I'm A SERVICE COORDINATOR

Now What Comes Next?

All I've Been Doing is Shadowing..

- You are now a Service Coordinator, and initially you shadow your peers. The purpose of Shadowing is:
- To help you become more familiar with the overall process of intake ,explanation of consents to the family, delivering the ASQ-SE, and RBI.
- To help you become familiar with how to facilitate the IFSP meeting with family and providers.
- To help you become familiar with the providers

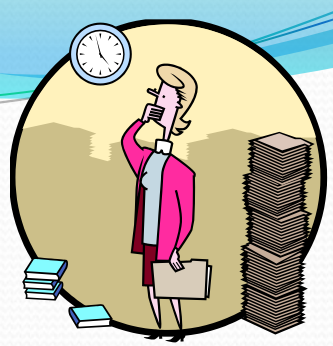
Flying Solo .....

- At some point, the Shadow Lead should allow you to begin to explain the program, consents and facilitate the entire meeting.
- You can prepare for this by practicing explaining the program to family members or using a mirror or television. Practice explaining the consents and make sure you understand them prior to your meeting.
- You can also prepare by preparing your intake packets the day before. Call the parent and become comfortable with speaking to them.

I'm Assigned the Case I Shadowed on……

- You came back to the office and you find out the case you shadowed on is actually yours.
- The Shadow Lead should sit down with you to explain what to do next.
- In any event, you should refer to your Service Coordinator Home Team Follow Up sheet….
- You can refer to the Initial Intake Checklist as well.
- Keep your Cornerstone EI Screen Flow Sheet handy
- When in doubt refer to your EI SC Manual

What Do I Do Now?



- When you arrive back at the office after team, you should prepare to Case Note your initial team meeting.
- Complete your “IM” authorizations for all your providers…Remember IM authorizations always have a code of “99” for the IFSP meeting. These authorizations are for “ 1 per day” for “60” minutes or how many minutes your meeting took place.
- Check and balance: Some SC’s choose to complete a “AS” authorization to ensure their providers have a assessment auth for 180 minutes. Some providers are added to the team at the last minute. So you want to ensure you completed all your authorizations to eliminate the future need of a “HEAT TICKET REQUEST”. Both authorizations should print on the same page but you must enter a date (i.e. 10/19/2013 to 10/19/2013) for this to occur while printing. In any event, be sure that all your providers have two authorizations and the AS (Assessment) auth should have a date that corresponds to your (IM) authorization.
- Authorizations should be faxed to providers…keep your confirmations and attach to authorizations. You should be in the practice of keeping all confirmations.

What Do I Do Now cont…

- After case noting, and completing your auth for IM meeting. Turn in your next day form to intake. Completely fill this out.
- Organize your file
- Send your Physician script and letter immediately so once you locate your provider services can begin. Send off the request for medical records.
- If your client has private insurance, it is IMPERATIVE that you send for insurance verification, as this process takes time. If your client has a HMO you may qualify for a waiver, Typically PPO's do not qualify for a waiver. Review your insurance section in your Service Coordinator manual as there are other ways your client may qualify for a waiver. Each case is determined based on what type of insurance the family have.

What Do I Do Now cont….

- Prepare your Eligibility Letter to send to the family.
- Begin to seek providers. Remember, DT's do not need a prescription so they should be able to start immediately. Request outstanding therapy assessments if recommended during the initial (i.e. You may need a physical therapy assessment, a medical diagnostic etc.)
- Wait for reports to arrive, review the reports for errors, make corrections and complete the IFSP….however, you do not need to wait for all the reports as your IFSP can be amended at anytime, but start the process of entering information.

What Do I Send to Providers

- The initial providers should receive their EA or AS authorization along with the IM authorization. They should also receive a copy of the IFSP and reports, along with the consents to complete assessment and insurance information.
- The ongoing providers should receive
  - The IFSP as soon as reasonably possible but no more than 15 business days after the IFSP meeting.
  - The Insurance Report
  - Front and back of family's insurance card (If applicable)

Send to Providers……

- Family information
- Notice to Consent to Use Private Insurance
- Parental Consent and Ability to Decline Services
- Consent to Collect and Store Personally Identifying Information (PII).
- IFSP packet including reports along with Prescription
- Authorizations
- ASQ/SE and RBI
    - Remember, a copy of the IFSP must be provided to every member of the IFSP team with the exception of AT and Transportation providers.
    - Case note that you provided this copy to the providers as well as mailed the family their personal copy. (Families do not need copies of the consents unless they request a copy)

Remember…….

- Remember your work reflects you as
  - well as the CFC…
- Please be mindful on how you send
  - out your request
- Make sure they are neat and legible
- Type out your outcomes when
  - Possible as they may be requested by SSI or Court
- Neat work helps to eliminate the possibility for mistakes
- Each CFC have their own process regarding how they would like their IFSP's to be entered and completed.

Communicate with the Family

- Communication with the family monthly or more is required. Communication can be via a face-to-face or phone call. Written correspondence may be utilized however face to face or telephone calls are preferred
- Always ask the family if insurance coverage has changed, are services being provided as authorized etc.
- Case notes should reflect monthly communication or more. Case note, Case note, Case note….if it isn't written it did not happen.

Whew! Finally….

- Begin keeping track of your caseload. A good way to complete this is using a excel spreadsheet which you will need for stats with your Lead SC anyway.
- *Remember, once your IFSP* is completed, print out and add all attachments. All providers should receive a copy as well as the parent. Case Note you sent this information. The office keeps the original IFSP with original signatures. You only send copies. Keep copies of everything you send in the file.
- Then, take a whoosah, check your messages and go on to the next file

What if I need to Change the IFSP Plan as written

- Prior to making any changes to existing authorizations in an IFSP the CFC must (refer to sect 12.6.3 in manual)
- Follow the Developmental Justification of Need to Change Frequency, Intensity of Location of Authorized Services Guidelines and Worksheet procedures
- Ensure the family is provided with a State of Illinois Infant/Toddler Family rights booklet
- If changes are agreed to by everyone and the family has private insurance, the family must also sign a new Notice to Consent to Use Private Insurance Form

Its time to complete Transition the case..What Now?

- At 2 years 6 months you started transition with CPS
- Prepare your CPS packet, enter the client name in the Transition Log Sheet and file the packet in the folder to be mailed. Write or Label the outside of the folder with the child's name, birthdate and EI number.
- Complete the EI to EC Tracking Form to include in packet.
- Complete the transition call with your assigned LEA rep. (Sometimes we have a transition liaison working within the CFC who can assist)

Happy Happy Birthday!!!!

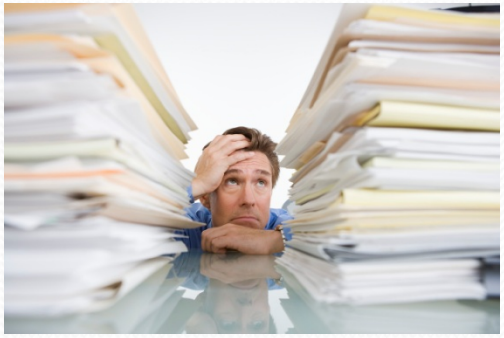
- Hurray! Your client has turned 3!
- Don't forget that your outcomes (8, 9, 10) should have been updated at least 120 days prior to the client aging out of EI. You complete this by going to PA35 and adding a new date and only completing the 8, 9, 10 section. Case note that you, the family and providers updated this section.
- Request all final discharge reports to send to the family
- Send the Happy Birthday Letter to the family
- Make sure everything is updated..once closed its closed.

Happy Birthday Continued

- Complete the case closure checklist which will serve as a guide
- Call CPS for any updates and case note
- If no answer is received from CPS after 30 days, mail the CPS transition outcome letter to cps and case note.
- Case notes that state the family provided the cps update is not sufficient, you must also hear from CPS that transition was successful or not.
- Take file out of the hard folders and convert into the manila folder with label for the name.
- Submit to closure section of office.

Don’t STRESS…Multi-tasking is a Must!

- It may seem that you have too many files and too little time.
- Create some timelines
- Ask for help, if available
- Utilize your time management skills
- Case Note as often as possible to stay
  - Abreast of your cases and who you
  - Speak to. Don’t make promises you
  - Cannot keep.



The Never Ending Syndrome…

- At some point, you may feel this process is never ending…and the truth is, it isn't….However….rest be assured to know that you are making a difference.
- It takes about 45 days to completely get a file on track, but remember we have 45 days to complete the process. Our goal is to complete this process in a timely and efficient manner. Some families do not fit this model so we adapt to our families needs. Be flexible.

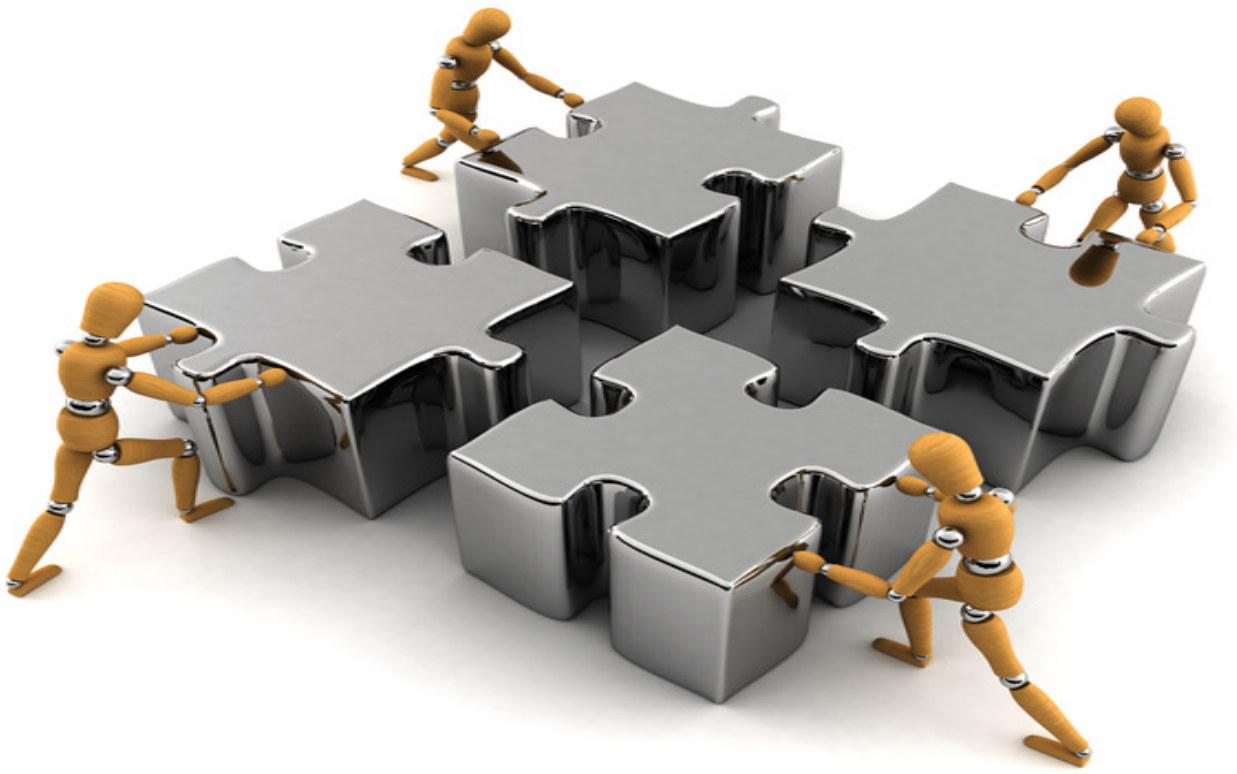
Things to Remember ….

- You have a multitude of support
- Case Consultation
- Consulting Pediatrician
- Lead Service Coordinators
- Managers
- You are not alone, SC's empathize and try to help
- Things are constantly changing, try to stay up to date
- Be Consistent & Return calls in a timely manner
- Please don't take anything personal..we all are working for the same goal.
- When in doubt refer to your manual or ask questions.

References

- The Illinois Early Intervention Training program
- The Dept of Human Services
- Illinois Early Intervention Clearinghouse
  - Illinoiseitraining.org (have a multitude of helpful forms for Service Coordinators)
  - Dhs.state.il.us (CFC forms, Procedure Manual and Sample letters)

Questions?.....



Welcome Aboard!!!!!!!

Thank you

Presented and Created by

Lead Service Coordinator, Alanda Lockhart, MS

CFC10

Weekly/Daily Checklist

Some service coordinators find it helpful to organize a checklist of the activities they need to follow up on a daily/weekly basis to make sure they don't forget to do something for a family. Service coordinators may use the fields below to list the family's names and due dates for the activities they are working on completing. Please remember to keep this stored in a confidential place to protect each family's privacy.

Evaluators/initial IFSP's scheduled & confirmed	IFSP's/Reports to IFSP team (including the family)	School Transition (consent, referral, transition meeting)
Closing Activities: Letter, D/C Report Requests, Exit IFSP Meeting, Close Case	Waiting For…..	Other

SC Name:_____ Child's ID#_____ Date_____

Initial Intake Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• Early intervention philosophy		
• The statewide early intervention system including eligibility criteria for children		
• The difference between assessment for evaluation and ongoing assessment		
• The role of the family in the assessment process		
• Procedural safeguards and family rights		
• Confidentiality policies and practices		
Gather information from the family about:		
• Family background, ethnicity and language preference		
• Family structure and composition		
• Child health and development status and history		
• Family resources, concerns and priorities		
• Other agencies and professionals involved with the child		
• Their child's reaction to strangers (e.g., the interventionist)		
Collaborate to:		
• Identify methods of sharing information with and from others, including the family		
Perform administrative tasks such as:		
• Obtain parent permission for the child's evaluation/assessment		
• Complete and submit releases for information		
• Complete and submit reimbursement information, if needed (insurance, Medicaid, family payment)		
• Obtain and share with the early intervention evaluators any records and past assessments on the child		
• Gather information about the child's disability		
• Obtain parent permission to store data		
• Send a letter to acknowledge contact was made with the family to the referral sources including the medical home		

SC Name:_____ Child's ID#_____ Date_____

Coordinate with Medical and Health Providers Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• Confidentiality and sharing of relevant information, both verbal and written		
• The concept of a medical home, where care is accessible, continuous, comprehensive, family- centered, coordinated, compassionate, and culturally effective		
• A child's nutritional needs for growth and development		
• A child's mental health needs		
• Environmental hazards and safety needs in the home and community		
Gather information from the family about:		
• The medical care providers/medical home		
• The child's physical health needs		
• The child's nutritional needs		
• The child's mental health needs		
• The family's medical insurance		
Collaborate to:		
• Facilitate the appropriate sharing of medical and EI information between the child's service providers (EI as well as health care)		
• Educate EI service providers about the child's medical needs		
• Identify and obtain additional medical/health services that may be needed for the child		
Perform administrative tasks such as:		
• Obtain written consent from family to receive and share development, health and medical records		
• Request child's health and medical records from the appropriate sources		
• Provide health and medical providers with early intervention evaluations and progress notes		
• Establish an ongoing medical/health record system for the child		

SC Name:_____ Child's ID#_____ Date_____

Coordinating Evaluation and Assessment Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• Early intervention philosophy		
• The statewide early intervention system including eligibility criteria for children		
• The family/child outcomes for Part C early intervention		
• The difference between assessment for evaluation and ongoing assessment		
• The role of the family in the assessment process		
• Procedural safeguards and family rights		
• Confidentiality policies and practices		
Gather information from the family about:		
• Family background, ethnicity and language preference		
• Family structure and composition		
• Child health and development status and history		
• The family perception of their child's developmental functioning compared to their chronological age		
• Family resources, concerns and priorities		
• The family's daily/weekly activity settings		
• The child's participation level in the activity settings		
• Accommodations the family has identified and used to enable the child to participate in activity settings		
• Other agencies and professionals involved with the child		
• The family's knowledge of their rights under Part C IDEA		
• The family's perception of their ability to help their children learn		
• The child's reaction to strangers (e.g., the interventionist)		
Collaborate to:		
• Identify methods of sharing information with and from others, including the family		
Perform administrative tasks such as:		

SC Name:_____ Child's ID#_____ Date_____

• Obtain parent permission for the child's evaluation/assessment		
• Complete and submit releases for information		
• Complete and submit reimbursement information, if needed (insurance, Medicaid, family payment)		
• Obtain and share with the early intervention evaluators records and past assessments on the child		
• Gather information about the child's disability		
• Obtain parent permission to store data		
• Send a letter to acknowledge contact was made with the family to the referral sources including the medical home		

SC Name:_____ Child's ID#_____ Date_____

IFSP Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• The purpose of the IFSP		
• The IFSP meeting, format and participants		
• Evaluation criteria for service delivery and learning acquisition		
• The development of outcomes and timelines for the child/family using the OSEP outcomes to categorize each outcome		
• The identification of EI services to enhance a child's learning opportunities		
• The ongoing role of the service coordinator		
• The development of a transition plan		
Gather information from the family about:		
• Activity settings/routines used currently for learning opportunities; and ones the family would like to use		
• Priorities for child participation in activity settings/routines in the home and community settings in which other children participate		
• Time and place preferences for the IFSP meeting		
• List of service providers and supports/services to be on the IFSP document (e.g., medical home, child care)		
• Comfort level with the IFSP meeting and document		
Collaborate to:		
• Identify IFSP meeting participants, including service providers involved in the child's evaluation		
• Identify meeting time, place and agenda with the family		
• Facilitate IFSP meeting		
• Identify how to integrate family's cultural traditions and informal supports within EI		
• Identify functional, integrated outcomes and objectives to support the child's and family's learning opportunities in identified activity settings/routines referenced to child and		

SC Name:_____ Child's ID#_____ Date_____

family outcomes		
• Identify how families will access supports and resources to meet family and child outcomes		

The service coordinator will:	√ / x	*Notes*
Perform administrative tasks such as:		
• Providing written notice to all involved in the IFSP meeting		
• Acting as the facilitator of the IFSP meeting		
• Ensuring that all forms are correctly completed, signed by and distributed to all relevant parties		
• Making a copy of the IFSP for a child's file, family, and providers and distribute accordingly (e.g. primary care providers		
• Ensuring that the family feels the IFSP is a document and plan they agree to		

SC Name:_____ Child's ID#_____ Date_____

Assist Family in Identifying Available Service Providers Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• A process for identifying members of professional disciplines as service providers		
• The role and competencies of different professional disciplines		
• The primary provider model		
• Ways to integrate service providers into family and community activity settings		
• Collaborative consultation and transdisciplinary teaming to integrate child's developmental needs across domains, disciplines and daily learning opportunities and routines		
• Community service providers outside of the EI system		
• Strategies for assessing the competence/effectiveness of a service provider		
Gather information from the family about:		
• Their knowledge about different disciplines		
• Their preferred time and place for intervention visits		
• Their comfort level with number and frequency of provider visits		
• Their comfort level with participating in intervention		
• Their comfort level with providing feedback to the interventionist		
Collaborate to:		
• Identify a primary service provider		
• Identify other service providers if needed		
• Identify the service delivery structure: time, place, length of intervention sessions, with the family & service provider		
• Identify team meetings times and communication strategies with family and/or service providers		
• Identify how to integrate family's cultural traditions and informal supports within EI		
• Share all relevant information (evaluations, IFSP) across service providers and the family		

SC Name:_____ Child's ID#_____ Date_____

Perform administrative tasks such as:		
• Gather a list of potential service providers		
• Contact potential service providers and describe IFSP		
• Schedule intervention visits		

SC Name:_____ Child's ID#_____ Date_____

Inform Families of the Availability of Advocacy Services Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• The definition and uses of advocacy		
• Parent resources for advocacy/support (PTI, parent to parent)		
• The use of mediation and due process		
Gather information from the family about:		
• Family involvement with resources such as PTI and parent to parent, and other support		
• Their knowledge about their rights, advocacy resources and due process		
Collaborate to:		
• Enable the family to access and use the advocacy supports they need		
• Enable the family to use conflict resolution techniques as needed		
Perform administrative tasks such as:		
• Facilitating the use of conflict resolution techniques as needed		
• Assisting the family to file for mediation/due process if they are dissatisfied with the EI process		

SC Name:_____ Child's ID#_____ Date_____

Coordinate and Monitor the Delivery of Available Services Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• Agency and provider responsibilities to collect and use data to document interventions and child/family process		
• Team process and integration of learning across domains		
• Effective communication strategies across service delivery team members		
• Functional interventions to facilitate the behavior and development of the child in home and community activity settings		
• Criteria by which to measure individual child and family IFSP progress		
• A system for tracking the delivery of services and intervention sessions		
• Strategies for requesting changes in IFSP and/or service delivery plan		
Gather information from the family about:		
• Where and when intervention sessions have occurred		
• Their satisfaction with the IFSP and service delivery		
• Their confidence in being able to facilitate their child's development as a result of intervention		
Collaborate to:		
• Monitor (or facilitate) the service delivery schedule		
• Establish and coordinate collaborative consultation and team meetings (via email, phone, or in person)		
• Monitor data collection from all members of the service delivery team on IFSP outcomes and objectives (and OSEP outcomes)		
• Establish a schedule for the sharing of information and/or formal reports on all child and family outcomes across the family and team members		
• Establish a system for the family to provide feedback on the EI service delivery model, the		

SC Name:_____ Child's ID#_____ Date_____

providers, and child and family progress		

Perform administrative tasks such as:		
• Establishing interagency agreements, interagency meetings, as needed		
• Establishing data collection strategies on child and family outcomes for all service providers		
• Keeping records of progress from all providers on IFSP outcomes		
• Coordinating the 6 month review of IFSP		

SC Name:_____ Child's ID#_____ Date_____

Transition Planning Checklist

The service coordinator will:	√ / x	*Notes*
Share information about:		
• Transition requirements of early intervention		
• Community and specialized services for which child and family may be eligible		
• IDEA preschool (Part B) policies, if appropriate		
• The child's opportunities to participate in community early childhood programs		
• The transition conference to be held at least 90 days prior to transition out of early intervention		
Gather information from the family about:		
• Their knowledge of their child's developmental needs, including disability		
• Their knowledge of early childhood community resources for their child		
• Their knowledge of preschool special education, if appropriate		
• Their preference for the child's preschool placement		
Collaborate to:		
• Arrange visits of the family to community and/or school placement options		
• Identify members of transition team		
• Schedule transition team meetings at a time and place preferred by parent		
• Facilitate transition team meetings		
• Develop a transition plan		
Perform administrative tasks such as:		
• Obtaining written consent from family to share information with potential service providers, including evaluation and assessment information and copies of IFSPs		
• Arranging a transition meeting at a time and location convenient for the family; forward current child information to future service providers prior to the transition meeting		
• Notifying LEA 9-12 months prior to child turning three		