



Technical Assistance Document: Evaluation and Assessment

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Purpose: Guidance on Evaluating and Assessing Infants and Toddlers Within the Family Infant Toddler (FIT) Program

This re-issued and revised document is dedicated to Harrie Freedman, one of the original authors, who dedicated her life to the families of infants and toddlers with and at risk for developmental delays and disabilities.

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Introduction

This technical assistance document was first developed in 2005, when an Interagency Coordinating Council (ICC) Work Group was brought together to assist the NM Family Infant Toddler Program (NM FIT) in developing a document to offer guidance regarding the provision of quality evaluations and assessments and determining eligibility for the FIT Program. This TA document is being updated in 2013 in order to address changes in the State and Federal regulations with regards to evaluation and assessment requirements and changes to New Mexico's eligibility categories and the process for determining eligibility. Significant input and direction was given by an ICC committee that consisted of personnel with experience in evaluation and assessment along with input from the National Early Childhood Technical Assistance Center (NECTAC).

The underlying values that guide this document are:

- Information is gathered and presented in ways that honor and focus on the **primary strengths, resources, concerns and priorities of the family.**
- Developmental information is strength-based and focuses on how each child is able to **participate in the everyday routines, activities, and places** that are a part of his/her family and community life.
- **Multiple sources of information** are used to inform decision making including observation, assessment tools, the family interview and informed clinical opinion.
- Evaluation and assessment are **individualized to meet the unique needs of each individual child and family.**
- Evaluation and assessment are "authentic" in that they **assess the child's skills in the real life contexts of family, culture and community, rather than in isolation.**

Implementing recommended practices regarding developmental screening, evaluation and assessment of infants and toddlers is central to an effective early intervention process. The evaluation and assessment of the child provide the team with an opportunity to collect information with their family about how to help the child develop and engage in meaningful activities within the context of their family and community life.

In order to do this, two key points are consistently found in the literature:

1. **Parent-professional collaboration is an essential component** of all developmental screening, evaluation, eligibility determination and ongoing assessment practices; and
2. The styles, methods, materials used and content of screenings, evaluations, and assessments are **individualized and appropriate for infants, toddlers and their families** (Neisworth & Bagnato, 2005).

This technical assistance document is intended to:

- Clarify the NM FIT Program requirements and expectations about developmental screening, comprehensive developmental evaluation, eligibility determination and ongoing assessment;
- Provide practical guidance regarding recommended practices from the professional literature;
- Support efficient and effective evaluation and eligibility determination practices so that the Individualized Family Service Plan (IFSP) can be developed within the required 45 day timeline; and
- Guide early intervention personnel in their use and documentation of ongoing assessment for decision making, individualized program planning, and preparing for smooth and effective transitions from the FIT program.

Clarification of Terms

It is important to note that the terms “screening,” “evaluation,” and “assessment” are frequently used together in the literature. Clarification of these terms is provided below regarding how they are used in this Guidance Document and within the FIT Program.

Developmental Screening: a brief assessment procedure that is designed to identify children who should receive more extensive assessment (Meisels & Provence, 1989). This screening process helps determine whether a child’s development is progressing typically or if there is cause for concern. A screening tool is not designed to provide a detailed description of developmental functioning, to determine eligibility for services, or to design intervention strategies.

According to the Federal Individuals with Disabilities Education Act regulations and state regulations (7.30.8 NMAC), **evaluation and assessment** are defined as closely linked, but separate processes. For the purposes of this document the terms are defined as follows:

Comprehensive Multidisciplinary Evaluation (CME): the initial evaluation process used to determine a child’s eligibility for NM FIT Program supports and services. The evaluation determines the child’s functioning in each developmental area including cognitive, physical (which includes motor and vision and hearing), communication, social and emotional, and adaptive development.

Diagnostic Evaluation: a diagnostic evaluation is conducted to provide in-depth information regarding the specific nature and extent of the child’s condition and may lead to specific intervention techniques based on the diagnosis. Some examples include but are not limited to: cerebral palsy, autism spectrum disorder, visual impairment, and hearing loss/deafness. In New Mexico the Early Childhood Evaluation Program (ECEP) at the University of New Mexico’s Center for Development and Disability (CDD) is the primary diagnostic program for children from birth to three years old. For more information on ECEP, see Appendix E.

Ongoing Assessment: includes the procedures used *throughout* the child’s eligibility for the NM FIT Program that identify the child’s unique strengths and needs, developmental functioning and progress made over time, as well as the concerns, priorities, and resources of the family.

Note: If a child under age three transfers from another state the FIT Regulations 7.30.8.10 F (7) state “If the child has a recent and complete evaluation current within the past six months, the results may be used, in lieu of conducting an additional evaluation, to determine eligibility”. Evaluations from other states can be used to determine eligibility even if other tools or protocols were used. If the evaluation from the other state is less than 6 months old the receiving FIT agency may utilize an ongoing assessment tool or domain specific tool to inform IFSP development and completion of the ECO.

The terms “evaluation” and “assessment” are used in this document to differentiate between a Comprehensive Multidisciplinary Evaluation (CME) for establishing a child’s eligibility for early intervention supports and services and the ongoing assessment of a child’s abilities and progress once eligibility has been established. These differences are further summarized below, and are also addressed in later sections of this document:

Note: If a child under three transfers from another FIT provider agency and there has been less than a 6 month gap in enrollment, the receiving FIT provider agency shall consider the child to be eligible. The receiving agency may utilize an ongoing assessment tool or domain specific tool to inform IFSP implementation.

The CME Includes:	Ongoing Assessment Includes:
<ul style="list-style-type: none"> • Determining a child’s eligibility for NM FIT Program utilizing FIT approved tools and processes to determine the child’s developmental levels compared to the development of children at their same age. • Evaluate how their cognitive, physical (including hearing, vision, and motor), communication, social and emotional and adaptive development affects participation in family and community life; • Evaluate the child’s unique abilities, strengths and needs in order to inform the development of outcomes, strategies and services with the initial Individualized Family Service Plan; 	<ul style="list-style-type: none"> • Ongoing and periodic review of a child’s progress toward reaching family-identified outcomes that address a child’s participation in family and community life; • Ongoing and periodic review of a child’s unique abilities, strengths and needs that support the development and/or revision of the outcomes on the IFSP, and assist planning for transition; • Utilizing multiple methods including an ongoing assessment tool (e.g. HELP, AEPS, etc.) to assist in ongoing intervention program planning with the family and to monitor developmental progress over time and identify areas of the child’s development that need to be addressed.

Developmental Screening

1. Screening as part of child find:

Developmental screenings are often conducted as part of a community-based child find efforts. Examples include health fairs, community based screening events, and screening at an early learning center, such as at a child care center.

If the child “fails” the screening the parents will be asked if they would like to be referred to the FIT Program for a Comprehensive Multidisciplinary Evaluation (CME) of their child’s development.

Note: the option of a screening as a first step in a possible CME process does NOT waive the requirement of completing the CME and IFSP within 45 days of referral.

2. Screening as a result of a referral to the FIT Program:

If the child has a diagnosis that would qualify them under established condition or biological medical risk or where the referral indicates a strong likelihood that the child has a delay in their development, including when a screening has already been conducted (e.g. by a medical provider, Early Head Start, etc.) the team would move straight to conducting a CME. However, if there is little presenting evidence that the child has a developmental delay, a developmental screening may be conducted with parent consent.

The family must be informed that they can request a full CME at any time, even if the child “passes” the screening.

The approved screening tool to be used for screenings based on a referral to the FIT Program is the *Ages and Stages Questionnaire* (ASQ), as it meets the following criteria for selecting screening tools (First Signs, 2004):

- Historical and statistical significance - established and valid tool that uses developmental milestones and is recognized by a national organization;
- Ease of use by the provider - brief to fill out (under 20-30 minutes), easy to tabulate (under five minutes), easy to store and maintain, easy to explain to the family;
- Ease of use for the parent or caregiver (when using parent questionnaires) - can be completed in under 20-30 minutes, is multiple choice, written for fourth to sixth grade reading level, is available in other languages with alternative methods of administration;
- Affordable for the provider.

The ASQ is designed to be completed by parents or other primary caregivers and supports the practice of parent-professional collaboration. It is necessary for the person who scores the ASQ to have a good understanding of child development. They can be available to answer questions that the parent may have either about items on the ASQ or more broadly about their child’s development.

In addition, the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) may be used as a child-monitoring system for social and emotional behaviors developed to complement the

ASQ. This screening tool identifies infants and young children where social and emotional development requires further evaluation to determine if referral for intervention services is necessary.

Parents must provide written consent for the screening and if the screening indicates the need for further assessment then a full CME would be completed with parent consent.

For information on additional screenings such as screenings for vision, hearing, or social-emotional development, please see the Appendices. For additional information regarding screening for Autism Spectrum Disorders (ASD), please see the NM FIT technical assistance document on ASD available on the FIT website: www.fitprogram.org

The New Mexico FIT Ages and Stages for Kids (ASK) Program:

The NM FIT Program also offers an ongoing developmental screening program to any family that was referred to a FIT provider agency whose child was determined to be *not eligible* or for a family whose child is no longer eligible but who is still under the age of three.

The ASK program is free for participating families and offers both paper and web-based Ages and Stages Questionnaire (ASQ) options for completing and submitting the age-based questionnaires. Local agencies will make a referral to the FIT Program with the parent(s) permission. Referral is made using the ASK Referral Form, which includes the parent's consent. Prior to the referral, the FIT provider should conduct a screening using the ASQ appropriate for the child's age. This will inform the family regarding what to expect from the ASQ they will receive in the mail or online.

All monitoring of the ASK Program is provided by the FIT Program at the state level. If a screening questionnaire reveals a that the child may be behind in their development compared to same age peers, the FIT Program will inform the family directly and provide them with referral information for local FIT agencies.

Principles of Evaluation and Assessment in Early Intervention

Unlike traditional, clinical, or academically-based evaluations and assessments, developmental evaluation and assessment in the early intervention field is a process of collecting information about a child to ultimately answer, “How can families and early intervention providers promote a child’s development through participation in family and community life?” The following principles provide a framework for conducting a meaningful evaluation and assessment (Greenspan & Meisels, 1996).

Effective Evaluation and Assessment:

1. *Is based on an integrated developmental model*, which places children in the context of their families and surrounding world. Areas of child development are viewed as interrelated, and are not evaluated in isolation of one another.
2. *Involves multiple sources of information*, including the parent’s description of a child’s capacities and developmental history, discussion with families to understand their questions and concerns, direct observation of the child, focused observation and/or assessment of specific developmental areas.
3. *Follows a certain sequence*, starting with establishing a relationship with family members. Collecting developmental information and making observations of a child, in the context of unstructured interactions with family members, are part of the evaluation/assessment process.
4. *Depends on a child’s relationship and interactions with his or her most trusted caregivers*. Interactions with familiar caregivers provide the optimal context for understanding a child’s competencies and patterns in *all* areas of development.
5. *Is guided by the sequences and timetables in typical development*. The sequence and timetable for various developmental areas provides an essential framework for interpreting the wide variation among infants and toddlers in how they learn “to do” and participate in family and community life.
6. *Emphasizes attention to a child’s level and pattern of organizing experience and functional capacities*, which represent an integration of emotional and cognitive abilities. A child’s level and pattern of organizing experiences must be understood within the framework of his or her family’s cultural context/environment and functional abilities.
7. *Identifies a child’s current competencies and strengths, as well as the competencies that will promote continuous development*. A child’s participation in meaningful activity settings depends on building his or her capacities, not identifying developmental delays. A child’s capacities in various developmental areas are interrelated and build on one another.

8. *Is a collaborative process between early intervention providers and family members.* Family members get to choose the extent they are involved, and their specific questions and desires are always considered.
9. *Becomes the first step in a potential intervention process* leading to recommendations for specific family supports and services.
10. *Involves reassessment in the context of day-to-day family or early intervention activities, or both.* Careful observation of a child's behavior and interaction in different yet familiar contexts, on multiple occasions, provides an in-depth perspective about developing competencies, and next steps for promoting participation in meaningful activity settings.

Effective evaluation strategies:

- The evaluation session should begin with the evaluators establishing a relationship with and engaging the child and the family. Supportive and comfortable interactions with the parents will typically assist the child in engaging with the evaluators.
- The evaluation should be play-based in nature and engaging for the child.
- Taking the time to observe the child with familiar objects will provide more information about the child's overall skills when unfamiliar objects are presented.
- Allowing the child to explore materials at her own pace and following her lead will assist the evaluation team in learning more about the child's functional skills.

The assessment chapter of the DEC Recommended Practices offers additional information and considerations in assessing infants and young children, as do many of the other resources listed in the references section of this document.

In support of the above principles, the NM FIT Program requires that each initial evaluation include:

- **Information provided by the parent** about the child's development and the daily routines and activities of the child and family;
- **Observation of the child** in interactions that are typical for him/her, preferably in environments and routines with people who are familiar to him/her;
- Documentation of developmental **abilities and functional skills in all five developmental areas** including cognitive, physical (which includes vision, hearing, and motor), communication, social and emotional, and adaptive development
- Obtaining and reviewing pertinent records regarding **health status and medical history**; and

- The use of a **tool or tools to assess the child’s developmental functioning.**

Each evaluation conducted to determine eligibility must:

- **Be multidisciplinary** and involve at least two qualified personnel from different disciplines who are working in a transdisciplinary manner throughout the process. “No one individual or discipline has all of the necessary information or expertise to gain a holistic perspective of a child’s behavioral repertoire” (Losardo & Notari Syverson, 2011). As a result, evaluators can be more effective when acting as both generalists (viewing the whole child) and as experts in their disciplines (viewing the child with the emphasis on a particular domain). In choosing which personnel will be on the evaluation team, the important question to consider is “Who has the expertise to evaluate how suspected delays in a child’s development affect his or her participation in family-selected activity settings?” (Hanft & Pilkington, 2000).
- **Be multidimensional** and include **more than one method** or source of information (family interview, observation, evaluation tool(s), medical records and/or informed clinical opinion) to determine eligibility and identify a child’s level of functioning in all five developmental areas.
- **Use nondiscriminatory evaluation and assessment materials and procedures** that are administered in a child’s native language, or primary mode of communication of the family. Early intervention providers must be particularly aware of the biases, limitations, and preconceived attitudes that become part of their “professional wisdom” and can influence how they interpret evaluation results. This is especially important given the potential for multiple levels of cultural bias contained within evaluation and assessment tools themselves. Use of an evaluation process that is more ecological in its scope and views the child within the context of the culture is necessary in order to determine the level and nature of any developmental delay (Banerjee & Guiberson, 2012; Lynch & Hanson, 2011).
- **Be timely.** The timeliness of the evaluation and IFSP development is critical. This process must be completed within 45 days of referral, unless family circumstances (child illness, family travel, etc.) cause a delay. If this is the case, the reason for the delay must be documented. Please note: the need for additional evaluation information does NOT allow the 45 day timeline to be extended. If additional information is needed in order to determine eligibility for the FIT Program, it must be obtained within the 45 day timeline. If the child is determined eligible, the team may decide to include in the initial IFSP additional assessments by disciplines that were not a part of the initial evaluation.

In the NM FIT Program, use of the IDA (Infant-Toddler Developmental Assessment) process is **required** for eligibility determination. The IDA provides a framework that incorporates information from parent interviews, health and medical records, and direct observation. It was designed to be utilized by a transdisciplinary team of least two professionals and it utilizes the *Provenance Birth to Three Developmental Profile*, which assesses development in all domains.

Example:

Carrie's parents referred Carrie for an evaluation because of concerns that she had seemed slow in learning to walk and slow in learning to do new things and they wanted more information about her development. A Developmental Specialist and Occupational Therapist evaluated Carrie using the IDA process. The results of the developmental evaluation indicated a delay in language but also that additional information was needed to understand how to provide appropriate family supports and services. A Speech-Language Pathologist provided additional assessment using a combination of a domain-specific tool and natural observation to evaluate Carrie.

NOTE: The speech evaluation can be completed prior to the IFSP or, as Carrie was determined eligible for services, further assessment and consultation from an SLP can be identified as a strategy for the outcome supporting language and communication, which can be a strategy to meet the 45 day timeline, and thus begin services on the IFSP quickly.

- Allow for the use of Informed Clinical Opinion, as defined by IDEA (2004) and state regulations NMAC 7.30.8

The Role of "Professional Wisdom" in the Evaluation Process

IDEA and NM FIT Program regulations both require that the evaluation team develop an "opinion" regarding a child's developmental status, and determination of eligibility, after they have gathered and synthesized multiple sources of information. This process of becoming "informed" about a child's developmental status within his environment is based on the knowledge and skills of the multidisciplinary team, including the parents.

A professional must utilize his/her "wisdom" - previous experiences, knowledge and expertise in child development, combined with the knowledge gained about a particular child - throughout the evaluation and assessment process and when interpreting evaluation results. Knowledge of typical development, appropriate training, previous experience with and knowledge of the child, previous experience with evaluation and assessment tools and procedures, sensitivity to cultural differences, sharing and including family perceptions are all important aspects of becoming informed (Shackelford, 2002). Additionally, knowledge of medical and/or biological diagnoses that may affect the child's development is critical in the evaluation and assessment process.

The Infant-Toddler Developmental Assessment (IDA) requires that evaluation teams utilize their "professional wisdom" throughout the process. By utilizing the framework of the IDA to direct the team's analysis and discussion, the IDA utilizes the collective knowledge and experiences of the team members to assist in determining the true functioning of the child.

Observations, evaluation findings, and impressions of individual team members are brought together to discuss and consider the functional impacts and implications of delays or differences in development on the child's ability to participate in the everyday routines,

activities, and places of his family and community life. It may be helpful to note that this team process of synthesizing information and examining potential impacts on daily life is the primary function of Phase Five of the IDA process and, is therefore, a built-in component of most evaluations if conducted properly.

Professional Qualifications of Evaluation Team Members

The New Mexico FIT Program requires that only professionals who are qualified and trained to do so may participate in evaluation procedures and activities. Qualified professionals include: Certified Developmental Specialists at levels II & III, and licensed personnel including Occupational Therapists, Physical Therapists, Speech Language Pathologists, Nurses, Psychologists, Social Workers, etc.

A Developmental Specialist I, Certified Occupational Therapy Assistant (COTA), or Physical Therapy Assistant (PTA) may contribute to the evaluation, but cannot serve as one of the two multidisciplinary team members representing two professional disciplines.

Certain evaluation instruments have specific educational level and training requirements for administration. Those requirements must be honored in order to have valid and reliable results that can be used in determining eligibility.

The NM FIT Program does not require that the team member from a specific professional discipline determine a child's eligibility for the developmental domain(s) typically associated with that discipline. For example, it is not necessary for a speech-language pathologist be the team member to determine that a child is developmentally delayed in communication. However, if the primary concern is that the child may have difficulties with language and/or communication it would be advantageous to include a speech-language pathologist on the evaluation team to conduct the IDA.

Reminder: The IDA Process requires that at least two professionals from different disciplines utilize a transdisciplinary team approach as this evaluation process is completed.

It is recommended that *all* professionals involved in evaluation activities be knowledgeable about:

- ◆ All developmental domains for children birth to age three;
- ◆ The expected sequences and generally expected timing of development across all domains; and
- ◆ The broad range of individual variations that may be seen in typically developing infants and toddlers (Shackelford, 2002; Greenspan & Meisels, 1996).

Comprehensive Multidisciplinary Evaluation (CME)

Planning the Comprehensive Multidisciplinary Evaluation

Effective evaluation is based on collaborative planning and decision making between family members and early intervention providers. The evaluation process is discussed with the parents along with the importance of their participation in the evaluation.

There are two primary tasks to accomplish during planning conversations with families:

- **Talk with the parent(s)** about what they want for their child, what their concerns and questions are and what information they would like; and
- **Review relevant health/medical records** to determine current health status, relevant medical history, and any medical follow up that have been recommended and may influence the child's developmental status.

Before and during evaluation and assessment, individualized information is collected with families about how a child participates in everyday routines and activities in various settings. Family members have their own perspectives about meaningful participation for a child in home and community activities, based on their family culture, values and traditions. The Family Service Coordinator or other evaluation team member can interview family members during planning conversations to:

- Reflect on their desires for their child's participation in daily life situations and activities (family priorities);
- Talk about the strategies, people and places that have been, or could be helpful in promoting their child's development and participation (family resources); and
- Identify what still needs to be addressed (family concerns).

Based on the primary concerns and ideas of the family and/or other referral source information, the Family Service Coordinator and family determine what expertise is needed on the evaluation team and who will participate in the evaluation. The Family Service Coordinator and family may also decide the tools and methods that should be used for the evaluation and how the family will participate in the evaluation.

Example:

After talking with Carrie's parents regarding their concerns about how she seemed to learn and do things throughout her usual day, the Family Service Coordinator and the family decided that a Developmental Specialist and an Occupational Therapist would be most helpful doing the initial evaluation. The family and Family Service Coordinator agreed that the IDA, along with observing Carrie at home during playtime, would provide the most appropriate information for the initial evaluation.

Roles Family Members May Assume During Evaluation and Assessment:

Observer	Narrator	Coach	Reflector
Watches child perform tasks or test items with evaluators; may hold an infant or toddler while specialist presents items or plays with child.	Presents a portrait of the child by describing and elaborating on the child’s behavior and performance; may identify emerging skills for more in-depth assessment.	Assists in eliciting optimal performance by suggesting modifications in how tasks and toys are presented; may speak to, touch, or move the child to focus his or her attention.	Comments on child’s performance and provides guidance to team members about whether performance is representative of typically demonstrated behavior.

Conducting the Comprehensive Multidisciplinary Evaluation (CME) Process

During the initial evaluation process, the evaluation team:

- **Carries out the methods** selected during prior planning conversations with family members e.g. observation of routines at home and early childhood setting (as applicable), play; administering of tools; discussion time with parents and other caregivers, etc.
- **Evaluates the status of a child’s development** in cognitive, physical/motor (including vision and hearing), communication, social and emotional, and adaptive development, and **assesses the unique needs of a child** in each developmental area, so that outcomes and family supports and services can be selected with families.
- **Collects data for the Early Childhood Outcomes (ECO) summary form.** The information gathered from the above methods/sources will also be used to complete ratings and supporting evidence for the initial ECO summary form.
- **Shares preliminary results with parents/guardians,** and explains why additional evaluation/assessment procedures, if indicated, might be helpful


While in most cases, the Provence Profile and the IDA Process yield enough information about the child’s development to make an eligibility determination; there may be certain circumstances when the evaluation team requires additional information.

The team may benefit from the use of a domain-specific tool in gathering more information to support the determination of the child’s eligibility, e.g. - A child who is presenting primarily with concerns in his expressive language may not yield a meaningful & definitive score with IDA and so as part of the IDA process, the team may decide to gather additional information through use of the Preschool Language Scales (PLS) to assist in eligibility determination.

- **Determines a child’s eligibility for early intervention services**

The multidisciplinary team uses a variety of sources of information viewed with each individual’s perspective and “wisdom” to shape an opinion regarding the child’s overall developmental status and eligibility for the NM FIT Program. Examples of sources of information include and are not limited to:

 - Parent-provided information such as information that is gathered through the parent interview component of the IDA process which may follow the format of the *Routines-Based Interview* (McWilliam, 2006);
 - Observations of parent-child interactions and the child’s physiological states, self-regulation, play and other behaviors;
 - Information from the child’s caregivers or early childhood teachers that also may be obtained through the *Routines-Based Interview* (McWilliam, 2006);
 - Administration of the *Providence Birth-to-Three Developmental Profile*, as part of the IDA process
 - Administration of other domain specific tools (as determined to be needed);
 - Observations of the child in typical settings and routines; and
 - Review of medical and other pertinent records.
- **Documents the eligibility determination in a written statement** that includes the child’s eligibility and basis for eligibility determination; this statement is included with the evaluation report. (See the section on Determining and Documenting Initial Eligibility for the FIT Program).
- **Prepares a written evaluation report:**
 - Prior to writing the report, and at the completion of the comprehensive multidisciplinary evaluation, the evaluation team or Family Service Coordinator shares a summary of “first impressions” with the family, telling them when they should expect to receive the results of the evaluation and what to expect in terms of “next steps” in the process.
 - The draft of the evaluation report integrates information from all team members and provides recommendations for approaches, activities, and strategies.
 - It is recommended that the evaluation team or Family Service Coordinator meet with the family to go over the draft report, discuss areas that need additional clarification, resolve any contradictions, if possible, or plan to resolve if needed.
 - The final report is completed (see Section VIII)
- **Makes arrangements for an evaluation team member to discuss the final report with the family prior to the IFSP.**



Information from the CME will be used to assist in the determination of a rating on the **Early Childhood Outcomes (ECO)** for any eligible child.

IDA Checklist:

The IDA Process:

- The Provence Profile was administered by a team of two professionals from different disciplines who were both present during the session.
- ALL eight developmental domains were assessed by BOTH professionals.
- ALL of the items in three age zones were either administered and/or reported on by the parent if direct observation was not a possibility.
- The TEAM discussed their impressions of the findings from the parent interview, health review, and developmental information.
- The TEAM considered potential contributing factors (such as experience, health issues, etc.) when interpreting the results from the Provence Profile.

The following must be completed on the IDA Record:

- Cover page (Page 1)
- Provence Profile protocols for Scoring Child's Development for the Child's Age (Pages 2 - 7):
 - o for least three different age zones i.e. above and below the child's age (adjusted if applicable)
 - o for all eight domains
- Worksheets for Applying Scoring Criteria (Pages 8 & 9) The TEAM "tallies" ALL of the credited items and transferred them to the scoring worksheets in the IDA Record for all domains and all three age zones:
 - o The TEAM determines a performance age range for each domain and records this at the bottom of the corresponding domain column (below the missed starred items).
- Summary of Scoring and Findings (Page 10):
 - o The TEAM determines a Developmental Rating of either "Competent" or "Of Concern" for each domain, in accordance with the IDA Directions for Scoring Section of the IDA Administration Manual.
 - o The TEAM calculates and documents the percentage of delay (if applicable) for each domain (using EITHER Table 5 or Table 6 in the IDA Administration Manual) and records the percentage of delay for each domain in the "Salient Qualitative Findings" column. e.g. ">25% delay", "<25% delay".
- Developmental and Behavioral Concerns (Page 11):
 - o The TEAM completes those items of concern and entered "None" if there were no concerns.

Not Required:

- Summary Paragraph (Page 14):
 - o The TEAM may this utilize this page to summarize areas of strengths and concerns to be incorporated into the CME report.
 - o The TEAM may this utilize this page to record their consensus regarding the child's eligibility under one or more of the following eligibility categories: "Developmental Delay", "Established Condition", "Biological / Medical Risk" and / or "Environmental Risk" OR if the child is not eligible for the FIT Program.

Eligibility Determination for the Family Infant Toddler (FIT) Program

Eligibility Categories for the New Mexico FIT Program:

The NM FIT Program has four different categories of eligibility (see NMAC 7.30.8 10 G for details). A child is considered eligible as long as he or she meets the requirements of at least one category; however, it is also possible for a child to be considered eligible under more than one category.

- **Established Condition:** A diagnosed physical, mental, or neurobiological condition that has a high probability of resulting in developmental delay. The established condition shall be diagnosed by a health care provider and documentation shall be kept on file.

- **Developmental Delay:** After correction for prematurity, a delay of 25% or greater, -1.5 Standard deviations or greater, or a designation of *Significant Atypical Development* determined through "Informed Clinical Opinion", in one or more of the five developmental areas:
 - Cognitive development
 - Communication development
 - Social and emotional development
 - Adaptive development
 - Physical development (including vision and hearing)

- **Biological / Medical Risk for Developmental Delay*:** A diagnosed physical, mental, or neurobiological condition. The biological or medical risk condition shall be diagnosed by a health care provider and documentation shall be kept on file.

- **Environmental Risk for Developmental Delay*:** A presence of adverse family factors in the child's environment that increase the risk for developmental delay in children. Eligibility determination shall be made using the tool approved by the FIT Program.

* New Mexico is one of only a handful states that serves children who are "at-risk". Children who qualify for services due to "at-risk" status are subject to the service package detailed in the *NM Developmental Disabilities Supports Division (DDSD) Service Standards & Definitions*, available at www.fitprogram.org

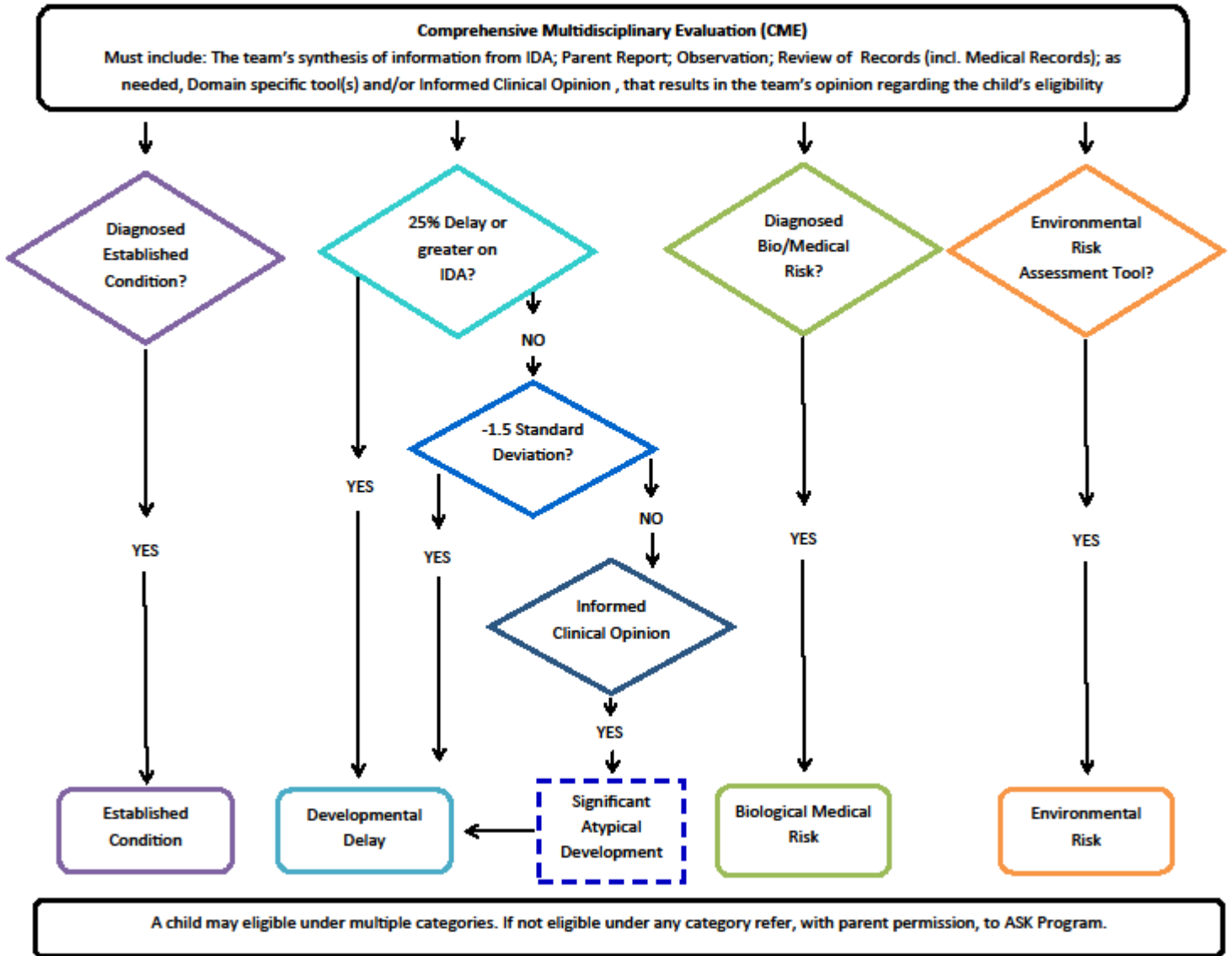
Determining and Documenting Initial Eligibility for the FIT Program

The determination of the child's initial eligibility is a team decision that involves the use of "professional wisdom" that includes the whole team's opinion of the child's development within the context of his or her family and environment. This opinion is based upon the team's synthesis of all relevant information, including:

- a. Medical and other pertinent health information;
- b. Parent information;
- c. Observations of the child;
- d. Results from developmental assessments; and
- e. Environmental Risk Assessment Tool (as appropriate).

Please see the following chart to view the FIT Program Eligibility Determination Process. Specific guidance on how to determine the eligibility category or categories is provided immediately following the chart. Included in the guidance are the specific avenues for determining a developmental delay.

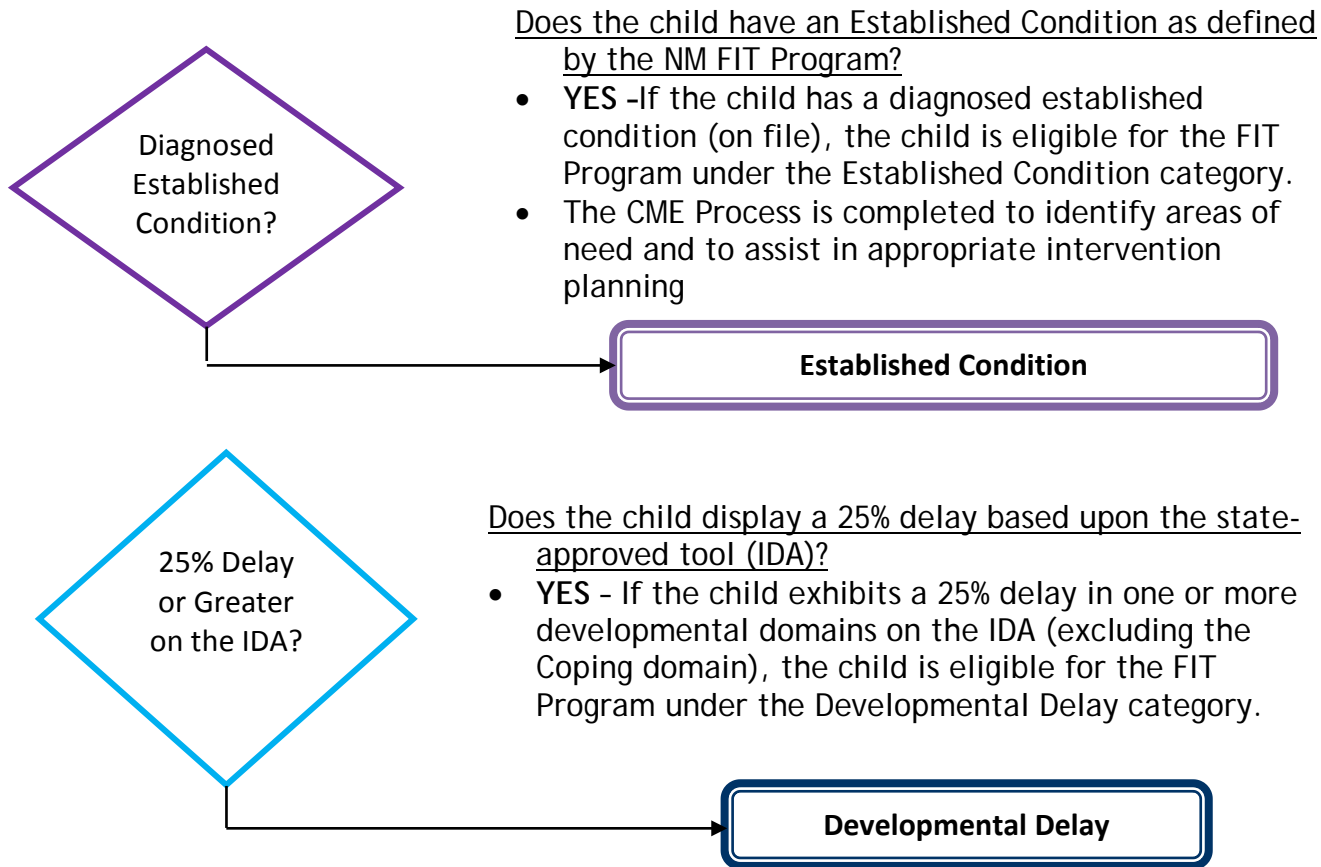
Please note the three discrete layers of the process which may eventually involve determining eligibility for Developmental Delay through the use of Informed Clinical Opinion.



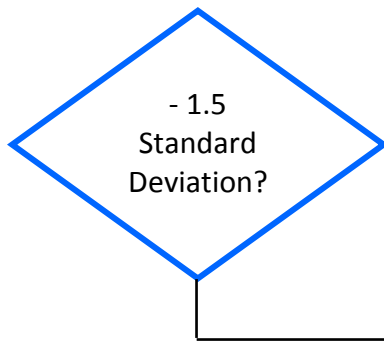
Comprehensive Multidisciplinary Evaluation (CME)

Must include: The team’s synthesis of information from IDA; Parent report; Observation; Review of records (including Medical Records); as needed, Domain-specific tool(s) and/or Informed Clinical Opinion, that results in the team’s opinion regarding the child’s eligibility

The primary focus of the Comprehensive Multidisciplinary Evaluation (CME) is to determine the eligibility status of a child. **All children referred for evaluation to the FIT Program must receive a CME**, with all of its required components - even children who may be eligible based upon a diagnosis in their medical record. If a child has a qualifying diagnosis in his/her medical record, the purpose of the CME is to determine the present levels of functioning for the child (including the presence of possible delays) in all five developmental domains in order to develop the most effective intervention planning and inform the initial ECO ratings.



- **NO, BUT THE TEAM HAS IDENTIFIED CONCERNS THAT THEY BELIEVE ARE SIGNIFICANT ENOUGH TO WARRANT ELIGIBILITY** - If the child does not exhibit a 25% delay in at least one developmental domain but the team has identified additional concerns that warrant further assessment, a domain-specific tool may be used to quantify those concerns. Continue with the following:



Does the child exhibit a -1.5 SD (or greater) on a domain-specific tool?

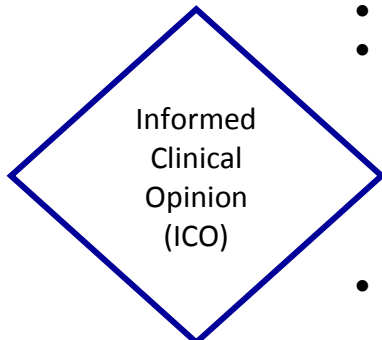
- YES- If the child exhibits a -1.5 SD (or greater) on a domain-specific tool, the child is eligible for the FIT Program under the Developmental Delay category.



- NO, BUT THE TEAM HAS IDENTIFIED CONCERNS THAT THEY BELIEVE ARE SIGNIFICANT ENOUGH TO WARRANT ELIGIBILITY - If the child does not exhibit a -1.5 SD (or greater) on a domain-specific tool, but the team has identified additional concerns that may warrant intervention, continue with the following:

Does the child display skills or behaviors that are considered to be *significantly* different from his or her same-age peers? In order to answer this question, in addition to the information gathered about the child through parent interview, observations, and medical or other pertinent records, the team may consider the following:

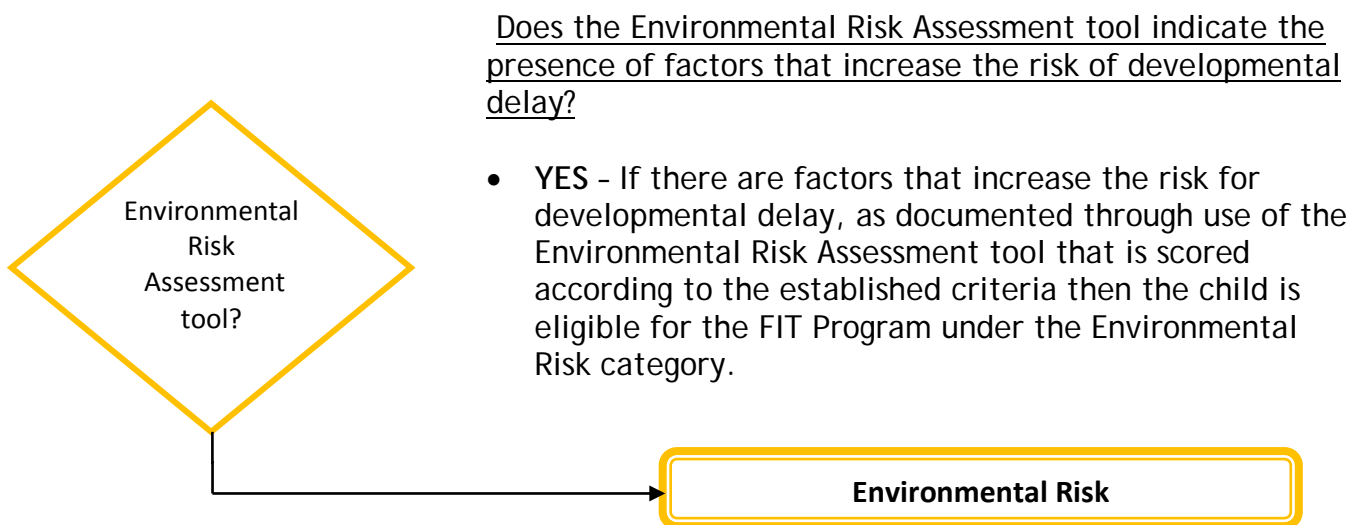
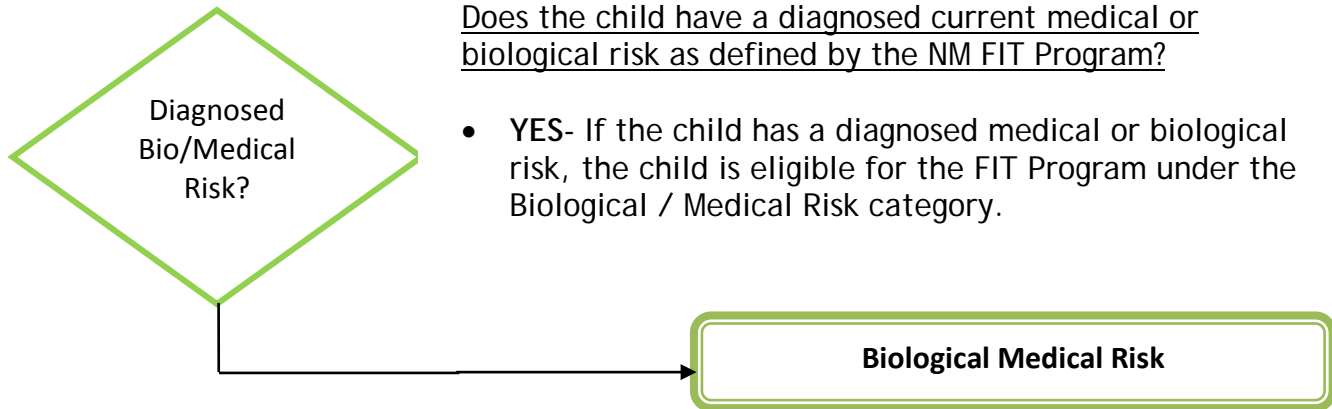
- Does the child utilize his/her skills across environments and with multiple people?
- Are the child's skills qualitatively different than typical same-age peers? AND do those qualitative differences appear to be impacting the child's functioning in daily activities?
- Does the child display skills that are scattered across a wide developmental range and are therefore difficult to measure?
- Does the child exhibit atypical and/or challenging behaviors that are interfering with his ability to complete the assessment and that are also impacting the child's ability to function in daily activities?
- Are there other behaviors that would be considered atypical and/or problematic?



YES- If the child displays skills and/or behaviors that are considered *significantly* different from his or her same-age peers, the evaluation team would use their **Informed Clinical Opinion** to determine that the child displays "Significant Atypical Development" and is eligible for the FIT Program under the Developmental Delay category



Please note: If the child does not meet the qualifications under any of these three options, the child would not be considered eligible with a Developmental Delay. It is possible, however, that the child may still be eligible under one of the other eligibility categories.



If the child is not eligible under any category, refer, with parent consent, to the Ages and Stages for Kids (ASK) Program.

It is possible that a child may not be eligible for the FIT Program under any category of eligibility. In these instances, the parents are notified that their child is not eligible but that they may elect to participate in the Ages & Stages for Kids (ASK) Program in order to monitor their child's developmental progress.

Note: A child may be determined eligible under multiple FIT Program eligibility categories. These must be documented on the IFSP, the ECO Summary Form, and in FIT-KIDS.

Documentation of the Child's Eligibility

The child's initial eligibility is documented in the Comprehensive Multidisciplinary Evaluation report. The CME report documents all the relevant information and procedures used in determining the child's eligibility. The child's initial eligibility is also documented on the IFSP and is typically listed as the date of the evaluation report. If the child is determined eligible for the FIT Program in more than one eligibility category, *all applicable categories must be documented and described in the evaluation report*. This allows the IFSP team to develop the most appropriate intervention plan to address the needs of the child and family.

If the child is eligible under the established condition or medical/biological risk categories, a **copy of the medical record showing the diagnosed condition must be kept in the child's record**. Similarly, if the child is determined eligible under the environmental risk category, a copy of the Environmental Risk Assessment tool must also be kept in the child's record.

Example:

Brittany was diagnosed as having Fetal Alcohol Effect (FAE). Her mother's use of alcohol during pregnancy has been confirmed. Brittany lives with her mother, Yvonne, who continues to binge drink. According to CYFD, the mother typically takes Brittany to her Grandma's during these periods. Last month CYFD substantiated neglect, and placed Brittany with the grandparents who live next door to Yvonne. Brittany was referred to the FIT Program and received an evaluation. The team determined that she had a 25% delay in social and emotional development and some mild delay in her cognitive development. The team used the following as their statement of eligibility:

"Based on the information described in this report, the team has determined that Brittany is eligible for the NM FIT Program under the following categories:

- Developmental Delay of 25% in social-emotional development;
- Biological/Medical Risk due to a diagnosis of Fetal Alcohol Effect (FAE); and
- Environmental Risk based on the results of the Environmental Risk Assessment Tool"

All three categories will be addressed in the CME report in order to design an IFSP to most effectively address Brittany's needs and those of her family.

Documentation of Significant Atypical Development through the Informed Clinical Opinion

IDEA § 303.321(a)(3)(ii) In the "*Discussion*" section states "qualified personnel to use their informed clinical opinion to establish a child's eligibility for early intervention services ... even when other instruments fail to identify or confirm the level of developmental delay." It is because of this stipulation that New Mexico created this process for establishing eligibility.

Informed Clinical Opinion as defined by the NM FIT Program:

Informed clinical opinion refers to the knowledgeable perceptions of caregivers and professionals who use qualitative and quantitative information regarding difficult-to-

measure aspects of a child's development in order to make a decision about the child's eligibility for the FIT Program.

The NM definition of Informed Clinical Opinion was developed by the FIT ICC Eligibility Subcommittee committee, November 30, 2010. It was drawn from two other sources; TRACE Center, 2006 and Jo Shakelford, NECTAC, 2006.

When Informed Clinical Opinion is used to determine eligibility, documentation must be provided to justify the decision. This documentation must provide a description of the child's abilities and areas of concern, including why these abilities differ from typical children of the same age and the manner in which they impact the child's daily activities. In order to determine if the documentation sufficiently describes these areas, a **second level review** and "sign off" on the evaluation report is required within the early intervention agency by someone who is of equal or higher certification or licensure and who was not part of the evaluation team.

In the evaluation report, a written description documents the sources of information gathered and interpreted by the multidisciplinary team that results in the Informed Clinical Opinion of the presence of **Significant Atypical Development** and thus, eligibility for the FIT program.

Example:

Phillip is an 18 month old who was evaluated with the IDA and, due to additional concerns, the PLS-4. The IDA did not indicate a 25% delay and PLS-4 did not indicate a -1.5 SD; however, the team had significant concerns regarding his language use. The team needs to write an eligibility statement that summarizes their Informed Clinical Opinion and demonstrates the Significant Atypical Development that Phillip is displaying:

SAMPLE Informed Clinical Opinion section of the CME report

Informed Clinical Opinion:

Team agrees that child is eligible based on Significant Atypical Development:

Yes No

Statement of informed clinical opinion documenting eligibility, including the use of any other instruments utilized (*Examples: quality of skills; performance of skills; Scatter of scores (including across domains); behavior significantly different for typical peers*): *Phillip displays significant differences in his language and communication skills. Based upon observations, evaluation tool results, and parent report, Phillip uses a combination of words, gestures, and other vocalizations to attempt to get his needs met but most of the words are generally out of context for the situation. For example, when he wanted his mother to give him the car they were playing with, he would say "uh-oh!" and instead of saying "Thank you" when he was handed a desired object, he would say "Bless you!" He was, however, observed using "Bless you!" when someone in the room sneezed. Phillip's overall verbal communication consists of the use of occasional words such as "mama", "dada", "ball", etc. but primarily involves isolated exclamations, usually out of context, to attempt to communicate his needs. This communication shows effort and understanding of the power of words but it is not effective in getting his needs met nor does it align with typical development. As a result, the evaluation team has determined that Phillip is eligible for the NM FIT Program due to "Significant Atypical Development" in the area of communication.*

Second Level Review (if Informed Clinical Opinion is used to determine developmental delay)

I have reviewed the CME and pertinent information, as well as the informed clinical opinion statement of the team, and concur that the child meets eligibility under Significant Atypical Development.

Yes No

Date: 4/12/13 Name: Rebecca Dillard, DS II Signature: *Rebecca Dillard*

In the above situation, determination of developmental delay based on a minimum of 25% delay would not be possible. The multidisciplinary team would use their Informed Clinical Opinion as “to establish eligibility when other instruments do not establish eligibility.” IDEA, 303.321(a)(3)(ii).

Guidance for Second Level Reviewers

In reading and signing off on the report, the **second level reviewer** must be able to:

- ✓ Understand the rationale of the team in looking beyond information obtained through evaluation processes and tools and in moving towards Informed Clinical Opinion, i.e. - why were the other evaluation tools and methods not sufficient in determining eligibility?
- ✓ Identify the evidence that the team used in reaching the decision to use Informed Clinical Opinion; examples of “evidence” include:
 - parent and other caregiver reports of ways in which daily activities are being impacted;
 - professional observations during the evaluation session and perhaps in other settings/situations;
 - description of the child’s abilities and/or behaviors and how they differ from those of a typical same-age peers, etc.
- ✓ Upon review of the evidence, reach the same conclusion as the evaluation team, i.e. that the child exhibits “Significant Atypical Development” that would qualify him under the developmental delay eligibility category.

If the reviewer is not able to do all of the above, the child would not be considered eligible for the FIT Program.

Please Note: Informed Clinical Opinion can only be used as the primary means of determining eligibility for one year, without prior review and approval from the FIT Program.

Documentation of Eligibility Status in FIT-KIDS (Key Information Data System):

The evaluation results for all five developmental domains **MUST** be entered into the FIT-KIDS database. The specific guidance related to this process and its requirements can be found in the FIT-KIDS User Manual on the FIT Program website: www.fitprogram.org

A sample Eligibility Determination Documentation Form is included in Appendix I that can be used to document eligibility and used to get the correct information to the person who enters data into FIT-KIDS. This information can alternatively be included in the CME report so that the person who enters data into FIT-KIDS clearly knows what they must enter.

The Written Evaluation Report

Results of the initial Comprehensive Multidisciplinary Evaluation are documented in a written report that summarizes the findings of the multidisciplinary team. The report is a synthesis of all that has occurred during the CME process and includes a description of the child's functioning in each of the five developmental areas. The report gives a picture of the child's overall functioning and ability to participate in family and community life (see Appendix G for example of an evaluation report).

NOTE: The final report *does not* include specific service recommendations. Decisions regarding what services a child and family will receive are made at the IFSP meeting and are selected to implement the strategies that will be utilized to address IFSP outcomes.

The written report plays an important part in building the relationship between the EI providers and the family. "The written word is powerful. It can memorialize events "in black and white" and has both negative and positive consequences." (Towle, Farrell, & Vitalone-Raccaro, 2008).

Given this fact, the final report should fulfill the following (Derer, Hall & Pederson, 2003):

- Responds to the family's primary concerns, as well as the concerns of the referral source;
- Describes what the child is able to do, as well as what developmental challenges are apparent;
- If statements are made regarding the child's ability/inability to perform specific test items or developmental tasks, the relevance of this information is described in terms of the child's ability to function and quality of the child's performance;
- Is understandable and in language that can be understood by all members of the team. When the use of jargon or technical terminology is necessary, the language is defined so that all team members, including the family, understand;
- Includes a statement of eligibility that documents the category or categories of eligibility and, for the Developmental Delay category, lists the domains and percentages of delay as appropriate;
- Documents the multiple procedures and tools used in conducting the evaluation;
- Includes recommendations about the approaches and strategies to be considered when developing IFSP outcomes; and
- Is signed and dated by the qualified personnel who conducted the evaluation and includes credentials along with signatures.

Evaluation of Infants Under Four Months of Age (Adjusted)

Evaluations of newborn infants and infants less than four months of age (adjusted) require similar processes and procedures for a comprehensive evaluation as do any child who is referred for early intervention services. Namely, that evaluation is multidisciplinary, multidimensional and includes more than one method, is nondiscriminatory, and is timely.

An evaluation of an infant includes the following:

- The family interview;
- Review of pertinent medical records;
- Assessment of strengths, needs, and abilities; and
- Determination of the infant's functioning in all developmental domains; physical and motor, vision and hearing screening, communication, precognition/cognition¹, social and emotional, and adaptive development.



Due to the complex inter-relatedness of development in infants and the relatively few number of items on the IDA Provence Profile, the NM FIT Program requires the use of an additional tool in order to provide more detailed information for the team to consider as part of the Comprehensive Multidisciplinary Evaluation (CME). A number of tools were selected that address the development of infants. Please see the NM FIT Program Service Definitions and Standards at www.fitprogram.org for the current list of approved tools.

There are two discrete processes to follow depending upon the age of the infant:

➤ **Infants Under One Month (Adjusted):**

These are the only children for whom the IDA is NOT required (although the framework that the process provides should still be followed, i.e. synthesizing information from: the Observation of the infant; parent interview; medical records; and observations, etc.). One of the FIT approved tools for infants must be used in order to provide some baseline developmental information. Eligibility under Developmental Delay is determined through use of Informed Clinical Opinion if it appears as though the child is displaying ***Significant Atypical Development***.

Reminder: A full Comprehensive Multidisciplinary Evaluation is still a requirement for all infants under 4 months of age (adjusted).

¹ It is generally recognized that behaviors that can be observed in newborns and young infants cannot be accurately designated as cognitive development. For that reason, the designation of these behaviors as precognitive is used.

- **Infants Between One and Four Months (Adjusted):**
For children in this age range, the IDA is used in combination with one of the FIT approved tools for infants. The use of the approved tools is to provide supplemental information to contribute to the team's discussion about the child's development and, if applicable, to support the team's Informed Clinical Opinion if they believe the child is displaying *Significant Atypical Development*. Eligibility under Developmental Delay can be determined by the IDA process if there is evidence of a 25% delay.

For more information and guidance on describing the developmental status of young infants, please see Appendix B *Recommendations for Presenting Descriptive Information of Infants*

Example for Infants Under One Month of Age (adjusted):

(excerpt of)Adaptive/Self-Help: Thanh is currently term age (40 4/7 weeks gestational age) and is primarily fed by an orogastric tube via bolus gavage feedings. He is nipping formula by bottle, one time per day. Thanh nipped for the first time two and a half weeks ago. His nipping performance is limited by the amount of respiratory support he continues to require secondary to his chronic lung disease. His ability to progress in his nipping skills is limited by his work of breathing and fatigue factors. He exhibited tachypneic (excessively rapid respiration) catch-up breaths following, generally about, 7 sucks. He became significantly fatigued towards the end of a feeding. Thanh's functioning in the area of Adaptive/Behavior was typical in the areas of regulation, responses to environmental stimuli, and sleep/wake cycles. However, his eating skills were significantly atypical for an infant his age.

Summary & Eligibility: Today's assessment results were felt to be an accurate estimate of Thanh's abilities as his observed skills were consistent with skills reported by the nursing staff. Thanh exhibited behaviors typical for an infant his age in the areas of social/emotional, pre-cognitive/communication, and sensorimotor skills. Thanh exhibited significantly atypical skills in the area of Adaptive skills due to a significant delay in his acquisition of eating skills. Thanh should be nipping all of his feedings at this time and is only able to nipple 1 time per day. Based upon Informed Clinical Opinion, the team has determined that Thanh is eligible for Family Infant Toddler (FIT) Program under Developmental Delay due to significantly atypical development in the area of Adaptive/Self-Help skills.

Annual Redetermination of Eligibility for the FIT Program

Eligibility for the NM FIT Program must be redetermined on an annual basis. In order to determine the child's continued eligibility for the NM FIT Program, the multidisciplinary IFSP team must follow the same guidelines for determination of the eligibility category or categories as described for the initial evaluation process.

The team that redetermines eligibility must be comprised of at least two professionals from different disciplines.

Note: A multidisciplinary team of at least two different disciplines is to be used even if there is only one ongoing service on the IFSP. A one-time E&A (Evaluation and Assessment) would be added to the IFSP to have a second discipline participate in the IDA process and the redetermination of eligibility.

If the ongoing IFSP team is comprised of two or more disciplines the team can use current ongoing assessment information combined with use of the IDA process to determine the child's continued eligibility for the NM FIT Program. During a transdisciplinary team consultation meeting, the team will discuss and synthesize the information that has been gathered through each professional's ongoing assessments, including:

- Developmental information obtained through ongoing assessment tools: This information can be used to score the developmental domains in the IDA Provence Profile. Given that the team has worked with the child and family using a transdisciplinary approach for an entire year, there should be very few items from the Provence Profile that would need to be directly administered in order to determine if the child possesses that particular skill;
- Review and updating of the child's health and medical status;
- Information regarding the child's performance in daily living activities, as reported by the parents and other caregivers

If the ongoing IFSP team is comprised of only one discipline, and a second discipline is added for the purpose of conducting the annual redetermination of eligibility, then the team needs to conduct an evaluation session utilizing the IDA. In order to determine the child's continued eligibility for the NM FIT Program, the team will discuss and synthesize the information that has been gathered, including information from the IDA Provence Profile.

The IFSP team, including the parent(s), determines the child's continuing eligibility for the NM FIT Program at each annual IFSP meeting.

The team should consider:

- Does the child continue to meet the eligibility requirements for the category or categories under which he/she was initially determined eligible? (e.g., based on assessment information, does Tiffany still have at least a 25% delay?)
- Is the child now eligible under a different, or additional, eligibility category? (e.g., Nicole was initially eligible under the Established Condition category due to a diagnosis of Down syndrome, but is she now exhibiting a 25% delay in any area of development?).
- For a child eligible under the biological/medical risk category, do those risk factors still exist? (e.g., if Jacob was born prenatally exposed, does that initial condition still pose a risk to his development?). If no, is he still eligible under another eligibility condition?
- If a child was eligible under developmental delay and the child has made enough progress that the level of his delay is now less than 25%, does the

NOTE:

If the child is found to be eligible under a different eligibility category or categories, this should be changed in the FIT database.

Informed Clinical Opinion of the IFSP team indicate that there are still significant differences in his development that would lead them to determine him eligible due to ***Significant Atypical Development?*** *If the team feels that the child is exhibiting significant atypical development and that designation was used previously to qualify the child, the Family Service Coordinator will need to petition the FIT Program to approve the child's continued eligibility utilizing Informed Clinical Opinion.*

Example: Tasha originally qualified for the FIT Program because of a Developmental Delay in Communication. At 19 months old she had no words and very few gestures, therefore she qualified with a greater than 25% delay on the Provence Profile as part of the IDA process. Now, at 31 months, she has made good progress in her communication skills and at her annual redetermination of eligibility, the IDA did not result in a 25% delay. However, the team has great concerns regarding her lack of expressive language (which can NOT be scored separately from the receptive communication skills using the Provence Profile). The team made the decision to utilize the PLS-4 which yielded a score somewhere between -1 and -2 SD's. The team noted that Tasha was able to answer YES or NO questions, used word approximations to request items or to get someone's attention, however, it was very difficult for the evaluators to understand what she was attempting to say and even mom reported difficulty understanding her at times. Tasha seemed to get frustrated when she was not understood and would occasionally throw tantrums or cease trying to communicate. Based upon Tasha's general lack of expressive language, especially as compared to typical same-age peers, and the impact of her failed communicative efforts on her behavior and desire to interact in a social manner, the team used Informed Clinical Opinion and determined that Tasha was still eligible for the FIT Program due to ***Significant Atypical Development*** in expressive communication.

A statement regarding the redetermination of eligibility is documented on the IDA Record - Summary Paragraph (page 14), as well as on the IFSP. If Informed Clinical Opinion is used to redetermine eligibility, this will need to be justified in a brief narrative report that includes the 2nd level approval. The team may wish to utilize the sample Eligibility Determination Form (see Appendix I).

If the team, including the family, determines that the child is no longer eligible for the NM FIT Program, the fact that the child no longer needs early intervention services should be celebrated!

If it is determined that the child is no longer eligible, the Family Service Coordinator should help the family access other community supports and services (e.g., parent and toddler groups, child care, etc.) as needed. The team may also give the family information on child development, including the option of enrolling in the Ages and Stages for Kids (ASK) Program in order for the parent to receive developmental screening in the mail or online in order to monitor their child's development, and encourage the parent to contact them if they have any future concerns.

At the time of redetermining eligibility, the team will develop next steps and recommendations for the annual IFSP and gather data for the annual ECO form.

Ongoing Authentic Assessment

Ongoing assessment is a process that is *authentic and functional*. Authentic in that information is collected over time including observations of the child and use of a tool to gather information about the child's development in a variety of settings, and *functional* in that it considers the various activities and routines in which the child interacts with their family and other caregivers.

IFSP teams use ongoing authentic assessment information to:

- Support the development of functional IFSP outcomes;
- Design and amend if necessary strategies to effectively address IFSP outcomes;
- Determine the expertise needed to implement the strategies and who on the team has the needed expertise;
- Track the child's developmental progress, including progress toward IFSP outcomes; evaluate the effectiveness of the strategies, supports and services so that changes can be made as soon as it is evident that the expected progress is not being made;
- Provide data to inform subsequent ECO ratings;
- Provide the information needed for ongoing eligibility determination (see the Redetermination of Eligibility Section); and
- Provide the information needed for transition planning including informing eligibility under IDEA Part B.

The logo for Early Childhood Outcomes (ECO) consists of the letters 'ECO' in a bold, blue, sans-serif font. The letters are slightly overlapping and have a white outline.

Note:

Ongoing authentic assessment information is used to assist the IFSP team in determining a child's developmental status compared to typical development for their age, in order to document their Early Childhood Outcomes (ECO) score

Ongoing authentic assessment includes a variety of methods and procedures including family and/or caregiver reports, observations of the child in everyday routines and activities, use of assessment tools and/or curricula, and "professional wisdom".

Ongoing assessment includes:

1. **Reviewing, with the family, their child's unique strengths and needs** related to his or her participation in family and community life. This typically occurs as part of every intervention visit.
2. **Reviewing and modifying, with families, the supports and services** that will promote a child's participation in family-selected activity settings;
3. **Observations** of a child engaged in specific tasks and activities in familiar contexts with familiar people. Observation provides valuable information about:
 - The nature of the relationships that the child has with familiar care givers
 - How a child *participates* in a specific activity setting;

- Developmental skills/behavior a child *spontaneously* uses during a specific activity or task;
- Which emerging behaviors and skills can be *prompted*;
- *How* a child communicates, interacts, problem solves, plays, cares for self and moves within a specific activity setting;
- What *compensatory strategies* a child uses in a specific activity setting, how effective they are, and how adults/peers can use other prompts to enhance a child's participation in these settings;
- Behaviors which *interfere* with a child's participation in a particular task or activity setting;
- How a child's participation improves by changing or modifying the *tasks, environment, materials/resources, and interaction with others*; and
- What interest motivates a child to engage in and persist with an activity.



4. *Results of criterion-referenced/curriculum-based tools* used by the transdisciplinary team for ongoing assessment and intervention activities combined with observation of the child.

"The process of evaluation/assessment should always be viewed as the first step in a potential *intervention* process." (Meisels & Fenichel, 1996, p.22)

How Does the Assessment Inform Supports and Services?

Assessment provides functional developmental information. This type of information helps all team members understand how the child's developmental strengths support him/her to participate effectively in everyday routines, activities, and places. Functional developmental information also helps team members understand what developmental challenges might be interfering with the child's ability to participate effectively in family and community life.

Functional assessment information provides "baselines" against which progress can be measured. The goal of the NM FIT Program is to support children to participate in the everyday routines, activities, and places that are important to them and their families. Research demonstrates that the child's developmental capacities increase as he/she is supported in meaningful participation. The team observes and documents the developmental skills and behaviors that support the child's effective participation, as well as the factors that interfere with participation. Through this process, the team becomes informed of the skills and behaviors that can be used to build on the child's capacities in order to address skills and behaviors that need to be targeted for improvement. Improvement is effectively measured when the team knows what the child's initial skills and behaviors look like.

Ongoing assessment information leads to systematic and well thought out intervention strategies. Identifying the child's current abilities, strengths and needs, including his/her interests and challenges, his/her everyday routines and activities, the family's resources and priorities, and defining the desired outcomes provides the framework of the intervention plan. Ongoing assessment information allows the team to develop the "blueprint" that will guide their interventions.

Ongoing assessment information tells us whether or not interventions are working to help make progress toward the outcomes on the IFSP (and the Early Childhood Outcomes). Each IFSP outcome must include a statement of how the team will know that progress is being made as expected. Ongoing assessment helps track the child's progress and decide if/when strategies might need to be changed. Intervention teams should *expect progress* for every child. If expected progress is not being made, the outcomes and/or strategies need to be looked at and revised.



An Authentic Assessment Approach to Ongoing Assessment

In utilizing the components of ongoing assessment, IFSP teams are able to lay out the plan for thoughtful and systematic interventions and strategies.

“Authentic assessment is a deliberate plan for investigating the natural behavior of children. Information is captured through direct observation and recordings, interviews, rating scales, and observed samples of the natural or facilitated play and daily living skills of children.” (Bagnato, 2007, pp.27-28)

“Authentic Assessment for Early Childhood Intervention: Best Practices” (Bagnato, 2007), offers the following guidelines for implementing authentic assessment practices:

- **Share assessment responsibilities with a team-** Understanding a child's developmental capacities relies upon the perspectives of multiple individuals, most especially those closest to the child - the family and other caregivers. Early intervention personnel must share the responsibility for ongoing assessment with a TEAM.

Example:

Developmental Specialist: *I notice Lester is getting into what we call a “half-kneeling” position. When children can get into that position easily, they usually find it easy to pull to stand at furniture.*

Childcare Teacher: *You know he's been doing that half kneel for the past couple of days. Yesterday he even pulled up to stand from that position a couple of times. Then he plopped right back down onto his bottom again.* Developmental Specialist: *I wonder what games Lester could play to help him practice this more often?*

Childcare Teacher: *Maybe we could play some games with his favorite cars and have other children join in and make it more fun for Lester.*

- **Conduct assessment over time-** Ongoing assessment occurs throughout the child's participation in early intervention. It occurs informally each time early intervention providers interact with a child and family, and formally when a family's IFSP is reviewed with them periodically (at minimum every 6 months), at annual intervals, and during the transition process.
- **Become the “orchestrator” of authentic assessments across people, contexts, and occasions** -The lead early intervention personnel should inform other team members of assessment options and opportunities. By using the Routines-Based Interview process,

families and other team members identify the routines, such as meal time, family outings, play time, etc., with which the family would like assistance. These routines become the basis for potential IFSP outcomes, inform the initial and ongoing assessment processes, and provide the framework for functional intervention planning.

- **Match the team assessment to the child-** Use of a transdisciplinary team approach offers the opportunity to tailor ongoing assessments to more effectively address child and family needs and preferences. Teams can choose who is most appropriate to assess which areas of functioning and development as needed.
- **Rely on parent opinions and observations** -Primary caregivers are important sources of ongoing assessment information. Early Intervention personnel need to know what skills and behaviors the child typically uses in everyday routines and activities in order to assess mastery of those skills. In order to capture the intervention that occurs between home visits or intervention sessions, contact logs or home visit notes can be used to document parent/caregiver observations regarding the child's skills and behaviors
- **Select a common instrument to promote transdisciplinary team approach-** The Division of Early Childhood (DEC) of the Council for Exceptional Children, recommends the use of curriculum-based tools. Most of these tools provide developmental information in an organized, easy to follow format that can guide and inform intervention techniques in addition to tracking progress in formats friendly to both families and professionals.
- **Employ jargon-free materials** -With or without the direct use of an ongoing assessment tool, observations should occur with the parent/caregiver so that what is being observed can be interpreted and conclusions about the child's progress can be shared in easy-to-understand, culturally appropriate, and family-friendly language.
- **Use sensitive instruments to gauge child progress** - Assessment tools should be chosen based upon which is the most appropriate to provide information regarding the child's progress, even if that progress is difficult to measure.
- **Use technology to facilitate authentic assessments and progress or program evaluations** - Brief videotaped clips of the child participating in a typical routine or activity taken periodically can also be helpful in contributing to ongoing assessment information. Brief 5-10 minute clips of a child playing with his parent or another child, taken every 3-4 months provides a valuable source of information about the child's developmental skills over time and across developmental areas. Reviewing these videotapes with the parent right after they are filmed provides a great opening for conversations about the child's progress, and the parents' perceptions/concerns if any. Notes about these conversations and observations can be documented in the home visit or contact log and reviewed before an IFSP review to note patterns in development, changes in skills and interests, and effectiveness of intervention strategies.

Examples of ongoing assessment tools that have been approved by the NM FIT program for use with ECO include the following:

- AEPS
- HELP
- Ounce

Evaluation and Assessment Information for Transitioning to Preschool



Children are required to transition out of early intervention at the time of their third birthday, often to a preschool setting.

To ensure developmental information to the school district for children who may be eligible for Part B preschool services, the Transition Assessment Summary form is sent, with parental consent, at least 30 days prior to the Transition Conference. This summary includes current evaluation and assessment information. IFSP teams are encouraged to meet to complete the Transition Assessment Summary form together. As a team, they can use the IDA process to analyze and organize current ongoing assessment information about the child's skills and areas of need in order to more accurately complete the Transition Assessment Summary form. This

process would mirror the process used for the annual redetermination of eligibility. The information provided by the IFSP team can be used to assist in the determination of eligibility for Part B services therefore specific, detailed information regarding the child's functioning and identified areas of need should be included on the Transition Assessment Summary form. This information should also include any applicable percentages of delay.

Developmental Delay for FIT is defined as 25% delay or -1.5 standard deviations. However, Developmental Delay for Part B is defined as a two-pronged process, in that a child must be two standard deviations or 30% delay below chronological age AND demonstrate an educational need for special education services.

At the transition conference, the team, which includes the parents, decides whether there is enough information to determine the child's eligibility for IDEA Part B or whether additional assessment information is needed.

For children who are not being referred to Part B, current assessment information can assist the IFSP team in deciding upon next steps and appropriate preschool options, including the need for any follow up support, during the transition conference.

NOTE: Table 5 on page 50 of the IDA Administration Manual provides teams with the ability to calculate additional percentages of delay, including the 30% that is needed by the Public Education Department to qualify a child for IDEA Part B.

Appendix A: Key Principles of the IDA Process in New Mexico

In order to determine both initial and ongoing eligibility for the NM FIT Program, use of the IDA is required. Implementing the IDA with integrity is the goal for all FIT provider agencies and requires that agencies and all evaluation staff embrace the following key principles of the IDA process.

The IDA:

- I. Is an *integrated system of assessment* that is designed to describe the story of who the child is in the context of her health and the context of the family.
- II. Requires that practitioners have a *thorough understanding of infant toddler development*.
- III. Utilizes a transdisciplinary approach. *All* practitioners act as both a generalist and expert, with a particular knowledge base, to observe and assess *all developmental domains* within the evaluation process.
- IV. Is a system of assessment rather than a test that is scored. Information from all six phases, including the Provence Profile (which *is* scored), are *integrated and synthesized* to develop a more complete picture of the child.
- V. Is designed to be *implemented by a team* who informs one another of information that has been gathered, who are present together for the evaluation, and who discuss their findings together in order view the developmental domains, and the child, as a whole.

The NM FIT Program, in adhering to the framework of the IDA process, expects that a child's eligibility determination through IDA will involve more than a team's review of the "score" from the Provence Profile. Rather, eligibility for the FIT Program should be based upon the team's understanding of the significance of those "scores" in relation to the child's current home environment, family relationships, and health status. If there are contributing factors that result in a "score" that is not substantiated by the evidence, the team is required to use their professional wisdom to make a determination regarding whether or not a delay truly exists.

Appendix B: Evaluation of Infants

Each infant has his own unique behavioral and developmental story to tell, a story that speaks to his/her needs, wants, and developmental abilities and challenges. The goal, as early interventionists, is to observe, assess, and interpret this story within the framework of development (Greenspan & Meisels, 1996). The following are recommended strategies needed to accomplish this:

- Obtain a picture of the infant within the family experience;
- Obtain a developmental history along with a medical history and understanding of the infant's current health status;
- Observe the infant playing or interacting with parents or caregivers;
- Observe the infant interacting with early intervention staff;
- Make specific assessments of the infant's individual developmental functioning; and
- Integrate the information gained from observation, family interview, and all other assessments using informed clinical opinion.

Using a multidimensional, multidisciplinary approach to infant evaluation underscores the concept that all areas of development are inextricably linked, and that one domain affects all domains. Specific measurement of developmental functioning using "conventional" assessment tools provide limited information of an infant's developmental progress, and may not provide information about an infant's developmental functioning necessary to formulate an IFSP and effective interventions.

Recommendations for Presenting Descriptive Information of Infants²

Describing infants' developmental functioning in the five developmental domains as required by the NM FIT Program presents challenges to early intervention personnel, particularly when assessing infants younger than four months of age. Given the complexity of development and physiological/neurobiological organization along with the emerging capacities of infants, traditional descriptions based on developmental milestones or formal quantitative assessment are generally not used.

Listed below are suggested ways to categorize and integrate information gathered from the multiple procedures used for evaluation. **Please note that every listed behavior does not have to be described, nor are these descriptions exhaustive of all behaviors and observations.** The following is meant to serve as a guideline as to how an observed behavior may be recorded and described.

² *Adapted from* Developmental Care Program, University of New Mexico, Department of Pediatrics/Division of Neonatology

Newborn Assessment - Birth to 1 Month (Adjusted)

Physical/Physiological Development:

- Description of medical history and health status based on the physician's physical exam;
- Description of the results of vision examination and of the newborn hearing screening examination;
- Physiological stability and autonomic functioning, for example hiccupping, color, respiratory rate, etc.;
- Growth parameters including length, weight, and head circumference;
- Listing of medications the infant may be taking or vaccinations received; and
- Dietary and nutrition requirements and/or recommendations from the medical provider.

Motor/Sensorimotor Development:

- Muscle tone;
- Posture when resting;
- Movement-quality and control;
- Symmetry of movement, posture, and muscle tone;
- Strength and endurance of movement; and
- Awareness, acceptance, and tolerance of sensory experiences, including movement, touch, taste, and smells.

Communication/Precognitive Development:

- Approach and avoidance behaviors;
- Vocalizations-type and frequency; and
- Ability to alert to, localize, and focus upon visual and auditory stimuli.

Social and Emotional Development:

- Responsiveness to others, emotional availability;
- Family-infant interactions;
- Temperament; and
- Responsiveness to other's efforts to console.

Adaptive/Self-help Development:

- Feeding, oral motor activity (including ability to suck or nipple), coordination of sucking, swallowing, and breathing;
- Sleep/wake cycles;
- Self regulation, ability to self-calm or self-console;
- Habituation to stimuli; and
- Infant states of Consciousness including: range, clarity, and state modulation; transition from one state to another and quality of states, particularly alertness.

Additional Assessment for Infants Aged 1-6 months

In addition to the observations and description of physical and motor, communication/precognitive development and adaptive/self-help development listed above, describe:

Motor/Sensorimotor Development:

- For infants from 1 - 6 months of age include: fine and gross motor developmental functioning

Social and Emotional Development:

- Attention;
- Distractibility;
- Frustration tolerance;
- Persistence;
- Negative/positive affect;
- Responsiveness to others, emotional availability;
- Family-infant interaction;
- Temperament;
- Responsiveness to other's efforts to console; and
- Approach and avoidance behaviors.

Adaptive/Self-help Development:

- Note that habituation to stimuli and state behaviors may no longer apply.

Appendix C: Social and Emotional Assessment

Identification of social and emotional concerns is part of both the initial evaluation and ongoing assessment processes. An appropriate assessment provides the information that is needed to determine the need for supports and services, the need for further assessment, and/or the need for referral for additional services. An assessment of a child's social and emotional development requires the integration of information from multiple sources or procedures in multiple settings and may include obtaining information in the following areas:

- The child's overall developmental functioning within the context of the family;
- The child-family relationships, cultural values and beliefs;
- Family concerns regarding the child's feelings and behaviors;
- Family resources, such as extended family and other natural supports;
- Family factors, such as adjustment to parenthood, economic constraints, history of mental health and/or substance abuse, etc.;
- Observations of a child's ability to regulate their emotional state and behavior (self-regulation); and
- Environmental or community stressors such as community violence, multiple foster placements, Child Protective Services (CPS) involvement.

Infant Mental Health Evaluation and Potential Treatment:

Increasingly, Infant Mental Health (IMH) being an interdisciplinary field concerned with maximizing the social and emotional well-being of infants and young children (birth to age 3 years) and their caregivers; and relationship-based practices are being incorporated into all early intervention strategies. The continuum of IMH practices includes: the use of specialized IMH consultations and evaluations to assist in the assessment of social and emotional development. These evaluations are essential when there is an awareness that infants and toddlers have been (or are currently) exposed to significant stressors or trauma, such as family violence, abuse, parental substance abuse, losses due to incarceration or death, or infants/toddlers living with multiple caregivers or in foster homes. The complexity of these difficulties and their impact on young children and their caregivers can often result in developmental delays, difficult or challenging behaviors, caregiver-child relationship difficulties, and/or the development of emotional disorders.

Thus, there are situations where seeking additional and more specialized evaluation and potential treatment around a child's social and emotional development, behavioral issues, and the caregiver-child relationship is appropriate. It is important to consider that when concerns about the child-caregiver relationship are present, they may affect the manner in which early intervention supports and services are delivered.

Early intervention providers may choose to utilize the services of an infant mental health practitioner to evaluate the parent-child relationship and potentially provide treatment for certain young children and their caregivers. Recommendations will be made based upon the results of the evaluation. These recommendations may include specific strategies and approaches for early intervention staff to utilize within their work or they may include a

referral for infant mental health treatment to address issues within the child-caregiver relationship and to provide the most effective support for enhancing that relationship. In these cases, it would be appropriate to make a referral to a qualified infant mental health treatment specialist. As a general rule, an infant mental health treatment practitioner's primary focus will be on the relationship between the child and the caregiver. Another qualification to note would be endorsement through the New Mexico Association for Infant Mental Health at the Infant Mental Health Specialist level (L3) or Infant Mental Health Mentor - Clinical level (L4).

It is possible that these personnel may be staff or contractors of the early intervention program or the program may need to seek such services from an outside infant mental health specialist. For a listing of Infant Mental Health Specialists in New Mexico, please see the New Mexico Infant Mental Health Association's website: <http://nmaimh.org/training.php>

Examples of When You Might Make an IMH Referral:

- Kevin, a 15 month-old boy with very low muscle tone, spends most of his time in a baby seat. He screams every time his mother leaves the room and is extremely wary of new people. His mother is concerned about his "separation anxiety" and that she thinks he is getting "low self esteem" because he cannot walk like his 12-month-old cousin. A physical therapist provides services in the home. Mom has a history of significant mental illness and prior psychiatric hospitalizations; she is followed by a psychiatrist and takes several psychiatric medications. She has an older child who is in state custody. The service coordinator is concerned that mom does not interact with Kevin much, keeps him seated most of the day, and that she has refused more visits with the PT. In the home, the apartment curtains are always drawn and the rooms are kept dark.
- Angel is an 18 month-old girl who has lived since birth with her maternal aunt and uncle who would like to adopt her. She recently began supervised visitation with her birth mother who had been incarcerated, but is now seeking to regain custody. Angel screams and cries when left for her visits, which is very upsetting for her aunt. Since the visits began, Angel has been pinching, hitting herself and others, and banging her head on the hardwood floor. Her aunt and uncle are at a loss as to how to address these behaviors.
- Carlos is an almost 3 year-old boy who recently ran into the parking lot at his child care center before staff could catch him. In the classroom he regularly hits and pushes other children and has difficulty staying still. He is in his third foster placement because he is so "hard to handle" and "aggressive." Carlos was prenatally exposed to cocaine and methamphetamine; he was removed from his birth parent's care at 16 months due to neglect. His current foster mother is dedicated to him and would like help to manage his behaviors. She wonders if he has "ADD." Carlos will likely be placed up for adoption soon and how long his current foster mother will be his caregiver is unclear.

Appendix D: Screening to Determine Current Vision and Hearing Status

Vision and hearing are integral to overall development. An accurate understanding of the status of a child's vision and hearing is necessary when determining his/her developmental status. This provides information that assists in the assessment of a child's developmental abilities in areas such as communication, cognition, gross/fine motor, social or emotional, and adaptive behavior. Further, vision and hearing screening help early intervention personnel and parents identify which children need additional assessment by professionals who specialize in these areas of development.

Vision Screening: The New Mexico FIT program requires that every child entering the Family Infant Toddler Program receive a vision screening and include the results in the CME report and in the Present Abilities, Strengths, and Needs section of the IFSP. The New Mexico Vision Screening Tool was designed by the New Mexico School for the Blind and Visually Impaired to support early intervention personnel and to help programs have a consistent method of screening vision for children in New Mexico. This tool should be used in identifying which children need to be seen by a pediatric ophthalmologist (for possible medical diagnosis and treatment), and/or a vision specialist (for a functional vision assessment to determine the impact of the child's vision issues on development and learning and the need for ongoing vision services). If a child has a current eye report with diagnosis, this information can be used in the CME report and in the IFSP instead of the results of the Vision Screening Tool. However, the team should still consider how the child is using his vision functionally for learning and to determine if a referral needs to be made to NMSBVI for a functional vision evaluation. Additionally, if the child has a diagnosis from an eye doctor, it is important to confirm whether the child needs a vision specialist to address function and impact on learning. Use of the Vision Screening Tool can assist early intervention personnel in determining if there are other concerns regarding the child's vision that would require additional and specialized support. The NMSBVI Vision Screening Tool itself can be found on the FIT Program website under "Forms" www.fitprogram.org and also on the NMSBVI website under "Infant Toddler Resources": www.nmsbvi.k12.nm.us

Universal Newborn Hearing Screening: Every infant born in NM is required to receive a hearing screening at birth. The documented results of this screening are required to be included in the child's medical records and are valid for up to six months following the date of the screening. If the newborn screening categorized the child as "referred," there may also be documentation in the child's medical record of follow up by an audiologist.

- If a referred child did not receive the necessary follow up by an audiologist, this activity occurs with the support of the Service Coordinator and the consent of the parent/guardian as a part of the initial evaluation process. Please call the New Mexico School for the Deaf's (NMSD) Early Intervention and Involvement Program (505-476-6402) if you need assistance in finding audiological supports in your area.

- If the child “passed” the newborn screening less than six months ago, the evaluation and IFSP teams can state, “Newborn hearing screening conducted on (date) indicated no concerns with hearing.”
- If the hearing screening or audiological follow-up occurred more than six months prior to the referral to the NM FIT Program, hearing must be re-screened.
- If the child has an identified hearing loss, please make sure the child and family are referred to NMSD’s EI services (505-476-6402).

NOTE: “Parent reports no concerns about hearing” or “No indication of hearing concerns in medical records” is NOT sufficient documentation of the child’s current hearing status.

Infant-Toddler Hearing Screening: All NM FIT Program agencies use a hearing screening protocol that includes an Otoacoustic Emissions (OAE) instrument in conjunction with a tympanometer to screen all children who, upon referral to the FIT Program, have not had their hearing screened or assessed within the previous six months. Again, this screening is a required component of the CME process.

- Children who demonstrate positive findings as a result of this screening are referred to an audiologist for further assessment.
- A summary of the results of the hearing screening and any follow up information is included in the evaluation report. IFSP teams should also include this information in the Present Abilities, Strengths, and Needs section of the IFSP.
- If agencies are having difficulty in obtaining reliable readings on a specific child or need additional training on the equipment, they may call NMSD’s EI Program for support (505-476-6402).

Risk Factors/Possible Indicators of Hearing Loss

Aside from the initial hearing screen prior to receiving FIT services, other factors may necessitate the continued monitoring of a child's hearing health.

Family History

- Family History of Hearing Loss

Mother's Gestational Health

- Toxoplasmosis
- Herpes1
- Syphilis
- CMV
- Gestational Diabetes

Birth History

- Prematurity
- In Newborn Intensive Care Unit for 3 or more days
- Birth weight less than 3.3 pounds
- Jaundice with exchange blood transfusion
- Cleft lip and/or palate
- Head trauma due to vacuum extraction/forceps delivery
- Ototoxic antibiotics (e.g., gentamycin, etc.)
- Ventilator support for 5 days or more

Child's Health

- Recent (in the past 3 months) or current ear pain
- Recent (in the past 3 months) or current ear drainage
- Ear infections during the first year of life
- Three or more ear infections in a calendar year
- Middle ear fluid remains after ear infection cleared
- Frequent respiratory problems (e.g., bronchial congestion, nasal congestion, asthma, colds)
- Ear ventilation tubes

Syndromes Associated with Hearing Loss

- Down Syndrome
- Usher Syndrome
- Waardenburg
- Jervell Lange-Neilsen Syndrome
- Goldenhar Syndrome (also known as Oculo-Auriculo-Vertebral Syndrome or OAV)
- Treacher-Colins Syndrome
- Stickler Syndrome
- Stickler Syndrome with Pierre-Robin Sequence
- Marshall Syndrome
- Pendred Syndrome
- Fetal Alcohol Syndrome (FAS)
- Enlarged Vestibular Aqueduct Syndrome
- Hunter Syndrome
- Kearns-Sayre Syndrome

Conditions Associated with Hearing Loss

- Bacterial Meningitis
- CHARGE Association
- Osteogenesis Imperfecta
- Neurofibromatosis Type II (NF2)
- Lebers Hereditary Optic Neuropathy
- Maternally Inherited Diabetes Mellitus & Deafness
- Kidney malformation
- Vision impairment

Parent/Caregiver has concern(s) regarding hearing, communication, language or speech which may include observations of their child such as:

- Responds inconsistently to sounds (i.e., does not respond most of the time, especially when sounds are behind or far away from him/her)
- Not awakened by loud sounds
- Responds inconsistently to talking (i.e., does not respond most of the time)
- Frequently wants the TV or radio to be turned up louder than comfortable for others
- Speech is hard to understand or delayed
- Seems louder than other children

Appendix E: When to Seek a Diagnostic Evaluation

A diagnostic evaluation is highly specialized, must be administered by trained professionals (Losardo & Notari-Syverson, 2011) and use diagnostic tools that are usually norm-referenced. The diagnostic teams may include professionals such as physicians and psychologists who are qualified to make a diagnosis. A diagnostic evaluation may be obtained through a medical facility/clinic or a specialized program designed for the purpose of conducting diagnostic developmental evaluations.

In New Mexico, the Early Childhood Evaluation Program (ECEP) at the University of New Mexico Center for Development & Disability is funded through the NM FIT Program, the Public Education Department and Medicaid. Services are available to children and their families for comprehensive developmental evaluations. The team provides services throughout the state seeing children and families at the CDD in Albuquerque or by traveling to NM communities. These evaluations are interdisciplinary and address the unique needs of families. An evaluation by ECEP is recommended when:

- The child's medical and/or developmental condition(s) are sufficiently complex or unusual that an interdisciplinary, comprehensive evaluation is warranted;
- A collaborative evaluation between ECEP and a community-based agency is warranted to learn more about an unusual or complex medical or developmental condition as part of ECEP's mission is to increase the capacity of community-based agencies;
- The family requests a second opinion and ECEP is the most appropriate agency to provide that opinion; or
- The family and community-based agency are questioning whether the child has a diagnosis of Autism Spectrum Disorder, some other complex developmental disorder, condition, or syndrome requiring diagnosis by a physician.

Please note that referrals to ECEP should be made before the child's third birthday. When the child is close to age three, it is preferable that referrals are received at least 90 days or more before the third birthday in order to prepare for transition.

The intent of ECEP is to provide evaluation services in collaboration with the local early intervention personnel and the family. Evaluations are individualized and guided by the specific concerns of the family and community-based program. Evaluations are comprehensive and are typically provided by a medical doctor with specialized knowledge regarding developmental delays and disabilities, a psychologist, an occupational or physical therapist, and a speech and language pathologist.

For more information please contact ECEP at:
Phone: (505) 272-9846 or toll free: 1-800-337-6076
Fax: (505) 272-0386
E-mail: ECEP@salud.unm.edu
Website: <http://www.cdd.unm.edu/ecspd/ECEP>

Appendix F: Environmental Risk Assessment Tool - Considerations for Reporting

Nature and Purpose of the Tool:

The purpose of the FIT Program Environmental Risk Assessment tool is to assess the extent and range of vulnerability in the child's family system in order to make a determination of eligibility for early intervention services due to environmental risk. The tool is designed to encourage current and new FIT providers to consider the "at environmental risk for developmental delay" category when determining eligibility for children birth to three for early intervention services. The assessment may also be used for making treatment planning and referral decisions for infants and toddlers living with multiple environmental or social stressors once eligibility has been determined. The Environmental Risk Assessment tool must be used in order to make a child eligible under the environmental risk category.

Tool Overview:

The Environmental Risk Assessment includes 12 parent, family, and social variables that place a young child at risk for later developmental delay and 4 categories related to "Primary Caregiver Disposition." These four categories are of particular value to programs who receive referrals under the revised Child Abuse Prevention & Treatment Act (CAPTA) regulations (i.e., children under the age of three who have a substantiated child abuse/neglect report are to be referred to an early intervention program, such as the FIT Program). An "other" section is included in the tool to accommodate unique or less common risk factors that place the child at significant risk for developmental delay, and may include factors not considered by caregivers but observed/assessed through clinical judgment.

Administration of the Tool:

It is recommended that the ERA tool be administered through a combined process of reviewing medical and other records, clinical observation and caregiver interview by an interdisciplinary team. It does not have to be completed in one interview. In fact, because of the sensitive nature of some of the items, the assessment may take several visits in order to develop a rapport with the family.

The tool is arranged to take advantage of previously documented information about the child and family structure that can be accessed through reviewing medical and other records and/or a FIT program's intake interview. Clinical observations of the child and of the quality of the child caregiver interaction are necessary to complete this tool. Home environment factors can be scored either through clinical observation of the home or through the administration of a set of structured questions. Factors that cannot be assessed through review of records are assessed through caregiver interview and

It is recommended that a conversational interviewing style of open-ended reflective questions be used to obtain the information covered on the Environmental Risk Assessment instrument. For example, "What was school like for you?" or "Who do you go to when you need some support with the kids?"

observation. Information may also be gathered through an interview with the Children Youth & Families Department -Child Protective Services - Case Worker.

For the purpose of determining a child's eligibility for services, it is not necessary to score every item on the risk assessment, and information offered by family members should be treated with respect and sensitivity. *Although it is possible to determine eligibility by scoring a few of the 17 items on the assessment, a complete assessment is clinically useful to facilitate the development of family outcomes on the IFSP.*

Reporting on the Results of the Tool:

Given the sensitive nature of the information about a family that is considered through use of the Environmental Risk Assessment Tool, it is best practice NOT to explicitly discuss the details of the child's eligibility within the context of the report. The tool itself is to be kept in the child's record and will be available to team members who may need to know about the details of the child's particular situation. However, evaluation reports are written for a wider audience, and as such, should discuss the child's overall eligibility under Environmental Risk from a general perspective. Information that describes the child's health and/or physiological status WOULD be included in the report but specific information regarding other family members and the ways in which they may have contributed to the child being in that state do not need to be included in the report itself.

Example: Two year-old Tommy was referred, with his mother's consent, by his child care teacher because of concerns regarding his behavior. The evaluation team did not note any developmental delays and he did not have any history of established conditions or medical/biological risk factors. However, his mother is only 17 years old and dropped out of high school about 4 months ago. There is no contact with the father and she has no other partners. Her parents kicked her out of the house when she dropped out of school and since then she has lived with multiple "friends" and a cousin, none of whom are very supportive. She is not a member of any community organization or group. She has recently started a new job as a waitress and would like to be able to have an apartment of her own soon. Based upon the above information, the ERA Tool would "score" as follows: (1) the lack of supportive resources rates a High; (2) mom dropping out of school rates a Medium; and (3) mom's age at Tommy's birth (approximately 15 years old) rates a High. This child is definitely eligible under the Environmental Risk category; however, not all of this information is necessary within the context of the report.

Given these facts, this information might be captured within the evaluation report as follows: "Tommy's mother is 17 years old. Mom left high school approximately four months ago and, since that time, has been living with a variety of friends in several different locations. She has expressed a desire to have her own apartment and would like assistance in achieving this goal. Tommy's father is not currently involved with the family."

A suggested eligibility may be: "Based upon the results of the NM Environmental Risk Assessment Tool, Tommy has been exposed to multiple stressors, which research has shown pose a substantial risk to a child's development. Tommy is therefore eligible for the NM FIT Program under the Environmental Risk category."

Appendix G - Sample Evaluation Report

COMPREHENSIVE MULTIDISCIPLINARY EVALUATION REPORT

Name: José Benevidez	Referred by: Dr. Trujillo, MD
DOB: 07-28-10	Family Service Coordinator: Jillian Maes
Chronological Age: 1 year, 11 months	Date Of Evaluation: 06-29-12
Adjusted Age: (if applicable)	Location of Evaluation: Family home

Participating Team Members:

Name:	Role / Discipline / Title:
Carlos and Maria Elena Garcia	Parents
Jillian Maes	Developmental Specialist II
Jan Torres	Physical Therapist

Referral Information:

Dr. Trujillo, MD, José’s pediatrician, referred José for a developmental evaluation. At previous clinic visits José’s mom, Maria Elena, expressed some concerns about José’s problems with eating, difficulty sleeping at night, and José’s being slow to move around and talk. A referral was also made to a pediatric neurologist in Albuquerque.

Child Background / Prenatal & Birth History / Current Health Status:

José was born 2 weeks early and weighed 4 lbs 10 ounces. Maria Elena reported that she was sick with a virus identified as “CMV” (Cytomegalovirus) during her first trimester and Jose has been diagnosed with this condition. She received regular prenatal care and no other problems were evident. José continues to be small for his age (15th percentile) in both weight and size. José does not take any medications at this time.

According to Maria Elena and Carlos, José is generally healthy. He has had two ear infections during the past 8 months and about two mild “colds.” However, he is frequently constipated and his parents want to know if José has food allergies.

Pertinent Family Information:

José is the second of two children in his family. He has an older sister Izzy, age six, who is in first grade. The family’s primary language is English but they also speak Spanish at home. He lives with both of his parents, Carlos and Maria Elena and has a large extended family. Maria Elena has found out recently that she is pregnant and expressed concern about the baby’s having any problems like José.

Information Provided by the Parent(s) Regarding Child’s Daily Routines and Activities:

José is described by his mom and dad as a “usually happy and friendly” little boy, who likes to be around them all of the time. José is very interested in people, especially other children and cries when he is left alone or feels left out of what’s going on. Mom and Dad reported that José does enjoy bath time, especially with his sister. He doesn’t mind being splashed or having his face wet as long as the water or soap doesn’t get into his eyes. They added that José could be very noisy in the bathtub.

Jose’s parents stated that José is very picky about what he will and won’t eat and they wonder if this contributes to his constipation.

During self-care routines José helps by lifting his arms in and out of sleeves. He cooperates when getting his diaper changed and allows his Mom or Dad to wipe his hands and face after eating.

His parents reported that the hardest time for them was at night. José wakes up frequently and it takes a long time for him to get back to sleep. He doesn’t sleep for more than two to three hours at a time and cries if left alone in his crib. José looks to Maria Elena when he is upset and needs comforting and needs her to help him go back to sleep.

Vision and Hearing (Screening / Testing Results):

José did not pass the Newborn Hearing Screening and was later referred for an ABR (Auditory Brainstem Response). Results of the ABR showed a mild-moderate bilateral hearing loss of 30-35 db at lower frequencies and 50-55 db at higher frequencies. The NMSBVI Vision Screening was completed as part of the evaluation and no immediate concerns were noted.

Developmental Evaluation:

Tools / Procedures Utilized:
Parent Interview
Review of Medical Records
Infant-Toddler Developmental Assessment (IDA)
Play-based Observation in Family Home

The evaluation team included a Developmental Specialist, Physical Therapist, and José’s Mom and Dad. The Infant-Toddler Developmental Assessment (IDA) process was used to assist the team in looking at José’s current skills and abilities from an ecological and developmental perspective. The developmental evaluation consisted of information gathered in the areas of fine and gross motor skills, relationship to inanimate objects (considered to reflect aspects of intellectual development, traditionally referred to as “cognitive”), language and communication, self-help, and relationship to persons, emotions and feeling states and coping behavior to describe various aspects of social and emotional development. During the evaluation session, José sat in his mother’s lap most of the time when playing with the evaluators. He was alert and cooperative and seemed comfortable.

Motor Development (Incl. gross motor, fine motor and sensory motor skills):

To move around, José will turn himself while on his tummy and can roll over. José seeks his favorite toys when he is placed on a blanket on the floor by rolling towards them so that they

are within his reach, although this process takes him a while. At home he can sit up if placed with the support of an upholstered chair or on the floor propped up with pillows. He can also sit well in the stroller with the seatbelt/harness. Jose typically uses his fist and forearm to move toys. He likes to push toys, such as large trucks on the tile floor in the kitchen and small cars and balls in the sand at the park. After several tries, he was able to grasp a cube that was presented to him and had greater success with his right arm than with his left. José did seem frustrated at times when he could not handle or grab objects or toys that were around him or when they were out of his reach. Jose's overall muscle tone appears to be high (his muscles are tighter) and makes movement activities more challenging for him. His difficulty in moving his body and his hands and fingers impacts his ability to interact with his surroundings. His skills, in both gross and fine motor, are in the 5.5 - 7 month age range.

Communication Development (Incl. expressive and receptive communication skills):

José uses vocal sounds and simple gestures to communicate. He is just beginning to imitate simple words like "bah" for bottle or drink, "mah" for Mom and "nuh" for no, but he sometimes need more time to respond. José can clearly communicate what he likes and what he doesn't. An example from his parents was mealtimes. If José doesn't want more of something being offered to him or just refuses to eat it he will arch his back, turn his head away or push away what he does not want, and vocalize his discontent loudly. José will vocalize toward his parents to get their attention or to get help with something he wants. He responds to his name by consistently looking to see who has called to him. José's Mom reported that he shows his understanding of the word "no" by immediately stopping what he is involved in to look at her. Jose's communication skills are in the 10-11.5 month age range.

Cognitive Development (Incl. relationship to inanimate objects, playing, thinking, problem- solving skills):

José does know where toys are kept even if he can't see them. His mom stated that he complains if things that he wants are out of sight. José will lift up his arms in anticipation of being picked up, and reaches toward something he wants or when offered a choice (either a food item or something he wants to do). He recognizes the names of many family members and "knows them in pictures." Jose was able to uncover a toy that was hidden from him but had difficulty attempting to grasp a cube in each hand and bring them together. After several attempts to grasp the second cube in other hand, Jose became frustrated and pushed the cubes away. He did explore objects he could hold by mouthing them, pushing them with his fist hand or by dropping them. He could offer a small foam ball to his Mom or one of the evaluators and smiled often when playing in a give and take fashion. Jose's difficulty in using his hands to interact with and manipulate objects appears to be impacting his ability to demonstrate his understanding of concepts. The skills that Jose was able to demonstrate and that his parents have reported are in the 7-8.5 month age range. However, Jose has the cognitive understanding of a back and forth game and anticipates each person's turn. This is a higher level skill for Jose and may indicate that his understanding of concepts is more developed than what he can demonstrate to others.

Social and Emotional Development (Incl. relationship to persons & emotions and feeling states):

She also said that one of his favorite games that he plays with Izzy and Dad is peek-a-boo. Socially, José loves people and will throw kisses. He shows a strong reaction to "strangers" and prefers to be near his Mom, Dad or close family members. He smiles and laughs easily and

likes it when his Dad and Izzy play silly games with him. His Mom reported that when José is unhappy he cries but is able to “calm down” by being held and talked to in a soothing manner. Jose’s social interactions with others are an area of strength for him. This is another area, however, that is impacted by his difficulty in moving his body as he cannot fully demonstrate the level of his skill. As a result, his skills in social-emotional are in the 8.5-10 month age range.

Self Help / Adaptive Development (Incl. feeding, washing, toileting skills):

Jose attempts to scoop food onto a spoon when the spoon is placed in his hand. He has great difficulty getting the spoon and/or food to his mouth. However, he is usually successful at feeding himself crackers, or similar foods, with his hands. As reported earlier, he will attempt to put his arms into sleeves when getting dressed. Jose’s self-help skills are also an area of strength for him. These skills are in the 10-13 month range.

Any Other Developmental Information (Incl. activities that occur across domains e.g. play; mealtime; preschool readiness, etc.):

Mealtimes are a challenge for José’s parents. His parents said that he can be fussy at mealtimes and that he hates to be messy, most especially wet or sticky. He will hold a spoon, but as he is not able to use it to scoop food or bring the spoon into his mouth, his mother usually feeds him. Jose will also take sips from a cup that is held for him but is not attempting to hold the cup himself.

Evaluation Summary:

Overall, José is a delightful, engaging little boy. His family is involved in promoting his development, responsive to his needs, and has expressed deep caring for him. They also expressed their concerns about how far behind he is and what that means. They asked about ways they can get José to eat more and to sleep through the night. They inquired about how much his hearing loss is affecting his ability to communicate and what can be done to help him sit up independently and crawl. José’s present abilities appear to be delayed in all domains and areas of strength for him appear to be impacted by his limited movement abilities.

Eligibility:

Based upon the information described in this report, the evaluation team has determined that José is eligible for the NM FIT Program under the following eligibility categories:

- Established Condition due to his diagnosis of CMV and bilateral hearing loss, and
- Developmental Delay due to a 25% or greater delay in motor, communication, cognition, social-emotional, and self-help developmental skills.

Recommendations:

José and his family would benefit by participating in early intervention services that address the family’s questions and concerns, and that support José in his continued growth and development in the following ways:

Use José’s strengths in the area of social and emotional development and his motivation to interact with others as the basis for programming in areas of need.

Consider *NMSD's Early Intervention and Involvement Division* as a resource for José and his family to address José's hearing loss and to help facilitate his language development.

Strategies for positioning José and adaptive equipment to support José during meal times and in play and active learning experiences are recommended.

Perhaps one of the most difficult aspects of parenting is the lack of sleep that can come from caring for an infant or young child. Help José's parents to set up a bedtime routine, so that José is doing the same things, in the same order, at the same time every day, just before going to bed and to sleep.

Consider consultation with a Nutritionist for José's family to support and encourage José to eat a variety of foods that he can enjoy.

Continue to support José's language development through playful interactions that incorporate language, i.e., "Peek a Boo," and modeling words for José that refer to people toys or objects in his environment so that José can imitate them.

Signatures of Evaluation Team:

Discipline/Credentials:

Jillian Maes - Jillian Maes

Developmental Specialist II

Jan Torres - Jan Torres

Physical Therapist

Appendix H. Assessment Tools for Infants Under Four Months of Age, Including the Infant-Toddler Developmental Assessment (IDA)

Instrument	Publisher	Ages	Description
<p>Alberta Infant Motor Scale (AIMS) Martha Piper and Johanna Darrah</p>	<p>Elsevier; Can order on Amazon.com (Motor Assessment of the Developing Infant = "manual")</p>	<p>Birth to 18 months</p>	<p>Incorporates the neuromaturational concept and the dynamical systems theory, and is used to measure gross motor maturation of infants from birth through the age of independent walking. The AIMS has been investigated for its practicality and the reliability and validity of its scores on infants in Canada.</p>
<p>Infant Toddler Developmental Assessment (IDA) S. Provence, J. Erikson, S. Vater, & S. Palmeri</p>	<p>Pro-Ed www.proedinc.com</p>	<p>Birth to age 3</p>	<p>The IDA is a clinical process that includes the Provence Birth to Three Developmental Profile. The IDA procedures, designed for use by a team of 2 or more professionals, consist of 6 phases, includes a guide for team process and decision making, and includes parents as partners in the assessment. The tool provides a link between assessment and intervention, ensuring parent participation in the process. It integrates health concerns into making decisions. A percentage delay may be computed based upon the Provence Profile in cases where it is required to determine eligibility.</p>
<p>Infant/Toddler Sensory Profile Catanna Brown, & Winnie Dunn</p>	<p>Pearson www.pearsonassessments.com</p>	<p>Birth to 36 months</p>	<p>The Infant/Toddler Sensory Profile provides a standard method for professionals to measure a child's sensory processing abilities and to profile the effect of sensory processing on functional performance in the child's daily life. This profile is a judgment-based caregiver questionnaire, and each item describes children's responses to various sensory experiences. Service providers such as occupational therapists, teachers, psychologists, speech-language pathologists, and physicians might use it to gain a picture of a child's performance during daily life, as well as determine areas of strength and areas of concern that can help provide the foundations for intervention planning.</p>

Instrument	Publisher	Ages	Description
<p>Motor Skills Acquisition Checklist</p>	<p>Pearson www.pearsonassessments.com Motor Skills Acquisition in the First Year: An Illustrated Guide to Normal Development (232-page softbound manual)</p>	<p>Neonatal to 12 months</p>	<p>The checklist was designed for physical therapists, occupational therapist, developmental psychologist, physicians, and other healthcare professionals with knowledge of normal motor development in infants. Users also must be proficient in the administration and interpretation of evaluation tools designed for babies with motor disorders and delays.</p>
<p>Newborn Individualized Developmental Care and Assessment Program (NIDCAP)</p>	<p>Developed by Heidelise Als, PhD and her colleagues; www.nidcap.org</p>	<p>ONLY FOR USE WITH: Preterm and fullterm newborns in the newborn intensive care setting.</p>	<p>A comprehensive approach to care that is developmentally supportive and individualized to the infant's goals and level of stability. Further it seeks to support families and the professionals who care for them. It provides and trains professionals within this NIDCAP framework. One component of the model of care is the direct observation of the infants within their environments in the newborn intensive care setting. Using a detailed observational tool, often referred to as the NIDCAP observation, the infant's behaviors can be interpreted as steady and relaxed or as representing stress or discomfort. By observing and then interpreting behaviors of infants within their environment and as reactions to care they receive, developmental care plans can be developed, with the caregiving team, that best support's the infant's overall goals and efforts at self regulation.</p>

Instrument	Publisher	Ages	Description
Peabody Developmental Motor Scales-2	Pro-Ed www.proedinc.com	Birth through 83 months	Measures gross and fine motor skills in children. The gross motor and fine motor scales are administered and scored separately. The scales are translated into a specific instructional program in the form of activity cards. Requires an appropriately trained, and experienced practitioner.
Receptive-Expressive Emergent Language Test Third Edition (REEL-3)	Western Psychological Services	Birth to three years of age	Identifies infants and toddlers who have language impairments or other disabilities that affect language development. The REEL-3 uses behavioral observations of parents or guardians to identify language problems and consists of two core subtests - Receptive and Expressive Language.
Test of Infant Motor Performance	IMPS, LLC www.thetimp.com	Infants between the ages of 34 weeks postconceptional age and 4 months post-term	The TIMP is a test of functional motor behavior in infants for use by physical therapists, occupational therapists, and other health professionals in special care nurseries and early intervention or diagnostic follow-up settings. THE TIMP MUST BE USED ONLY BY PERSONS EXPERIENCED IN THE SAFE HANDLING OF FRAGILE INFANTS

Appendix I - Sample Eligibility Determination Form



Eligibility Determination Form (Shaded areas are data to be entered into FIT-KIDS)



Child's First Name:	MI:	Child's Last Name:
Child's Date of Birth:	Child's Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's corrected age (if was born more than 3 weeks prematurely):		

Eligibility Type:	
<input type="checkbox"/> Initial Comprehensive Multidisciplinary Evaluation	<input type="checkbox"/> Annual Redetermination of Eligibility

Check ALL eligibility categories that the child meets requirements for:

<input type="checkbox"/> Developmental Delay (<input checked="" type="checkbox"/> if child meets eligibility for this category)

a). IDA Results		Date IDA Completed:		
Domain:	IDA Results:			
Cognitive Skills	<input type="checkbox"/> Age Appropriate / within Typical Age Range	<input type="checkbox"/> Less than 25% Delay	<input type="checkbox"/> 25% or Greater Delay	<input type="checkbox"/> Percent Delay Not Obtained
Communication Skills	<input type="checkbox"/> Age Appropriate / within Typical Age Range	<input type="checkbox"/> Less than 25% Delay	<input type="checkbox"/> 25% or Greater Delay	<input type="checkbox"/> Percent Delay Not Obtained
Self Help / Adaptive Skills	<input type="checkbox"/> Age Appropriate / within Typical Age Range	<input type="checkbox"/> Less than 25% Delay	<input type="checkbox"/> 25% or Greater Delay	<input type="checkbox"/> Percent Delay Not Obtained
Sensory Motor, Gross & Fine Motor	<input type="checkbox"/> Age Appropriate / within Typical Age Range	<input type="checkbox"/> Less than 25% Delay	<input type="checkbox"/> 25% or Greater Delay	<input type="checkbox"/> Percent Delay Not Obtained
Social / Emotional Skills	<input type="checkbox"/> Age Appropriate / within Typical Age Range	<input type="checkbox"/> Less than 25% Delay	<input type="checkbox"/> 25% or Greater Delay	<input type="checkbox"/> Percent Delay Not Obtained

2. Domain Specific Tool:	
Domain Specific Tool(s) used:	Date Administered:
Domain(s) Addressed:	
Standard Deviation 1.5 or Greater: <input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Informed Clinical Opinion:
Team agrees that child is eligible based on Significant Atypical Development: <input type="checkbox"/> Yes <input type="checkbox"/> No

Provide a statement of informed clinical opinion documenting eligibility (including the use of any other instruments utilized):

Examples: quality of skills; performance of skills; Scatter of scores (including across domains); behavior significantly different for typical peers.

Child's First Name:	MI:	Child's Last Name:
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<input type="radio"/> Established Condition (Diagnosed by Primary Care Provider) (<input checked="" type="checkbox"/> if child meets eligibility for this category)	
PCP Name:	Date of Diagnosis:
Primary diagnosis	ICD-9 Code
Secondary diagnosis	ICD-9 Code
Other diagnosis	ICD-9 Code

<input type="radio"/> Biological / Medical Risk (Diagnosed by Primary Care Provider) (<input checked="" type="checkbox"/> if child meets eligibility for this category)	
PCP Name:	Date of Diagnosis:
Primary diagnosis	ICD-9 Code
Secondary diagnosis	ICD-9 Code
Other diagnosis	ICD-9 Code

<input type="radio"/> Environmental Risk (<input checked="" type="checkbox"/> if child meets eligibility for this category)	
Date Environmental Risk Assessment (ARA) Tool Completed:	
<input type="checkbox"/> a "high" rating in 6, 7, 8, or 9; or	
<input type="checkbox"/> a "high" rating in a minimum of two risk factors; or	
<input type="checkbox"/> a medium rating in at least four risk factors	

Hearing & Vision:

Hearing Screening / Testing:
Date Completed:
<input type="checkbox"/> Pass <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unable to Screen

Vision Screening / Testing:
Date Completed:
<input type="checkbox"/> Pass <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unable to Screen

Second Level Review (if Informed Clinical Opinion is used to determine developmental delay) I have reviewed the CME and pertinent information, as well as the informed clinical opinion statement of the team, and concur that the child meets eligibility under Significant Atypical Development.			
Date:	Name:	Position / Discipline:	Signature:

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Glossary

Adjusted Age - means adjusting/correcting the child's age for children born prematurely (i.e. - born less than 37 weeks gestation). The adjusted age is calculated by subtracting the number of weeks the child was born before 40 weeks of gestation from their chronological age. Adjusted age should be used until the child is 24 months of age. Adjusted age may be reported in weeks or in months.

Comprehensive Multidisciplinary Evaluation (CME) - means the process used by appropriately qualified personnel through which a child's eligibility for early intervention services is determined. This process involves a review of pertinent records related to the child's current health status and medical history, observations of the child, and both the qualitative and quantitative information gathered about the child that contributes to the team's opinion regarding the child's eligibility. The initial evaluation includes an assessment of the child's strengths, needs and functioning in each developmental area (cognitive, communication, physical/motor [including vision and hearing], social and emotional, and adaptive), and an explanation of how the status in each of the developmental areas affects the child's overall functioning.

Criterion-Referenced Assessment measures attainment, mastery or learning of developmental skills qualified by a stated criterion. The scoring is defined by whether or a pre-specified level of accomplishment has been met. The criterion-referenced assessment supplies information on whether a child has accomplished a skill or task and what skills or tasks need to be acquired.

Curriculum-Based Assessment in general, refers to assessments of a child's performance relative to an instructional curriculum and is a form of criterion-referenced measurement, where the curricular objectives are the criteria for the identification of instructional targets and for the assessment of progress.

Developmental Delay means an evaluated discrepancy of 25% or -1.5 SD or more between the chronological age and the developmental age, after correction for prematurity, or a designation of *Significant Atypical Development* in one or more of the following areas of development: cognitive, communication, physical/motor (including vision and hearing), social and emotional, and adaptive.

Developmental Screening is a brief assessment procedure that is designed to identify children who should receive more extensive developmental assessment or evaluation. Developmental screening instruments are standardized, valid and reliable. They are brief in nature and may be easily administered by a provider or as a questionnaire to a parent or caregiver (see also Screening)

Diagnostic Evaluation is an evaluation process that is conducted to provide in-depth information regarding the specific nature and extent of the child's developmental problem. The evaluation is highly specialized, administered by trained professionals

and uses diagnostic tools that are usually norm-referenced. A diagnostic evaluation may be obtained through a medical facility or a specialized program designed for the purpose of conducting diagnostic developmental evaluations.

Informed Clinical Opinion means the required process used by early intervention personnel to determine the child's initial and continuing eligibility as a result of *Significant Atypical Development*. The use of Informed Clinical Opinion is a safeguard against eligibility determination based upon isolated information or test scores alone.

Instruments are tools used to collect and organize information and include written measures such as questionnaires, scales, and tests.

Multidisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including the initial multidisciplinary evaluation and assessment, and the individualized family service planning process.

Ongoing Assessment means the ongoing procedures used by appropriately qualified personnel throughout the child's eligibility for NM FIT Program supports and services to identify the child's unique strengths, needs, developmental functioning and the concerns, priorities and resources of the family. Ongoing assessment involves multiple procedures, including the use of an assessment tool.

Professional Wisdom the NM FIT Program has opted to use the term "professional wisdom" to represent the use of professional knowledge and experience to synthesize information from a review of pertinent records related to the child's current health status, medical history, observations of the child and any information gathered about the child from earlier evaluation and assessment processes. It makes use of a professional's training, previous experience with evaluation and assessment, previous experience with children, sensitivity to cultural needs, and the ability to gather and include family perceptions as important elements in order to form a collective opinion regarding the child's development.

Qualitative Information or data is information that is difficult to measure, count, or express in numerical terms and usually includes informal procedures and methods, such as observation and interviews, to document complex behaviors of a child engaged in context-bound activities that occur within everyday routines, activities and places. Qualitative information is an important part of both evaluation and assessment. A child who is determined to have *Significant Atypical Development* as a result of the team's Informed Clinical Opinion, typically displays qualitative differences in development.

Qualified Personnel means persons who have met state of New Mexico and/or New Mexico Department of Health, Family Infant Toddler program approved or recognized

certification, licensing, registration, or other comparable requirements that apply to the area in which the personnel are providing early intervention services.

Qualified personnel who provide early intervention services are responsible for: a) consulting with parents, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services in the area in which they provide service; b) training parents and others regarding the provision of those services; and c) participating in the multidisciplinary team's assessment of a child, with the child's family, and in development of integrated outcomes and strategies for the individualized family service plan.

Quantitative Information or data is information that can be expressed in numerical terms, counted or compared on a scale and usually used formal procedures and methods to focus on specific areas of child development that can be observed and scored.

Screening refers to the process of proactively testing whole populations of children to identify those at risk of clinically significant but, as yet, unsuspected health problems, developmental problems, and/or disabling conditions, who may need to receive intervention services as early as possible. It is a brief assessment procedure that is designed to identify children who should receive more extensive assessment or diagnostic procedures.

Early intervention personnel provide screening to determine current vision and hearing status of infants and toddlers who have been referred to community early intervention programs. Children who demonstrate positive findings as a result of these screenings are referred for further assessment.

Significant Atypical Development refers to the observable differences in a child's development that sets him apart from typical same-age peers and are of significant enough concern to warrant eligibility for the FIT Program. These differences usually interfere with a child's ability to fully participate in family and community life.

Transdisciplinary refers to members of a team who cross professional discipline boundaries in an effort to integrate perspectives by working collaboratively and consulting with one another. Team members do not abandon their discipline, but blend specific skills with other team members to align strategies and achieve integrated outcomes for the child and family.