reasons will NOT constitute grounds for payment from WCES).

3. To inform the assigned Early Steps Service Coordinator and Fiscal Coordinator if the Provider identifies any changes in the payor funding sources listed on the IFSP.

4. To accept the Early Steps rate of payment for services provided as payment in full.
   https://floridaearlysteps.com/part-c-fee-schedule/

5. To document and maintain records of each Providers' travel. Travel is paid only in conjunction with an authorized and delivered service in the natural environment.

6. To establish and maintain books, records, and documents in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided by the Department under this contract.

7. To retain all client records, financial records, supporting documents, statistical records, and any other documents pertinent to this contract for a period of six years after termination of the contract, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records must be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract.

8. Upon completion or termination of this contract and at the request of the Department, Provider will, at its expense, cooperate with the Department in the duplication and transfer of any said records or documents during the required retention period as specified in paragraph C.7., above.

9. Persons duly authorized by the Department and federal auditors, pursuant to 2 C.F.R. section 200.336, will have full access to and the right to examine any of Provider's records and documents related to this contract, regardless of the form in which kept, at all reasonable times for as long as records are retained.

10. To provide a copy of an audit package, as required under OMB Circular A-133, if a Provider is subject to OMB A-133 and receives $500,000 or greater in federal funds or state financial assistance during its fiscal year.

D. FEDERAL AND STATE CERTIFICATIONS

1. To certify to the best of his or her knowledge and belief, that no federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or an employee or any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. To submit Standard Form-LLL, Disclosure to Report Lobbying, in accordance with its instructions, if any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement.

3. To sign a *Certification Regarding Debarment, Suspension, Eligibility and Voluntary Exclusion* (Attached).

4. As per Ch.20-149, Laws of Fla., which created section 448.095, Florida Statutes to require all public employers, contractor, and subcontractors register with and use the E-Verify system (https://www.e-verify.gov/) to verify the work authorization status of all newly hired employees. A public employer, contractor, or subcontractor may not enter into a contract unless each party to the contract registers with and uses the E-Verify system. Accordingly, the contract is amended as follows:

   Employment Eligibility Verification: Effective January 1, 2021, Provider is required to use the U.S. Department of Homeland Security's E-Verify system to verify the employment eligibility of all newly hired employees used by the Provider under this Contract, pursuant to section 448.095, Florida Statutes. Also, the Provider must include in related subcontracts, if authorized under this Contract, a requirement that subcontractors performing work or providing services pursuant to this Contract use the E-Verify system to verify employment eligibility of all newly hired employees used by the subcontractor for the performance of services under this Contract. The subcontractor must provide the Provider with an affidavit stating that the subcontractor does not employ, contract with, or subcontract with an unauthorized alien. The Provider must maintain a copy of such affidavit for the duration of the Contract. If the Department has a good faith belief that a subcontractor knowingly violated section 448.095(1), Florida Statutes, and notifies the Provider of such, but the otherwise complied with this statute, the Provider must immediately terminate the contract with the subcontractor.

5. The provider and any subcontractors agree to comply with the Pro-Children Act of 1994, Public Law 103-277, which requires that smoking not be permitted in any portion of any indoor facility used for the provision of federally funded services including health, day care, early childhood development, education or library services on a routine or regular basis, to children up to age 18. Failure to comply with the provisions of the law may result in the imposition of civil monetary administrative compliance order on the responsible entity.

6. The relationship of the parties shall be an independent contractor relationship and not an agency, employment, joint venture, or partnership relationship. Neither party shall have the power to bind the other party or contract in the name of the other party. All persons employed by a party in connection with operations under this Contract shall be considered employees of that party and shall in no way, neither directly nor indirectly be considered employees of the other party.

E. LOCAL QUALITY ASSURANCE

To ensure quality of services, WCES will conduct quality assurance audits of Providers utilizing survey tools, site and record reviews, fiscal records and interviews with family and staff to determine Provider compliance with agreement terms, federal regulations, state policies, quality of service and family satisfaction as required in the State Contract. By entering into this agreement, the Provider agrees to comply and cooperate with any monitoring procedures or processes conducted by WCES personnel as well as any other monitoring or audits that are deemed appropriate by the State of Florida, Department of Health.

F. TERMS OF THIS AGREEMENT AND TERMINATION

1. If the State Contract is terminated during the term of this agreement, the Early Steps program or JHACH may, by written notice to the Provider, terminate or renegotiate this agreement.

2. Either the Provider or JHACH may terminate this agreement at any time without cause, upon no less than a thirty (30) day notice in writing to the other party by Certified Mail. It is understood this agreement is subject to renegotiations based upon any changes in new or revised federal or state laws, which may have an adverse impact on the conditions hereof to either party. This agreement may not be modified, amended, or renewed except in writing and signed by both parties.

3. In signing below, you indicate you have read this letter of agreement, including the referenced website links, attachments, and WCES Operations Handbook 2024.

THE AGREEMENT WILL EXPIRE ON JUNE 30, 2027.

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL, Inc: **PROVIDER:**

_____ _____ _____

Signature Title Date

_____

Your Name (please print)

_____ _____

Date EIN# or SS#

_____

Agency/Provider NPI Number

_____

Address

_____

Phone Number

_____

Fax Number

_____

Cell Phone Number

_____

Agency E-mail Address

_____

Administrative Contact

_____

Administrative E-mail Address

_____

Referral Contact Name for WCES E-Blast

_____

Preferred E-Mail address for WCES E-Blast

THE AGREEMENT WILL EXPIRE ON JUNE 30, 2027.

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL, Inc: **PROVIDER:**

_____ _____ _____

Signature Title Date

_____

Your Name (please print)

_____ _____

Date EIN# or SS#

_____

Agency/Provider NPI Number

_____

Address

_____

Phone Number

_____

Fax Number

_____

Cell Phone Number

_____

Agency E-mail Address

_____

Administrative Contact

_____

Administrative E-mail Address

_____

Referral Contact Name for WCES E-Blast

_____

Preferred E-Mail address for WCES E-Blast

STATE OF _____)
COUNTY OF_____)

The foregoing instrument was acknowledged before me by means of
□ physical presence or □ online notarization, this_____day of_____, 20____,

(SIGNATORY NAME) _____
(NAME OF ENTITY),_____
Florida (TYPE OF ENTITY), _____
on behalf of the company. He/she is personally known to me or has produced

_____(TYPE OF ID) as identification.

_____
NOTARY PUBLIC

_____
(Name of Notary Typed, Printed or
Stamped)

_____
Title or Rank

_____
Serial number, if any

Attachment 4

W-9

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

___ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▸ **Date ▸**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Attachment 5

Active Provider List

Johns Hopkins All Children's Hospital
West Central Early Steps
Provider Information

Agency Name: _____

1) Names of Early Steps providers in your agency (Including yourself if Applicable) serving Part C children in Citrus, Hernando, Pasco, Pinellas Counties (Attach list, if needed):

Name of Provider as enrolled in Early Steps	Occupation as Enrolled in Early Steps	EI Medicaid	EI Medicaid #
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

2) Attach copy of current liability insurance for each provider not covered by your agency's liability insurance.

Please note that throughout the year agency personnel information must be kept current and updated by the Agency within 10 Business days should a Provider resign or terminate employment with that Agency.

Return: Sidney Lawyer
West Central Early Steps
(727) 503-4751/Fax: (727) 767-4715
slawyer1@jhmi.edu

Attachment 6

Enrollment Form

Johns Hopkins All Children's Hospital
West Central Early Steps
PO Box 31020 – Dept 6500006005
St. Petersburg, FL 33701
727-767-4403 T
727-767-4715 F

WEST CENTRAL EARLY STEPS PROVIDER ENROLLMENT APPLICATION

Agency Name: _____

Doing Business As: _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code (with ext):** _____

Mailing Address (if different than physical address): _____

City: _____ **State:** _____ **Zip Code (with ext):** _____

Phone Number: (_____) _____ **Extension:** _____ **Fax Number:** _____

Cell Phone number: (_____) _____ **E-Mail:** _____

Tax ID: _____ **Medicaid Group Number(s):** _____

Administrative Contact: _____ **Fiscal Contact:** _____ **Service Contact:** _____

Date Liability Insurance Expires: _____ **Group NPI Number:** _____

Provider Name: _____ **Title:** _____

Social Security Number: _____ **NPI Number:** _____ **CAQH Number:** _____

Individual Medicaid Provider Number: _____ **Date Eligible to Bill Medicaid:** _____

Individual EI Medicaid Number: _____ **Date Eligible to bill Medicaid:** _____

License Number: _____ **License Expiration:** _____ **Liability Insurance Expires:** _____

Area of Specialty (e.g., feeding, sensory integration, autism): _____

Languages Spoken

BDI-2 Training or BDI-3 Training:

Yes_____ **No**_____**(If yes, please provider documentation)**

COS Training:

Yes_____ **No**_____**(If yes, please provider documentation)**

***Where will the provider serve families? List all locations below:**

Attachment 7

Work Experience

Early Steps Certification of Experience Form

Early Steps, Florida's early intervention system, requires that an individual seeking approval as a provider of early intervention services meet state requirements. You have been identified by the applicant below as having first-hand knowledge of his/her professional work experience with infants and toddlers (birth to five) who have special needs and/or developmental delays and their families. Please complete this form and return it to the applicant.

Applicant's Name: _____ _____ _____
Last First MI

1. Provide a detailed description of the applicant's role and job responsibilities which support the required hands-on experience. Additional information may be attached as needed and must be signed and dated by the individual completing the form. Job descriptions are not acceptable. If applicable, time spent in a practicum or internship, up to 400 hours, may apply toward the total amount of required hands-on experience. All other experience must be professional, post-degree experience. Volunteer work is not considered professional experience.

2. Provide the dates and the number of hours per week for which the applicant worked in the described role above.

   _____/____ to _____/____ Hours per week: _____
   Month/ Year Month/ Year

3. What was your working relationship to the applicant during the dates above?

   _____

Please Print

Respondent's Name: _____ Title: _____
Last First

Address: _____
Street City State Zip Code

Telephone: _____ Agency/Organization: _____

Signature: _____ Date: _____

Attachment 8

Mentorship

Early Steps
Mentorship Documentation Form

Mentee Information

Mentee Full Name: _____ _____ _____ SS#: _____ - ____ - _____
Please Print *Last* *First* *MI*

Provider Type: ____ Licensed Healing Arts ____ Infant Toddler Developmental Specialist (ITDS) ____ Other (Specify) _____

Address: _____
Please Print *Street* *City* *State* *Zip Code*

Telephone: _____ Fax: _____ Email: _____

Agency: _____ Local Early Steps: _____

Date of Hire or Contract with Agency/LES: _____ Date Mentorship Initiated: _____

Mentor Information

Primary Mentor _____ _____ ____
ITDS -Mentor must be either an Early Steps certified ITDS or an Early Steps enrolled EI Provider. All others-Mentor must be same discipline as mentee. *Last* *First* *MI*

Provider Type: ____ Licensed Healing Arts ____ Infant Toddler Developmental Specialist (ITDS) ____ Other (Specify) _____

Address: _____
Please Print *Street* *City* *State* *Zip Code*

Telephone: _____ Fax: _____ Email: _____

Agency: _____ Local Early Steps: _____

Mentorship Observation Requirements (under the direct supervision of mentor)

___ Direct Observation of Same Discipline for three multi-disciplinary Eligibility Evaluations
1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Observation of Same Discipline for three multi-disciplinary Assessments (may be the same as the Eligibility Evaluations if conducted together)
1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Direct Observation of Same Discipline for three Initial IFSP meetings**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Direct Observation of Same Discipline for three IFSP Periodic Review meetings**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____ ___

Direct Observation of Same Discipline for three IFSP Annual meetings

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Direct Observation of Same Discipline for one Transition Conference meeting**

1. Date: _____ Location: _____ Mentor's Signature: _____

___ **Direct Observation of Same Discipline for three Sessions in the Child/Family's Everyday Routines and Places (one session must be in a site other than the family home)**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Direct Observation of three joint visits in the Child/Family's Everyday Routines and Places each with a different licensed healing arts professional (FOR ITDS ONLY)**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Documentation of six (6) debriefing/critique/discussion meetings with Mentor on observations**

1. Date: _____ Mentor's Signature: _____
2. Date: _____ Mentor's Signature: _____
3. Date: _____ Mentor's Signature: _____
4. Date: _____ Mentor's Signature: _____
5. Date: _____ Mentor's Signature: _____
6. Date: _____ Mentor's Signature: _____

Mentorship Performance/Participation Requirements (under the direct supervision of mentor)

___ **Performance of three multi-disciplinary Eligibility Evaluations**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ **Performance of three multi-disciplinary Assessments (may be the same as the Eligibility Evaluations if conducted together)**

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____

3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Participation in three Initial IFSP meetings

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Participation in three IFSP Periodic Review meetings

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Participation in three IFSP Annual meetings

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Participation in one Transition Conference meeting

1. Date: _____ Location: _____ Mentor's Signature: _____

___ Performance of three Sessions in the Child/Family's Everyday Routines and Places (one session must be in a site other than the family home)

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Direct Participation in three joint visits in the Child/Family's Everyday Routines and Places each with a different licensed healing arts professional (FOR ITDS ONLY)

1. Date: _____ Location: _____ Mentor's Signature: _____
2. Date: _____ Location: _____ Mentor's Signature: _____
3. Date: _____ Location: _____ Mentor's Signature: _____

___ Documentation of six (6) debriefing/critique/discussion meetings with Mentor on performance

1. Date: _____ Mentor's Signature: _____
2. Date: _____ Mentor's Signature: _____
3. Date: _____ Mentor's Signature: _____
4. Date: _____ Mentor's Signature: _____
5. Date: _____ Mentor's Signature: _____
6. Date: _____ Mentor's Signature: _____

Comments by Mentee:

Comments by Mentor:

Mentorship Completion Date: _____

Signature of Mentee: _____ Date: _____

Signature of Mentor: _____ Date: _____

Submitted to Early Steps Enrollment Specialist by: _____ Date: _____

Attachment 9

ITDS Recertification

Florida Infant Toddler Developmental Specialist Certification Renewal

PROVIDER INFORMATION				
Full Name:	First	Middle	Last	
Home Address:	Street /Apt. #	City	State	Zip
Home Phone number:				
Work Phone number:				
E-mail Address:				
Individual NPI# (or SS#):				
Local Early Steps enrollment (provide LES name):				
Date of Initial Certification or Approval:				
Certification Renewal Due Date:				
Date of Completion:				

CONTINUING EDUCATION CREDITS OR IN-SERVICE HOURS	
By checking the boxes below, I acknowledge that I understand the following requirements:	
☐	ITDS Certification must be renewed every three years from the date of the last certification
☐	Twenty-four hours of continuing education credits **AND/OR** in-service hours are required every three years. Documentation to be placed on attached ITDS CEU or In-Service Hours form

SIGNATURES	
Signature of Applicant	Date
Signature of Early Steps Director	Date

Attachment 10

Credits or Hours

Local Early Steps: _____

Early Steps Infant Toddler Developmental Specialist

Continuing Education Credits or In-Service Hours

(Attach to ITDS Certification Renewal Form)

Agency Name: _____

ITDS Name: _____

Telephone No.: _____

Required information to document CEUs or In-Service Hours	
Course Title and Nature of Activity (live, conference, on-line training, etc.):	
Name of Speaker/Lecturer:	
Sponsoring Agency or Organization:	
Course/Lecture Description AND Objectives:	
Program Date:	
Location:	
Number of Hours:	
ATTACH ALL CERTIFICATES OF COMPLETION OR OTHER DOCUMENTATION	
Course Title and Nature of Activity (live, conference, on-line training, etc.):	

Name of Speaker/Lecturer:	
Sponsoring Agency or-Organization:	
Course/Lecture Description AND Objectives:	
Program Date:	
Location:	
Number of Hours:	
ATTACH ALL CERTIFICATES OF COMPLETION OR OTHER DOCUMENTATION	
Course Title and Nature of Activity (live, conference, on-line training, etc.):	
Name of Speaker/Lecturer:	
Sponsoring Agency or Organization:	
Course/Lecture Description AND Objectives:	
Program Date:	
Location:	
Number of Hours:	
ATTACH ALL CERTIFICATES OF COMPLETION OR OTHER DOCUMENTATION	

Add additional pages if necessary

Total Number of CEUs for Year: _____

Total Number of In-Service Hours for Year: _____

Johns Hopkins All Children's Hospital
West Central Early Steps
PO Box 31020 – Dept 6500006005
St. Petersburg, FL 33701
727-767-4403 T
727-767-4715 F

West Central ESPD Support Fee Guidelines

Updated 03/01/2024

Providers participating in FL-EPIC Early Steps Professional Development will be compensated for tasks related to FL-EPIC that require time outside of their regularly scheduled sessions.

Reimbursement will be at a rate of $50/hour. Reimbursement for specified professional development activities will be maintained and tracked by the WCES FL-EPIC team. Providers/Agencies are responsible for accurately tracking their professional development activities using the agencies format or system.

WCES will email the professional development data to the agency on a monthly basis. Upon receiving the data, the agency is encouraged to review the submitted information for accuracy and compliance. Any discrepancies should be communicated to the FL-EPIC Lead Implementation Coach (LIC) for review.

Additionally, please contact Jennifer Johnston, LIC at jjohn131@jhmi.edu should any questions arise regarding FL-EPIC procedures or professional development activities.

FL-EPIC ESPD Approved Tasks/Activities and Trainings

- FL-EPIC Orientation (one time, up to 2 hours)
- FL-EPIC COS Training (one time, 2 hours)
- FL-EPIC TORSH and Technology Training (one time, up to 2 hours)
- Caregiver Coaching Workshop (one time, 12 hours)
  - This is a virtual training that occurs over 4 days in 3-hour sessions.
- Upload of Video, Completion of Rubric(s)/Self-Assessment(s) and Upload of the Visual Model (1.5 hours)
  - Providers must complete **all three tasks** **4 business days** **PRIOR** to their scheduled coaching session to receive the support monies.
- Monthly Coaching Session (1 hour monthly)
- Monthly Professional Development Meeting (up to 2 hours monthly)
- Ongoing Professional Development approved by the FL-EPIC Team

- Note: All tasks and trainings are at the discretion of WCES and are subject to change at any time.

Attachment 12

FL-EPIC Reimbursement Policy

Johns Hopkins All Children's Hospital
West Central Early Steps
PO Box 31020 – Dept 6500006005
St. Petersburg, FL 33701
727-767-4403 T
727-767-4715 F

Policy Title: FL-EPIC ESPD (Early Steps Professional Development) Reimbursement Procedure Policy

Effective Date: March 1, 2024

Policy Statement:

Providers participating in WCES FL-EPIC This policy outlines the FL-EPIC ESPD activities and trainings reimbursement procedure for agencies contracted with West Central Early Steps.

Policy Details:

1. Purpose:
   - The purpose of this policy is to establish clear guidelines and procedures for WCES and the contracted agencies to follow when seeking reimbursement for FL-EPIC ESPD services rendered. By tracking provider activities and requiring monthly submission of data spreadsheets, accurate and timely reimbursement occurs while maintaining accountability and transparency.

2. Responsibilities:
   - **Agencies/Providers:** Providers are responsible for accurately tracking their activities and submitting monthly data to the agency for reimbursement. They must ensure that all information provided is complete, accurate, and compliant with agency requirements.
   - **West Central Early Steps FL-EPIC Team:** The FL-EPIC-Team is responsible for tracking provider activities, completing data spreadsheets, and processing reimbursements in a timely manner. They must provide the reimbursement spreadsheet to the agency in a timely manner. Additionally, the WCES FL-EPIC Team is responsible for clear guidance and support to providers and agencies regarding reimbursement procedures.

3. Reimbursement Procedure**:**

   - **Provider/Agencies**: Providers are required to track their activities using the agency's specified format or system. This may include recording details such as service dates, types of services provided, quantities, and any other relevant information
   - **WCES FL-EPIC Team:** WCES will attain and track all data (tasks, coaching sessions and trainings, etc.) that meet the reimbursement guidelines and email the data to the agency on a monthly basis.

4. Review and Approval:

   - Provider/Agencies: Upon receiving the data, the agency will review the submitted information for accuracy and compliance with reimbursement guidelines. Any discrepancies or missing information will be communicated to the FL-EPIC Lead Implementation Coach for review.
   - WCES FL-EPIC Team: will submit the data and an in-house invoice to the WCES director for approval

5. **Documentation:**

   - Both the agency and the provider should maintain copies of all submitted data spreadsheets, correspondence related to reimbursement, and any other relevant documentation for record-keeping purposes.
   - The responsibility for entering and maintaining FL-EPIC ESPD related records in the internal and UFES database should be clearly defined. The primary responsibility of data input is the FL-EPIC Lead Implementation Coach (LIC) and the Professional Development Credentialing Coordinator (PDCC) but may involve multiple departments across WCES.
   - Documentation and data should be stored in a secure and easily accessible manner, ensuring that authorized personnel can review the documentation when needed.
   - All data is entered in a timely manner.
   - All providers that meet the WCES FL-EPIC criteria for receiving the FL-EPIC NESF are noted in the UFES Data System:

     - The date in which criteria is met is denoted
     - The checkbox "yes" is denoted

4. Approval and Fee Distribution Process:

   - Once a provider meets the criteria, a member of the FL-EPIC ESPD Team shall notify the WCES Fiscal Coordinator(s) of the provider's status.
   - The Fiscal Coordinator will notify the stakeholders of the status of the provider's NESF Fee Criteria.

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5. Fee Disbursement:

- Providers who have met the eligibility criteria are eligible to fee disbursement in accordance with the WCES fee schedule.
- The Fiscal Coordinator(s) shall ensure accurate and timely fee disbursement to eligible providers.

6. Records and Retention:

- Provider records and their associated documentation shall be retained for a period as required by contract and Johns Hopkins All Children's Hospital and West Central Early Steps organizational policies.
- Clear procedures should be in place for the secure storage and disposal of provider records in accordance with data protection laws.

Review and Revision:

This policy will be periodically reviewed and revised as necessary to ensure its effectiveness.

Approval: This policy is approved by Harry Fogle and is effective as of 11/06/2023
This policy has been updated and approved on

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FL-EPIC ESPD Letter of Commitment

This letter serves as notification to West Central Early Steps Early that I am committing to participate in:

☐ Date & Cohort Number

☐ Date & Cohort Number

I am unable to participate in the current FL-EPIC ESPD cohort due to:

By signing this commitment letter, I understand that I will be assigned to the cohort indicated above to fulfill my requirement of participation in FL-EPIC ESPD.

For questions or requests for amendment to this plan, please contact Jennifer Johnston at jjohn141@jhmi.edu.

Provider Name _____

Signature _____

Date _____

Attachment 14

FL-EPIC Provider Agreement

Johns Hopkins All Children's Hospital
West Central Early Steps
PO Box 31020 – Dept 6500006005
St. Petersburg, FL 33701
727-767-4403 T
727-767-4715 F

Dear West Central Early Steps Provider:

Florida Embeded Practices and Intervention with Caregivers Early Steps Professional Development (FL-EPIC ESPD) is part of a statewide system of professional development ("PD") being implemented by Florida Early Steps. FL-EPIC ESPD supports the goal of Florida's State Systemic Improvement Plan, which is to improve positive social-emotional outcomes for infants and toddlers receiving Early Steps services. It also supports a primary purpose for early intervention, which is to enhance the capacity of families/caregivers of infants and toddlers with or at risk for disabilities to support the development and learning of their children.

A key part of FL-EPIC ESPD is ongoing PD, including job-embedded coaching for Early Steps providers. As part of this process, you will participate in ongoing workshops and meetings focused on evidence-based home visiting practices that help caregivers support their children's development and learning within every-day family routines and activities. You will also receive individualized coaching with feedback from an Early Steps implementation coach who is part of our local Early Steps program. You will collaborate with your coach to identify your PD goals related to the home-visiting practices that are part of FL-EPIC ESPD, and to develop a plan for how to achieve those goals.

All West Central Early Steps providers will be required to participate in FL-EPIC ESPD and corresponding activities. Providers will initially participate in a six-month intensive PD, followed by ongoing professional development tasks as determined by the WCES FL-EPIC team.

Activities related to the initial 6 months include the following:

- Completing the pre-FL-EPIC tasks prior to workshops
- Identifying two families with which to practice caregiver coaching home-visiting practices, as defined by FL-EPIC ESPD
- Attending the Caregiver Coaching Workshop either virtually (4 half-day sessions) or in person (2 full-day sessions)
- Video recording a a minimum of one home visit per month with one identified FL-EPIC family
- Submitting home visit videos and completing self-assessment(s) of FL-EPIC home-visiting practices for each video recording in TORSH
- Participating in one coaching session per month for up to six months with an Early Steps Implementation Coach at West Central Early Steps program; and
- Attending one targeted professional development meeting per month

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Provider Agreement letter updated 08/4/2023

Activities related to ongoing PD after the first six months of FL-EPIC ESPD will be determined collaboratively with your coach. The frequency of ongoing PD will vary and might include monthly, bi-monthly, quarterly, or semi-annual coaching or participation in large-group PD meetings with other Local Early Steps ("LES") providers. Different types of ongoing PD you might participate in include:

- Individual coaching sessions
- Small-group coaching sessions with other LES providers
- Self-Coaching
- Large group, practice-focused PD meetings with other LES providers

You will be provided with all the necessary materials (recording device and accompanying accessories) to complete the required activities. You will also be provided with the necessary media release and agreement letter for families prior to video recording their home visit sessions.

One of the requirements of being a provider for the West Central Early Steps Program will be to complete the FL-EPIC coaching program, it is important to note that it is also an invaluable resource to support your ongoing PD to promote positive outcomes for children and families.

We are very grateful for the support you provide to our children and families, and we are excited to further enhance your pofessional development opportunities!
This section is to be completed by the provider and returned to the West Central Lead Implementation Coach.

I, _____ (print full name) acknowlege the above information and agree to participate in the FL-EPIC coaching program.

_____ (signature) _____(date)

Attachment 15
Service Initiation Form

West Central Early Steps
Service Initiation Report

Part C requires services be started within 30 days of authorization on Services Page of the IFSP

Agency Name: _____

Service Authorized: ☐Early Intervention ☐ST ☐OT ☐PT

IFSP Authorization dates: _____ to _____

Service must begin no later than (date): _____

To be completed by Provider:

Above Services Started on (date): _____

Provider: _____

Documentation of Contact Attempts:
[i.e. Reason for Delay in Initiation of Service]

Date:	

Return to:

Child Name:
DOB:

(Service Coordinator)

Attachment 16

Consultation

Consultation Documentation

(To be completed by those participating in consultation session)

Parent was notified and invited to participate on _____ by (method)_____

If the consultation meeting will potentially result in change of outcomes or services, the Primary Service Provider will contact Service Coordinator prior to meeting. Service Coordinator contacted on _____ by (method) _____

Child's Name: _____ DOB: _____

Service Coordinator: _____ Date of Consultation: _____

Start Time: _____ End Time: _____ Location: _____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

_____

IFSP Team meeting is needed to discuss recommended changes in services, frequency, and/or duration of services:

☐ **YES** ☐ **NO**

Participating Team Members/Signatures: (PSP indicated with *)

Parent/ Guardian: _____	Face-to-Face	Phone	ITDS _____	Face-to-Face	Phone
OT _____	Face-to-Face	Phone	PT _____	Face-to-Face	Phone
SLP _____	Face-to-Face	Phone	EI _____	Face-to-Face	Phone
Service Coordinator:_____	Face-to-Face	Phone	Other _____	Face-to-Face	Phone

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)

Revised Jan 2015

Consultation Documentation, Continued

Child's Name: _____ DOB: _____

Service Coordinator: _____ Date of Consultation: _____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

_____

_____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)

CONSULTATION DOCUMENTATION FORM INSTRUCTIONS

The purpose of this form is to serve as uniform documentation of consultation services. Each team member who is billing must have a form completed for each Consultation in which they participate. During consultation sessions, the members participating should appoint a recorder to LEGIBLY complete the form from *Child's Name* to *IFSP Team Meeting Yes No*. Copies should then be made for each participant and the family. The original goes to the Service Coordinator to place in the child's file. Each enrolled Early Steps provider can bill for Consultation using the form as invoice documentation. Although they may participate in the consultation, professionals and providers who are not enrolled would not be able to bill. If any team provider did not participate in the Consultation session, a copy should be provided to them so they can be informed.

Instructions:

Child's Name: *Full name of child* **DOB**: *Date of birth of child*

Service Coordinator: *Name* **Date of Consultation:** *MM/DD/YYYY*

Start Time: *Beginning time of consultation session* **End Time:** *End time of consultation session*

Location: *This is the location where the meeting occurred. If face-to-face, enter the location as i.e. Home, Local Early Steps, Playpen Therapy; if occurred by phone, enter the location as Phone.*

Successes and Challenges to implementing strategies and achieving goals: *Narrative of the discussion, by individual outcome.*

The team (*family, caregivers, primary service provider and supporting providers*) will continue or modify the following strategies to achieve goals: *Narrative of the recommendation(s) resulting from the consultation, by individual outcome.*

PSP: *Name and credentials of the current Primary Service Provider*

Consulting Team Members: *List all members participating in the consultation and check Face-to-Face or Phone and obtain signatures of those present.*

Family Participation: *The name(s) of the family member(s) and check Phone, Face-to-Face or Declined Invitation*

ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS' FORMS

When each provider receives their copy of the completed form, they will complete the remaining fields before billing.

Provider/Participant Name (Print): *LEGIBLE name of provider/participant* **Signature**: *Provider/Participant signature*

Each participant should find their designation and sign, if face-to-face. Provider signature lines should include the code signifying if participation was Face-to-Face or Phone

Consultation time must be authorized on the Individualized Family Support Plan (IFSP). Billing is based on the location of the Consultation session.

Attachment 17

Progress Report

Child Information

Child Name: _____ **Service Coordinator:** _____

Child DOB: _____ **Date of Assessment:** _____

Assessment/Eligibility Information

For children to be active and successful participants at home and in the community, they need to develop skills in the three functional areas described below. We use this information about your child's abilities and your concerns and priorities to understand your child's progress.

Type of Report: ☐ **6 Month/Periodic** ☐ **12 Month/Annual** ☐ **Service change request**

Instruments/Sources Used: (ASQ, HELP, Parent Report, Observation, Other)

1.	2.	3.

Functional Areas		**Activities Your Child Does Well** What are some things your child likes to do? What skills does your child demonstrate or is beginning to demonstrate?	**Activities Your Child Finds Difficult** What are skills that your child does not do or skills that are difficult for your child? In what activities or skill areas does your child need support and/or practice?	Your Child's developmental levels based on the evaluation and assessment:
DEVELOPLING POSITIVE SOCIAL-EMOTIONAL SKILLS	This includes your child's ability to engage others including developing relationships, self-soothing strategies for becoming and remaining calm, getting along with others, and expressing feelings.			**Social/Emotional:** _____ Score Or age equivalent
ACQUIRING AND USING KNOWLEDGE AND SKILLS	This refers to your child's ability in areas such as thinking, reasoning, remembering, problem solving, number concepts, and counting. It also includes skills related to language and literacy.			**Communication:** _____ Score Or age equivalent **Cognitive:** _____ Score Or age equivalent
USING APPROPRIATE ACTIONS TO MEET NEEDS	This includes your child's ability to take care of basic needs such as getting from one place to another, dressing, feeding, toileting, and using tools (forks, toothbrushes, crayons).			**Fine Motor:** _____ Score Or age equivalent **Gross Motor:** _____ Score Or age equivalent **Self Help:** _____ Score Or age equivalent

Additional Information Regarding Eligibility/Assessment:

Progress toward current outcomes & goals, suggestions for new outcomes, next steps, and/or any other new concerns or important information:

New/Updated demographic, health/medical information or other updates:

_____	_____	_____
Provider Name and Credentials	*Provider Signature*	*Date*

Attachment 18
COS Form

Child Outcomes Summary Form

Child Name	Click or tap here to enter text.	Child ID	Click or tap here to enter text.
Completion Date	Click or tap to enter a date.	Date of Birth	Click or tap to enter a date.
Location/LES	Click or tap here to enter text.	Age	Click or tap here to enter text.

☐ Entry Summary ☐ Periodic/Annual Summary ☐ Exit Summary

If **Entry** Summary, list date of initial IFSP: Click or tap to enter a date.

If **Exit** Summary, list date of last service: Click or tap to enter a date.

Persons involved in deciding the summary ratings:

Name & Organization	Role
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.
Click or tap here to enter text.	Choose an item.

Sources of Evidence: *Check all that apply*

Family information on child functioning

- ☐ Received in a team meeting
- ☐ Collected separately through family report
- ☐ Incorporated into assessment(s)
- ☐ Not included

Evidence collected in a variety of settings and situations

- ☐ Child engaged in caregiver-directed and self-initiated activities
- ☐ Child engaged in preferred and non-preferred activities
- ☐ Child engaged in activities across different social settings (e.g., home with family, playground with multiple children; please specify)

  Click or tap here to enter text.

Child engaged in activities across different routines

- ☐ Play/Learning
- ☐ Caregiving
- ☐ Chores/Community
- ☐ Transition
- ☐ Child engaged in easy to difficult activities

Evidence collected using variety of methods

Formal sources & methods

- ☐ Monthly progress notes
- ☐ Screening instruments (e.g., ASQ-SE)
- ☐ Curriculum-based (e.g., AEPS-2, DPIYC)
- ☐ Standardized, norm-referenced (e.g., BDI)
- ☐ IFSP progress determination
- ☐ Other source

  Click or tap here to enter text.

Informal assessment methods

- ☐ Live observations of the child
- ☐ Video observations of the child
- ☐ Interview with caregivers and service providers
- ☐ 5Q Visual Model

Child Outcomes Summary Form

1. POSITIVE SOCIAL-EMOTIONAL SKILLS (INCLUDING SOCIAL RELATIONSHIPS)

1a. To what extent does this child show age-appropriate functioning, across a variety of settings and situations, on this outcome? *(Select rating with descriptor)*

Choose an item.

Provide a written explanation for the selection of the above rating.

Click or tap here to enter text.

1b. (Do not complete at entry): Has the child shown any new skills or behaviors related to positive social-emotional skills (including positive social relationships) since the last outcomes summary? *(Check one box)*

Progress measured from what point in time (Provide month/year): Click or tap to enter a date.

☐Yes	1 → Describe progress: Click or tap here to enter text.
☐ No	2

2. ACQUIRING AND USING KNOWLEDGE AND SKILLS

2a. To what extent does this child show age-appropriate functioning, across a variety of settings and situations, on this outcome? *(Select rating with descriptor)*

Choose an item.

Provide a written explanation for the selection of the above rating.

Click or tap here to enter text.

2b. (Do not complete at entry): Has the child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last outcomes summary? *(Check one box)*

Progress measured from what point in time (Provide month/year): Click or tap to enter a date.

☐Yes	1 → Describe progress: Click or tap here to enter text.
☐ No	2

3. TAKING APPROPRIATE ACTION TO MEET NEEDS

3a. To what extent does this child show age-appropriate functioning, across a variety of settings and situations, on this outcome? *(Select rating with descriptor)*

Choose an item.

Provide a written explanation for the selection of the above rating.

Click or tap here to enter text.

3b. (Do not complete at entry): Has the child shown any new skills or behaviors related to taking action to meet needs since the last outcomes summary? *(Check one box)*

Progress measured from what point in time (Provide month/year): Click or tap to enter a date.

☐Yes	1 → Describe progress: Click or tap here to enter text.
☐ No	2

Insurance Denial Reasons

A	Service not authorized by insurer
B	No such benefit- Not covered service
C	Beyond reasonable/customary charges
D	Deducible
E	Exceeds maximum benefits
F	Consent to bill Medicaid (family declined)
G	Third party insurance (family declined)
I	Inclusive with other CPT code/charges
J	Records closed prior to consent received
L	Late/exceeds filing time limitation
M	Service not medically necessary
N	No coverage at time of service
P	Provider not enrolled/ineligible