

Early Intervention Program

Memorandum 2005-02

**Standards and Procedures for Evaluations, Evaluation  
Reimbursement, and Eligibility Requirements and Determinations  
Under the Early Intervention Program**



New York State Department of Health  
Bureau of Early Intervention  
July 2005

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

**New York State Department of Health  
Early Intervention Program  
Memorandum 2005-02**

**Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determinations Under the Early Intervention Program**

<u>I. Referrals to the Early Intervention Program</u> .....	2
<u>Children Referred as “At-Risk for Disability”</u> .....	2
<u>Children Referred by the Child Protective System</u> .....	3
<u>Children Referred With a Confirmed or Suspected Disability</u> .....	5
<u>II. Multidisciplinary Evaluation Procedures</u> .....	6
<u>Purpose of the Multidisciplinary Evaluation</u> .....	6
<u>General Requirements for the Evaluation Process</u> .....	7
<u>A Special Note on Standardized Evaluation and Assessment Instruments</u> .....	9
<u>A Special Note on Informed Clinical Opinion</u> .....	10
<u>A Special Note on Parent Participation in the Multidisciplinary Evaluation Process</u> .....	11
<u>Intake and Screening Procedures</u> .....	12
<u>Composition of the Evaluation Team</u> .....	13
<u>Required Components of the Multidisciplinary Evaluation</u> .....	14
<u>Voluntary Family Assessment</u> .....	15
<u>Use of Findings From Other Examinations</u> .....	16
<u>III. Evaluation Reports and Documentation Requirements</u> .....	18
<u>Informing Parents of Results</u> .....	18
<u>Evaluation Report</u> .....	18
<u>Role of the Multidisciplinary Evaluation Team in the IFSP Meeting</u> .....	20
<u>Children Found To Be Typically Developing and Who Are Not Eligible for the EIP</u> .....	22
<u>IV. Reimbursement Mechanisms for Screening and Evaluation</u> .....	22
<u>V. Eligibility Criteria</u> .....	25
<u>Federal Eligibility Requirements</u> .....	25
<u>State Eligibility Requirements</u> .....	26
<u>Diagnosed Conditions With a High Probability of Resulting in Developmental Delay</u> .....	26
<u>Developmental Delay</u> .....	27
<u>Measuring Developmental Delay</u> .....	27
<u>Developmental Domains Used to Establish Eligibility for the EIP</u> .....	28
<u>New York State Definition of Developmental Delay</u> .....	30
<u>Determining Eligibility Based on Developmental Delay</u> .....	31
<u>VI. Monitoring Progress</u> .....	33
<u>VII. Procedures and Criteria for Ongoing Eligibility</u> .....	34
<u>Procedures for Ongoing Eligibility</u> .....	34
<u>Criteria for Ongoing Eligibility</u> .....	36
<u>VIII. Frequently Asked Questions</u> .....	38

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

<a href="#"><u>Appendix A – Risk Factors Pertaining to Referrals of At-Risk Children</u></a> .....	48
<a href="#"><u>Appendix B – Personnel Qualified to Diagnose EIP Eligible Conditions</u></a> .....	50
<a href="#"><u>Appendix C – Recommendations for Preventive Pediatric Health Care</u></a> .....	53
<a href="#"><u>Appendix D – Evaluation Summary Forms</u></a> .....	55
<a href="#"><u>Appendix E – Clinical Clues Adapted From the NYS EIP Clinical Practice Guidelines</u></a> .....	58
<a href="#"><u>Appendix F – Predictors of Continued Language Delay</u></a> .....	67
<a href="#"><u>Appendix G – Developmental Surveillance Recommendations for Children At Risk for Communication Delays</u></a> .....	69
<a href="#"><u>Appendix H – Components of an In-depth Speech-Language Evaluation</u></a> .....	71
<a href="#"><u>Appendix I – Milestones on Normal Feeding, Clinical Clues of a Possible Feeding Problem, and Components of an Oral Motor Assessment</u></a> .....	72

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

New York State Department of Health  
Early Intervention Program  
Memorandum 2005-02

TO: Early Intervention Officials  
Providers of Early Intervention Services  
Families  
Other Interested Parties

FROM: Bureau of Early Intervention

DATE: June 2005

SUBJECT: Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determinations Under the Early Intervention Program

The purpose of this guidance is to review procedures for referral to the Early Intervention Program (EIP); clarify requirements, procedures, and reimbursement for conducting multidisciplinary evaluations; and, clarify procedures and requirements for determining children's eligibility and ongoing eligibility for the EIP. Consistent use of these requirements statewide is important to ensure that evaluations are appropriately performed, and eligibility is appropriately established and documented, for all children and families participating in the EIP. This document reviews procedures for:

- referrals to the EIP;
- multidisciplinary evaluations and State regulations pertaining to the responsibilities of evaluators;
- evaluation reports and documentation requirements;
- use of EIP rates for payment of evaluators for performance of screenings and evaluations for children referred to and enrolled in the EIP;
- statutory and regulatory requirements for EIP eligibility;
- strategies for children found to be typically developing after evaluation;
- monitoring child and family progress; and,
- procedures and criteria to determine ongoing eligibility for the EIP.

## **I. Referrals to the Early Intervention Program**

Section 2542 (1)(a) of the Public Health Law (PHL) requires Early Intervention Officials (EIOs)<sup>1</sup> to identify and locate children who are eligible for the Early Intervention Program and to provide for the identification, screening, and tracking of children at risk for developmental delay.<sup>2</sup> PHL and regulations further require the following primary referral sources to refer children suspected of having disabilities, or at risk of having disabilities, to the EIO of the municipality in which the child resides (unless the child has been referred or the parent objects to the referral). Primary referral sources include: all individuals who are qualified personnel; all approved evaluators, service coordinators, and providers of early intervention services; hospitals; child health care providers, including pediatricians; day care programs; local school districts; public health facilities; early childhood direction centers; local health units; local school districts; local social service districts; public health facilities; and operators of any clinic approved under Article 28 of the PHL, Articles 16 or 31 of the Mental Hygiene Law, and other such social service and health care agencies and providers specified in State regulation.

If a parent objects to a referral to the EIP by a primary referral source, the primary referral source is required to document the parent's objection to the referral; provide the parent with the name and telephone number of the EIO in the child's county of residence; and, make reasonable efforts within two months to follow up with the parent, if appropriate, to refer the child unless the parent objects.<sup>3</sup>

Parents may also refer their child directly to the EIP if they have a concern about their child's development, or when they agree with a concern raised by someone else about their child. For example, if a child's primary health care provider is concerned about his or her development, the parent may directly refer the child to the EIP or ask the physician to refer the child.

### **Children Referred as "At-Risk for Disability"**

It is important to differentiate the responsibilities of municipalities for children referred to the EIO as *at risk* for disability and children referred *with a suspected or confirmed disability* (either a developmental delay or diagnosed condition with a high probability of resulting in developmental delay). In New York State, children *at-risk* for disability are not eligible for the Early Intervention Program. However, any child who meets risk criteria established in EIP regulations (see Section 10 NYCRR §69-4.3 (f) – see Appendix A) must be referred to the Early Intervention Program for developmental surveillance (screening and tracking). The purpose of developmental surveillance is to identify potential delays or disabilities, as early as possible, in children who are typically developing but are at high risk for developmental problems due to medical/biological neonatal or medical/biological post-neonatal and early childhood risk factors. Developmental surveillance has been described by the American Academy of Pediatrics as a "flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care." The components of developmental surveillance include eliciting and attending to parental concerns, developmental history, making accurate and

---

<sup>1</sup> Throughout this document, the term "EIO" will be used to reference both Early Intervention Officials and their designees.

<sup>2</sup> PHL §2542(1)(a)(c)

<sup>3</sup> 10 NYCRR §69-4.3(a)(3)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

informative observations of children, and sharing opinions and concerns with other professionals.<sup>4</sup>

Developmental surveillance, which may include developmental screening (a brief assessment procedure to identify children who should receive more intensive diagnosis or assessment), for these children is generally accomplished through their primary health care providers. When families cannot be engaged with a primary health care provider, municipalities may directly provide developmental screening (for example, by using the Ages and Stages Questionnaire or other appropriate developmental screening tools).

*Children Referred by the Child Protective System*

A new provision of the Federal Child Abuse Prevention and Treatment Act (CAPTA)<sup>5</sup> requires state child protection agencies to establish “provisions and procedures for referral of a child under three years of age, who are involved in substantiated child abuse or neglect, to early intervention services funded under Part C of the Individuals with Disabilities Education Act.” In the 2004 reauthorization of the Individuals with Disabilities Education Act (IDEA), a new provision was added to Part C that requires states to provide “a description of State policies and procedures that require the referral for early intervention services ...of a child under the age of three who (A) is involved in a substantiated case of child abuse or neglect; or, (B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal exposure.”<sup>6</sup> As part of its reauthorization of IDEA, Congress clarified that the intent of this provision is *not* to require state early intervention programs to provide a multidisciplinary evaluation for all children referred to Part C as the result of being the subject of a substantiated case of child abuse or neglect or affected by illegal substance abuse. Rather, the intent of these provisions is to *ensure that these children are screened*, either by a designated primary referral source or Part C provider *to determine whether a referral for an evaluation for early intervention services under Part C is warranted.*<sup>7</sup>

State PHL and EIP regulations<sup>8</sup> require EIOs, as part of their role in the child find system, to coordinate the efforts made by other agencies and community programs that serve infants and toddlers to identify, locate, and track children, and identify, track, and screen at-risk children, using available resources and resources allocated by the Department for this purpose. Under the new provisions of IDEA and CAPTA, municipalities are required to ensure that children involved in substantiated cases of child abuse and neglect and those affected by illegal substance abuse are included in child find efforts. Early Intervention Program regulations at 10 NYCRR §69-4.3(a) *require* primary referral sources to refer children at risk of having a disability to the EIO based on medical/biological risk criteria identified at 10 NYCRR §69-4.3(f), including maternal prenatal alcohol abuse, maternal prenatal abuse of illicit substances, and prenatal exposure to therapeutic drugs with known potential developmental implications (such as psychotropic, anticonvulsant, or antineoplastic medications). EIP regulations further specify that

---

<sup>4</sup> American Academy of Pediatrics: Developmental Surveillance and Screening of Infants and Young Children. Committee on Children with Disabilities. *Pediatrics*, Vol 108, No. 1, July, 2001, pp 192-195.

<sup>5</sup> 42 U.S.C. 5106a(b)(xxi)

<sup>6</sup> H.R. 1350, Sec. 637(a)(6)

<sup>7</sup> Conference Report on H.R. 1350, pg 126

<sup>8</sup> PHL §2542(1) and 10 NYCRR §69-4.2 (a)(2)(3)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

the following risk criteria may be considered by a primary referral source in the decision to make a referral: no prenatal care; parental developmental disability or diagnosed serious and persistent mental illness; parental substance abuse, including alcohol or illicit drug abuse; no well child care by six months of age or significant delay in immunizations; and/or, other risk criteria as identified by the primary referral source.<sup>9</sup>

In accordance with new IDEA and CAPTA requirements, and existing PHL and regulations governing the EIP, children involved in substantiated cases of child abuse and neglect, and those affected by illegal substance abuse or withdrawal symptoms resulting from prenatal exposure *should be considered at-risk for developmental delay and included in local child find efforts* (unless a child also has a developmental delay or diagnosis that makes him or her potentially eligible for the EIP). This means that EIOs are responsible for collaborating with all available resources in the community to ensure that these children are identified, screened, and tracked, so that a referral to the EIP for a multidisciplinary evaluation can be made if a developmental delay or disability is suspected. Municipalities should provide direct developmental screening for those children for whom no other resources are available to provide screening and tracking services, *using Early Intervention Administration funds allocated to municipalities to administer the EIP*.<sup>10</sup> Municipalities should already have child find procedures in place to work with hospitals and health care providers to ensure that children affected by illegal substance abuse are referred to the EIP for screening and tracking purposes.

EIOs and local EIP program staff should work with their local departments of social services and local early intervention coordinating councils to collaborate on the development of local procedures to ensure appropriate referrals of children in the child protective system to the EIP. As mentioned above, resources allocated to municipalities by the Department, through Early Intervention Administration contracts to administer the EIP (including child find), can be used to collaborate with local departments of social services to identify children involved in substantiated cases of child abuse or neglect for whom a referral to the EIP may be appropriate. For example, it may be appropriate for municipalities to conduct developmental screening programs in conjunction with local departments of social services for children involved in substantiated cases of child abuse and neglect. It is also important for EIOs and staff to educate child protective staff about eligibility requirements for the EIP and the types of developmental services available through the program, so that families and staff have appropriate expectations about early intervention services.

Finally, many young children in the child protective system who have been involved in a substantiated case of child abuse and neglect may be in the foster care system. *The Protocol for Children in the Early Intervention Program and Foster Care*, issued by the Department in 2003, should be helpful to assist you in collaborative efforts to implement the new IDEA and CAPTA requirements.

---

<sup>9</sup> 10 NYCRR §69-4.3(g)

<sup>10</sup> Rates established by the Department for screening can only be used by evaluators to perform a screening, when appropriate, for a child referred to the EIP as a potentially eligible child for a multidisciplinary evaluation. See page 15 for a discussion about when it may be appropriate for evaluators to conduct a screening.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

As mentioned above, for *all* children at-risk who are referred to the EIP, municipalities should be working closely with primary health care providers and other community resources to ensure that children receive periodic developmental screening. Local child find efforts related to children involved in substantiated cases of child abuse or neglect, or who are affected by illegal substance abuse, should include efforts to assist families in accessing primary health care providers who can provide preventive health care services, including developmental surveillance.

It is important to note that under the PHL and regulations governing the EIP, the involvement of a child in a substantiated case of child abuse and neglect or prenatal exposure to illicit substances (including withdrawal symptoms), in the absence of a suspected or confirmed developmental delay or diagnosed condition with a high probability of resulting in developmental delay is insufficient to qualify the child for the EIP, including service coordination services, multidisciplinary evaluations, development of an individualized family service plan (IFSP), and provision of early intervention services. Only those who are referred to the EIO as having a suspected or confirmed disability (either a developmental delay or diagnosed condition with a high probability of developmental delay), and are therefore thought to be eligible children, are entitled to receive service coordination services and a multidisciplinary evaluation to determine eligibility for the EIP. Therefore, an initial service coordinator should be designated and a multidisciplinary evaluation provided *only to those children* referred to the EIO because they are involved in an indicated case of child abuse and neglect or have been exposed prenatally to illicit substance abuse (or have experienced withdrawal symptoms), and for whom a developmental delay or diagnosed condition is also suspected or confirmed and identified by the primary referral source at the time of the child's referral.

**Children Referred With a Confirmed or Suspected Disability**

State and federal law and regulations require that children who are referred to EIOs with a *confirmed or suspected disability* are entitled to receive a comprehensive, multidisciplinary evaluation to determine whether they meet the eligibility criteria for the EIP. EIP regulations at 10 NYCRR §69-4.1(m) define evaluation to mean “the procedures used by appropriate qualified personnel to determine a child’s initial and continuing eligibility for the Early Intervention Program, including determining the status of the child in each of the following areas of development: cognitive, physical, communication, social or emotional, and adaptive.” EIP regulations at 10 NYCRR §69-4.1(ac) define multidisciplinary as “the involvement of two or more professionals from different disciplines in the provision of integrated and coordinated services, including evaluation and assessment services...” For children with a confirmed disability (i.e., a diagnosed condition with a high probability of developmental delay), the purpose of the multidisciplinary evaluation is to confirm the diagnosis through a review of appropriate medical or other child records, with parent consent (see Section II of this document, “Use of Findings of Other Examinations”); and, to conduct an evaluation and assessment of all developmental domains to assist in development of the Individualized Family Service Plan (IFSP). Requirements for multidisciplinary evaluations are described in detail in Section II of this document (see pages 8-21).



*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

Because children thought to be eligible for the EIP are entitled to a multidisciplinary evaluation,<sup>11</sup> municipalities cannot “prescreen” them (for example, complete a developmental screening such as the ASQ or other type of screening) to determine whether or what type of an evaluation should be completed. Upon receipt of a referral for a child with a suspected or confirmed disability, the EIO must promptly designate an initial service coordinator to assist the child’s parent(s) in selection of an evaluator to conduct a multidisciplinary evaluation.

Municipalities are responsible for ensuring that parents have the opportunity to select an evaluator from the list of approved evaluators under contract with the municipality to deliver early intervention evaluations, and to ensure that initial service coordinators have access to and use an up-to-date list of available evaluators in their discussions with parents about selection of an evaluator. The initial service coordinator is responsible for providing parents with: a list of all evaluators approved and under contract with their municipality; and, *objective* information about potential evaluators to assist parents in selecting evaluators appropriate for the individual needs of their children at the time of referrals.

When children in foster care are referred to the EIP with a suspected disability, the EIO is responsible for making a determination, in conjunction with the local Commissioner of Social Services or his/her designee, regarding the availability of the child’s parent and the need to appoint a surrogate parent for purposes of the EIP, including providing consent for the evaluation and participation in the evaluation process.

## **II. Multidisciplinary Evaluation Procedures**

### **Purpose of the Multidisciplinary Evaluation**

Under federal and State law and regulations, children thought to be eligible (e.g., referred with a suspected or confirmed disability) for the EIP are entitled to a multidisciplinary evaluation.<sup>12</sup>

The multidisciplinary evaluation is necessary to:

- determine whether a child is eligible for the Early Intervention Program;
- assess the status of the child’s physical, cognitive, communication, social-emotional, and adaptive development;
- identify areas of developmental strengths and needs; and,
- learn and understand the parent’s resources, priorities, and concerns related to their child’s development.

The initial multidisciplinary evaluation and assessment results are fundamental to documenting children’s eligibility for services under the EIP. While the evaluation includes an assessment of the unique needs of the child in each developmental domain, including the identification of services appropriate to meet those needs, the evaluator should avoid making recommendations regarding the frequency, intensity, and duration of specific services until such time as the family’s total priorities, resources, and concerns have been assessed and the total plan for

---

<sup>11</sup> PHL §2544(1)

<sup>12</sup> 34 CFR §303.322; PHL §2544 (1)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

services under the IFSP is under discussion.<sup>13</sup> In addition, the evaluation or assessment must not include a reference to any specific provider of early intervention services.<sup>14</sup> The decisions about the frequency, intensity, and duration of services to be provided to a child and family, or about the provider(s) to deliver EIP services, are not recommended as part of the evaluation. These decisions must be made during the IFSP meeting when the goals, services and strategies necessary to assist the child and family in meeting those goals are agreed upon. The results of the multidisciplinary evaluations and family assessments are an important source of information for development of IFSPs to meet children's developmental strengths and needs, and the priorities, resources, and concerns of families related to their child's development.

It is important to note that for children who are found eligible on the basis of a diagnosed condition with a high probability of resulting in developmental delay, such as Down syndrome, cerebral palsy, extreme prematurity, etc., a primary purpose of early intervention is to mitigate the impact of the condition on a child's developmental progress. These children do not have to be experiencing developmental delays to receive specific services available under the EIP. In determining outcomes to be achieved for these children and the services needed to achieve child and family outcomes, the IFSP team should consider the potential impact of the condition on child development and functioning as well as information on children's developmental status obtained through the evaluation process.

**General Requirements for the Evaluation Process**

EIP regulations at 10 NYCRR §69-4.8 detail the responsibilities of evaluators for conducting screenings, evaluations, and assessments to establish children's eligibility for the EIP. The multidisciplinary evaluation must be completed within sufficient time to develop an individualized family service plan (IFSP) within forty-five days of referral for those children found eligible for the EIP. If the time from the date of referral to the development of an IFSP exceeds forty-five days, municipalities must document the reason for the delay (including lack of timeliness in completion of a child's evaluation or submission of the evaluation summary and report to the EIO) in the child's record and in the Kids Integrated Data System (KIDS) (or other data system or data reporting mechanisms required by the Department). Under federal and State law and regulation, nondiscriminatory evaluation and assessment procedures must be used in all aspects of the evaluation and assessment process.<sup>15</sup> Specifically, evaluation and assessment procedures must be responsive to the cultural and linguistic background of the family.

In addition, *no single procedure or instrument may be used as the sole criterion or indicator of eligibility*. In other words, when making a determination as to whether a child is eligible for the EIP, the multidisciplinary evaluation team must rely on information from a variety of appropriate sources, which should include standardized instruments and procedures, when appropriate or possible; observations of the child; parent interviews; informed clinical opinion; and, any other sources of information about the child's developmental status available to the team conducting the child's evaluation. This *should not* be interpreted as requiring that two or more standardized tests or instruments be used to evaluate the child, unless the child's developmental status clearly indicates the need for more than one standardized test (e.g., a hearing test to assess hearing loss

---

<sup>13</sup> 10 NYCRR §69-4.8(4)(iv)

<sup>14</sup> 10 NYCRR §69-4.8(15)

<sup>15</sup> 34 CFR §303.323; 10 NYCRR §69-4.8(14)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

and a standardized developmental test to assess the impact of the child's hearing loss on his/her development).

Federal and State regulations also require that evaluations must:

- be conducted by personnel trained to utilize appropriate methods and procedures;
- be based on informed clinical opinion; and,
- include a review of pertinent records related to the child's current health status and medical history.<sup>16</sup>

State regulations further specify that multidisciplinary evaluations must be conducted in a professional, objective fashion and must:

- consider the unique characteristics of the child;
- use several sources and types of information about the child.<sup>17</sup> Examples of other sources of information might include, with parent consent, the child's primary health care provider or medical specialists, relatives or family members, family day care or child care provider, etc.;
- employ appropriate instruments and procedures. Instruments used as part of a multidisciplinary evaluation must be reliable and valid, have appropriate levels of sensitivity and specificity; and, be sensitive to the child's and parent's culture and dominant language or other mode of communication;<sup>18</sup> and,
- be conducted in a setting conducive to ensuring accurate results, and the parent's input regarding the preferred environment should be considered.<sup>19</sup> Prior to the evaluation, parent input about the setting in which their child is likely to be most comfortable should be obtained. After the evaluation, the family should be asked whether they believe their child's response was optimal, and the family's response should be included in the evaluation summary and report.

The New York State Department of Health (Department) clinical practice guidelines include descriptions of comprehensive, in-depth assessments for children with or suspected of having autism/pervasive developmental disorders or communication disorders. The Department will be releasing four additional clinical practice guidelines, addressing motor disorders, hearing loss, vision impairment, and Down syndrome in the near future. The guideline recommendations for in-depth assessment procedures for each of these conditions should be used as part of the multidisciplinary evaluation procedures once each of the guidelines are published and disseminated. (The guidelines on assessment and intervention for children with autism/pervasive developmental disorders and communication disorders were published in 1999 and have been widely distributed.)

---

<sup>16</sup> 34 CFR §303.323; 10 NYCRR §69-4.8

<sup>17</sup> 10 NYCRR §69-4.8(6)

<sup>18</sup> 10 NYCRR §69-4.8(6)(i)

<sup>19</sup> 10 NYCRR §69-4.8(6)(ii)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

*A Special Note on Standardized Evaluation and Assessment Instruments*

Standardized evaluation, assessment and/or diagnostic instruments *should be used*, whenever such instruments are available and **appropriate for the child's age, culture/language**, and developmental concern, as part of a child's multidisciplinary evaluation to determine initial or ongoing eligibility for the EIP. Standardized evaluation and assessment instruments must be used by appropriately trained and qualified professionals. Some test developers require professionals to complete additional training and/or certification prior to using the instrument, and under these circumstances, only those professionals with this training are qualified to use the instrument. In addition, evaluators are responsible for ensuring that standardized tests are used and scored as specified in the test manual, in a manner that does not violate the psychometric properties of the test or the purpose for which the test was designed. Subscores returned on standardized tests must be used in a manner consistent with the test manual, and are generally not averaged unless the manual provides explicit instructions for use of subscores in this manner. Standardized instruments selected should be norm-referenced to the population to be evaluated. Tests and other materials and procedures used must be administered in the child's dominant language or other mode of communication unless it is clearly not feasible to do so. When evaluation and assessment instruments are revised or re-normed and reissued by test developers, the most recent edition of the instrument should be used as soon as practicable (that is, when the new edition is available to professionals) to assure valid results.

If a child is suspected of having a condition with a high probability of resulting in developmental delay, such as autism, standardized assessment instruments designed specifically to diagnose and assess the presence of the condition should be used. The six clinical practice guidelines developed by the Department make specific recommendations on standardized assessment instruments and clinical procedures for evaluation of children with autism/pervasive developmental disorders, communication disorders, Down syndrome, motor disorders, hearing loss, and vision impairment.

There are two types of standardized tests that are used to assess children's developmental status. The use of each of these two types of tests to determine eligibility for the EIP is briefly described below.

***Norm-referenced***, standardized tests yield standard scores, standard deviations, and percentile ranks that are derived in relationship to a normal distribution, and therefore have a consistent and predictable relationship to each other and provide comparable information about a child's performance relative to a normative sample. Standard deviation scores, deviation quotients, and percentile ranks are all acceptable ways of reporting test scores to document children's eligibility, when norm-referenced, standardized instruments are used.

However, some norm-referenced tests also yield a "developmental age" or "age equivalency" score. These scores represent the chronological age of the children in the sample for whom a specific raw score was the mean score (i.e., the scores represent a mathematically calculated performance rather than actual performance of children in the standardization sample [Andersson, 2004]). Assessment experts discourage the reporting of age-equivalent/developmental age scores because these scores do not provide comparative information and *do not indicate the presence of a disorder or delay*. These scores do not indicate

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

what a child's performance should be, nor do they indicate qualitative differences in a child's performance. In addition, a reduction in an age equivalent score does not have the same consequence at all stages of development or across all developmental domains. Finally, these scores can be imprecise, because age-equivalent scores may not be available to match the full range of chronological ages.

Age-equivalent or developmental age scores derived from standardized tests *should not be used* for eligibility determinations unless the test manual explicitly indicates that the test has been designed to calculate percentage of delay and the manual provides data to support the use of these scores as valid and reliable.

**Criterion-referenced tests** are not designed to compare one child's performance to other children. Criterion-referenced instruments are helpful in assessing children's functionality, measuring progress, and linking assessment to intervention; however, these tests generally do not provide sufficient information to determine the extent to which a child is experiencing developmental delays. In addition, criterion-referenced tests can be helpful in evaluating children for whom norm-referenced tests are not available or appropriate due to the child's age, condition, language/culture, or other factors that influence test performance. Criterion-reference tests can be used in conjunction with other methods of gathering information about a child's development (e.g., parent report, observation, etc.) and informed clinical opinion to establish a child's eligibility based on level of developmental delay.

Norm-referenced test are known to have a higher degree of reliability and validity than criterion-referenced tests, and are specifically designed for use in comparing the performance of an individual child to the performance of a referent group (for example, children of the same age). Norm-referenced tests should be used, whenever possible and appropriate to the child's individualized needs, as part of the eligibility determination process. Norm-referenced tested can be particularly helpful when evaluating children who are referred to the EIP based only on a concern about development and when no underlying condition with a high probability of resulting in developmental delay is suspected or confirmed.

See Andersson, L. "Appropriate and Inappropriate Interpretation and Use of Test Scores in Early Intervention," *Journal of Early Intervention*, 2004, Vol. 27, No.1, pp 55-68 for an excellent discussion on these issues.

*A Special Note on Informed Clinical Opinion*

In guidance issued by the Department in 1999 (EIP Memorandum 1999-2), it was emphasized that diagnostic instruments and informed clinical opinion must be used in combination to interpret results of the comprehensive evaluation, determine the degree of developmental delay, and formulate a statement of eligibility where the evaluator has determined that a child meets State eligibility criteria. **Informed clinical opinion** for purposes of the EIP is defined at 10 NYCRR §69-4.1(w) as "the best use of quantitative and qualitative information by qualified personnel regarding a child, and family if applicable. Such information includes, if applicable, the child's functional status, rate of change in development, and prognosis." Informed clinical opinion is more generally used to describe professionals' use of qualitative and quantitative information to assess a child's development. The use of informed clinical opinion and diagnostic procedures is particularly important when, due to the child's age, culture, language, and/or nature

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

of the developmental problem or concern, standardized instruments are not available or appropriate.

When using informed clinical opinion in the evaluation process, practitioners draw upon clinical training and experience; standardized instruments, as available and appropriate; recognized clinical assessment procedures (e.g., observation techniques; interviewing techniques; use of objective measurement techniques specific to the developmental problem or circumstances and concerns related to child and family, etc.); experience with children of different cultures and languages; and, their ability to gather and include family perceptions about children's development. Clinicians should also refer to recognized clinical practice guidelines and standards, including the Department's clinical practice guidelines. An article on informed clinical opinion is available through the Web site of the National Early Childhood Technical Assistance Center (NECTAC) at <http://www.nectac.org/>.<sup>20</sup>

*A Special Note on Parent Participation in the Multidisciplinary Evaluation Process*

EIP regulations require that parents have the opportunity to participate in the performance of screenings, evaluations, and assessments *unless the parent's circumstances prevent the parent's presence*.<sup>21</sup> For children in the care and custody, or custody and guardianship, of the local social services commissioner, the commissioner or designee (i.e., the child's case worker or other local department of social services staff designated by the commissioner) may be present in lieu of a parent (or surrogate parent) who elects not to participate.<sup>22</sup>

The importance of parental involvement in the performance of children's multidisciplinary evaluations (which include by definition, screenings, evaluations, and assessments) cannot be overstated. Parents should always be present and participate in the child's evaluation, unless there are exceptional circumstances as to why the parent(s) cannot be present. The presence and participation of a parent (or parents) is necessary for many reasons. Parents have a responsibility to be informed about, understand, and consent to the evaluation procedures. In addition, parents can assist the multidisciplinary evaluation team with the evaluation process, can help elicit optimal responses from their children and/or can help the team understand the extent to which children's responses are typical/optimal.

The evaluation team is required to conduct a parent interview about the family's resources, priorities, and concerns about the child's development and developmental progress.<sup>23</sup> With the parent's consent, the evaluation team may also interview other family members or individuals who have pertinent knowledge about the child's development (e.g., child care providers). Children's parents have critical information about their children to share and are integral to the evaluation process.

---

<sup>20</sup> Shackelford, J. (2002). *Informed clinical opinion* (NECTAC Notes No. 10). Chapel Hill: The University of North Carolina FPG Child Development Institute, National Early Childhood Technical Assistance Center

<sup>21</sup> 10 NYCRR §69-4.8(a)(2)(iii) and (7)

<sup>22</sup> 10 NYCRR §69-4.8(a)(2)(iii)

<sup>23</sup> 10 NYCRR §69-4.8(a)(4)(iii)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

Parental presence and participation in their child’s multidisciplinary evaluation is important to facilitating parents’ understanding of evaluation results. The multidisciplinary evaluation team is responsible for fully sharing the results of child evaluations with parents following the completion of evaluations and assessments. Parents must be afforded the opportunity to discuss the evaluation results with evaluators, including any concerns they have with the evaluation process.

**Intake and Screening Procedures**

The evaluator is responsible for obtaining parental consent to perform the screening and/or evaluation prior to initiating evaluation procedures. The evaluator may, with parent consent, screen the child to determine what type of evaluation, if any, is necessary unless the child has a confirmed diagnosis with a high probability of resulting in developmental delay.<sup>24</sup> When a child has a confirmed diagnosis of a condition with a high probability of resulting in developmental delay (such as Down syndrome), a full multidisciplinary evaluation must be performed for the child.<sup>25</sup>

While parents always have the option to pursue a multidisciplinary evaluation for their child upon referral to the EIP, there are some circumstances when performance of a screening is appropriate. Screening tests are generally intended to be brief, easy to administer, and lead to a yes/no decision as to whether or not a developmental problem is likely and further in-depth assessment/evaluation is needed. The evaluator is responsible for determining what type of screening should be conducted (for example, whether a screening should address one or more domains of development, or if the screening should address a specific concern, such as potential hearing loss).

Circumstances under which it may be appropriate for an evaluator to conduct a screening include when there are:

- concerns about only one area of development (e.g., communication development, physical development, etc.), or if there is a *generalized concern* about the child’s development, a screening may be conducted to determine whether the child is typically developing or whether there are indications of problems that require further evaluation and assessment; or,
- very specific concerns for which procedures exist to clearly “rule out” or identify a problem (e.g., hearing loss).

Screenings may be helpful in the following ways:

- When a screening indicates that a child’s development is within normal range, and no problems or delays are identified, parental concerns can be alleviated without necessitating that the child and family undergo a full evaluation (unless the parent requests a full evaluation).
- Screenings can assist the evaluator in deciding upon the most effective *composition* of the child’s multidisciplinary evaluation team. For example, if a screening indicates that a child’s communication development is age appropriate, but motor development is delayed, the

---

<sup>24</sup> 10 NYCRR §69-4.8(a)(2)(i)

<sup>25</sup> 10 NYCRR §69-4.8(a)(2)(i)(a)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

multidisciplinary evaluation team should include a professional who can assess the child's motor functioning.

If the screening results are within normal limits, the child is not eligible for the EIP and does not require a full multidisciplinary evaluation. The evaluator must inform the parent of the results of the screening, including that the child's development is appropriate and further evaluation is not indicated at this time. The evaluator must prepare and submit a report to the Early Intervention Official, parent, and with parent consent, the child's primary health care provider. The evaluator may recommend developmental surveillance for the child, if appropriate. If the parent requests a full multidisciplinary evaluation for the child, the evaluator must provide a multidisciplinary evaluation.

If the screening indicates cause for concern, a multidisciplinary evaluation must be completed to determine whether the child is eligible for the EIP. It is important to note that the multidisciplinary evaluation must include an in-depth assessment of all five areas of development, regardless of screening results.

When a screening is completed as part of the evaluation process, the evaluator must use, whenever feasible and appropriate, standardized instruments with demonstrated reliability and validity, and appropriate sensitivity and specificity.<sup>26</sup> In addition, parents must consent to and be present for the screening, unless the parent's circumstances prevent the parent's presence.

Evaluators who perform a screening are responsible for discussing the results of the screening with the parent, facilitating the parent's understanding of the screening results, and addressing any concerns identified by the parent.

### **Composition of the Evaluation Team**

The composition of the multidisciplinary evaluation team is critical to ensuring accurate and comprehensive results, including a diagnosis, if appropriate. At a minimum, the team must include two differently qualified professionals.<sup>27</sup> In addition, State EIP regulations stipulate that at least one member of the evaluation team must be a specialist in the area of the child's suspected delay or disability, if known.<sup>28</sup> The team must be trained in appropriate methods and procedures, and across the members of the team, have sufficient expertise to fully assess all five developmental domains. At least one member of the team must also have expertise and be trained in appropriate methods and procedures to conduct the family assessment (optional to the parent[s]).

In determining the composition of the multidisciplinary evaluation team, the evaluator should consider the concerns expressed by the parent regarding the child's development, information available from the referral source (e.g., diagnostic information, medical/developmental history, etc.), and screening results if a screening was conducted. If a child is referred with a suspected diagnosed condition with a high probability of developmental delay, or a suspicion of such a condition emerges during the evaluation, it is important for the multidisciplinary evaluation team to assist the family in obtaining a diagnosis. For example, the multidisciplinary evaluation team

---

<sup>26</sup> 10 NYCRR §69-4.8(a)(2)(ii)

<sup>27</sup> 10 NYCRR §69-4.8 (a)(3)

<sup>28</sup> 10 NYCRR §69-4.8(a)(3)



*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

should be comprised of, or expanded to include, professionals who are qualified to diagnose the suspected condition (e.g., autism/pervasive developmental disorders, cerebral palsy, etc.). Appendix B, which may also be found in Early Intervention Guidance Memorandum 1999-2, on reporting children's eligibility, contains a list of eligible conditions and information about which professionals are qualified to diagnose them. The multidisciplinary evaluation team may recommend that a supplemental evaluation (conducted either by a physician or other personnel qualified to make a diagnosis) be completed for this purpose.

**Required Components of the Multidisciplinary Evaluation**

Evaluators are responsible for ensuring that evaluations are conducted in a manner consistent with State and federal law and regulations.

Under the EIP regulations, the following components must be included in performance of multidisciplinary evaluations:

1. A parent interview about the family's resources, priorities, and concerns related to the child's development and developmental progress. Interviews with other family members or individuals knowledgeable about the child, such as childcare providers, may be conducted with parent consent.<sup>29</sup>
2. With parent consent, a review of pertinent records related to the child's current health status and medical history.
3. An evaluation of the child's level of functioning in each of five developmental domains: cognitive, physical (including vision and hearing), communication, social or emotional, and adaptive development.<sup>30</sup> The evaluation of the child's physical development must include a health assessment. The health assessment is comprised of a physical examination, routine vision and hearing screening, and where appropriate, a neurological assessment.

If a health assessment has recently been completed in accordance with schedules recommended by the American Academy of Pediatrics (see Appendix C, or access the chart on the AAP website<sup>31</sup>), however, and there are no clinical indications that a re-examination is necessary, the evaluator shall, with parental consent, rely on a record review to meet the requirements for the health assessment.<sup>32</sup>

4. With parent consent, findings from current examinations, evaluations or assessments, in addition to health assessments described above that have been performed for the child, may be used to augment and not replace the multidisciplinary evaluation to determine eligibility, as long as these assessments have been performed in a manner consistent with the requirements for multidisciplinary evaluations, and no clinical indicators are present to suggest the need to repeat procedures.<sup>33</sup>
5. An assessment of the unique needs of the child in each developmental domain, including

---

<sup>29</sup> 10 NYCRR §69-4.8 (a)(4)(iii)

<sup>30</sup> 10 NYCRR §69-4.8(a)(4)(i)

<sup>31</sup> <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf>

<sup>32</sup> 10 NYCRR §69-4.8(a)(4)(a)(1)

<sup>33</sup> 10 NYCRR §69-4.8 (a)(5)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

identification of services appropriate to meet those needs. It is appropriate for evaluators to identify the types of interventions and services that are indicated for the child, and family based on the results of the evaluation. However, it is important to note that PHL §2544(5) *specifically prohibits an evaluation from including reference to any specific provider of early intervention services*. In addition, 10 NYCRR §69-4.8(a)(4)(iv) states that the evaluator should avoid making recommendations regarding frequency and duration of specific services until such time as the family's total priorities, concerns, and resources have been identified and the IFSP is under discussion. The evaluator should also avoid making recommendations about the intensity of specific services until the IFSP is under discussion.

6. An evaluation of the transportation needs of the child, which must include the parent's ability or inability to provide transportation; the child's special needs related to transportation; and, safety issues and parent concerns about transportation.<sup>34</sup> It is the evaluator's responsibility in particular to discuss the child's developmental and health concerns related to transportation in the event that the child requires transportation to early intervention services included in the IFSP. PHL §2545(3) also requires that the EIO first consider whether the parent may provide transportation to the early intervention services. Other modes of transportation can be used only if the parent can demonstrate an inability to provide appropriate transportation services.

*Voluntary Family Assessment*

EIP regulations at 10 NYCRR §69-4.8(a)(8) require that all parents be given the opportunity to participate in a family-directed assessment to determine the resources, priorities, and concerns of the family related to enhancement of the child's development, conducted by appropriately qualified personnel on the multidisciplinary evaluation team. Family assessments are *voluntary* on the part of the family; however, evaluators approved under the EIP must have the personnel resources to offer a family assessment to all families and to conduct these assessments for parents who wish to participate in a family assessment.

It is important to differentiate between the *parent interview* that must be conducted as part of the *child's multidisciplinary evaluation* and the *family assessment* process, which is voluntary on the part of the family. The purpose of the *parent interview* is to obtain information from the perspective of the child's parents, and with parent consent, from other individuals familiar with the child's development regarding concerns about the *child's developmental status and progress*. The parent interview assists the multidisciplinary evaluation team in assessing the unique needs of the child in each developmental domain, and the family's resources, priorities, and concerns related to the *child's* development. The subject of the parent interview, in other words, is the *child's development*. The parent interview (and/or interviews with other individuals, with the parent's consent) is a *required* part of the child's evaluation, *focused on the child's developmental status*.

The purpose of the voluntary *family assessment* is to assist the family in determining the resources, priorities, and concerns of the *family* related to enhancing their child's development. The multidisciplinary evaluation team is required to offer families the opportunity to participate in a family assessment; however, participation in this assessment process is voluntary for the family. The family assessment process is defined in EIP regulations as "the process of

---

<sup>34</sup> 10 NYCRR §69-4.8(a)(4)(v)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

information gathering and identification of family priorities, resources and concerns, which the *family* decides are relevant to their ability to enhance their child's development."<sup>35</sup> An important part of the family assessment process is to help the family identify the formal and informal supports and services needed by the family to assist them in enhancing their child's development. These might include both those formal supports and services available through the EIP (for example, family training, family counseling, family/parent support groups, etc.) and services needed by the child and family available through other service delivery systems, such as the Office of Mental Retardation and Developmental Disabilities' Home-and Community-Based Waiver Program), and informal supports and community resources available to the family (for example, recreational programs and facilities, family and friends, neighbors, etc.) that can assist the family in enhancing their child's development. The focus of the family assessment is the *family* and their priorities, resources, and concerns related to their child's developmental needs.

When carried out, family assessments must:

- be conducted by qualified personnel trained to utilize appropriate methods and procedures;
- be based on information provided by the family through a personal interview;
- incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development; and,
- be completed within a sufficient time frame to enable convening of the IFSP meeting within 45 days of the date of the child's referral to the EIP.<sup>36</sup>

The family assessment is *not* intended to be a *professional assessment of the family's functioning*, as might occur in other types of service delivery settings or circumstances.

Professional assessments of family functioning can be provided under the EIP if these services are included in the IFSP (for example, through social work services, family counseling, etc., related to the impact of the child's developmental problems on the parent(s)/family unit).

Because the voluntary family assessment is intended to be a family-directed process to identify the family resources, priorities, and concerns related to enhancing their child's development, the family assessment may be conducted by any member (or members) of the multidisciplinary evaluation team who is trained in methods and procedures to conduct the family assessment. As part of the family assessment process, the evaluator should discuss with the parent how the results of the family assessment should be documented, including what information should be included in the evaluation report.

### **Use of Findings From Other Examinations**

Evaluators may use findings from other current examinations, evaluations, assessments, or health assessments performed for the child, with parental consent, including those conducted prior to the initiation of the multidisciplinary evaluation. This can facilitate the timeliness of the evaluation process by reducing the amount of time needed to complete the evaluation, and by reducing the number of professionals involved and/or evaluations that must be completed. Use

---

<sup>35</sup> 10 NYCRR §69-4.1(o)

<sup>36</sup> 10 NYCRR §69-4.8(8)(a)(1)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

of such findings will also ensure that children do not have to undergo duplicative or unnecessary evaluation procedures. Under these circumstances, the evaluator must ensure that:

- the procedures were performed in a manner consistent with EIP requirements;
- the findings are used to augment and not replace the multidisciplinary evaluation to determine eligibility; and,
- there are no indications present which suggest the need to repeat such procedures (e.g., the strengths/needs of the child have changed sufficiently to warrant re-examination).

In addition, where feasible the evaluation team should consult with the professional(s) who performed the procedures being reviewed as part of the child's multidisciplinary evaluation for the EIP.<sup>37</sup>

If a child has been evaluated using a specific standardized instrument/test/procedure *prior to his/her referral* to the EIP, the EIP multidisciplinary evaluation team is responsible for determining whether it is necessary and appropriate (i.e., will not impact the validity/reliability of test scores) to repeat the instrument/test/procedure. The multidisciplinary evaluation team is responsible for ensuring that all required components of the evaluation are completed, and may rely on existing records for components of the evaluation to the extent these records are current and appropriate.

Finally, if a child is referred to the EIO as having a diagnosed physical or mental condition with a high probability of resulting in developmental delay, which has also been identified on the Department's list of conditions that establish a child's eligibility for the EIP, the evaluator is responsible for confirming that the child has the condition and is eligible for the EIP based on the presence of the condition. The evaluator will frequently be able to confirm the presence of the child's condition by requesting and receiving, with parental consent, the records of other current examinations, evaluations, assessments, or health assessments performed for the child. In particular, genetic and/or medical conditions included on the Department's list of conditions that establish eligibility for the EIP (such as Down syndrome, Fragile X syndrome, extreme prematurity in infants, etc.) will usually be able to be confirmed through a review, with parent consent, of a child's medical records. Under these circumstances, it is unnecessary for the multidisciplinary team to perform or request that any additional tests or assessments be performed to confirm the presence of the condition.

However, there may be circumstances under which the evaluator has insufficient information to confirm the presence of a diagnosed condition with a high probability of resulting in developmental delay. This could be a result of lack of parental consent to access necessary records, or insufficient information or findings from the results of other examinations, assessments, or health assessments in records that have been provided to the evaluator. These circumstances are more likely to occur when children are referred with conditions that are identified on the basis of behavioral and developmental assessments (such as autism/pervasive developmental disorders) or when children are referred on the basis of a screening that requires follow-up (for example, infants referred through universal newborn hearing screening with

---

<sup>37</sup> 10 NYCRR §69-4.8(a)(5)(iv)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

suspected hearing loss). Under these circumstances, it is within the purview of, and the responsibility of, the evaluator, to complete whatever appropriate tests and procedures are necessary to establish the child's eligibility for the EIP (whether on the basis of a diagnosed physical or mental condition with a high probability of resulting in developmental delay, or the presence of a developmental delay).

### **III. Evaluation Reports and Documentation Requirements**

#### **Informing Parents of Results**

The evaluator is responsible for sharing the results of the child's evaluation and assessment with his/her parents, in a manner that is understandable to parents. The parent must have the opportunity to discuss the results of the evaluation with the evaluation team, or a designated member of the evaluation team, who conducted the evaluation, including any concerns the parent has about the evaluation process and the extent to which the parent believes the evaluation accurately reflects the child's abilities and needs.<sup>38</sup> The evaluator is responsible for helping parents to understand the results and ensuring the evaluation has addressed the parent's concerns and observations about the child.<sup>39</sup> The evaluator cannot recommend any specific service provider to the parent and should refrain from making recommendations regarding frequency, intensity, and duration of specific services until such time as the family's total priorities, concerns, and resources have been identified and the IFSP is under discussion. The evaluator is responsible for using the results of the developmental assessment to identify the types of services that are clinically appropriate to meet the unique developmental needs of the child.

The evaluator must provide the written and oral summary of the evaluation to the parent in the parent's dominant language or other mode of communication, to the extent feasible, and within confidentiality requirements and the parent's preference and consent to using an interpreter.<sup>40</sup>

#### **Evaluation Report**

EIP regulations also require the evaluation team to prepare an evaluation report and written summary and submit the summary, and upon request the report, to the following individuals within sufficient time to ensure completion of the IFSP within 45 days of a child's referral to the EIP:

- the child's parent(s);
- the EIO; and,
- the initial service coordinator.

Because the EIP regulations at 10 NYCRR §69-4.8(a)(9) require the evaluator to fully share the results of the child's evaluation and assessment with the parent, it is appropriate for all parents to receive a copy of their children's full multidisciplinary evaluation reports. In addition, EIOs *must* receive a copy of children's multidisciplinary evaluation reports to ensure that eligibility for the EIP has been established and assist them in preparing for IFSP meetings for children eligible for the EIP. With parent consent, the evaluation summary and report should also be

---

<sup>38</sup> 10 NYCRR §69-4.8(a)(9)(ii)

<sup>39</sup> 10 NYCRR §69-4.8(a)(9)(iv)

<sup>40</sup> 10 NYCRR §69-4.8(a)(9)(v)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

shared with the child's primary health care provider<sup>41</sup> and the local social services commissioner or designee for those children in the care and custody, or custody and guardianship, of such commissioner.<sup>42</sup>

The evaluation report and summary must include the following information:

- the names, titles, and qualifications of the persons performing the evaluation and assessment;
- a description of the assessment process;
- the child's responses to the procedures and instruments used as part of the evaluation process, and the family's belief about whether the responses were optimal;
- the developmental status of the child *in each of the five developmental domains*, including the unique strengths and needs in each area;
- documentation of how clinical opinion was used by the evaluation team in evaluating and assessing the child's developmental status and potential eligibility for the EIP; and,
- measures and/or scores that were used, if any; and, an explanation of these measures or scores.<sup>43</sup> The evaluation report should also include diagnostic information and ICD-9 codes related to the child's eligibility, where appropriate.

In addition, *the evaluation report must include a clear statement of the child's eligibility. The eligibility statement must include either a diagnosed condition with a high probability of resulting in developmental delay and associated ICD-9 code; or, a statement of developmental delay consistent with the state definition of developmental delay and associated ICD-9 code for developmental delay.*<sup>44</sup> When a diagnosis is made by the evaluation team, one or more members of the team must be qualified under the practice acts in the education law governing their profession to render a diagnosis (see Appendix B). If the results of the multidisciplinary evaluation indicate the child is not eligible for the EIP, the evaluation report should also clearly document reasons why the child is not eligible (for example, the child's development is within normal range, or the child is not experiencing a developmental delay consistent with the State's definition of developmental delay). When children are found eligible for the EIP, the evaluation team should submit written summaries and reports in a timely manner, so that information from the multidisciplinary evaluation is available for review and consideration at the time of the IFSP meeting. See Appendix D for an example of an evaluation report format.

Upon receipt of an evaluation report from an evaluator, the EIO should review the evaluation report to ensure that the evaluator has followed regulatory requirements and Department standards and procedures explicated in this document, in performing the child's evaluation. If the EIO determines that the evaluation report indicates that the evaluator has not followed PHL, regulatory, and/or Department issued standards when performing the child's evaluation, the EIO

---

<sup>41</sup> 10 NYCRR §69-4.8 (a)(9)(i)

<sup>42</sup> 10 NYCRR § 69-4.8 (a)(9)(i)

<sup>43</sup> 10 NYCRR §69-4.8(a)(9)(ii)

<sup>44</sup> 10 NYCRR §69-4.8(a)(9)(iii)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

may require that the evaluator immediately submit additional documentation to support the eligibility determination made by the multidisciplinary evaluation team. If the multidisciplinary evaluation team does not provide the requested documentation, or the documentation provided continues to be inconsistent with PHL, regulatory requirements, and/or Department standards and procedures, the child's eligibility has not been established and the EIO can require that the parent select another evaluator to complete a multidisciplinary evaluation to determine whether the child is eligible for the EIP. Under these circumstances, if a parent does not consent to another evaluation, the EIO must inform the parent of the right to due process, including mediation or an impartial hearing, regarding the child's eligibility determination. The child's eligibility for the EIP is not established until either another multidisciplinary evaluation or due process proceedings have been completed.

*Role of the Multidisciplinary Evaluation Team in the IFSP Meeting*

If the evaluator determines the child is eligible for the EIP, the EIO is responsible for convening a meeting within 45 days of the child's referral to the EIO, to develop an initial IFSP. The evaluator is responsible for participating in the IFSP meeting. If the evaluator is unable to attend the meeting, arrangements must be made for the evaluator's involvement in the meeting by participating in a telephone conference call, or having a knowledgeable, authorized representative attend the meeting.<sup>45</sup> A person or persons directly involved in conducting the child's multidisciplinary evaluation must participate in the IFSP meeting.<sup>46</sup> An employee of the evaluation agency who did not participate in the evaluation is not considered a knowledgeable representative and is not an acceptable substitute.

EIP regulations require that the IFSP, including the outcomes to be achieved for the child and family, the services needed to meet the unique strengths and needs of the child and family, and, the frequency, intensity, location, and method of delivering early intervention services, be jointly developed by the following members of the IFSP team:

- parent;
- the EIO;
- initial service coordinator;
- the evaluator (i.e., a person or persons involved in the child's evaluation); and,
- any other persons, such as the child's primary health care provider, or child care provider, who the parent or the initial service coordinator, with parent consent, invite.

Other individuals requested by the parent, or who may be appropriate (such as persons providing services to the child or family), may also participate in the IFSP meeting. For children in the care and custody, or custody and guardianship of the local social services commissioner or such commissioner's designee should be invited to participate in the IFSP meeting.

---

<sup>45</sup> 10 NYCRR §69-4.11(a)(2)(iii)(a)

<sup>46</sup> 34 CFR §303.343(a)(1)(v)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

As previously mentioned, although evaluators make recommendations about the type of services that may be needed by the child and family, based on the results of the evaluation, the EIP regulations at 10 NYCRR §69-4.8(a)(4)(iv) require evaluators to avoid making recommendations regarding the frequency, duration, and intensity of specific services until such time as the family's total priorities, resources, and concerns have been assessed, and the total plan for services under the IFSP is under discussion with the IFSP team. The multidisciplinary evaluation team is responsible for making clinically appropriate service recommendations, based on their evaluation and assessment of the child's developmental strengths and needs, to inform the IFSP decision-making process. The evaluation and assessment of the child cannot include any reference to a specific service provider.<sup>47</sup> Municipal staff, service coordinators, and service providers should also refrain from making recommendations about the frequency, duration, and intensity of services to parents prior to IFSP meetings.

In contrast to the evaluation process, parents do not select providers of early intervention services included in their IFSPs. Once an IFSP is agreed upon, the municipality is responsible for ensuring the provision of services included in the child's IFSP, including identifying and arranging for service providers to deliver these services.<sup>48</sup> Municipalities must maintain contracts with a sufficient number of service providers to deliver timely and effective services to eligible children and their families. Municipalities should not select providers to deliver services to an eligible child based on a provider's position on a list. Such a practice does not ensure adequate consideration of the child's and family's individual needs. Municipalities should consider the extent to which it is appropriate for evaluators to deliver early intervention services to children whom they evaluated. In all cases, when arranging for services included in a child's IFSP, the EIO must consider the individualized needs of each child and family, and should consider a range of factors when identifying an appropriate service provider(s) for the child and family, such as the:

- the child's specific diagnosed condition(s) and/or areas of developmental delay, include level of delay;
- unique developmental strengths and needs of the child;
- goals, strategies, outcomes, and intervention modalities included in the child's and family's IFSP;
- strengths and needs of the family with respect to enhancing their child's development;
- expertise and experience of the provider relative to the child's and family's needs;
- language and cultural considerations;
- provider capacity to deliver the services the child and family needs;
- setting/location in which services are to be provided (e.g., the proximity of a provider to the home or community-based setting, transportation needs of the child, etc.); and,

---

<sup>47</sup> PHL §2544(5)

<sup>48</sup> PHL §2552(1)



*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

- other factors related to the quality and consistency of services to be included in the IFSP.

*Children Found To Be Typically Developing and Who Are Not Eligible for the EIP*

When the results of the multidisciplinary evaluation show that children are typically developing, or developing at a level above the EIP eligibility criteria, the multidisciplinary evaluation team and the service coordinator should ensure that the child's parents receive practical information regarding possible next steps as appropriate. For example, the multidisciplinary evaluation team can provide parents with information about child development milestones and what to look for as their child grows and develops to ensure they continue to make age-appropriate progress. If a child does not meet the threshold for eligibility for service delivery under the Early Intervention Program, but there are concerns about the child's progress, it may be reasonable for the family to seek assistance through other service delivery systems or other early childhood programs (e.g., Early Head Start, community-based programs). The multidisciplinary evaluation team is responsible for providing clinical information and making recommendations about alternative resources or services that may be beneficial to the child and family. For children who appear to be at-risk for developmental problems in the future, the multidisciplinary evaluation team may recommend that the child be included in municipal child find activities for at-risk children (screening and tracking), with parent consent. Service coordinators can provide parents with information about available resources in their communities, including contact information for such programs and services.

#### **IV. Reimbursement Mechanisms for Screening and Evaluation**

Screenings and evaluations, as defined in EIP regulations at 10 NYCRR §69-4.1 and performed in accordance with EIP regulations at 10 NYCRR §69-4.8, are reimbursable at rates set by the Department with the approval of the New York State Division of Budget.

Multidisciplinary evaluations, including screenings performed in the course of an evaluation, must be conducted by *approved evaluators under contract with municipalities* and selected by parents to determine initial, and when indicated, ongoing eligibility for the EIP. Only one claim can be submitted for the screening, regardless of the number of visits required to complete a screening.<sup>49</sup> Up to two screenings may be conducted in a twelve-month period, starting with the date of the child's referral to the EIP. Reimbursement *is not* available for screenings conducted after a child has been found eligible for early intervention services (i.e., when developmental delays consistent with the State definition of developmental delay have been substantiated or when a diagnosed condition with a high probability of developmental delay has been established).

Multidisciplinary evaluations performed in accordance with programmatic procedures described in Section II are reimbursed as either a core evaluation, or a core and one or more supplemental evaluations, depending on the nature and extent of the concerns about the child's development.<sup>50</sup> Evaluators can only submit one claim for one core or one supplemental evaluation, regardless of the number of visits required to complete the core or supplemental evaluation. Reimbursement regulations at 10 NYCRR §69-4.30(c)(2)(iii)(a) allow for reimbursement of one core evaluation

---

<sup>49</sup> 10 NYCRR §69-4.30(c)(1)

<sup>50</sup> 10 NYCRR §69-4.30(c)(2)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

and up to four different supplemental evaluations within a twelve-month period in conjunction with the initial development or annual evaluation of IFSPs.

A *core evaluation* must include a developmental assessment; a review of pertinent records and the parent interview; and, at the option of the family, a family assessment. The developmental assessment completed for the core evaluation must be conducted by qualified personnel, with sufficient expertise in early childhood development and who are trained in the use of professionally accepted methods and procedures to evaluate each of the five developmental domains: physical development, cognitive development, communication development, social or emotional development, and adaptive development. If there is a specific concern about an area of the child's development at the time a child is referred, the qualified personnel who conduct the core evaluation should have sufficient expertise to assess that developmental area. The family assessment must also be conducted by qualified personnel who are trained in the use of professionally accepted methods and procedures to assist the family in identifying their concerns, priorities, and resources related to the development of their child.<sup>51</sup> A core evaluation is required for all children who receive an evaluation to determine eligibility under the EIP. In many instances, the core evaluation will be sufficient to establish children's eligibility for the EIP and to initiate the development of an IFSP. The need for additional in-depth assessments can be identified as part of the IFSP team meeting, and can be accomplished through supplemental evaluations included in the child's IFSP.

*Supplemental evaluations* are provided at the recommendation of the multidisciplinary team conducting the core evaluation; or, after the child's initial multidisciplinary evaluation, in accordance with a child's IFSP. There are two types of supplemental evaluations: physician and non-physician supplemental evaluations.<sup>52</sup> Supplemental non-physician evaluations are performed by qualified personnel, with specialized expertise, for the purpose of assessing *specific* child needs in one or more of the five developmental domains. Information obtained from supplemental evaluations must provide direction as to the specific early intervention services that may be required for the child.<sup>53</sup> Supplemental non-physician evaluations must be performed by qualified personnel with specific expertise and training in the area of the child's development or condition that requires an in-depth assessment.<sup>54</sup>

Supplemental physician evaluations must be provided by a licensed physician for the purpose of assessing specific child needs in one or more developmental domains (including physical development) or for the purpose of providing specific medical information regarding physical or mental conditions that may impact on the growth and development of the child.<sup>55</sup>

It is important to note that supplemental evaluations are not intended to be routinely provided to all children in the EIP. The following are circumstances under which supplemental evaluations may be used in conjunction with a core evaluation for reimbursement of the child's *initial*

---

<sup>51</sup> 10 NYCRR §69-4.30(c)(2)

<sup>52</sup> 10 NYCRR §69-4.30(c)(2)(ii)

<sup>53</sup> 10 NYCRR §69-4.30(c)(2)(ii)(b)

<sup>54</sup> 10 NYCRR §69-4.30(c)(2)(ii)(b)

<sup>55</sup> 10 NYCRR §69-4.30(c)(2)(ii)(a)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

multidisciplinary evaluation to establish a child's eligibility for the EIP, and as necessary to complete the development of an initial IFSP:

1. If the multidisciplinary team that is conducting the core evaluation identifies the need for an *in-depth assessment* of a child's strengths and needs in a specific area of development, a supplemental evaluation may be recommended to the parent and provided with the parent's consent. The supplemental evaluation *must be necessary to provide direction as to the specific early intervention services that may be needed by the child*. Parent consent for the supplemental evaluation must be obtained, even when all evaluations for a child are being performed by professionals employed or under contract with a single agency.
2. If, at the time of referral, the child has no established primary health care provider, a supplemental physician evaluation, or a non-physician evaluation by a qualified health practitioner working within the scope of his/her profession (e.g., a nurse practitioner or physician's assistant), may be used to complete the health assessment required as part of the evaluation of the child's physical development. The parent must agree to and provide consent for the supplemental physician evaluation or non-physician supplemental evaluation.
3. If, at the time of referral, a child is suspected of having a diagnosed condition with a high probability of developmental delay, which necessitates the involvement of an expert qualified to evaluate and diagnose the condition, a non-physician or physician supplemental evaluation can be used to provide an evaluation by a psychologist, developmental pediatrician, psychiatrist, nurse practitioner, or other professional qualified to conduct an in-depth assessment resulting in a diagnosis.
4. If, as the result of completing a core evaluation, a diagnosed condition with a high probability of developmental delay is suspected, for which the multidisciplinary team does not have sufficient expertise to conduct an in-depth assessment of the child's strengths and needs in that area, or to make a diagnosis, the multidisciplinary evaluation may recommend and the parent may agree to a supplemental evaluation. For example, if the multidisciplinary evaluation team has completed an evaluation of the child's communication development, and suspects that the child may have a hearing problem, the team may recommend that an audiologic evaluation be conducted to assess the child for possible hearing loss. The parent must agree and provide consent for this supplemental evaluation, and the evaluator selected by the parent to complete the core evaluation is responsible for assisting the parent in arranging the supplemental evaluation.

Subsequent to the child's initial multidisciplinary evaluation to establish eligibility and facilitate development of an initial IFSP, certain evaluation and assessment procedures may be repeated, with parent consent, if deemed necessary and appropriate by the Early Intervention Official. Specifically, evaluation and assessment procedures may be performed or repeated in conjunction with the annual evaluation of the IFSP:

- when an observable change in the child's developmental status indicates the need for modification of the IFSP;
- when an observable change in the child's developmental status indicates a change in the child's eligibility status; and,

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

- when the parent, early intervention official or service coordinator, or service provider(s) request a re-assessment at the six-month review of the IFSP.<sup>56</sup>

See Section VII for additional information on ongoing eligibility.

Core and/or supplemental evaluations provided subsequent to the child's initial IFSP must be authorized by the EIO. Reimbursement regulations at NYCRR §69-4.30(c)(2)(iii)(a) allow for reimbursement of one core evaluation and up to four supplemental evaluations in a twelve-month period in conjunction with the annual evaluation of IFSPs. After a child's initial multidisciplinary evaluation, any supplemental evaluations must be stated in the child's IFSP and must include the type of supplemental evaluation and the date and evaluator if known.<sup>57</sup>

As mentioned above, all evaluations performed under the EIP must be conducted by State-approved evaluators under contract with the municipality in which the child resides. In addition to licensure and certification within specific disciplines, individuals that perform evaluations should be experienced and trained in the use of the standardized instruments and clinical evaluation procedures. The six clinical practice guidelines developed by the Department EIP offer specific recommendations on the training and experience of professionals involved in evaluation and assessment procedures.

The Department EIP currently offers training sessions on the two published clinical practice guidelines (autism/pervasive developmental disorders and communication disorders), and is in the process of finalizing training curricula on the four guidelines currently in press (Down syndrome, motor disorders, vision impairment, and hearing loss). In addition, the Department EIP has a plan in place to develop training curricula and offer training sessions on standards and procedures for evaluations, evaluation reimbursement, and eligibility requirements and determination under the EIP. In the future, as these training sessions become available, all evaluators will be required to participate in Department EIP-sponsored training in these specific content areas.

## **V. Eligibility Criteria**

### **Federal Eligibility Requirements**

Federal regulations for Part C of IDEA define infants and toddlers with disabilities as individuals birth through age two who require early intervention services because they:

- Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and/or adaptive development.
- Have a diagnosed physical or mental condition that has a high probability of developmental delay. Examples of diagnosed conditions with a high probability of developmental delay as set forth in Note 1 to 34 CFR §303.16 include *chromosomal abnormalities, genetic or congenital disorders; severe sensory impairment; inborn errors of metabolism; disorders*

---

<sup>56</sup> 10 NYCRR §69-4.8(a)(12)

<sup>57</sup> 10 NYCRR §69-4.8 (a)(13); 10 NYCRR §69-4.30(c)(2)(iii)(b)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

*reflecting disturbance of nervous system development; disorders secondary to exposure to toxic substances, and severe attachment disorders.<sup>58</sup>*

Within this basic eligibility framework, states have significant responsibility for defining eligibility requirements. Federal regulations at 34 CFR §303.300 require states to include eligibility criteria and procedures as a component of their early intervention systems. These regulations specify that each state must define developmental delay by:

- Describing, for each of the defined developmental areas, the procedures, including the use of informed clinical opinion that will be used to measure a child’s development.
- Stating the levels of functioning or other criteria that constitute a developmental delay in each of those areas.
- Describing the criteria and procedures, including the use of informed clinical opinion that will be used to determine the existence of a condition that has a high probability of resulting in developmental delay.

**State Eligibility Requirements**

PHL § 2541(8) defines eligible child as meaning an infant or toddler from birth through age two with a disability.<sup>59</sup> Section 2541(5) of the PHL defines disability as a developmental delay; or, a diagnosed physical or mental condition with a high probability of resulting in developmental delay, such as extreme prematurity (birthweight of 999 grams or less<sup>60</sup>), Down syndrome or other chromosomal abnormalities, sensory impairments (hearing loss, vision impairment), inborn errors of metabolism, or fetal alcohol syndrome.

**Diagnosed Conditions With a High Probability of Resulting in Developmental Delay**

In 1998, the Department, in collaboration with the Early Intervention Coordinating Council, convened several meetings with expert clinicians to further specify the diagnosed conditions with a high probability of resulting in developmental delay that can be used to establish a child’s eligibility for the EIP. The result of this effort was issuance of a guidance document, Early Intervention Guidance Memorandum 1999-2 on the reporting of children’s eligibility status based on diagnosed conditions with a high probability of resulting in developmental delay, including an extensive appendix with a list of conditions and associated International Classification of Diseases – 9 (ICD-9 codes). Appendix B provides a list of these conditions and indicates the licensed professionals qualified to diagnose these conditions under New York State education law.

---

<sup>58</sup> 34 CFR §303.16

<sup>59</sup> PHL §2541(8) further provides that “any toddler *who has been found eligible for program services under section 4410 of education law* shall, if requested by the parent, be eligible to continue to receive early intervention services contained in an IFSP for a prescribed period of time on and after the child’s third birthday. Detailed policies and procedures about the transition of children from the EIP to program services under section 4410 of the education law are explicated in the joint Department and State Education Department guidance memorandum, *The Transition of Children from the New York State Department of Health Early Intervention Program to the State Education Department Preschool Special Program or Other Early Childhood Services*.

<sup>60</sup> The ICD-9 code 765.9 (extreme immaturity) contains a note indicating that this condition usually implies a birthweight of less than 1000 grams and/or a gestation of less than 28 completed weeks.

## **Developmental Delay**

### *Measuring Developmental Delay*

Because of the complex interactions among the various aspects of development in very young children, it is important to assess all five areas of development as defined under EIP regulations. To assist in understanding the State definition of developmental delay, the terms development, developmental norms, and developmental milestones are defined below, followed by definitions of each of the developmental areas specified in the EIP regulations (communication, physical, cognitive, social/emotional, and adaptive).

“**Development** involves changes that persist over time, rather than those that are temporary or situation-specific, and commonly refers to progressive, cumulative change toward complex levels of function. The term often refers to children’s growing physical and mental capacities that allow them to participate in the social, intellectual, and cultural worlds.”<sup>61</sup> **Developmental norms** are defined as standards by which the progress of a child’s development can be measured.<sup>62</sup> **Developmental milestones** are defined as the major developmental tasks of a period of development and in an area of development, usually described in months or month-ranges in a developmental area. It is important to note that there are normal variations in children around the *average* ages at which developmental milestones are achieved. Children who have not achieved developmental milestones at the average age may be experiencing individual variations in development and may not have a developmental delay that qualifies them for (or warrants) intervention.

The term “*developmental delay*” is used to describe the developmental status of children who are generally following a typical pattern of development but develop at a slower rate than is average for a child of the same age. Developmental delays include mild to extreme variations in development and the failure of a child to reach developmental milestones in one or more areas of development.

Marked *regression* or *loss of developmental milestones* in any area of development (e.g., communication, cognitive, physical, social-emotional, or adaptive) can be a sign of a serious underlying medical or neurological problem and may indicate the need for medical assessment by the child’s health care provider(s).

The terms “disorder” or “impairment” are used *to describe conditions that are expected to continue indefinitely and result in limitations in one or more areas of development, such as physical, sensory, cognitive, communication, behavioral, emotional, or social development* (i.e., diagnosed conditions with a high probability of resulting in developmental delay). For the purposes of eligibility for the EIP, children with disorders or impairments in development will typically also have a diagnosed physical or mental condition with a high probability of resulting in developmental delay (e.g., cerebral palsy, Down syndrome, extreme prematurity, etc.). However, particularly for infants, there may be clinical indicators of disorder or impairment (i.e., clinical clues of disorders) that should be considered in determining whether a child is eligible

---

<sup>61</sup> Child Development: The MacMillan Psychology Reference Series, 2002 (Liesette Brunson)

<sup>62</sup> Child Development: The MacMillan Psychology Reference Series, 2002 (Neil Salkind)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

for the EIP (see Appendix E for clinical clues reproduced from Department EIP Clinical Practice Guidelines).

*Developmental Domains Used to Establish Eligibility for the EIP*

The federal and State law and regulations identify five areas of development that must be assessed as part of the eligibility determination process for the EIP. These are: communication, cognitive, physical, social-emotional, and adaptive development. To assist municipalities, EIP providers, and families in establishing a common understanding of these developmental domains, each of these domains is described below.

*Communication Development*

*Communication development* involves the overall developmental progress in young children in acquiring the ability to comprehend and produce messages that allow them to understand and interact with the social world. *Communication development* typically progresses from the development of gestural and social pre-linguistic communication to the onset of first words and production and use of language. Children who experience *delays* in the acquisition of speech and language skills usually follow a typical pattern of development but at a slower rate than children who are not delayed. Marked regression or loss of language can be a sign of a serious underlying medical or neurological problem and may indicate the need for a comprehensive medical, psychological, and audiologic evaluation.

*Communication disorders* are impairments in the ability to receive, send, process, and comprehend concepts or verbal, non-verbal, and graphic messages. A disorder may be evident in the processes of hearing, language, and/or speech. Individuals may demonstrate one or any combination of these three aspects of communication disorders. Communication disorders in children may be the primary disability or may be secondary to other disabilities.<sup>63</sup>

*Physical Development*

*Physical development*, including hearing and vision, refers to physical changes in childhood, including alterations in body structures and functions. Aspects of physical development include gross and fine motor skills, the degree or quality of the child's motor and sensory development, health status, and physical skills or limitations. In addition, physical development interacts with psychological, behavioral, and social aspects of the developing child. Physical development is typically measured through the use of growth charts and physical indicators (such as height for weight and head circumference); assessment of sensory functioning, including hearing and vision; and, assessment of motor development.

*Motor development*, as with other areas of development, occurs in an orderly, predictable sequence of events for most children, although the rate and age of motor skill attainment varies from child to child. The process of motor development depends on the maturation of the central nervous system and muscular system. As these systems develop, a child's ability to move progresses. Motor milestones are defined as the major developmental tasks of a period that depend on movement by the muscles. Gross motor development involves skills that require coordination of the large muscle groups (e.g., sitting, walking, rolling, standing, etc.). Fine

---

<sup>63</sup> American Speech-Language-Hearing Association. (1993). Definitions of communication disorders and variations. *Asha*, 35, (Suppl. 10), pp. 40-41.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

motor development is concerned with the coordination of smaller muscles of the body, including the hands and face. Fine motor skills use the small muscles of both the hands and the eyes for performance.

*Developmental motor disorders* are manifested by mild to severe abnormalities of muscle tone, movement, and motor skill acquisition. These include global developmental delays, hypotonia, hypertonia, and mild neuromotor dysfunction. Delays in motor development and clinical indicators of motor disorders or a diagnosis of motor disorders may be associated with delays or impairments in cognitive development.

*Cognitive Development*

*Cognitive development* refers to the changes over time in children's thinking, reasoning, use of language, problem solving, and learning, and children's approaches to interaction with their physical and social environments. Components of cognition include intelligence; arousal, orientation, attention, and executive function; memory (short and long term); information processing functions (such as pattern recognition, facial-emotional content, imitation, cause-and-effect associations, processing multiple sources of information simultaneously); representational thought; and reasoning and concept formation (problem solving, language, perspective-taking, social context and rules).

For children age birth through two, cognitive development involves learning to coordinate sensory input with emerging motor skills, development of object permanence, differentiation of self from others, and emergence of representational thought and symbolic play. Cognitive development is often assessed using standardized tests to derive a developmental quotient, mental index, or intelligence quotient. For children under age three, cognitive development is measured using a developmental or mental index. Children who score significantly below average using a standardized test would be considered to have substantial limitations in cognitive functioning.

Cognitive impairments in very young infants and toddlers are generally associated with a diagnosed physical or mental condition with a high probability of resulting in developmental delay (e.g., central nervous system abnormalities, syndromes or conditions, etc.) and include deficits in one or more components of cognition.

*Social-Emotional Development*

*Social-emotional development* involves progressive change in the way that children relate to their social world and their ability to differentiate and express emotions and perceive emotional states of other individuals. Social development refers to relating to others; the degree and quality of the child's relationships with parents and caregivers; feelings about self; and, social adjustment to a variety of interactions over time. Emotions reflect an individual's attempt or readiness to establish, maintain, or change the relation between him or herself and his or her environment (e.g., a child who overcomes an obstacle to a goal is likely to experience happiness); emotions become more differentiated as infants develop (e.g., crying behavior differs depending on whether the infant is hungry or angry); and, infants' strategies for regulating their emotions change over time (e.g., responses to distress develop from gaze aversion to self-soothing behaviors).



*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

Children who are experiencing *disorders or impairment in social-emotional* development may exhibit patterns such as inability to form attachment relationships with caregivers, failure to develop joint-attention skills, perseverative behaviors, etc. Examples of disorders in this area of development may be found in Appendix B, which lists and describes psychiatric disorders that can affect young children. Diagnosed conditions such as those in Appendix B are characterized by qualitative and extreme problems and variations in child behavior and emotional development, in comparison with the “testing” or “trying” behaviors typical of most children in the two-to-three-year-old age group.

*Adaptive Development*

*Adaptive development* refers to the development of behaviors and self-help skills that assist children in coping with the natural and social demands of the environment, including sleeping, feeding, mobility, toileting, dressing, and higher-level social interactions. A child who is experiencing delays in adaptive development has difficulty in learning and acquiring these behaviors and skills. Delays in adaptive development may be associated with delays or impairments in other areas of development, including fine and gross motor skills, oral-motor functioning, cognitive development, communication development, and social-emotional development.

**New York State Definition of Developmental Delay**

As required under federal regulations, the EIP has established a state definition of developmental delay, which is incorporated in regulation.<sup>64</sup> Specifically, developmental delay is defined as a child who has not attained developmental milestones expected for the child’s chronological age, adjusted for prematurity<sup>65</sup> in one or more of the following areas: cognitive, physical (including vision and hearing), communication, social or emotional development, or adaptive development. The evaluator is responsible for determining, based on the developmental assessment instruments being used and the individual child’s developmental status, when to adjust for prematurity; and, is responsible for documenting reasons why this adjustment is appropriate in the evaluation report. In New York State, consistent with federal requirements, a child must be experiencing a delay in an *area (i.e., domain) of development* that is significant enough to require early intervention.

EIP regulations at 10 NYCRR §69-4.1(g) describe the process for measuring developmental delay to determine whether a child is experiencing a developmental delay of sufficient significance to meet EIP eligibility criteria. *Specifically, the regulations require that developmental delay must be:*

- *measured by qualified personnel using informed clinical opinion, appropriate diagnostic procedures, and/or instruments; and,*

---

<sup>64</sup> 10 NYCRR §69-4.1(g)

<sup>65</sup> Evaluators should adjust for prematurity, as appropriate to the clinical situation and the test/diagnostic/assessment instruments being used to evaluate the child. While it is generally thought to be appropriate to adjust for prematurity up to two years of age, the decision about how and whether to adjust must be individualized to the child and circumstances. See Wilson and Cradock, *Journal of Pediatric Psychology*, 2004, for a relevant discussion on this topic.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

- *documented for eligibility purposes.*

To be initially eligible for the EIP based on developmental delay, the following criteria must be met:

- *a child must be experiencing a 12 month delay in one or more functional areas; or,*
- *a 33% delay in one functional area or a 25% delay in each of two areas; or,*
- *if standardized instruments are used during the evaluation process, a score of at least 2 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas.*

**Determining Eligibility Based on Developmental Delay**

Consistent with federal requirements, which define eligibility for the Early Intervention Program based on a delay in one or more developmental areas, the New York State definition of developmental delay uses the term “*functional area*” to mean a delay in the *developmental area* (i.e., *domain*). That is, for a child to be eligible for the EIP, the child must have a 12 month or 33% delay, or a score of at least 2 standard deviations below the mean, in an *area of development* (e.g., communication development or social/emotional development or physical development, etc.). Alternatively, a child must have a developmental delay of 25% or a score of at least 1.5 standard deviations below the mean in each of *two areas of development* (e.g., adaptive development *and* cognitive development; social emotional development *and* physical development, etc.) to be eligible for the EIP. A delay of 25% or 1.5 standard deviations below the mean in two aspects of a *single* developmental domain, such as *communication* development or *cognitive* development, as measured on subtests of a standardized test, or using clinical procedures, does not in and of itself constitute eligibility for the EIP. For example, a child with a score of 1.5 standard deviations below the mean in *expressive language* and 1.5 standard deviations below the mean in *receptive language*, and no other developmental delays, would not be eligible for the EIP. Similarly, a child with a score of 2 standard deviations below the mean in expressive language development, who shows no (or a less significant) delay in receptive language development would not be eligible for the EIP.

No single measure or source of information may be used to establish the child’s eligibility. If a standardized test is used in combination with other procedures (diagnostic tests, observation, parent report, examination of medical records, etc.), *any scores from the test must be used in combination with all other sources of information to determine eligibility.* For example, if the evaluation team uses a standardized language test, and the child receives a subscore of 2 standard deviations below the mean in expressive language, but shows no, or a less significant delay, in receptive language, the child would not be eligible for the EIP, *unless* the results of the evaluation also substantiate the existence of a preponderance of clinical clues/indicators of problems in language and communication development. Such clinical clues/indicators may be found in Appendix F (Table III-7, “Predictors of Continued Language Delay in Children with Language Delays at 18-36 Months”) and Appendix E, (Table III 5, “Normal Language Milestones and Clinical Clues [Birth – 36 Months],” New York State Department of Health Early Intervention Program Clinical Practice Guideline, Report of the Recommendations, Communication Disorders – Assessment and Intervention for Young Children [Age 0-3 Years]). In the absence of a preponderance of clinical clues/indicators of communication

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

disorders/development (i.e., specific behaviors or physical findings that heighten concern about a child's development), the child does not meet the eligibility criteria of a developmental delay of 2 standard deviations below the mean in a developmental area. Appendix H provides recommended components of an in-depth speech-language evaluation from this same clinical practice guideline.

In other words, it is possible for a child to have a developmental delay and not meet the eligibility criteria for the EIP. Children who appear to be experiencing a normal variation in development (e.g., "late talkers," "late walkers") may continue to receive screening and tracking, preferably through their primary health care providers, to monitor their developmental progress. The Department's Clinical Practice Guidelines on the Assessment and Intervention with Young Children with Communication Disorders has explicit recommendations on developmental surveillance for children experiencing expressive language delays and for whom there are no other developmental problems (see Appendix G for recommendations on developmental surveillance reproduced from the guideline).

The multidisciplinary evaluation team is responsible for using the procedures described in this document to complete a comprehensive developmental evaluation for children referred with a suspected developmental delay, and using the information from the evaluation to *determine and document* the child's eligibility based on the *five developmental domains*. Professionals are responsible for adhering to *recognized standards of practice* for their respective disciplines, and to use evidence-based practice recommendations when available, including the clinical practice guidelines issued by the Department, in the conduct of multidisciplinary evaluations and eligibility determinations under the EIP. The use of standardized testing can assist in clarifying eligibility determinations because resulting scores factor out normal variation in child development as opposed to delay. Eligibility determinations *cannot* be made on the basis of isolated delays in specific skill areas. Rather, the evaluation team must, using their informed clinical opinion, decide whether composite evaluation findings, *considered together*, are consistent with eligibility criteria for the EIP including:

- evaluation results, including testing data, physical findings, data gathered through clinical procedures, etc., as appropriate;
- information gathered through review of child records, parental interviews, and other available sources of information about the child's development; and,
- a preponderance of clinical clues/clinical indicators (i.e., the more clinical indicators or predictors of continued problems, the more serious the concern that a child will continue to experience developmental problems).

In cases where symptoms or problems do not occur alone, but may be secondary to other problems or conditions, it is incumbent upon the evaluation team to determine whether: the presenting symptom or problem represents a normal variation in development that *any* child and his/her family might experience (e.g., difficulties in regulating sleep-wake cycles, feeding problems, challenging behaviors, etc.); or, the child is experiencing significant developmental delays affecting one or more domains or a physical or mental condition with a high probability of resulting in developmental delay that qualify the child for the EIP.

**Finally, it is important for evaluators to recognize and understand: 1) the necessity of documenting clearly the evidence that supports eligibility determinations under the EIP, including the use of standardized instruments and informed clinical opinion; and, 2) that such documentation is subject to monitoring (which could include clinical record reviews) by municipal and state representatives.**

## **VI. Monitoring Progress**

For all children in the EIP, it is important to ensure that parents, providers, service coordinators, and Early Intervention Officials work together to evaluate the effectiveness of interventions and children's progress. All interventions should be tied to ongoing assessment and modification of intervention strategies as needed.

EIP regulations<sup>66</sup> require that the IFSP include the criteria and procedures that will be used to determine whether progress toward achieving the outcomes included in the IFSP is being made, and whether modifications or revisions of the outcomes or services are necessary. EIP service providers are required to maintain session notes and progress notes, documenting the services being delivered and progress achieved by the child through provision of these services. Session notes and progress notes are a valuable source of information regarding the effectiveness of early intervention services and whether there is a need to modify the outcomes or services being provided to the child and family.

The IFSP must be reviewed at six month intervals and evaluated annually to determine the degree to which progress is being made toward achieving outcomes in the IFSP and whether there is need to modify the IFSP to revise the services being provided or anticipated outcomes, and to review whether a child's eligibility status may have changed. Upon the request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals.

The six-month review can be conducted by a meeting or other means amenable to the parent (for example, a telephone conference call or a "paper" review). However, a meeting must be conducted for the annual evaluation of the IFSP, and must include the EIO, service coordinator, and parent(s), and may include other participants as appropriate (such as the child's service providers, and any other participants invited by the parent or service coordinator).<sup>67</sup> The annual evaluation of the IFSP must use the results of any current child evaluations and any other information from the ongoing assessment of the child and family, including session and progress notes, to determine the services that are needed and will be provided.

Evaluations may also be performed, with parental consent and if deemed necessary and appropriate by the EIO, when there is an observable change in the child's developmental status which indicates the need for modification of the IFSP *or a change in eligibility status*; or, the parent, early intervention official or service coordinator, or service provider(s) request a reassessment at the six-month review of the IFSP.<sup>68</sup>

---

<sup>66</sup> 10 NYCRR §69-4.11(a)(10)(iv)

<sup>67</sup> 10 NYCRR §69-4.11(a)(2) and (3)

<sup>68</sup> 10 NYCRR §69-4.8(a)(12)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

Modifications to interventions, including the frequency, intensity, duration, and types of services provided, should be considered as part of the IFSP review and annual evaluation process when:

- the child has progressed and the target objectives have been achieved;
- progress is not observed after an appropriate trial period;
- the child has shown some progress but target objectives have not been achieved after an appropriate trial period;
- there is an unexpected change in the child’s behavior or health status;
- there is a change in the intervention setting; or,
- there is a change in family circumstances and/or priorities for the child and family.

It is important to note that the EIO is responsible for providing written notice to parents ten working days before the EIO proposes or refuses to initiate or change the identification, evaluation, service setting, or the provision of appropriate early intervention services to the child and the child’s family. This requirement applies to a potential change in a child’s eligibility status. The notice must be written in language understandable to the general public; and, provided in the dominant language of the parents, unless it is clearly not feasible to do so. In addition, the EIO must make reasonable efforts to ensure the parent receives written notification about the right to due process and the method by which mediation and an impartial hearing can be requested at the following times: upon denial of eligibility; upon disagreement between the EIO and the parent on an initial or subsequent IFSP or proposed amendment to an existing IFSP; and, upon request from the parent for such information.<sup>69</sup>

Most children with a diagnosed condition with a high probability of resulting in developmental delay, such as Down syndrome or autism, will continue to be eligible for the EIP based on the existence of the condition. It is unlikely that there will be a question about their ongoing eligibility for the EIP, or that additional multidisciplinary evaluations will be needed once an initial IFSP is developed. The results of ongoing assessments conducted by service providers in the course of delivering services, progress notes, and other documentation available regarding the child’s progress should be sufficient for six month reviews and annual evaluations of the IFSP for these children. Supplemental evaluations may be agreed upon and conducted when there is a change in the child’s development that indicates the need for a change in the services included in the IFSP.

## **VII. Procedures and Criteria for Ongoing Eligibility**

### **Procedures for Ongoing Eligibility**

The EIP is a voluntary program for parents and their children. When parents believe their child and family have made sufficient progress to no longer need early intervention services, it is

---

<sup>69</sup> 10 NYCRR §69-4.17(b)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

appropriate to discharge the child from the program. This should be clearly documented in the child's IFSP and retained as part of the child's record. In accordance with Section 2545(8) of the PHL, if at any time the parent and the service coordinator agree in writing that the child has met all the goals set forth in the IFSP or the child is otherwise no longer in need of early intervention services, the service coordinator is required to certify that the child is no longer an eligible child.

It should be noted that achieving the outcomes stated in the IFSP may, or *may not*, mean that the developmental delay or other condition that established the child's eligibility has been resolved. If a parent chooses to voluntarily leave the EIP when there are continuing developmental concerns about the child, it is appropriate for the service coordinator to inform the parent about services that can be accessed in the future, including preschool special education programs and services.

Federal regulations at 34 CFR §303.322(b)(1) define the multidisciplinary evaluation as procedures used by appropriate qualified personnel to establish a child's initial and continuing eligibility for the EIP. State regulations at 10 NYCRR §69-4.8(a)(2) require that a multidisciplinary evaluation be performed to determine the child's initial and *ongoing eligibility* for early intervention services. State regulations at 10 NYCRR §69-4.8(12) specify the circumstances under which evaluation and assessment procedures should be performed, with *parental consent*, in conjunction with the annual evaluation of the IFSP or more frequently, if deemed necessary and appropriate by the EIO, under the following conditions (1) an observable change in the child's developmental status which indicates the need for a modification of the IFSP or a *change in eligibility status*; and (2) the parent, early intervention official or service coordinator, or service provider(s) request a reassessment at the six-month review of the IFSP.

If the child's developmental status suggests that s/he is making substantial progress, the child should be evaluated to determine whether s/he continues to be eligible for the EIP. Children who, upon their initial multidisciplinary evaluation of the program, were found to have a delay in only one area (i.e., domain) of development can make rapid progress with appropriate intervention. It is appropriate for the EIO and/or service provider, to request a re-evaluation of the child when there is an observable change in the child's developmental status that may indicate a change in eligibility status.

If it is determined that an evaluation is necessary to establish the ongoing eligibility of a child, a multidisciplinary evaluation must be performed to make this determination.<sup>70</sup> The parent has the right to select an evaluator to conduct the multidisciplinary evaluation to determine ongoing eligibility. In most instances, a core evaluation will be sufficient to determine whether a child continues to be eligible for the EIP. As discussed in Section II of this guidance document on multidisciplinary evaluation procedures, evaluators may use findings from other current examinations, evaluations, assessments, or health assessments performed for the child, with parent consent, as part of the evaluation process. Parents should be encouraged to provide the evaluator with access to all of the child's recent EIP records, including any annual evaluations and/or assessments conducted during the child's participation in the EIP. This will ensure that children and their families are not required to undergo procedures that are unnecessary or duplicative.

---

<sup>70</sup> 10 NYCRR §69-4.8(a)(2)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

If there is a question about the child's ongoing eligibility for the EIP, and the parent refuses to consent to a multidisciplinary evaluation to establish the child's ongoing eligibility, ongoing eligibility has not been established and the child is no longer an eligible child. The EIO must provide the parent with written notice ten working days before the EIO proposes to discharge the child from the EIP. The notice must be in sufficient detail to inform the parent about the action that is being proposed, the reasons for taking such action, and all procedural safeguards available under the EIP, including the right to a mediation or impartial hearing on the child's ongoing eligibility for the EIP.<sup>71</sup>

All multidisciplinary evaluations, whether conducted to establish initial or ongoing eligibility, should be conducted in accordance with the requirements included in the PHL, regulations, and standards and procedures document. In addition, evaluators are responsible for adhering to *recognized professional standards of practice*, including use and scoring of clinical procedures and standardized instruments, when conducting evaluations under the EIP.

**It is important for evaluators to recognize and understand: 1) the necessity of documenting clearly the evidence that supports ongoing eligibility determinations under the EIP, including the use of standardized instruments and informed clinical opinion; and, 2) that such documentation is subject to monitoring (which could include clinical record reviews) by municipal and state representatives.**

**Criteria for Ongoing Eligibility**

**The following criteria should be used to establish whether a child continues to be eligible for the EIP** upon a re-evaluation conducted, with parent consent, as part of the annual evaluation of the IFSP, or at the request of the EIO, parent, or service provider(s):

1. The child continues to meet the criteria used to establish initial eligibility for the EIP (developmental delay consistent with the State definition; or the presence of an unresolved or emergent diagnosed physical or mental condition with a high probability of resulting in developmental delay).
2. The child has made sufficient developmental progress and is no longer experiencing a delay in development *to the extent required for initial eligibility*; however, s/he continues to experience a developmental delay in one or more developmental domains and ***is not yet within normal developmental range***. As measured on a standardized, norm-referenced test, a child who has a score of *between 2 standard deviations below the mean and 1 standard deviation below the mean in one or more areas of development would still be eligible to participate in the EIP*. **As an example only**, if the mean score on a particular test is 100 and the standard deviation is 15, a child with a standard score of between 70 and 85, or a percentile score of between 2.14 and 16, would still be eligible for the EIP. Standardized tests should be used whenever there are such instruments appropriate for use with the child. **As discussed previously in “A Special Note on Standardized Evaluation and Assessment Instruments,” standardized tests must be used and scored as specified in the test manual.**

---

<sup>71</sup> 10 NYCRR §69-4.17

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

If there are no standardized tests available and ***appropriate for the child's language/culture and developmental concern***, the evaluator must provide sufficient documentation that, based on procedures and methods used to evaluate the child, the child continues to be experiencing developmental delays in one or more areas of development and *is not within normal developmental range*.

**The following criteria should be used to establish that a child is no longer eligible for the EIP and must exit the program:**

1. The child is no longer age-eligible for the program and does not meet the eligibility criteria for special education programs and services.
2. The child continues to be age-eligible for early intervention services, and development is within the normal range. If measured using clinical procedures and methods, the child who *is demonstrating developmental milestones within the range expected for his/her age and for whom there are no documented clinical clues or indicators of a continuing problem is no longer an eligible child.* As measured on a standardized norm-referenced test, *a child who has a standard score within one standard deviation of the mean in all areas of development is no longer an eligible child.* **As an example only,** if the mean score on a particular test is 100 and the standard deviation is 15, a child with a standard score of between 85 and 100, or a percentile score of between 16 and 50, *in all areas of development* is within normal range and no longer is eligible for the EIP. Standardized tests should be used whenever there are such instruments appropriate for use with the child. **As discussed previously in "A Special Note on Standardized Evaluation and Assessment Instruments," standardized tests must be used and scored as specified in the test manual.**
3. A change in the status of a diagnosis for a child found eligible based on a diagnosed physical or mental condition with a high probability of resulting in delay, as documented by an appropriately qualified medical/clinical professional (for example, resolution of failure to thrive; resolution of delays/impairments associated with extreme prematurity; resolution of delays/impairments associated with cleft palate). In general, this category would apply only in circumstances where the condition is associated with age (e.g., prematurity) or a physical condition that can be ameliorated with medical/surgical treatment provided through the health care system combined with developmental-rehabilitative services provided through the EIP.

As referenced in Section V of this document, PHL §2541(8) provides that any toddler *who has been found eligible for program services under section 4410 of education law* shall, if requested by the parent, be eligible to continue to receive early intervention services contained in an IFSP for a prescribed period of time on and after the child's third birthday. It is important to note if a child is evaluated by a committee on preschool education (CPSE) *before age three*, and is found *ineligible* for services under section 4410 of education law, such a determination does not *necessarily* mean that the child does not meet ongoing eligibility criteria for the Early Intervention Program. To be eligible for preschool special education services, a child must exhibit a significant delay or disability in one or more functional areas related to cognitive, language and communicative, adaptive, social or emotional or motor development ***that adversely***



*affects the student's ability to learn.*<sup>72</sup> Therefore, a child may continue to experience a developmental delay in one or more areas that meets either the initial or ongoing eligibility criteria for the EIP, and a CPSE may determine the child does not qualify for preschool special education programs and services. ***Under these circumstances, since the child meets the criteria for ongoing eligibility under the EIP, the child is eligible to continue to receive early intervention services until his/her development is within normal limits, or until his/her third birthday, whichever is first.***

If a child is evaluated by the CPSE and is found to be within normal limits in all areas of development, and the parent and the service coordinator agree that all goals in the IFSP have been met, the service coordinator can certify that the child is no longer an eligible child.<sup>73</sup> However, if the parent does not agree that all goals in the IFSP have been met when the CPSE evaluation indicates the child has made substantial progress, the EIO should request a re-evaluation of the child to determine whether the child continues to be eligible for the EIP. As previously discussed, the parent has the right to select an evaluator to conduct the multidisciplinary evaluation to determine ongoing eligibility. The parent should be encouraged to provide the evaluator with access to all of the child's recent EIP records, and to the evaluation conducted by the CPSE. If the parent does not consent to the evaluation, ongoing eligibility has not been established and the child is no longer an eligible child. The EIO must provide the parent with written notice ten working days before the EIO proposes to discharge the child from the EIP. The notice must be in sufficient detail to inform the parent about the action that is being proposed, the reasons for taking such action; and, all procedural safeguards available under the EIP, including the right to a mediation or impartial hearing on the child's ongoing eligibility for the EIP.<sup>74</sup>

A transition plan must be developed for all children who exit the EIP, which may include transition to preschool special education programs and services, or other early childhood supports and services as needed by the child and family.<sup>75</sup> The transition plan should describe the steps to be taken to discharge the child from the EIP, which may include a plan for developmental surveillance as needed, or other appropriate services to assist the child and family after they exit the EIP. The service coordinator is responsible for assisting the parent in identifying, locating and accessing other early childhood and supportive services that may be needed by the child and family. The service coordinator is responsible for incorporating the transition plan into the IFSP, with parent consent.

## **VIII. Frequently Asked Questions**

### **1. What is the difference between screenings conducted for children at risk and screenings that may be conducted by a multidisciplinary evaluation team?**

When children are referred to the EIP as at risk for developmental delay or disability, the EIO is responsible for using available resources in the community, including children's primary health

---

<sup>72</sup> Part 200 Regulations of the Commissioner of Education

<sup>73</sup> PHL § 2545(8)

<sup>74</sup> 10 NYCRR §69-4.17

<sup>75</sup> 10 NYCRR §69-4.20(a)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

care provider, to ensure that children are tracked and screened for potential developmental problems. Under these circumstances, developmental screening and developmental surveillance may include a variety of techniques and strategies, including standardized screening tools such as the Ages & Stages Questionnaires. Municipalities receive administrative funding from the Department for child find activities, including arranging for screening and tracking of at-risk children. Developmental screening for *at-risk* children is not separately reimbursable under the EIP, since these children are not eligible for the EIP and are not entitled to a multidisciplinary evaluation.

When children are referred to the EIP with a suspected or confirmed developmental delay or disability, the EIO must designate a service coordinator who is responsible for assisting the family in arranging for a multidisciplinary evaluation by an evaluator selected by the parent. The purpose of the screening conducted by the evaluation team is to assist in determining what type of evaluation, if any, is necessary (10 NYCRR §69-4.8(a)(2)(i)). If a screening is conducted, the evaluation team must discuss the results of the screening with the parent. If the child passes the screening (e.g., no problems are identified with the child's development), the evaluator and parent may agree to conclude the evaluation process at that point. If the screening results indicate that a multidisciplinary evaluation is warranted, the evaluator(s) must discuss the implications of this result and the composition of the evaluation team with the parent (10 NYCRR §69-4.8(a)(2)(iv)).

See section on **Intake and Screening Procedures** (pages 13-15) for a full discussion about this issue.

**2. How is developmental screening conducted as part of the multidisciplinary evaluation for a child suspected of having a developmental delay reimbursed under the EIP?**

If only a screening is performed, and further evaluation is not needed, the evaluator will be reimbursed for the screening at the established rate. An approved evaluator may bill for both a screening *and* an evaluation for the same child only when the screening is performed at home or off-site at a location different from the evaluator's business site. When a screening and evaluation are performed at an approved evaluator's site, the evaluator may only bill for the evaluation.

**3. How many screenings are permitted?**

Reimbursement may be provided for up to two screenings for a child suspected of having a developmental delay in any twelve-month period, without the prior approval of the Early Intervention Official. Screenings are not reimbursable for children who have already been found eligible for the EIP. For example, if an evaluator decides a screening should be performed, and the parent consents, and the screening suggests that an in-depth assessment is not yet warranted, but there are sufficient clinical clues or concerns about the child's development, the evaluator may recommend to the parent that the child be re-screened at some specified time period and be reimbursed for the second screening. See Appendix F for recommendations on enhanced developmental surveillance from the Department of Health clinical practice guidelines on communication disorders.

**4. May a parent choose one approved evaluator to conduct a developmental screening and a different approved evaluator to conduct the evaluation?**

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

No. The parent selects an evaluator to conduct the multidisciplinary evaluation for the child. The evaluator may, with parent consent, screen a child to determine what type of evaluation, if any, is necessary *unless the child is known to have a condition with a high probability of resulting in developmental delay*. If the evaluator conducts a screening, with parental consent, the evaluator is responsible for conducting the full multidisciplinary evaluation if the screening indicates an evaluation is needed.

**5. Is it permissible to use older versions of standardized test instruments when revised editions have been published?**

Consistent with regulatory requirements about the reliability and validity of test instruments and procedures, the most recent edition of a standardized test instrument should be used as soon as practicable (e.g., when the standardized instrument has become widely available, including the availability of training, if required by test developers) when conducting evaluations for the purpose of determining a child's initial or ongoing eligibility for the EIP.

**6. Is it always necessary to have both a physical therapist and an occupational therapist participate in the multidisciplinary evaluation to assess physical development (particularly motor development)?**

No. The multidisciplinary team does not necessarily have to include either a physical therapist or an occupational therapist to assess physical development. However, it may be appropriate to include either a physical therapist, or an occupational therapist, or both, on the multidisciplinary evaluation if there are specific concerns about the child's motor development that indicate that an evaluation by one or both of these professionals is needed.

**7. Is a delay in either fine motor development or gross motor development sufficient to establish the child's eligibility for the EIP?**

A delay of 2 SD below the mean or 33% in either gross motor or fine motor can be sufficient to establish a child's eligibility for the EIP. Motor development delays are often indicative of more serious underlying problems. The multidisciplinary evaluation should include a thorough assessment of the child's motor and physical functioning, including a health and diagnostic assessment (which can be completed through a review of recent and current examinations, if available and with parental consent). The multidisciplinary evaluation team should document the extent of the motor delay, including any clinical clues and indicators of motor problems. The Department's clinical practice guideline on motor disorders includes clinical clues and indicators of motor disorders, as well as comprehensive assessment and evaluation information. The multidisciplinary evaluation team is responsible for documenting the impact of the delay in motor development on the child's physical development and functioning to establish the child's eligibility for the EIP.

**8. Is a feeding problem sufficient to establish a child's eligibility for the EIP?**

An isolated feeding problem in and of itself may not be sufficient to establish a child's eligibility for the EIP. Feeding and swallowing problems often co-occur in children who have motor disorders, and may be an early indicator of a motor or other developmental or health problem. Feeding and swallowing problems are signs and symptoms, and it is important to determine the underlying cause.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

A child demonstrating serious feeding dysfunction may experience physical, social, cognitive, and emotional problems related to the feeding dysfunction that significantly impact on their development and functioning. A serious feeding dysfunction, impacting on the child's physical development and functioning and adaptive development, can be sufficient to establish a child's eligibility for the EIP under the physical and adaptive domains. See Appendix I, Table IV-5, IV-6, and IV-7, from the Department's clinical practice guideline on motor development, for clinical clues of a possible serious feeding problem; questions that should be considered when taking a feeding history; and, recommended components of an initial oral-motor assessment for children with significant feeding problems. If the central concern for a child is feeding dysfunction, the multidisciplinary evaluation must provide sufficient evidence the feeding problem is significantly impacting on the child's developmental status. The nature of the feeding dysfunction (e.g., oral-motor and self-regulatory substrates, etc.) and its impact on the child's development must be documented in the multidisciplinary evaluation report, including the statement of the child's eligibility for the EIP. A child who is a "picky eater" or whose family needs guidance in food selection and introduction, would not be eligible for the EIP

**9. What is the difference between the parent interview and the family assessment?**

The parent interview is a required part of the child's multidisciplinary evaluation, which focuses on the child's developmental status. The parent interview assists the multidisciplinary evaluation team in assessing the unique needs of the child in each developmental domain, and the family's resources, priorities, and concerns related to the child's development. The multidisciplinary evaluation team is required to offer families the opportunity to participate in a family assessment; however, participation in this assessment process is voluntary on the part of the family. The family assessment process is defined in EIP regulations as "the process of information gathering and identification of family priorities, resources, and concerns, which the family decides are relevant to their ability to enhance their child's development."

**10. Can tests of sensory integration functioning be used to establish eligibility for the EIP?**

No. Tests and assessment tools on sensory integration functioning cannot be used to establish eligibility for the EIP. To be eligible for the EIP, a child must have a developmental delay in one of the following five areas: communication, physical, cognitive, social-emotional, and adaptive development. Problems with sensory integration, sensory processing, hypersensitivity, or other sensory issues must be affecting the child's overall development in one or more of these areas to establish the child's eligibility for the EIP, and this must be documented by the multidisciplinary evaluation team.

**11. Are problems with articulation or phonology sufficient to establish eligibility for the EIP?**

No. However, problems with articulation or phonology may be among a constellation of clinical clues and indicators that establish the child's eligibility for the EIP, based on a delay in communication development.

**12. Is it permissible to schedule an IFSP meeting directly following completion of a child's multidisciplinary evaluation (e.g., on the same day and consecutive to the evaluation)?**

EIP regulations at 10 NYCRR §69-4.11(a) require that IFSP meetings must be conducted within 45 days of the child's referral to the Early Intervention Official, except under exceptional circumstances, including illness of the child or parent. EIP regulations at 10 NYCRR §69-

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

4.11(a)(4) require the meeting to be conducted in times and settings that are convenient to the parent. The evaluator is required to participate in the meeting, and if the evaluator is unable to attend the meeting, arrangements must be made for the evaluator's involvement in the meeting by telephone conference call or having a knowledgeable representative directly involved in the child's evaluation attend the meeting. Federal regulations specifically require that a person or persons directly involved in conducting the child's multidisciplinary evaluation must participate in the IFSP meeting.<sup>76</sup>

It is permissible, but not required, to schedule the IFSP meeting directly following completion of the multidisciplinary evaluation, if the parent agrees to schedule the meeting at that time. In addition, the municipality cannot require that the IFSP meeting be routinely scheduled for all families on the same day and immediately following the multidisciplinary evaluation.

Considerations as to whether or not to schedule the IFSP meeting immediately following the multidisciplinary evaluation include: the nature of the child's condition; the extent to which the evaluation team requires an opportunity to review, score, discuss, and integrate the results of the evaluation prior to explaining the evaluation results to the parent(s); whether the parents are comfortable with a verbal explanation of the evaluation results or prefer to receive a written evaluation report and/or summary before the IFSP meeting; the extent to which parents and the EIO may require additional time to understand the results of the evaluation prior to convening the IFSP meeting; and, the availability of other participants the parents may wish to have present at the meeting; and, other circumstances that may impact on the quality of the IFSP meeting.

Whether the evaluation and the IFSP meeting will occur on the same day, or on different days, requirements to notify the family and required participants of the initial IFSP meeting date, in writing, remain in effect.<sup>77</sup>

**13. How should the evaluation team document their multidisciplinary evaluation results/eligibility determination?**

Reports of multidisciplinary evaluation results must include a statement of the child's eligibility, including a diagnosed condition with a high probability of resulting in developmental delay, if any, or developmental delay in accordance with the definition of developmental delay. When the child has a diagnosed condition with a high probability of resulting in developmental delay, the eligibility determination should include confirmation that a diagnosis has been made by a physician or other qualified personnel, and the relevant ICD-9 code(s). When a child is eligible based on a developmental delay consistent with the State definition of developmental delay, the evaluation team should document the specific findings that establish the child's eligibility, including the results of any standardized instruments or clinical procedures used to evaluate the child that substantiate the child has a delay in one or more areas of development consistent with eligibility criteria.

It is insufficient for an evaluator to indicate that a child is eligible based on a percent delay and informed clinical opinion, without providing findings to support this statement. Relevant ICD-9 codes should also be incorporated in the evaluation findings.

**14. How should conductive hearing loss be addressed relative to eligibility for the EIP?**

---

<sup>76</sup> CFR § 303.343(b)

<sup>77</sup> 10 NYCRR Section §69-4.11(a)(5)

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

EIP regulations (10 NYCRR §69-4.3(e)(5)) specify that a hearing impairment qualifying as a diagnosed condition with a high probability of resulting in developmental delay is a diagnosed hearing loss that cannot be corrected with treatment or surgery. Thus, for the purposes of this diagnostic category, only conductive hearing losses that are not amenable to resolution through medical or surgical means, are chronic in nature, and/or have an impact on other areas of development, particularly communication development (including speech/language development), constitute diagnosed conditions with a high probability of resulting in developmental delay for the purposes of eligibility in the EIP. Consistent with the regulatory language, *an occasional or transient conductive hearing loss occurring in isolation*, i.e., without concomitant delays in other developmental domains, would typically be managed through the child’s primary medical care provider, and would not be sufficient to establish a child’s eligibility for services under the EIP.

See Early Intervention Guidance Memorandum 1999-2 for further information on other types of hearing loss and other diagnosed conditions with a high probability of resulting in developmental delay.

**15. Why does hearing appear in both the physical and communication development domains? How is eligibility established when the child has a hearing loss?**

The EIP regulations include hearing and vision in the physical domain in the definition of developmental delay at 10 NYCRR §69-4.1(g). EIP regulations specify that the multidisciplinary evaluation conducted to determine eligibility for EIP services must include an evaluation of the child’s physical development, including a health assessment, which consists of a physical examination and routine vision and hearing screening, and, where appropriate, a neurological assessment (10 NYCRR §69-4.8(a)(4)(i)). In addition to determining the child’s developmental status with respect to physical development (and in particular motor development and functioning), the health assessment is important to ensure that children are physically able to tolerate intervention services, identify any health issues to which providers of early intervention services should be alerted and informed about, and to ensure that any physical health issues that may impact on the extent to which children may benefit from early intervention services are identified.

Because hearing is fundamental to oral language development, it is also discussed in the context of the communication development domain. Hearing loss (impairment) is a diagnosed condition with a high probability of resulting in developmental delay if the hearing loss cannot be corrected with treatment or surgery (10 NYCRR §69-4.3 (e)(5)). If children are diagnosed with a hearing loss meeting this definition (e.g., a sensorineural hearing loss or a conductive hearing loss that is not amenable to medical treatment or surgery), their eligibility for the EIP is established by this diagnosis.

For the purposes of establishing EIP *eligibility*, the diagnosis of a permanent hearing loss as described above would constitute the reason for the child’s eligibility. Children with hearing loss would not be eligible due to a delay in “physical development” and in “communication development” – they are eligible due to a condition with a high probability of resulting in developmental delay.

**16. What professional qualifications are necessary to be an evaluator under the EIP?**

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility  
Requirements and Determination Under the EIP*

Section 635(9) of IDEA requires states to establish and maintain qualifications for early intervention personnel that are consistent with any State-approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which such personnel are providing early intervention services. Federal regulations at 34 CFR §303.361(a)(2) require states to adopt policies to ensure that personnel who provide early intervention services meet the highest entry level academic degree needed for any State-approved or recognized certification, licensure, registration, or comparable requirements that apply to a specific profession/discipline in which the individual is providing services. In New York State, the State Education Department (SED) is responsible for the certification and licensing of professionals. Persons who provide services in the EIP are subject to the SED's regulation of professional practice. In addition to their certification or licensure, professionals must be approved by the Department of Health to provide early intervention evaluations. Qualifications established in the Department's provider approval process include educational requirements consistent with the SED requirements for each profession, experience working with the children age birth to five years with special needs, and a satisfactory character and competency review.

Consistent with the applicable credentials for their professional certification and/or licensure, individuals who provide evaluations under the EIP should possess knowledge of early childhood development and developmental disabilities in young children, competence in their discipline, be experienced in the evaluation of young children, and have expertise in working with young children and their families. The Department's clinical practice guidelines provide specific recommendations for the training and experience of professionals involved in the evaluation and assessment of children with communication disorders, motor disorders, autism/pervasive developmental disorders, Down syndrome, vision impairment, and hearing loss.

- 17. Reimbursement regulations at 10 NYCRR §69-4.30(c)(2)(iii)(a) allow for reimbursement of one core evaluation and up to four supplemental evaluations in a twelve-month period without prior approval from the EIO. When does the twelve-month period begin?**

Reimbursement regulations allow for reimbursement of one core evaluation and up to four supplemental evaluations in a twelve-month period to develop and implement initial IFSPs, and subsequent annual IFSPs, without prior approval of the Early Intervention Official. Supplemental evaluations conducted after the initial IFSP must be agreed to by the EIO and included in the child's IFSP. The "start date" for the 12-month-period is the date of the child's referral to the EIP.

- 18. If the evaluator completes a core evaluation, but a supplemental evaluation is recommended in an area of concern that was not the expertise of one of the core evaluators, should the determination of eligibility wait until the supplemental evaluation is completed?**

Eligibility is established through a multidisciplinary evaluation. The evaluator is responsible for conducting an evaluation that is sufficient to establish the child's eligibility. If a core evaluation is completed, and the child is found to be within normal developmental range in all five areas of development, the child can be found ineligible for services. If a core evaluation is completed and a concern is identified that requires an in-depth assessment by an individual with specific expertise, a supplemental evaluation may be recommended by the evaluation team and

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

completed with the consent of the parent. Eligibility cannot be established until the full multidisciplinary evaluation is completed, including the supplemental evaluation.

- 19. If a child is referred to the EIP and is determined not eligible for the EIP with a core evaluation, and the child is re-referred three or six months later, is it appropriate to repeat the core evaluation, or if there is a single area of concern, such as communication development, can a supplemental be done and used in combination with the previous core to determine eligibility?**

If a child is re-referred to the EIP, an initial service coordinator must be assigned and the parent must select an evaluator to evaluate the child. The evaluator is responsible for determining the type of evaluation needed to assess the child's development in all five areas and determine whether the child is eligible for the EIP. As discussed on page 20, the evaluator should review records from previous evaluations, including evaluations conducted under the EIP, with parent consent. If the evaluator believes, based on a review of the child's records, parent interview, and the length of time between the previous evaluation and the child's re-referral, that a re-evaluation is necessary; the evaluator may recommend that the core evaluation be repeated. Since the first core would have been conducted within a twelve-month period, the EIO must provide prior approval for another core evaluation to be conducted.

- 20. How should municipalities handle referrals of children who are adopted from foreign countries to the Early Intervention Program?**

The purpose of the EIP is to provide early intervention services to children with developmental delays and/or disabilities. The EIP is not intended to be a source of English as a second language education, or to provide assistance to these children in adapting to a new culture or family. Primary referral sources are responsible for ensuring that only those children who are at risk for developmental delays or disabilities, or suspected of having a developmental delay or disability, are referred to the EIP.

However, some children involved in foreign adoption will be experiencing developmental delays or diagnosed conditions with a high probability of resulting in developmental delay. When EIOs receive referrals of children who are adopted from foreign countries from a primary referral source, the EIO should ascertain the reason for the referral and substantiate that the presenting problem involves a suspected developmental delay and/or disability.

- 21. If a child's and family's dominant language is a language other than English, and the child is referred due to a concern about communication development in his/her native language, and there is no professional available to evaluate the child in his/her native language, what is the responsibility of the EIP?**

EIP regulations at 10 NYCRR §69-4.8(a)(14) require that tests and other evaluation materials and procedures must be administered in the dominant or other mode of communication of the child, unless it is clearly not feasible to do so. Dominant language is defined at 10 NYCRR §69-4.1(i) to mean the language or mode of communication used by parent or the potentially eligible child, including Braille, sign language, or other mode of communication. For purposes of the multidisciplinary evaluation, the dominant language of the potentially eligible child, and not the parent, is relevant. The EIO and initial service coordinator should assist the family in accessing a bilingual evaluation if possible. If an evaluator cannot be identified to conduct a bilingual



evaluation, the EIO and initial service coordinator should arrange for the services of an interpreter to assist in the evaluation process.

**22. If a child's dominant language is not English, can the parent insist that the evaluation be conducted in English and refuse to have the evaluation conducted in the child's dominant language?**

No. As stated in EIP State regulations, evaluators must administer tests and other evaluation materials and procedures in the dominant language of the child, unless it is clearly not feasible to do so. Participation in the EIP is voluntary to families. If a parent does not consent to a multidisciplinary evaluation consistent with federal and State requirements, eligibility cannot be established for the EIP and the municipality is not obligated to develop an IFSP and provide services to the child.

There may be circumstances under which a child may be considered to be bilingual (e.g., have two dominant languages, one of which is English). Under these circumstances, the evaluator is responsible for determining the appropriate language in which to administer the evaluation in accordance with the requirement that non-discriminatory evaluation and assessment procedures are used.

**23. How does the determination of eligibility based on a diagnosed condition with a high probability of resulting in developmental delay apply for a child with a history of extreme prematurity when a child is referred when s/he is no longer an infant, i.e., when the child is one year of age or older?**

If a child is referred to the EIP when s/he is one year of age or older, with a history of extreme prematurity, the child must receive a multidisciplinary evaluation to determine his/her eligibility for the EIP. Eligibility determinations for children in this instance are based on documentation of developmental delay, and are not the same as referral of infants in the neonatal and post-neonatal period (i.e., the time period immediately after birth up to one year of age) with a diagnosed condition of extreme prematurity, when eligibility is based on the existence of a condition with a high probability of resulting in developmental delay.

**24. Are evaluators required to adjust for chronological age, when conducting an evaluation of a child with a history of prematurity, to determine initial or ongoing eligibility?**

Decisions regarding the use of adjusted age for children with a history of prematurity should be made by clinicians on the evaluation team, as appropriate to the clinical situation and the test/diagnostic assessment instrument being used in the evaluation process. Evaluation reports should clearly state the amount and type of adjustment that was made during developmental assessments, if any.<sup>78</sup>

**25. What professional disciplines can diagnose apraxia?**

Physicians, nurse practitioners, and speech-language pathologists can make a diagnosis of apraxia. Professionals are responsible for being aware of and acting within the scope of practice for the profession(s) in which they are licensed and/or certified. EIOs are responsible for

---

<sup>78</sup> Wilson, S. and Craddock, M. (2004) Review: Accounting for prematurity in developmental assessment and the use of age-adjusted scores. *Journal of Pediatric Psychology*, 29 (8) pp. 641-649.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

ensuring that multidisciplinary evaluations to determine eligibility for the EIP are conducted by qualified personnel as defined in 10 NYCRR §69-4.1 (aj) of the EIP regulations.

**26. Are children diagnosed with torticollis automatically eligible for the EIP?**

Torticollis is viewed as a medical condition for which there is wide variability in clinical expression, from mild to severe. Therefore, congenital torticollis is not routinely considered a condition that has a high probability of resulting in a developmental delay, and children with this condition are not automatically eligible for the EIP. If a primary health care provider observes that an infant or toddler is not attaining expected milestones during routine developmental surveillance, or if a parent or other primary referral source has concerns about a child's development, they should refer that child to the EIP in the child's municipality of residence to determine whether the child is eligible for the EIP.

**Appendix A – Risk Factors Pertaining to Referrals of At-Risk Children**

10 NYCRR 69-4.3(f) provides that referrals of children at risk of having a disability shall be made based on the following medical/biological risk factors:

- (1) Medical/biological neonatal risk criteria, including:
  - (i) birth weight less than 1501 grams
  - (ii) gestational age less than 33 weeks
  - (iii) central nervous system insult or abnormality (including neonatal seizures, intracranial hemorrhage, need for ventilator support for more than 48 hours, birth trauma)
  - (iv) congenital malformations
  - (v) asphyxia (Apgar score of three or less at five minutes)
  - (vi) abnormalities in muscle tone, such as hyper- or hypotonicity
  - (vii) hyperbilirubinemia (> 20mg/dl)
  - (viii) hypoglycemia (serum glucose under 20 mg/dl)
  - (ix) growth deficiency/nutritional problems (*e.g.*, small for gestational age; significant feeding problem)
  - (x) presence of Inborn Metabolic Disorder (IMD)
  - (xi) perinatally- or congenitally-transmitted infection (*e.g.*, HIV, hepatitis B, syphilis)
  - (xii) 10 or more days hospitalization in a Neonatal Intensive Care Unit (NICU)
  - (xiii) maternal prenatal alcohol abuse
  - (xiv) maternal prenatal abuse of illicit substances
  - (xv) prenatal exposure to therapeutic drugs with known potential developmental implications (*e.g.*, psychotropic medications, anticonvulsant, antineoplastic)
  - (xvi) maternal PKU
  - (xvii) suspected hearing impairment (*e.g.*, familial history of hearing impairment or loss; suspicion based on gross screening measures)
  - (xviii) suspected vision impairment (suspicion based on gross screening measures)
- (2) Medical/biological post-neonatal and early childhood risk criteria, including:
  - (i) parental or caregiver concern about developmental status
  - (ii) serious illness or traumatic injury with implications for central nervous system development and requiring hospitalization in a pediatric intensive care unit for ten or more days
  - (iii) elevated venous blood lead levels (above 19 mcg/dl)
  - (iv) growth deficiency/nutritional problems (*e.g.*, significant organic or inorganic failure-to-thrive, significant iron-deficiency anemia)
  - (v) chronicity of serous otitis media (continuous for a minimum of three months)  
HIV infection

10 NYCRR 69-4.3(g) provides that the following risk criteria may be considered by the primary referral source in the decision to make a referral:

- (1) no prenatal care
- (2) parental developmental disability or diagnosed serious and persistent mental illness
- (3) parental substance abuse, including alcohol or illicit drug abuse
- (4) no well child care by 6 months of age or significant delay in immunizations; and/or
- (5) other risk criteria as identified by the primary referral source

**Diagnosed Physical and Mental Conditions  
with a High Probability of Resulting in Developmental Delay<sup>79</sup>**

Diagnosed physical and mental conditions with a high probability of resulting in developmental delay found at 10 NYCRR §69-4.1(3)(e) of the New York State Department of Health EIP regulations:

- Chromosomal abnormalities associated with developmental delay (*e.g.*, Down syndrome);
- Syndromes and conditions associated with delays in development (*e.g.*, fetal alcohol syndrome);
- Neuromuscular disorder (*e.g.*, any disorder known to affect the central nervous system, including cerebral palsy, spina bifida, microcephaly or macrocephaly);
- Clinical evidence of central nervous system (CNS) abnormality following bacterial/viral infection of the brain or head/spinal trauma;
- Hearing impairment (a diagnosed hearing loss that cannot be corrected with treatment or surgery);
- Visual impairment (a diagnosed visual impairment that cannot be corrected with treatment (including glasses or contact lenses) or surgery);
- Diagnosed psychiatric conditions, such as reactive attachment disorder of infancy and early childhood (symptoms include persistent failure to initiate or respond to primary caregivers; fearfulness and hypervigilance that does not respond to comforting by caregivers; absence of visual tracking); and
- Emotional/behavioral disorder (the infant or toddler exhibits atypical emotional or behavioral conditions, such as delay or abnormality in achieving expected emotional milestones such as pleasurable interest in adults and peers; ability to communicate emotional needs; self-injurious/persistent stereotypical behaviors).

---

<sup>79</sup> For additional information, consult Early Intervention Guidance Memorandum 1999-2 on Reporting of Children's Eligibility Status Based on Diagnosed Conditions with a High Probability of Developmental Delay

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

**Appendix B – Personnel Qualified to Diagnose EIP Eligible Conditions**

Condition	Licensed Physician	Nurse Practitioner <sup>80</sup>	Audiologist	Optometrist	Psychologist (licensed)	Speech-Language Pathologist	Licensed Clinical Social Worker
<b>Syndromes/Conditions</b>							
Cleft Palate	X	X					
Extreme Prematurity	X	X					
Angelman's	X	X					
CHARGE	X	X					
Down	X	X					
Edwards'	X	X					
Fetal Alcohol	X	X					
Fragile X	X	X					
Patau's	X	X					
Prader-Willi	X	X					
<b>Neuromuscular/Musculoskeletal Disorders</b>							
Congenital Muscular Dystrophy	X	X					
Other Myopathies	X	X					
Werdnig-Hoffman Syndrome	X	X					
Spinal Cord Injury	X	X					
Lobster Claw	X	X					
Arthrogryposis	X	X					
Phocomelia	X	X					
Spina Bifida w/o hydrocephalus	X	X					
<b>Central Nervous System (CNS) Abnormalities</b>							
Infantile Cerebral Palsy	X	X					

<sup>80</sup> A nurse practitioner may diagnose these conditions provided that the diagnosis is related to the nurse practitioner's specialty and competency. Otherwise, the nurse practitioner must refer the child and family to a licensed qualified professional with the training and expertise needed to make an appropriate diagnosis.

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

Condition	Licensed Physician	Nurse Practitioner <sup>80</sup>	Audiologist	Optometrist	Psychologist (licensed)	Speech-Language Pathologist	Licensed Clinical Social Worker
Infantile Spasms	X	X					
Encephalocele	X	X					
Microcephalus	X	X					
Reduction Deformities of Brain	X	X					
Congenital Hydrocephalus	X	X					
Cystic Periventricular Leuko malacia (CPVL)	X	X					
Intraventricular Hemorrhage (Grade IV)	X	X					
Kernicterus	X	X					
Multiple Anomalies of the Brain	X	X					
<b>Hearing, Vision, and Communication Disorders</b>							
Retinopathy of Prematurity	X	X					
Conductive Hearing Loss	X	X	X				
Sensorineural Hearing Loss	X	X	X				
Mixed Conductive & Sensorineural Hearing Loss	X	X	X				
Unspecified Anomalies of Ear w/ Hearing Impairment	X	X	X				
Dyspraxia syndrome	X	X				X	
Blindness, both eyes	X	X		X			
Blindness one eye, low vision other eye	X	X		X			
Low vision both eyes (Mod. to severe)	X	X		X			

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

Condition	Licensed Physician	Nurse Practitioner <sup>80</sup>	Audiologist	Optometrist	Psychologist (licensed)	Speech-Language Pathologist	Licensed Clinical Social Worker
Optic Nerve coloboma (bilateral), congenital	X	X		X			
Optic Nerve coloboma (bilateral), acquired	X	X		X			
Aniridia	X	X		X			
Albinism	X	X		X			
Visual Deprivation Nystagmus	X	X		X			
Psychiatric/ Emotional/ Behavioral Disorders							
Infantile Autism active state	X	X			X		X
Pervasive Developmental Disorder (PDD)	X	X			X		X
Prolonged Post Traumatic Stress Disorder	X	X			X		X
Emotional Disturbance of Childhood (Unspecified)	X	X			X		X
Attention Deficit Disorder w/o Hyperactivity	X	X			X		X
Attention Deficit Disorder with Hyperactivity	X	X			X		X

**Appendix C – Recommendations for Preventive Pediatric Health Care**

The following chart has been reproduced by permission of PEDIATRICS vol. 105(3), pages 645-646, copyright 2000, and may also be viewed by accessing the American Academy of Pediatrics web site at, <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf>



# Recommendations for Preventive Pediatric Health Care (RE9535)

## Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.


AGE <sup>1</sup>	INFANCY <sup>1</sup>							EARLY CHILDHOOD <sup>2</sup>					MIDDLE CHILDHOOD <sup>3</sup>							ADOLESCENCE <sup>4</sup>									
	PRENATAL <sup>1</sup>	NEWBORN <sup>2</sup>	2-4d <sup>1</sup>	1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
<b>HISTORY</b> Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>MEASUREMENTS</b> Height and Weight Head Circumference Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>SENSORY SCREENING</b> Vision Hearing	S	S	S	S	S	S	S	S	S	S	S	S	S	S	O <sup>5</sup>	O	O	O	O	O	S	S	S	S	S	S	S	S	S
<b>DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT<sup>6</sup></b>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>PHYSICAL EXAMINATION<sup>6</sup></b>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>PROCEDURES-GENERAL<sup>16</sup></b> Hereditary/Metabolic Screening <sup>11</sup> Immunization <sup>12</sup> Hematoctrit or Hemoglobin <sup>13</sup> Urinalysis	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>PROCEDURES-PATIENTS AT RISK</b> Lead Screening <sup>14</sup> Tuberculin Test <sup>17</sup> Cholesterol Screening <sup>18</sup> STD Screening <sup>19</sup> Pelvic Exam <sup>20</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>ANTICIPATORY GUIDANCE<sup>21</sup></b> Injury Prevention <sup>22</sup> Violence Prevention <sup>23</sup> Sleep Positioning Counseling <sup>24</sup> Nutrition Counseling <sup>25</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>DENTAL REFERRAL<sup>26</sup></b>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. A prenatal visit is recommended for parents who are at high risk for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and nutrition and support offered. Every breastfeeding infant should have an evaluation 45-12 hours after discharge from the hospital to include weight, tonal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the patient is uncooperative, reassess within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement, "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
8. By history and appropriate physical examination; if suspicious, by specific objective developmental testing. Parenting skills should be assessed at every visit.
9. At each visit, a complete physical examination is essential, with intent totally unstated, older child undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (eg, thyroid, hemoglobinopathy, PKU, galactosemia) should be done according to state law.
12. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP Pediatric Nutrition Handbook (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States," *MMWR*, 1994;47 (RR-3):1-29.
14. All menstruating adolescents should be screened annually.
15. Conduct physical, urine/urine for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Lead" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Children" (1991). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active patients should be screened for sexually transmitted diseases (STDs).
20. All sexually active females should have a pelvic examination. A pelvic examination and routine Pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP Guidelines for Health Supervision of (1998).
22. From birth to age 12, refer to the AAP injury prevention program (1999) as delineated in A Guide to Safety Counseling in Office Practice (1994).
23. Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Positioning and Sudden Infant Death Syndrome (SIDS): Update" (1994).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP Handbook of Infant Feeding (1998).
26. Extensive dental examinations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key: ● = to be performed  
 S = subjective, by history  
 O = objective, by a standard testing method  
 ← → = the range during which a service may be provided, with the dot indicating the preferred age.

MR: Speech checked, neurologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn leg, born errors of metabolism, sickle disease, etc) is discretionary with the physician.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 1999 by the American Academy of Pediatrics. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.



American Academy of Pediatrics

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

**Appendix D – Evaluation Summary Forms**

**EARLY INTERVENTION PROGRAM  
MULTIDISCIPLINARY EVALUATION SUMMARY FORM**

Child's Name: _____			
	Last	First	Middle
DOB: _____ / _____ / _____	Date of Evaluation Establishing Eligibility _____ / _____ / _____		

**NOT ELIGIBLE**  
**Write V79.3 – Not Eligible**  
**Attach evaluation report.**  
**Attach Core/ Supplemental Evaluation Summary Sheets**

<p><input type="checkbox"/> <b>ELIGIBLE - BASED ON DIAGNOSED CONDITION</b></p> <p>Sufficient to determine eligibility. Submit the following to assist in developing service plan:</p> <ol style="list-style-type: none"> <li>1. Indicate Diagnostic Condition in Part A. Attach documentation of diagnosis.</li> <li>2. Attach <i>Core Evaluation - Data Entry Form, Supplemental Data Entry Form(s), and Narrative Summary of Evaluation.</i></li> <li>3. Attach all evaluation reports</li> </ol>	<p><input type="checkbox"/> <b>ELIGIBLE - BASED ON DELAY</b></p> <p>Submit the following to assist in developing service plan:</p> <ol style="list-style-type: none"> <li>1. This page.</li> <li>2. <i>Core Evaluation-Data Entry Form, Supplemental Evaluation-Data Entry Form(s), and Narrative Summary.</i></li> <li>3. Attach all evaluation reports.</li> <li>4. Indicate ICD 9 Code in Part B.</li> </ol>
---	---

**A. Diagnosed Physical and Mental Conditions With a High Probability of Developmental Delay.** Complete this section only if child is eligible based on diagnosed condition. Attach documentation of diagnosis by physician or clinician.

<ul style="list-style-type: none"> <li><input type="checkbox"/> 270.2 - Albinism</li> <li><input type="checkbox"/> 759.89 - Anglemans</li> <li><input type="checkbox"/> 743.45 - Aniridia</li> <li><input type="checkbox"/> 728.3 - Arthrogryposis</li> <li><input type="checkbox"/> 314.00 - Attention Deficit Disorder w/o Hyperactivity</li> <li><input type="checkbox"/> 314.01 - Attention Deficit Disorder with Hyperactivity</li> <li><input type="checkbox"/> 369.00 - Blindness, both eyes</li> <li><input type="checkbox"/> 369.10 - Blindness one eye, low vision other eye</li> <li><input type="checkbox"/> 749.00 - Cleft Palate</li> <li><input type="checkbox"/> 759.7 - CHARGE Association</li> <li><input type="checkbox"/> 389.00 - Conductive Hearing Loss - Nos</li> <li><input type="checkbox"/> 742.3 - Congenital Hydrocephalus</li> <li><input type="checkbox"/> 359.0 - Congenital Muscular Dystrophy</li> <li><input type="checkbox"/> 348.8 - Cystic Periventricular Leukomalacia (CVPL)</li> <li><input type="checkbox"/> 315.31 - Dyspraxia Syndrome</li> <li><input type="checkbox"/> 758.0 - Down (Trisomy 21 or 22, G)</li> <li><input type="checkbox"/> 758.2 - Edwards' (Trisomy 18 D 1)</li> <li><input type="checkbox"/> 313.9 - Emotional Disturbance of Childhood (Unspecified)</li> <li><input type="checkbox"/> 742.0 - Encephalocele</li> <li><input type="checkbox"/> 760.71 - Fetal Alcohol</li> <li><input type="checkbox"/> 759.83 - Fragile X</li> <li><input type="checkbox"/> 299.00 - Infantile Autism active state</li> <li><input type="checkbox"/> 343.9 - Infantile Cerebral Palsy - Nos</li> <li><input type="checkbox"/> 345.60 - Infantile Spasms w/o intractable epilepsy</li> <li><input type="checkbox"/> 345.61 - Infantile Spasms with intractable epilepsy</li> <li><input type="checkbox"/> 772.1 - Intraventricular Hemorrhage (grade IV)</li> <li><input type="checkbox"/> 774.7 - Kernicterus</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> 765.0 - Less than 500 grams - Low Birth Weight</li> <li><input type="checkbox"/> 765.02 - 500 - 749 grams - Low Birth weight</li> <li><input type="checkbox"/> 765.03 - 750-999 grams - Low Birth Weight</li> <li><input type="checkbox"/> 755.58 - Lobster Claw (Hand)</li> <li><input type="checkbox"/> 369.20 - Low vision both eyes (moderate to severe)</li> <li><input type="checkbox"/> 742.1 - Microcephalus</li> <li><input type="checkbox"/> 389.2 - Mixed conductive and sensorineural hearing loss</li> <li><input type="checkbox"/> 742.4 - Multiple anomalies of brain - Nos</li> <li><input type="checkbox"/> 377.23 - Optic nerve coloboma (bilateral), Acquired</li> <li><input type="checkbox"/> 743.57 - Optic nerve coloboma (bilateral), Congenital</li> <li><input type="checkbox"/> 359.8 - Other Myopathies</li> <li><input type="checkbox"/> 758.1 - Patau's (Trisomy 13 D 1)</li> <li><input type="checkbox"/> 299.80 - Pervasive Developmental Disorder (PDD)</li> <li><input type="checkbox"/> 755.4 - Phocomelia (absence of limb)</li> <li><input type="checkbox"/> 759.81 - Prader-Willi</li> <li><input type="checkbox"/> 309.81 - Prolonged Post Traumatic Stress Disorder</li> <li><input type="checkbox"/> 742.2 - Reduction deformities of brain (Holoprosencephaly/Lissencephaly)</li> <li><input type="checkbox"/> 362.21 - Retinopathy of prematurity (grades 4 &amp; 5)</li> <li><input type="checkbox"/> 389.10 - Sensorineural Hearing Loss - Nos</li> <li><input type="checkbox"/> 741.00 - Spina Bifida with hydrocephalus</li> <li><input type="checkbox"/> 741.90 - Spina Bifida w/o hydrocephalus</li> <li><input type="checkbox"/> 952.9 - Spinal Cord Injury, Nos</li> <li><input type="checkbox"/> 744.00 - Unspecified anomalies of ear with hearingimpairment.</li> <li><input type="checkbox"/> 379.53 - Visual deprivation nystagmus</li> <li><input type="checkbox"/> 335.0 - Werdnig-Hoffman Syndrome (Infantile Spinal Muscular Dystrophy)</li> </ul>
---	--

**B.** Indicate Diagnostic Condition and ICD 9 Code(s) below if eligible due to delay or if different from above.

1. \_\_\_\_\_
2. \_\_\_\_\_

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

**EARLY INTERVENTION PROGRAM  
CORE EVALUATION SUMMARY FORM**

INSTRUCTIONS: This form must be accompanied by a Multidisciplinary Evaluation Summary form, a Supplemental Evaluation Data Entry form (when applicable), and a Narrative Summary. Please print or type.

<b>Name of Child:</b> _____ <div style="display: flex; justify-content: space-between;"> <span><b>Last.</b></span> <span><b>First</b></span> </div> <b>Middle</b> DOB: ____/____/____		
EI Evaluator Name: _____ Provider ID#: _____ Contact Person: _____		Phone#:(____)_____ Fax#:(____)_____
<u>Core Evaluation - Individuals Involved</u> Name: _____ Speciality: _____ Instrument(s): _____	<input type="checkbox"/> Check if Bilingual Evaluation Performed Language _____ Summary of evaluation must be translated. Dates of Core: From ____/____/____ To ____/____/____	
Name: _____ Speciality: _____ Instrument(s): _____	Name: _____ Speciality: _____ Instrument(s): _____	
<input type="checkbox"/> Family Assessment Offered & Refused		<input type="checkbox"/> Family Assessment Completed and Attached
<u>Disciplines involved in Core Evaluation</u> <input type="checkbox"/> Audiologist <input type="checkbox"/> Other Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input type="checkbox"/> Nutritionist <input type="checkbox"/> Social Worker <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Special Educator <input type="checkbox"/> Pediatrician <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Physical Therapist		<u>(1) Developmental Status Codes</u> A - No Delay (development within acceptable ranges) B - 2.0+ SD below the mean (sufficient alone for eligibility) C - 1.5+SD below the mean (similar delay in another functional area needed to establish eligibility) D - 12 month delay (sufficient alone for eligibility) F - 33% or more delay (sufficient alone for eligibility) G - 25% or more delay (similar delay in another functional area needed to establish eligibility)
Method P - Informed Clinical Opinion                      T - Standardized Test		
<b>EVALUATION SUMMARY</b>		
		Diagnosed Condition(s)                      ICD 9 Code
Functional Area	Developmental Status	Method
Adaptive		
Cognitive		
Communication		
Social/Emotional		
Physical		

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

**EARLY INTERVENTION PROGRAM  
SUPPLEMENTAL EVALUATION SUMMARY FORM**

Name of Child: \_\_\_\_\_  
Last. First Middle  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

EI Evaluator Name: _____ Provider ID#: _____ Contact Person: _____	Phone :(____) _____ Fax :(____) _____
--	--

<b>Supplemental Evaluation</b> <input type="checkbox"/> Bilingual Evaluation    Evaluation Type: _____ <input type="checkbox"/> Physician <input type="checkbox"/> Non-Physician Dates: From: ____/____/____ To: ____/____/____ Name: _____ Discipline: _____	<b>Supplemental Evaluation</b> <input type="checkbox"/> Bilingual Evaluation    Evaluation Type: _____ <input type="checkbox"/> Physician <input type="checkbox"/> Non-Physician Dates: From: ____/____/____ To: ____/____/____ Name: _____ Discipline: _____
--	--

Functional Area	Developmental Status (1)	Method (2)	Functional Area	Developmental Status (1)	Method (2)

<b>Supplemental Evaluation</b> <input type="checkbox"/> Bilingual Evaluation    Evaluation Type _____ <input type="checkbox"/> Physician <input type="checkbox"/> Non-Physician Dates: From: ____/____/____ To: ____/____/____ Name: _____ Discipline: _____	<b>Supplemental Evaluation</b> <input type="checkbox"/> Bilingual Evaluation    Evaluation Type: _____ <input type="checkbox"/> Physician <input type="checkbox"/> Non-Physician Dates: From: ____/____/____ To: ____/____/____ Name: _____ Discipline: _____
---	--

Functional Area	Developmental Status (1)	Method (2)	Functional Area	Developmental Status (1)	Method (2)

<b>(1) Developmental Status Codes</b> A - No Delay (development within acceptable ranges) B - 2.0+ SD Below the mean (sufficient alone for eligibility) C - 1.5+SD Below the mean (similar delay in another functional area needed to establish eligibility) D - 12 month delay (sufficient alone for eligibility) F - 33% or more delay (sufficient alone for eligibility) G - 25% or more delay (similar delay in another functional area needed to establish eligibility)	<b>(2) Method of Determination</b> P - Informed Clinical Opinion    T - Standardized Test <b>Evaluation Type Code</b> A - Assistive Technology            J - Psychological Services B - Audiology                            L - Social Work F - Nursing                                M - Special Instruction G - Nutrition                              N - Speech and Language H - Occupational Therapy            Q - Vision I - Physical Therapy
--	---

List Diagnosis and ICD 9 Numbers:  
 1 \_\_\_\_\_ 2 \_\_\_\_\_

**Appendix E – Clinical Clues Adapted From the NYS EIP Clinical Practice Guidelines**

**Clinical Clues for Communication Disorders<sup>81</sup>**

---

**Normal Language Milestones and Clinical Clues for Possible Language Disorders  
During the First 3 Months**

**Normal Language Milestones and Clinical Clues**

***Normal Language Milestones***

- looks at caregivers/others
- becomes quiet in response to sound (especially to speech)
- cries differently when tired, hungry or in pain
- smiles or coos in response to another person's smile or voice

***Clinical Clues / Cause for Concern***

- lack of responsiveness
- lack of awareness of sound
- lack of awareness of environment
- cry is no different if tired, hungry, or in pain

**From 3-6 Months**

**Normal Language Milestones**

- fixes gaze on face
- responds to name by looking for voice
- regularly localizes sound source/speaker  
cooing, gurgling, chuckling, laughing

***Clinical Clues / Cause for Concern at 6 Months***

- cannot focus, easily over-stimulated
- lack of awareness of sound, no localizing toward the source of a sound/speaker

**From 6-9 Months**

**Normal Language Milestones**

- imitates vocalizing to another
- enjoys reciprocal social games structured by adult (peek-a-boo, pat-a-cake)
- has different vocalizations for different states
- recognizes familiar people
- imitates familiar sounds and actions
- reduplicative babbling ("bababa," "mamamama"), vocal play with intonational patterns, lots of sounds that take on the sound of words
- cries when parent leaves room (9 mos.)
- responds consistently to soft speech and environmental sounds

***Clinical Clues / Cause for Concern at 9 Months***

- does not appear to understand or enjoy the social rewards of interaction
- lack of connection with adult (lack of eye contact, reciprocal eye gaze, vocal turn-taking, reciprocal social games)
- no babbling, or babbling with few or no consonants

---

<sup>81</sup> Reproduced from Table III-5, Assessment Chapter, New York State Clinical Practice Guideline on Communication Disorders

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

---

**Normal Language Milestones and Clinical Clues for Possible Language Disorders  
From 9-12 Months**

**Normal Language Milestones**

- attracts attention (such as vocalizing, coughing)
- shakes head "no," pushes undesired objects away
- waves "bye"
- indicates requests clearly; directs others' behavior (shows objects; gives objects to adults; pats, pulls, tugs on adult; points to object of desire)
- coordinates actions between objects and adults (looks back and forth between adult and object of desire)
- imitates new sounds/actions

***Clinical Clues / Cause for Concern at 12 Months***

- is easily upset by sounds that would not be upsetting to others
- does not clearly indicate request for object while focusing on object
- does not coordinate action between objects and adults
- lack of consistent patterns of reduplicative babbling
- lack of responses indicating comprehension of words or communicative gestures

**From 12-18 Months**

**Normal Language Milestones**

- single-word productions begin
- requests objects: points, vocalizes, may use word approximations
- gets attention: vocally, physically, maybe by using word (such as "mommy")
- understands "agency": knows that an adult can do things for him/her (such as activate a wind-up toy)
- uses ritual words ("bye," "hi," "thank you," "please")
- protests: says "no," shakes head, moves away, pushes objects away
- comments: points to object, vocalizes, or uses word approximation

***Clinical Clues / Cause for Concern at 18 Months***

- lack of communicative gestures
- does not attempt to imitate or spontaneously produce single words to convey meaning
- child does not persist in communication (for example, may hand object to adult for help, but then gives up if adult does not respond immediately)
- limited comprehension vocabulary (understands <50 words or phrases without gesture or context clues)
- limited production vocabulary (speaks <10 words)

**From 18-24 Months**

**Normal Language Milestones**

- uses mostly words to communicate
- begins to use two-word combinations: first combinations are usually memorized forms and used in one or two contexts
- later combinations (by 24 months) with relational meanings (such as "more cookie," "daddy shoe"), more flexible in use

***Clinical Clues / Cause for Concern at 24 Months***

- reliance on gestures without verbalization
  - limited production vocabulary (speaks <50 words)
  - does not use any two-word combinations
  - limited consonant production
  - largely unintelligible speech
  - compulsive labeling of objects in place of commenting or requesting
  - regression in language development, stops talking, or begins echoing phrases he/she hears, often inappropriately
-

---

**Normal Language Milestones and Clinical Clues for Possible Language Disorders  
From 24-36 Months**

**Normal Language Milestones**

- engages in short dialogues
- expresses emotion
- begins using language in imaginative ways
- begins providing descriptive details to facilitate listener's comprehension
- uses attention getting devices (such as "hey")
- preparative development characterized by collections of unrelated ideas and story elements linked by perceptual bonds

***Clinical Clues / Cause for Concern at 36 Months***

- words limited to single syllables with no final consonants
- few or no multi-word utterances
- does not demand a response from listeners
- asks no questions
- poor speech intelligibility
- frequent tantrums when not understood
- echoing or "parroting of speech" without communicative intent

---

**Clinical Clues for Motor Disorders<sup>82</sup>**

---

**Clinical Clues for a Possible Motor Disorder**

**Abnormalities of Muscle Tone**

- Asymmetric (not equal on both sides) tone or movement patterns
- Greater passive flexor tone in arms when compared to legs at any age
- Popliteal angles (bend of knee joint) of 90° or more after 6 months post term
- An imbalance of extensor and flexor tone of the neck and trunk
- Extensor posturing of the trunk or excessive shoulder retraction at rest or when pulled to sit
- Hypotonia (floppiness) of the trunk:
  - The baby slips through the hands when held under the arms in a vertical position
  - There is excessive draping over the hand when held in prone (face down) suspension
- Plantar flexed feet
- Hands held habitually in a fist position

**Non-Sequential Motor Development**

- Early rolling
- Brings head and chest up on forearms in prone position prior to developing good head control
- Preference for early standing prior to sitting
- Walking with support before crawling

---

<sup>82</sup> Reproduced from Table 3, Assessment Chapter, New York State Early Intervention Program Clinical Practice Guideline on Motor Disorders

**Clinical Clues for a Possible Motor Disorder**

**Qualitative Differences in Motor Development Commonly Reported by Parents and Caregivers**

- Startles easily; jittery
- Does not like to cuddle; seems “stiff”
- Arches back frequently
- Baby seems “floppy”
- Infrequent or limited variety of movement
- Favors one side of body more than other
- Feeding problems, particularly after 6 months
- Falls backward when in a sitting position
- Crawls in a “bunny hop” fashion
- Walks on tiptoes
- “Scissors” legs while standing
- Sits with legs in “w” position (reversed tailor position)

**Observations of Movement and Posture**

- Rolling as a unit (log rolling) after the age of 6 months
  - Hyperextension of head and neck when prone in conjunction with significant head lag when pulled to sit
  - When prone, readily lifts head and neck, but arms are kept extended along trunk
  - When pulled to sit from lying down position, comes to standing instead of sitting position
  - One or more of the following occurs in the sitting position:
    - Child sits on lower lumbar sacral region
    - Hips and knees are flexed and hips are adducted
    - Legs are positioned in a reverse tailor or “w” posture
    - A tendency to thrust trunk backward while sitting
  - One or more of the following is observed during crawling:
    - Legs are moved as a unit resulting in “bunny hop” movements
    - Hips are excessively adducted, reciprocal movements of legs are done very slowly, and movements are “jerky” in appearance
  - Legs are kept extended and adducted while child creeps (pulls body forward with arms)
  - In a supported standing posture, legs are excessively extended and adducted and child stands on toes
  - While walking, one or more of the following are observed:
    - Crouched gait (hips are flexed and adducted, knees are flexed and feet are pronated)
    - Intermittent tiptoe gait and overextension of the knees
-



### **Clinical Clues for Possible Autism<sup>83</sup>**

- Looks through people; not aware of others
- Not responsive to other people's facial expressions/feelings
- Lack of pretend play; little or no imagination
- Does not show typical interest in, or play near peers purposefully
- Lack of turn taking
- Unable to share pleasure
- Qualitative impairment in nonverbal communication
- Not pointing at an object to direct another person to look at it
- Lack of gaze monitoring
- Lack of initiation of activity or social play
- Unusual or repetitive hand and finger mannerisms
- Unusual reactions, or lack of reaction, to sensory stimuli
- Delay or absence of spoken language
- Looks through people; not aware of others

### **Clinical Clues for Down syndrome<sup>84</sup>**

#### **Common Characteristics of Children With Down Syndrome**

Physical Characteristics	Developmental Characteristics
Short stature	Developmental delay
Low muscle tone	▪ cognitive
Joint laxity	▪ motor
Flat facial profile	▪ communication
Upward slanting eyes	▪ social skills
Abnormal shape of the ears	▪ adaptive/self-help
Little finger with only one joint	
A deep crease across the palm	
Obesity	

#### **Hall's Ten Signs of Down Syndrome in Newborns**

Neonatal sign	% Frequency (percent of newborns affected)
Poor Moro reflex	85
Hypotonia	80
Flat facial profile	90
Upward-slanting palpebral fissures (eyelid openings)	80

<sup>83</sup> Reproduced From Table III-4, Assessment Chapter, New York State Early Intervention Program Clinical Practice Guideline on Autism

<sup>84</sup> Tables 1 and 3, Assessment Chapter, New York State Early Intervention Program Clinical Practice Guideline on Down Syndrome

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

---



---

**Common Characteristics of Children With Down Syndrome**

---

Physical Characteristics	Developmental Characteristics
Morphologically simple, small round ears	60
Redundant loose neck skin	80
Single palmar crease	45
Hyperextensible large joints	80
Pelvis radiograph morphologically abnormal	70
Hypoplasia of fifth finger middle phalanx	60

*Adapted from: Tolmie 1998*

---



---

**Clinical Clues for Vision Impairment<sup>85</sup>**

---

**Clinical Clues of Possible Vision Impairment: Physical Exam Findings**

- Abnormal head posture
- Abnormal craniofacial features (such as microcephaly, ptosis)
- Abnormal pupil response
  - Abnormal red reflex
  - Asymmetrical Bruckner test
  - Afferent pupil response (APD)
- Absence or abnormality of optokinetic nystagmus (OKN) after age 6 months
- Coloboma
- Corneal opacification or congenital cataracts
- Asymmetrical corneal light reflex
- Direct observation of an eye turn
- Delayed, absent, or abnormal visual fixation/following
  - Absence of any fixation at birth
  - Has not developed good fixation (saccade) by 6-9 weeks
  - Has not developed good following (pursuit) by 2-3 months
- Iris abnormalities
  - Albinism (findings of albinism such as transillumination)
  - Aniridia (absence of the iris)
- Nystagmus (other than reflex nystagmus such as OKN)
- Strabismus
- Abnormal head posture
- Abnormal craniofacial features (such as microcephaly, ptosis)
- Abnormal pupil response

---

<sup>85</sup> Reproduced from Table 7(a), New York State Early Intervention Program Clinical Practice Guideline on Vision Impairment

---

**Clinical Clues of Possible Vision Impairment: Physical Exam Findings**

---

**Clinical Clues of Possible Vision Impairment: Visual Behaviors**<sup>86</sup>

Information about visual behaviors that may indicate a possible vision problem can be obtained from observation of the child, from expression of parental concern about the child's vision, or from information provided by the parent(s) in response to specific questions. Examples of clinical clues of a possible vision problem include:

---

**Visual Behaviors**

- Photophobia (avoidance of bright light/squints in bright light/preference for dim light)
  - Stares at bright lights
  - Closes one eye
  - Non-directed or "roving" eye movements
  - Does not seem to respond to parent's face
  - Does not seem to imitate parent's facial expression
  - Does not seem to follow movement of objects or people
  - Does not reach for bottle when presented quietly
  - Does not seem to show interest in toys/objects within reach
  - Does not seem to show visual interest in television
  - Does not seem to show interest in books
  - Seems to have limited interest in different kinds of toys
  - Does not seem to recognize colors or shapes
  - Bumps into objects
  - Visual self-stimulatory behaviors (e.g., eye rubbing, pressing, or poking)
- 

**Clinical Clues of Possible Vision Impairment: Visual Developmental Milestones**<sup>87</sup>

The age ranges for the visual developmental milestones are approximate and will vary somewhat for each child. Because many of the visual milestones are dependent on other areas of development (such as development of cognitive and motor skills), a delay or failure to achieve a visual developmental milestone may be an indication of a vision problem, or it may be an indication of some other developmental delay. Failure to achieve the following milestones may be an indication of a vision problem

---

**Visual Developmental Milestones**

**By 6 weeks:**

- Stares at surroundings when awake
  - Momentarily holds gaze on bright light or bright object
  - Blinks at camera flash
  - Eyes and head move together
- 

<sup>86</sup> Reproduced from Table 7(b), New York State Early Intervention Program Clinical Practice Guideline on Vision Impairment

<sup>87</sup> Reproduced from Table 7(c), New York State Early Intervention Program Clinical Practice Guideline on Vision Impairment

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

---

**Visual Developmental Milestones**

**By 24 weeks:**

- Eyes begin to move more widely with less head movement
- Eyes begin to follow moving objects or people (8-12 weeks)
- Watches parent's face when being talked to (10-12 weeks)
- Begins to watch own hands (12-16 weeks)
- Eyes move in active inspection of surroundings (18-20 weeks)
- While sitting, looks at hands, food, bottle (18-24 weeks)
- Begins to look for and watch more distant objects (20-28 weeks)

**By 48 weeks:**

- May turn eyes inward while inspecting hands or toy (28-32 weeks)
- Eyes more mobile and move with little head movement (30-36 weeks)
- Watches activities in the environment for longer periods of time (30-36 weeks)
- Visually attends to dropped toys (32-38 weeks)
- Visually inspects toys while holding (38-40 weeks)
- Creeps after favorite toy when seen (40-44 weeks)
- Sweeps eyes around room to see what's happening (44-48 weeks)
- More and more visual inspection of objects and persons (46-52 weeks)

**By 18 months:**

- Uses both hands and visually steers hand activity (12-14 months)
- Visually interested in simple pictures (14-16 months)
- Often holds objects very close to eyes to inspect (14-18 months)
- Points to objects or people using words "look" or "see" (14-18 months)
- Looks for and identifies pictures in books (16-18 months)

**By 36 months:**

- Smiles, facial brightening when views favorite objects and people (20-24 months)
- Likes to watch movement of wheels, egg beater, etc. (24-28 months)
- Watches own hand while scribbling (26-30 months)
- Visually explores and steers own walking and climbing (30-36 months)
- Watches and imitates other children (30-36 months)
- Begins to keep coloring on the paper (34-38 months)
- "Reads" pictures in books (34-38 months)

---

**Clinical Clues for Hearing Impairment<sup>88</sup>**

Any one clue at any age may be a clinical clue of hearing loss

---

**Clinical Clues of Possible Hearing Loss**

**At 3 Months**

- Lack of responsiveness to voice
- Lack of awareness of environmental sound
- Does not visually track to voice

**At 6 Months**

- Lack of awareness of sound, no localizing toward the source of a sound/speaker
- Vocalizes with little variety

---

<sup>88</sup> Reproduced from the Assessment Chapter, Table 5, New York State Early Intervention Program Clinical Practice Guideline on Hearing Loss

*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

---

**At 9 Months**

- Lack of connection with adult (vocal turn-taking, reciprocal social games)
- Does not associate a sound with its source (such as not responding to sound toys)
- No babbling, or babbling with few or no consonants

**At 12 Months**

- Lack of consistent patterns of reduplicative (canonical) babbling (such as “babababa”)
- Lack of responses indicating comprehension of words
- Exclusive reliance on context for language understanding
- Lacks vocalizations that sound like first words (such as “ma-ma” or “da-da”)

**At 18 Months**

- Does not attempt to imitate words
- Does not spontaneously produce single words to convey meaning
- Limited comprehension vocabulary (understands <50 words or phrases without gesture or context clues)
- Limited production vocabulary (speaks <10 words)
- Speech largely unintelligible
- Lack of progress in vocabulary development from 12 to 18 months (plateau or lack of progress at any age)
- Limited consonant production

**At 24 Months**

- Reliance on gestures without verbalization
- Speech largely unintelligible
- Limited production vocabulary (speaks <50 words)
- Does not use two-word combinations

**At 36 Months**

- Social interactions with peers are primarily gestural
  - Words limited to single syllables with no final consonants
  - Few or no multi-word utterances
  - Does not demand a response from listeners
  - Asks no questions
  - Poor speech intelligibility
  - Frequent tantrums when not understood
-

## **Appendix F – Predictors of Continued Language Delay**

### **Table III-7: Predictors Of Continued Language Delay In Children With Language Delays At 18-36 Months (from New York State Department of Health Early Intervention Program – Clinical Practice Guideline on the Assessment and Intervention with Young Children with Communication Disorders)**

This table lists factors that predict which children found to have language delay at 18-36 months will continue to have language delay in the future. The more of these predictors a child exhibits, the more serious the concern that the child will continue to have language problems and the greater the need for speech language therapy. Some of the specific predictors may not apply to children 18-24 months if typically developing children would not be expected to exhibit the communicative behaviors.

#### **SPEECH**

##### **Language Production**

- Particularly small vocabulary for age
- Less diverse vocabulary particularly in regard to verbs
- Preponderance of general all-purpose verbs (such as “do,” “make,” “want,” “go”)
- More transitive and fewer intransitive verbs (such as “give ball”)

##### **Language Comprehension**

- Presence of 6-month comprehension delay
- Large comprehension-production gap with comprehension deficit

##### **Phonology**

- Few prelinguistic vocalizations
- Limited number of consonants
- Limited variety in babbling structure
- Fewer than 50% consonants correct (substitution of glottal consonants and back sounds for front)
- Restricted syllable structure
- Vowel errors

**Imitation**

- Few spontaneous imitations
- Reliance on direct model and prompting in imitation tasks of emerging language forms

**Table III-7: Predictors Of Continued Language Delay In Children With Language Delays At 18-36 Months (Continued)**

**NON-SPEECH**

Play

- Primarily manipulating and grouping
- Little combinatorial and/or symbolic play

Gestures

- Few communicative gestures, symbolic sequences, or supplementary gestures

Social Skills

- Behavioral problems
- Few conversational initiations; interactions with adults more than peers
- Difficulty gaining access to activities

Health and Family History

- Recurrent otitis media
- Family history of persistent problems in language learning

**Appendix G – Developmental Surveillance Recommendations for Children At Risk for Communication Delays**

1. When in-depth speech/language assessment finds that a child has a speech/language problem, but the developmental assessment indicates no general developmental delay or other developmental problems, then it may be useful to consider if the child has the following:
  - a delay in expressive language but normal language comprehension, and no other specific language impairments
  - a specific language impairment [D1]

*Children with severe speech/language delays*

2. For children at age 18-36 months who have had an in-depth assessment that indicates a severe delay and who have no other apparent developmental problems, it is recommended that formal speech/language therapy be initiated. A severe delay may be indicated by:
  - at 18 months, no single words
  - at 24 months, a vocabulary of fewer than 30 words
  - at 36 months, no two-word combinations [B]
3. It is also recommended that children with a severe speech/language delay receive a comprehensive health assessment to look for medical conditions that might be causing or contributing to the delays. [D2]

*Children with milder expressive delays only*

4. When deciding to initiate speech/language therapy for children age 18 to 36 months who have a delay in expressive language only and no other apparent developmental problems (normal language comprehension, no hearing loss, and typically developing in all other ways), it is important to:
  - assess if the child has a higher or lower likelihood of continuing to exhibit a language delay
  - recognize that predicting whether a child has a higher or lower likelihood of continuing to have a language delay requires experienced clinical judgment [D1]
5. In assessing the likelihood that a child with a current mild delay in expressive language will continue to have ongoing language problems or will catch up with typically developing peers, it may be useful for the speech language pathologist to consider the extent to which the child exhibits the factors predicting continued language delay as shown in Table III-7 . [D1]
6. For children with a current delay who exhibit more of the prognostic factors in Table III-7, it is recommended that:
  - formal speech/language therapy be tried



*Standards and Procedures for Evaluations, Evaluation Reimbursement, and Eligibility Requirements and Determination Under the EIP*

- ongoing monitoring of the child's progress and activities to promote language development (described in the part on Enhanced Developmental Surveillance) be continued
  - children receive periodic in-depth assessment of their communication level and progress (whether or not speech/language therapy is initiated) [D1]
7. For children with current delay who exhibit fewer of the prognostic factors listed in Table III-7, it is recommended that:
- formal speech/language therapy not be initiated at this time
  - activities to promote language development be continued, along with the parents' ongoing monitoring of the child's progress
  - the child be reevaluated by the speech language pathologist in no more than 3 months to assess progress in communication development
  - the child's need for speech/language therapy be reconsidered at the time of re-evaluation depending on the child's progress [D1]

---

Note: Each guideline recommendation is followed by one of the strength of evidence ratings described below, which is intended to indicate the quality, clinical applicability and amount of scientific evidence used as the basis for that guideline recommendation.

[A] = Strong evidence is defined as evidence from two or more studies that met criteria for adequate evidence and had high quality and applicability to the topic, with the evidence consistently and strongly supporting the recommendation

[B] = Moderate evidence is defined as evidence from at least one study that met criteria for adequate evidence and had high quality and applicability to the topic, and where the evidence supports the recommendation

[C] = Limited evidence is defined as evidence from at least one study that met criteria for adequate evidence and had moderate quality or applicability to the topic, and where the evidence supports the recommendation

[D] = Panel consensus opinion (either [D1] or [D2] below):

[D1] = Panel consensus opinion based on information not meeting criteria for adequate evidence, on topics for which a systematic review of the literature was done

[D2] = Panel consensus opinion on topics for which no systematic literature review was done

**Appendix H – Components of an In-depth Speech-Language Evaluation**<sup>89</sup>

Components of an In-Depth Speech-Language Evaluation

It is recommended that an in-depth speech-language evaluation include an assessment of the child's:

- Hearing ability and hearing history
- History of speech-language development
- Oral-motor functioning and feeding history
- Expressive and receptive language performance (syntax, semantics, pragmatics, phonology)
- Social development
- Quality/resonance of voice (breath support, nasality of voice)
- Fluency (rate and flow of speech)

---

<sup>89</sup> Source: Section on In-depth Assessment of Children with Communication Disorders, General Approach, Recommendation 5. *Clinical Practice Guideline Report of the Recommendations, Communication Disorders, Assessment and Intervention for Young Children (Age 1-3 Years)*. 1999: New York State Department of Health. pg. 100

**Appendix I – Milestones on Normal Feeding, Clinical Clues of a Possible Feeding Problem, and Components of an Oral Motor Assessment**

**Motor Disorders Clinical Practice Guideline – Tables on Feeding<sup>90</sup>**

**TABLE IV-5 MILESTONES RELEVANT TO NORMAL FEEDING**

<b>Age (months)</b>	<b>Progression of liquid and food</b>	<b>Oral-motor skills</b>	<b>Motor skills</b>
Birth to 4	Liquid	Suckle on nipple	Head control develops
4 to 6	Purees	Suckle off spoon Suckle ? suck	Sitting balance Hands to midline Hand-to-mouth play
6 to 9	Purees Soft chewables	Assisted cup drinking Vertical munching Limited lateral	Reach, pincer grasp Assists with spoon Finger feeding begins tongue movements
9 to 12	Ground Lumpy purees	Cup drinking with assistance	Refines pincer grasp Finger feeding Grasps spoon with whole hand
12 to 18	All textures	Lateral tongue action Diagonal chew Straw drinking	Independent feeding increases Scoops food, brings to mouth
18 to 24	More chewable food	Rotary chewing Decrease in food intake by 24 months	Increased control of utensils
24 +	Tougher solids	Increase in mature chewing for tougher solids	Total self-feeding Increased use of fork Cup drinking, open cup and no spilling

Adapted from: Arvedson 1996

<sup>90</sup> Reproduced from the New York State Early Intervention Program Clinical Practice Guideline on Motor Disorders

---

**Table IV-6: Clinical Clues of a Possible Feeding Problem**

- Prolonged feeding times (>30 minutes)
  - Stress during or following feeding for child and/or parent
  - Poor suck, difficulty latching on to nipple
  - Loss of liquid or food around lips
  - Excessive tongue retraction or protrusion
  - Holding food in mouth or prolonged chewing before swallowing
  - Excessive drooling
  - Indication of respiratory distress during oral feeds (for example, arching back, turning away, eye widening, nasal flaring, difficulty catching breath)
  - Gurgly voice quality
  - Difficulty in making transition to a new texture at developmentally appropriate stages
  - Coughing or gagging while eating
  - Frequent vomiting or excessive spitting up during or after meals
  - Poor weight gain
  - Reduced interest in or negative response to oral presentation of food
- 

---

**Table IV-7: Components of an Initial Oral-Motor Assessment**

- Physical examination and comprehensive history:
    - Structure and function of oral, facial, pharyngeal, respiratory, and gastrointestinal systems
    - Other conditions that could affect the child's tolerance and stamina (such as cardiac conditions)
  - Observation of interaction patterns between the child and caregiver
  - Effects of muscle tone, posture, movement, and positioning
  - Oral-motor exam, to be performed prior to offering liquid or food, including:
    - Presence/absence of oral reflexes
    - Structure and coordination of movement of the lips, tongue, soft palate, and jaw
    - Oral sensation
    - Laryngeal function
    - Control of oral secretions (drooling)
    - Respiratory rate and effort
    - Oral postural control and voice quality
  - Feeding assessment including:
    - Feeding environment
    - Level of alertness and attention
    - Affect, temperament, and responsiveness
    - Ability to self-calm and self-regulate
    - Non-nutritive sucking (such as on a pacifier)
    - Observation of trial feeding
    - Swallowing
    - The effect of alternate positioning and modifications of the feeding process
  - Evaluation of the diet for adequate nutritional intake
-