Children's Integrated Services Guidance Manual

08/31/2022

VERMONT

DEPARTMENT FOR CHILDREN AND FAMILIES

CHILD DEVELOPMENT DIVISION

Table of Contents

Section One – What You Need to Know

Introduction to the Guidance Manual

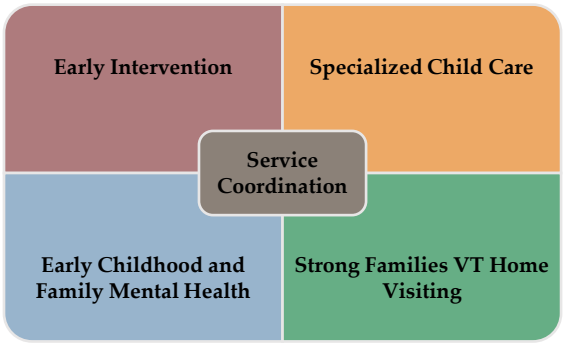
This manual is designed to provide guidance to individuals and organizations in Vermont that have a role in providing services under the umbrella of Children's Integrated Services (CIS). This includes:

- **Fiscal Agents**: organizations contracted by Vermont's Agency of Human Services (AHS), Department for Children and Families (DCF), Child Development Division (CDD) to oversee the use of CIS funds in their region.
- **CIS Service Providers**: individuals and organizations subcontracted by the Fiscal Agent to provide specific services, for example, Specialized Child Care (SCC) Coordination, Strong Families Vermont (SFVT) Home Visiting, Early Childhood and Family Mental Health (ECFMH), and IDEA Part C, CIS Early Intervention (CIS-EI) services.
- **CIS Coordinators**: professionals usually hired by the Fiscal Agent to oversee the provision of services in their region and be a liaison between the CIS State Team, Fiscal Agent, and the CIS Service Providers.

These roles are not siloed. In some cases, the Fiscal Agent is also an organization providing direct services, and in some regions the CIS Coordinator is hired by an agency separate from the Fiscal Agent. Each region in Vermont coordinates services in its own unique way.

We hope you find this manual useful regardless of the role you play in the provision of CIS to Vermont families and early childhood education programs.

Introduction to Children's Integrated Services

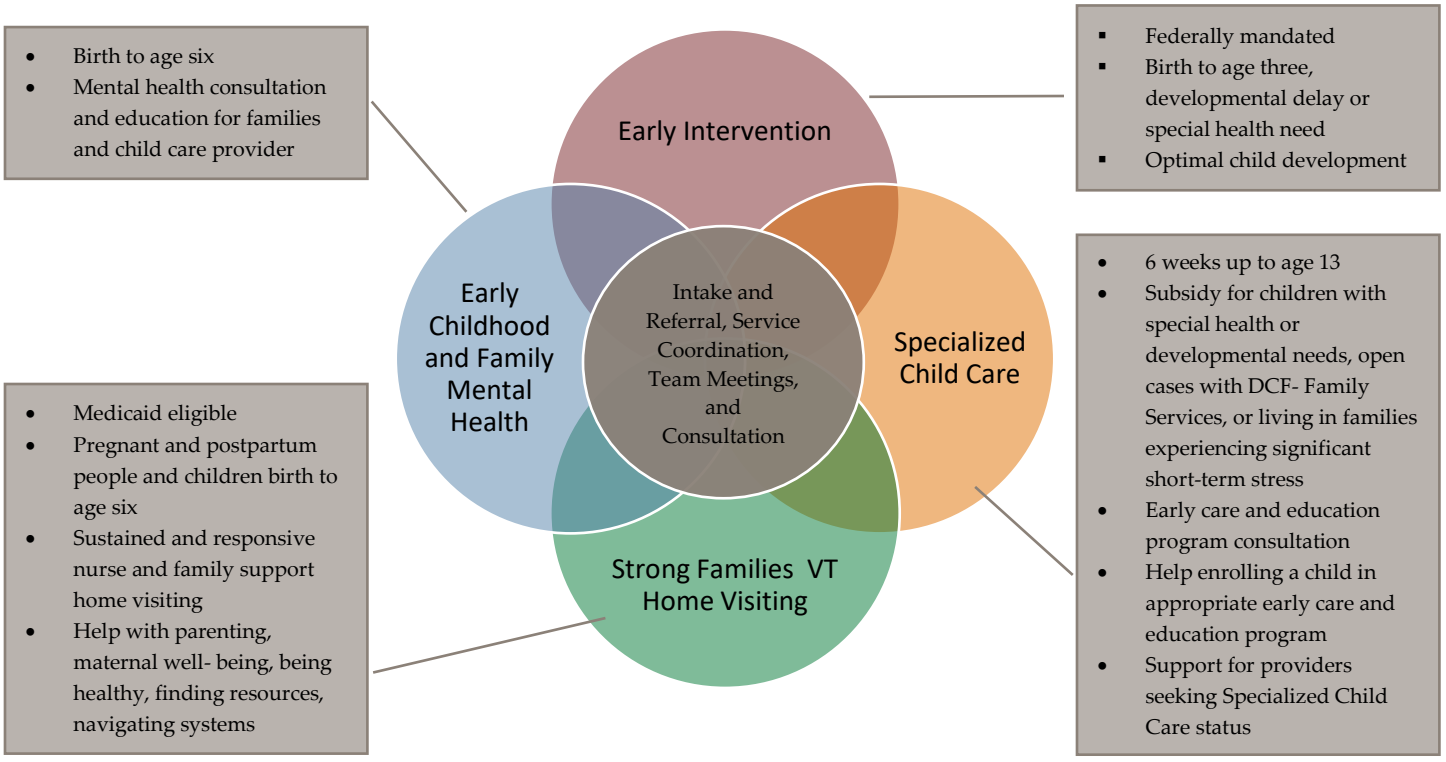


Unique to Vermont, CIS is a noteworthy innovation in delivering evidence-based and evidence-informed services to pregnant and postpartum people, families with young children. The model requires CIS Service Providers not to simply cooperate or collaborate but to integrate the care they provide CIS clients. CIS's core values (i.e., family-centered, child-focused, and strength and outcomes-based) are the foundation of the integrated approach. Before CIS's implementation, services were often siloed, and Vermont families found themselves burdened by multiple home visitors and appointments and sometimes contradictory plans of care.

The CIS funding model requires CIS Service Providers to continually provide improved, consistent, and comprehensive collaboration regarding the early detection of health, mental health, or developmental needs or delays and expand young children's access to Medicaid services to address these needs. This includes finding opportunities for community resource development through program planning, policy development, and interagency coordination and consultation. Staff funded through CIS support families' access to Medicaid insurance and Medicaid-covered services. CIS Service Providers work as a team, meeting regularly to fully integrate the services each CIS Service Provider's organization is responsible for and collaborating on creating a coordinated One Plan that strategically addresses how best to meet the family's goals.

The purpose of CIS is to:

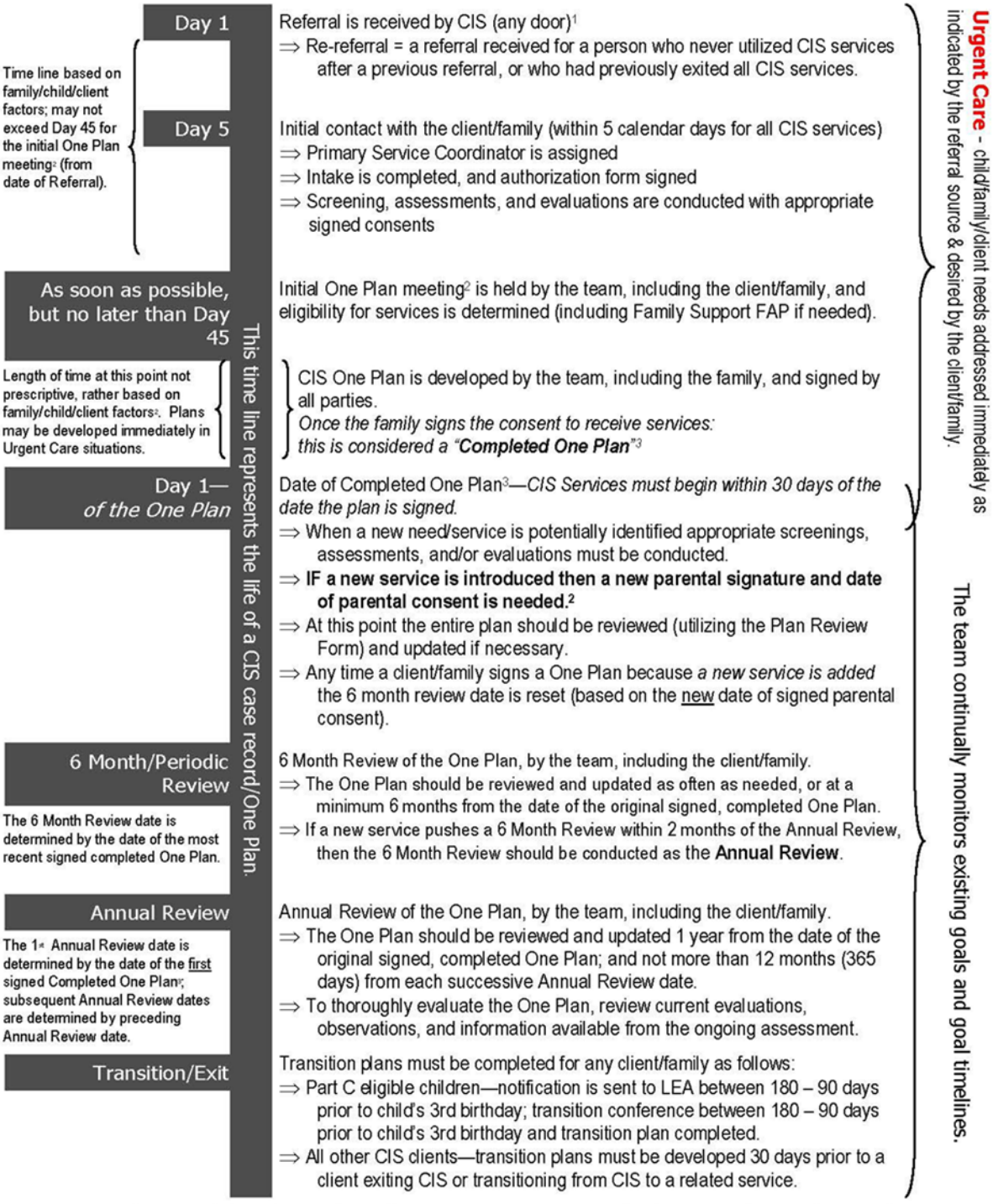
- Ensure child and family access to high-quality child development services needed to improve the health, development, and social well-being of the recipients of these services.
- Ensure standardization of the CIS system with an emphasis on:
    - coordinated service delivery and transition
    - infrastructure
    - outreach
    - referral and intake
    - universal screening at regular intervals
    - multidisciplinary evaluation and assessment
    - integrated services planning and delivery
    - primary service coordination
    - family engagement
- Ensure the provision of services to pregnant and postpartum people, children from birth up to age six (up to age 13 for Specialized Child Care) and their families/caregivers/guardians, as well as .
- Ensure client's and their families/caregivers/guardians have access to health insurance and a medical and dental home.
- Maintain a consistent, comprehensive, and collaborative approach to service delivery, including:
    - coordinated delivery of direct services
    - consultation
    - coordinated professional development
    - CIS Service Provider teaming and supervision time
- Ensure full participation, capacity building, and self-advocacy of clients and families/caregivers/guardians in all aspects of service planning and delivery as evidenced by a reflection of their voices in all case documentation.



Timelines

Version 7-29-13

Children's Integrated Services Timelines



[1] *Any non-CIS service that is needed may be coordinated by a CIS Primary Service Provider, but is not subject to these timelines.*

[2] *A delay caused by family/child/client circumstances (using OSEP definitions of client circumstances) is an allowable exception to the timeline* ***with appropriate documentation*** *identifying this cause.*

[3] *"Completed One Plan" means the date of the most recent One Plan with signed parental consent for services.*

Allowable Exceptions to Timelines

It is important the CIS Service Providers work to meet the established timelines in service delivery; however, there are allowable exceptions due to family circumstances where that may not be possible. Family circumstances may include family illness, the family's choice to cancel, or unable to contact the family. It is also permissible to consider inclement weather as an allowable "family circumstance" with appropriate documentation. It is critical in such instances that CIS Service Providers document their contact with the family to inform them that they will not be providing a planned service at a scheduled time due to hazardous weather conditions. It is also helpful if CIS Service Providers include in their documentation a copy of a published severe weather advisory from the national weather service, Vermont Agency of Transportation, or other such organization.

Documentation of the severe weather event and of the CIS Service Provider's communication with the client or family/caregiver/guardian is required for such events to count as an allowable exceptional circumstance.

Contact the CIS State Team if you need technical assistance.

Transition Timeline and Exit Planning

Planning for seamless transition is essential for all clients and their families/caregivers/guardians. Clients need to move smoothly from one program or system to another or among services within the same program or system. A seamless transition ensures that clients and their families/caregivers/guardians have timely access to appropriate services and resources that continue to meet their needs. All CIS Service Providers are responsible for supporting clients and their families/caretakers/guardians as they transition out of or within CIS services.

The reason for transitioning may include:

- Successful achievement of all goals
- Ongoing services for people beyond two months postpartum
- Children in CIS-EI who reach age three or six years for other non-CIS-EI services (Please Note: Specialized Child Care can support children up to age 13 years)

At a minimum, transition planning includes:

- For people beyond two months postpartum, supporting transition in accordance with CIS guidance or applicable evidence-based home visiting model requirements, or
- For children eligible for CIS-EI in accordance with federal regulations (34 CFR Sub Part B, Section 303.111) and State of Vermont Special Education (2360.5.5 and 2360.5.7), or
- For children beyond age six receiving non-CIS-EI services, CIS Service Providers must support transition, including any applicable evidence-based home visiting model requirements, to other community-based supports such as Children with Special Health Needs (CSHN) or Head Start, or
- For child care programs who may need on-going support to provide quality child care facilitation, transition to other community-based supports such as educational or parent child center resources.

Part C Federal regulations require the following activities to be completed between 180 and 90 days of the child's third birthday for all children exiting CIS-EI services with a disability:

- Reviewing the child's present levels of functional development (including all formal and ongoing assessments performed within at least the last three months) and sending a notice to the Local Education Agency (LEA) and State CIS-EI program if a child may be potentially eligibility for Part B

Early Childhood Special Education (ECSE) because they are demonstrating at least a 25% delay in at least one domain of development.
- With parent/guardian's consent, convening a transition conference, including the LEA for all children who may be potentially eligible for Part B ECSE.
- With the parent/guardian's consent, develop a transition plan including at least one outcome with steps to support the child's successful transition. This must be done for all children served by CIS-EI. However, it must be done between 180 and 90 days of the child's 3rd birthday for children who may be potentially eligible for Part B ECSE.

Section Two – Fiscal Agents

There is specific language in the Fiscal Agent's contract with the State that should be referred to if the Fiscal Agent has questions about the following:

- Minimum system expectations
- Levels of training required for new staff and professional development
- CDD CIS website
- Descriptions of services

Fiscal Model Requirement

The fiscal agent is expected to manage the following key aspects of an integrated delivery model:

- Regular participation of representatives from all four CIS services (CIS-EI, SFVT Home Visiting, ECFMH, and SCC) at Referral and Intake meetings, Systems meetings, and scheduled Consultation meetings.
- A system for reliable data collection and reporting, and one regional report to the State with unduplicated, accurate and complete data from all CIS services on all performance measures.
- A mechanism to evaluate costs and efficiencies of current service delivery system, and the ability to make changes that result in cost savings and quality services.
- A coordinated entry of individuals, families, education into the system through a local CIS Coordinator and Referral and Intake team.
- A multi-disciplinary consultation team so CIS clients with intense or complex needs are supported comprehensively across multiple systems.
- A primary service coordinator who actively assists and enables CIS clients to access services and assures procedural safeguards acts as the single point of coordination of all childhood services for the family.
- One Plan shared by the family and all CIS service providers.

Outreach

Regional CIS Outreach must target the following specific populations and organizations serving these populations:

- Families experiencing homelessness
- Families living in rural areas
- Children whose families are considered "low income," i.e., are unemployed, or below poverty guidelines

- Families/children who have witnessed crime, including domestic violence
- Wards of the State
- Families with a history of child abuse and neglect
- Indigenous families
- Families at-risk due to prenatal, postpartum (less than 6 weeks), maternal, newborn, mental health conditions, or child health concerns, e.g., maternal depression and substance use; pre-term birth, low birth weight, infant mortality due to neglect, infants/children exposed to toxic substances during pregnancy
- Children, and their families, experiencing health needs and/or delayed development

Outreach activities include, at a minimum, on-going efforts to strengthen and improve coordination of services through:

- Education of and coordination with primary referral sources, such as families, public schools, hospitals, physicians, health care providers, medical homes, home health agencies, public health services, DCF – Family Services Division, Help Me Grow/2-1-1, and child care providers about the resources available through CIS and how to access them on an ongoing basis;
- Efforts to use the Child Find and referral system to identify children birth to age three with a developmental delay or a heath condition that could result in a developmental delay; and
- Community resource development to improve access to services for pregnant and postpartum people, families with young children, and .

Any materials used for outreach activities must be either produced by or submitted to the CIS State Team for review and approval prior to use.

Special Requirements For CIS-EI

- The fiscal agent must submit staff qualifications (education and any applicable credentials), title, role, and contact information within thirty (30) days of hire to the CIS State Team. This requirement serves to assure the United States Department of Education, Office of Special Education (OSEP) that all CIS-EI staff meet the Vermont Part C position requirements.
- The fiscal agent must use the current Agency of Education/Agency of Human Services Interagency Agreement template to develop and implement, the Regional Interagency Agreement with area Local Education Agencies (LEA) responsible for Part B services. These agreements must be reviewed and updated at least annually or any time an LEA changes. The Agreement addresses the regional responsibilities outlined in the Part C Interagency Agreement between the Agency of Human Services and Vermont Agency of Education (revised version 2019). All agreements must be submitted to the CIS Part C Program Administrator at the CDD.
- The fiscal agent must provide outreach to the Department for Children and Families, Family Services Division (FSD) district office to ensure this office is aware of and referring to Part C Early Intervention Services as required under the Child Abuse Prevention and Treatment Act (CAPTA).
- The fiscal agent must adhere to Fiscal Certification 34 CFR §303.202 requirements, including:
    - Ensuring Part C funds are not used to satisfy a financial commitment for services that would otherwise have been paid for from another private or public source consistent with 34 CFR §303.510.

- Data must be submitted to the State by secure means, using the required State data submission documentation/tools, on or before the 8th of each month. These data reports must include:
  - Specified information on:
    - referrals, including ethnicity and social security numbers for each child
    - children for whom no one plan resulted
    - children who are found eligible and whose family consents to services on a One Plan (aka "actives"), including those children's insurance information
    - all service grids, including actual start dates for each service and plan updates each time service frequency changes, ends, or a new service is added to which the family provides consent
    - exit data
    - entry and exit child outcome summary forms
  - Updated, accurate, and complete service grids must be submitted for the State to process any prior authorization (PA) requests to assure timely payments through Payor of Last Resort (POLR). "Accurate" and "Complete" includes:
    - actual start dates of service
    - identifying a single primary location of service for each direct service listed on the grid
    - when a service is added, changed, or deleted, the service grid lists all services being delivered, including any that have changed, and/or ended
    - all changes to services are made in accordance with IDEA Part C (for example: 34 CFR subsections 303.7, 303.420 through 303.421, 303.340 through 303.346. Be aware, this is not an exhaustive list of all applicable federal regulations).
    - All changes must also be made ensuring parental rights are maintained and families understand the State's system of payments for Part C services
  - Written notification of children identified as potentially eligible for Part B (34 CFR §303.209) are sent to schools between 180 days and 90 days prior to a child's third birthday. Copies of these notifications must be submitted to the State with the monthly data reports due by the 8th of each month. Information sent to schools and the State office must include only the:
    - child's name
    - child's date of birth
    - parents'/guardians' contact information including names, address(es) and phone number(s)
- Additionally, the fiscal agent is responsible for participating in and responding to CIS General Supervision and required reporting activities as follows:
  - Participating in any required training such as the CIS-EI orientation and/or any training identified based on the State's monitoring, findings, or determination processes.
  - Timely, accurate, and complete submission of all CIS-EI data for every child referred to, served by, or exiting CIS-EI services each month in order to meet federal reporting timelines.
- Responding within ten business days to all State requests for data or data correction.
- The fiscal agent must also respond within 30 calendar days to any special data requests made by the State for monitoring.

- The fiscal agent must ensure correction is made to any Part C Findings of Non-compliance, which the State conveys through formal written notification, within 90 calendar days of receipt of this notification. Once correction is made, the fiscal agent must notify the State through secure transmission of the data needed to verify the correction made by the CIS-EI service provider.
- The fiscal agent must monitor service delivery data and continuous quality improvement (CQI), including having available and referencing at the CIS-EI site copies of:
    - The Vermont Part C/Early Intervention State Performance Plan
    - Annual Performance Report including the State Systemic Improvement Plan
    - Any Monitoring Reports
    - Corrective Action Plans related to Findings of non-compliance
    - Annual Determinations:
        - Quality Improvement Plans to address areas of non-compliance. All Quality Improvement Plans must be submitted in accordance with the timelines issued by the State Part C Program Administrator.
        - The CIS-EI program must make available and discuss Part C data, findings, determinations, and develop any Quality Improvement Plan(s) with the local CIS Administrative Team and key partners who collaborate in the delivery of the CIS-EI services.

Section Three – CIS Coordinator

The CIS Coordinator will be employed at least .5 FTE at a level adequate to ensure that the following functions are satisfactorily completed, in addition to meeting the minimum qualifications and requirements outlined in the position description. For more information, please refer to the Fiscal Agent's Contract for Services.

The CIS Coordinator is responsible for:

- The orientation of new team members to the CIS integrated system, including:
    - The function of the three CIS teams.
    - Team members' roles and responsibilities.
    - Expectations for information and data sharing (including performance measure data and billing).
- Collecting data and ensuring timely submission of required encounter data, CIS performance measure data, and narrative reports to the State.
- Monitoring the CIS clients served within the region, identifying both Medicaid and non-Medicaid clients, and status of billing toward the regional allocation and communicating that data to the Regional Administrative Team.
- Serving as the liaison between the CIS State Team, regional CIS teams, and other community partners and disseminating all State communications and documents to partners.
- Knowing the parent education resources in the community and sharing the information with CIS service providers.
- Attending required CIS Coordinator meetings. If the CIS Coordinator is unable to attend, a designee must attend in the coordinator's stead.
- Ensuring representation by the region when required for scheduled CIS calls or meetings as indicated in the meeting invitation.

Section Four – CIS Teams

The CIS model is based on integrated team collaboration and coordination of services. This is achieved through the three teams described below that meet on a regular basis with representatives from each agency and service delivery. The teams are an integral part of CIS and promote the delivery of high-quality health promotion, prevention, and early intervention services. The teams maintain the close connection that is needed to support families in their service decisions. The CIS Coordinator plays a key role in the planning and facilitation of the teams described in this Section.

The CIS Administrative Team

The team meetings are regularly scheduled monthly meetings to discuss local systemic issues and monitor and govern regional CIS activities. The regional Fiscal Agent (referred to as the "Contractor" within the CIS contract) must participate in these meetings and ensure required activities occur. Activities of this team include:

- Development of a Governance Document. The Governance Document shall be reviewed and updated at least annually and will address issues of membership, voting protocols, budget development, and other items as determined by the Team. These new and revised documents must be submitted to the State annually and upon request. See Governance Documents below.
- Supporting the contractor in monitoring the regional allocation. This shall include reviewing monthly reports that detail the status of billing and paid claims toward the drawdown of the regional allocation by the end of the State fiscal year.
- Review regional data to determine population need and service capacity and use this data to inform and adjust regional fiscal allocations among service areas in accordance with local governance agreements.
- Develop, implement, govern, and evaluate the regional CIS system to ensure clients get needed services in a coordinated and integrated manner.
- Ensuring CIS participation in community initiatives addressing issues for children prenatally up to age thirteen and their families, as well aseducation, as appropriate.

CIS Regional Governance Documents

- Bennington (PDF)
- Brattleboro (PDF)
- Chittenden (PDF)
- Hartford (PDF)
- Morrisville (PDF)
- Rutland (PDF)
- Springfield (PDF)
- Washington (PDF)

The CIS Referral and Intake Team

The team reviews referrals and intakes for all services to determine initial primary service coordinators and make determinations for CCFAP, family support service need. At a minimum, the team holds a weekly scheduled meeting to address all referrals, even if the client/family is known to CIS. The primary service

coordinator will be adjusted as needed. For a full description of referral and intake guidance and policy, see Section Six of this manual.

The CIS Consultation Team

The team meetings must be held at least monthly but may also be held as needed upon request of the client/family/team. If the client/family is not present for the meeting, client/parent/guardian consent must be obtained in order to share personally identifiable information (PII).

The Consultation Team consists of service providers with diverse experiences and expertise and convenes to support the client/family/team in providing services to pregnant and postpartum people, families with young children, and early childhood programs. Consistency of team membership supports collaborative relationships and practices and provides consistent feedback to the referring team(s). The multidisciplinary composition of the team should complement the client/family/team membership so that the needs of the client/family can be fully addressed.

Section Five – CIS Services

CIS services are part of a consistent, comprehensive, and collaborative continuum of care across multiple types of providers and settings, through connections with high-quality health care and community support services. The goal is to improve the health and well-being of pregnant and postpartum people, infants, and children, to achieve progress on parental and child safety, family stability, and optimal healthy development. Described below are the four CIS services:

- Strong Families Vermont Home Visiting
- Early Intervention in accordance with IDEA Part C
- Early Childhood and Family Mental Health
- Specialized Child Care Support

Strong Families Vermont Home Visiting

Strong Families Vermont (SFVT) is a continuum of nurse and family support home visiting services, provided through a collaboration with the Vermont Department of Health (VDH). SFVT supports pregnant people and new parents through home visits delivered by trained professionals using a continuum of services. Home visitors' partner with each family to set goals and promote optimal development, health and wellbeing. Home visits also provide an opportunity for early screening and identification of potential challenges facing families, as well as connections to the broader array of CIS and other local services and supports. SFVT serves pregnant and postpartum people, infants and children birth to age six.

Resources:

- Strong Families Vermont. Start At Home
- CIS Continuum Graphic

strong families
VERMONT start at home

Strong Families Vermont supports pregnant people and new parents through home visits delivered by trained professionals using a continuum of services. Home visitors partner with each family to set goals and promote optimal development, health and wellbeing. Home visits also provide an opportunity for early screening and identification of potential challenges facing families, as well as connections to the broader array of Children's Integrated Services (CIS) and other local services and supports.

SUSTAINED HOME VISITING

Nurse Home Visiting Program
Registered nurses from home health agencies deliver a long-term, structured, evidence-based home visiting program for families including at least 25 visits during pregnancy up to age two. The program improves maternal and child health and family economic self-sufficiency, promotes optimal child development, prevents child abuse and neglect, and coordinates referrals to community resources.

Family Support Home Visiting Program
Trained professionals from CIS partner agencies deliver a long-term, evidence-informed home visiting program for families through regular visits up to age five. The program strengthens the parent-child relationship, builds social connections, prevents child abuse and neglect, and promotes optimal child development and school readiness.

RESPONSIVE HOME VISITS

Children's Integrated Services teams work together to connect families with Maternal and Child Health nurses and/or Family Support Workers to provide regular home visits in response to time-limited needs. These visits support and strengthen families' health, wellbeing, parenting skills, social connections and ability to address stressors.

UNIVERSAL HOME VISITS

Many communities in Vermont offer universal home visits through a range of community partners working together to ensure every family receives 1-3 visits during pregnancy and in the first months of parenting. These visits take many forms to provide a warm welcome and promote social connections, check in on the health and wellbeing of parents and baby, and share information about community resources to meet their needs.

Delivered in partnership with Children's Integrated Services, Vermont Department of Health Division of Maternal and Child Health, and your local community.

Nurse Home Visiting

SFVT nurse home visiting can utilize either a responsive or sustained model, providing comprehensive, community-based health education, advocacy, risk reduction, and/or case management activities. Eligible expectant people receive individualized assistance during pregnancy, preparing for childbirth, and becoming a parent. New parents/guardians receive supports in understanding the complex social, emotional, physical, and economic challenges and changes that occur during these role transitions to becoming a parent/guardian and learn about available community resources and supports. Infant and child health is monitored and supported through a prevention, anticipatory guidance, and health promotion lens.

SFVT nurse home visiting services must be provided in accordance with:

- Maternal and Child Health (MCH) perinatal nursing standards and competencies; the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision (4th edition); the Maternal Early Childhood Sustained Home-visiting (MECSH) curriculum as appropriate, and Vermont specific standards and guidance, including the VT Assembly of Home Health and Hospice Agencies (VAHHA) MCH goals and outcome.
- MECSH is an approved evidence-based home visiting model by the U.S. Department of Health and Human Services Maternal and Child Health Bureau. Regions implementing MECSH evidence-based home visiting model will participate fully in all required trainings, meetings, community of practice and implementation activities, curriculum, tools, and data collection as directed by the State and will:
    - Adhere to the MECSH "5 Core Elements," which are as follows:
        - Support parent and child health and wellbeing
        - Supporting parents to be future-oriented and aspirational
        - Supporting family and social relationships
        - Additional support in response to need
        - Child development parent education
    - Collect and record data to meet model fidelity and CIS requirements
    - Administer the required MECSH parent surveys

Family Support Home Visiting

SFVT family support home visiting services can be delivered utilizing either a responsive or sustained model with a focus on increasing parenting knowledge and skills, social supports, and child and family access to high-quality child development services, medical and dental care, and safe environments. Using culturally competent, family-centered supports, staff provide role modeling, parent education, and mentoring to develop functional skills of parents/caretakers/guardians and their child(ren). Families are encouraged to plan for and achieve their health, education, economic, interpersonal, social, and parenting goals and receive assistance to learn about and connect with community resources as needed.

Additionally, family support home visiting services must:

- Maintain linkages with health and other community provider systems to coordinate planning and service delivery for the MCH population, including addressing:
    - Barriers to health care access or other community services; and
    - Emerging population risks and/or trends.
- Provide health-focused prevention, promotion, and anticipatory guidance based on American Academy of Pediatrics Bright Futures Guidelines for Health Supervision (4th Edition).

- Parents as Teachers (PAT) is an approved evidence-based home visiting model by the U.S. Department of Health and Human Services Maternal and Child Health Bureau. When implementing PAT evidence-based home visiting model, regions will participate fully in all required trainings, meetings, community of practice and implementation activities, curriculum, tools, and data collection as directed by the State and will:
    - Participate in reflective supervision in a goals-oriented practice.
    - Comply with all PAT essential requirements as dictated by Affiliate Status.
    - Use data for continuous quality improvement (CQI).

Providing Services Within a Residential Program

Family support services may be delivered in a residential program setting (such as the Lund Family Center) for at-risk people and their children. These services focus on increasing social supports, parenting knowledge and skills, and child and family access to high-quality child development services, medical and dental care, and safe environments. Using culturally aware, family-centered supports, staff provide role modeling, counseling, and mentoring to successfully develop parent and child life skills. Young adults are encouraged to plan for and achieve their health, education, economic, interpersonal, social, and parenting goals and receive assistance to learn about and connect with community resources as needed.

In addition to those services listed in the section above, SFVT Family Support Home Visiting services delivered in a residential program include:

- Providing services to residents within the program regardless of the geographic region from which they originated.
- Facilitation of family connections with center-based or other community resources from the geographic region that the person identifies as being where they will be living after leaving the residential program. If the person is unable to make this identification, the program will work with the person's region of origin until such time as the person is able to articulate their preference. This work includes:
    - Identification of and providing access to resources that can support the person upon completion of the residential program.
    - Maintaining linkages with health and other community provider systems to ensure coordinated planning and seamless service delivery as the person transitions back to the community.
    - Regular contact and ongoing team meetings that include, at a minimum, an identified primary point of contact for the person from the geographic region that is identified as either the originating region or where they will live after completing the residential program.
    - Transition planning from the beginning of the person's participation in the residential program for their return to the geographic region that is identified as either the originating region or where they will live after completing the residential program.
    - Concurrent planning as needed for the person's child(ren)'s transition back to the community.
    - Ongoing support of the child(ren)'s needs throughout the person's participation within the residential program.

Early Intervention

Early Intervention (CIS-EI) services are provided to children birth to age three who are experiencing cognitive, physical, communication, social/emotional or adaptive delays, or who have a diagnosed medical condition that has a high probability of resulting in developmental delay as determined in accordance with State of

Vermont Special Education Rules (§2360.5.4). Fiscal Agents are required to provide references onsite at their CIS-EI program regarding the current federal and state laws, regulations, rules and state policies and procedures, and guidance related to Part C Early Intervention and Part B Special Education for Preschool Children. The following information applies to all CIS-EI practitioners including contractors, and direct service sub-contractor practitioners.

- Part C Early Intervention must be provided in accordance with Part C of the 2004 IDEA and in accordance with the reauthorized Part C regulations in effect for the contract period and the current State of Vermont Special Education Rules. Part C Early Intervention services must follow any additional State policies and/or guidance clarifying these regulations, rules, and data reporting responsibilities. The Part C Interagency Agreement between the Agency of Human Services and the Agency of Education can be found on the Agency of Educations website.
- Early Intervention practitioners must adhere to the position requirements as outlined in this manual. Additionally, all timeline requirements must be met in accordance with the timeline found in Section One of this manual, except in any instance where the federal law and/or the Vermont Special Education Rules are more restrictive.

Kinds of Services

CIS-EI services bring together families and service providers from many aspects of the community, including public and private agencies, parent child centers, local school districts, and private providers. Supports and services come together to meet each child's unique needs and the needs of their family in their home and community. Payment for services comes from a variety of sources, including insurance, Medicaid, participating agencies, local schools, family cost share, etc. By assisting in the coordination of locally available services, CIS is working to ensure that Vermont's young children and their families have access to the widest possible array of CIS-EI services.

Federal regulation for EI services: 34 CFR §303.13

CIS-EI services may include the following:

- Audiology
- Assistive Technology
- Counseling/Psychological
- Family training, counseling, and home visits
- Medical Evaluation (for diagnostic purposes only)
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Service Coordination
- Social Work
- Special Instruction
- Speech/Language
- Transportation
- Vision

Part C Timeline Tracker/Calculator

The Part C Timeline Tracker/Calculator (Excel) is a tool that regions can use to project forward and be planful in developing the one plan and transition activities for a client's time in early intervention to ensure compliance with IDEA Part C regulations.

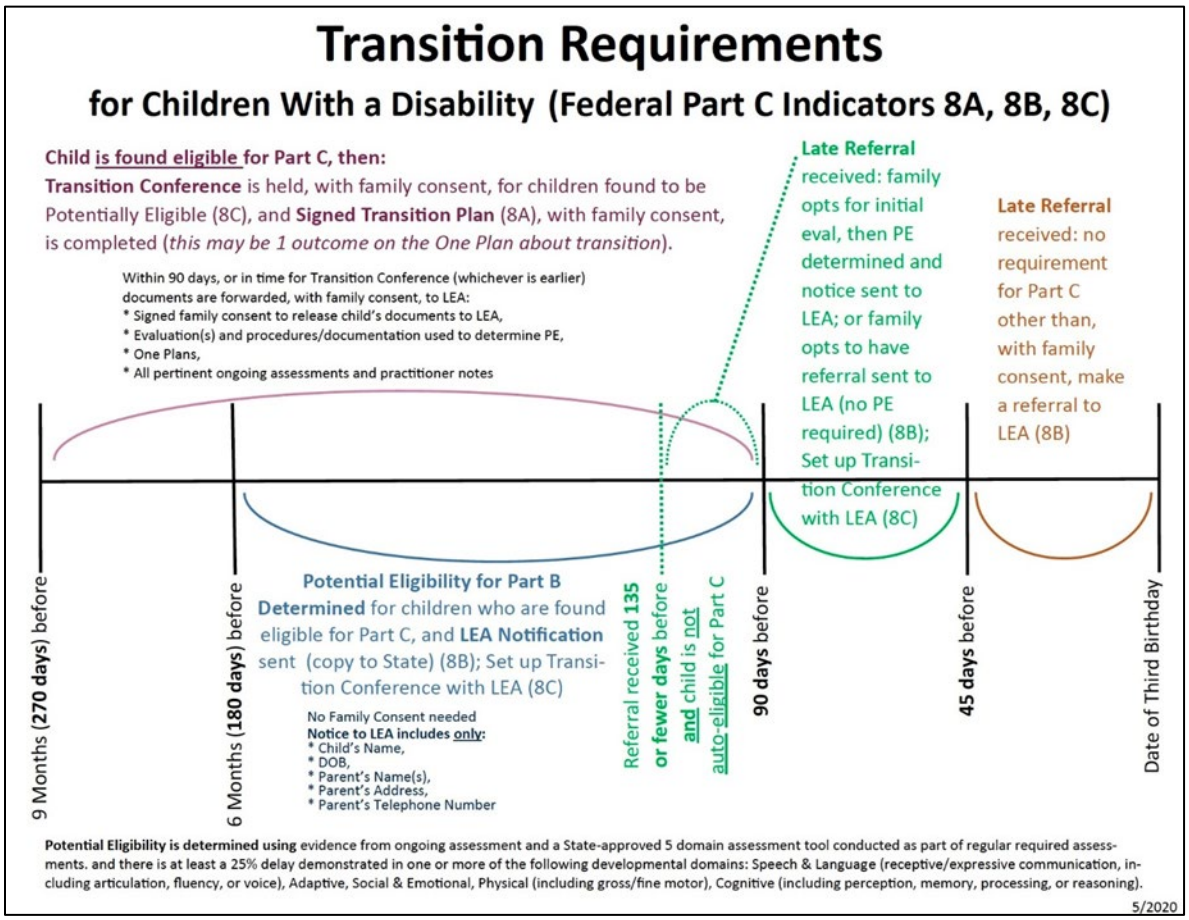
Part C to Part B Late Referral Transition Policy and Procedures

In compliance with federal IDEA Part C 34 CFR §303.209(b)(ii)(iii) regulations and Vermont Special Education Rules 2360.5.8 (June 1, 2013), the AOE and AHS jointly developed late referral transition policies and procedures to implement when children are referred to CIS-EI within 90 days of their third birthday. The complete policy and a helpful PowerPoint outlining the transition can be found on the AOE website.

Form 6B – Part C to Part B Transition

Form 6B is used to determine a child's eligibility for Early Childhood Special Educations Services once the child has turned three years old.

Transition Requirements



Definitions

- Every child who exits on their third birthday whose development is not age-appropriate (even if only in one domain) is considered to be **exiting with a disability**.
- **Received at least six months of services** means there were six months between the date of signed parental consent on the child's initial One Plan to the date of the child exited Part C.

- **Potentially Eligible** means the child has at least a 25% delay in at least one developmental domain as determined by a formal assessment tool administered in the regular course of service provision to the child between 270 and 90 from the child's third birthday. Potential eligiblity is determined:
    - By at least two members of the child's team,
    - Involves parental information and ideally the parent themselves is included in the determination process, and
    - Is done only once, at a point in time between 180 and 90 days of the child's third birthday.
    - Whether or not there is evidence of a 25% delay at that point in time, the determination of PE stands. There is no redetermination, regardless of whether there is evidence found at that point in time.
- **LEA Notification** means a written notice, mailed to the school, containing:
    - Child's name
    - Child's date of birth
    - The date of the child's third birthday
    - Parent/guardian(s) name(s)
    - Parent/guardian(s) address and phone number
    - A statement that the child may be potentially eligible for Part B services on their third birthday
- **Late Referral** is a referral that is received that is received by CIS less than 135 days from the child's third birthday and the child is not auto-eligible for Part C services. Children who are auto-eligible for Part C services are considered late if the referral is received by the CIS less than 90 days from the child's third birthday. Part C auto-eligible criteria meet the criteria for PE, therefore an LEA notification may be sent without parental consent.
- **Transition Conference** is a meeting for every child determined to be potentially eligible held:
    - With parental consent and,
    - Participation of the parent and other members of the child's CIS-EI team,
    - With the school (LEA) to:
        - Discuss the evidence of delay that CIS-EI has in the child's file and the services that have been provided under Part C to the child and family,
        - An opportunity for the parent to share what they think their child needs, and
        - Develop the transition plan, and
        - Discuss the family's rights and procedural safeguards under Part B
        - Eligibility for Part B may or may not be determined by the LEA during this meeting. That is the discretion of the LEA. Any additional information needed to determine eligiblity for Part B may be requested from the child's Part C record, or may require additional assessment(s) conducted by the LEA.
        - The LEA may also discuss with the family other services or supports that may be available through the school to children after they turn three.
- **Transition Plan** is the plan developed for every child who receives CIS-EI services whose parent/guardian consents to a plan:
    - By the child's CIS-EI service coordinator with the child's team, including their family, and
    - Including the LEA if a transition conference is held, and
    - Includes steps and services that will be provided to the child and family to support the child's exit from Part C services regardless of the child's age or reason for exit.

Data Needed for CIS-EI When a Client Changes Regions

For the Region where the client is Exiting:

1. There should be a transition plan date for when the family talked about their exit from the Region.
2. An Exit COS should be performed.
3. Exit data should be sent to the state with child count.
4. The exiting Region should make a referral to the new Region.

For the Region where the client is Entering:

1. The referral date should be the date that the exiting region contacts the new Region.
2. The initial evaluation date, in most cases, will be the same as the previous Region's. If the child was out of the program for more than six months, then the Region the client is entering must perform a new evaluation.
3. The One Plan date should be the date that the family signs off on the One Plan for the new Region they are entering, even if there are no outcome changes made to the plan.
4. A new service grid with the date the family signs consent for the new Region should be sent to the state, even if the outcomes/services have not changed.
5. An entry COS should be performed.

Serving Early Intervention Clients Who Are Not US Citizens

Early intervention services under Part C of the Individuals with Disabilities Education Act cannot be denied to otherwise eligible children and their families on the basis of lack of citizenship or immigration status. Please reach out to the Part C Program Manager to determine the next steps.

Helpful Links

- CAPTA and Differential Response Memo
- CIS Part C Federal Reporting – APR Indicator 8a – Transition Plans Memo

Early Childhood and Family Mental Health

CIS Early Childhood and Family Mental Health (ECFMH) services assist children up to age six, and their families, child care providers, and programs or organizations serving the needs of young children and their families. Services address parent/child relational concerns, support access to and effectively utilize community services and activities, and develop parent, caregiver, and practitioner skills to promote and support children's healthy social, emotional, and behavioral development. The services, using evidence-based practices, are provided in settings identified by the child's family as their natural environment. ECFMH is not intended for intensive or long-term mental health treatment services, or treatment services delivered in non-natural settings.

- Services are delivered as described in Section 3 of the Medicaid Fee-For-Service Provider Manual produced by the Vermont Department of Mental Health.
- Consultation and Education Training services:
    - Provided beyond three sessions must be outcomes-based using a pre and post-assessment tool and utilize the One Plan.
    - Are intended to improve the overall capacity of caregivers and child care providers to support the healthy social, emotional, and behavioral development of young children.

- May be provided as requested by a family, child development professional, child care program, or other child-/family-serving community group and maybe either in-person (face-to-face) or by phone (but not by email).
- Consultation services may include:
  - Outreach, information, and referral for families who are not already receiving community mental health center treatment services. In this case, consultation may result in referrals to Dr. Dynasaur/Medicaid treatment covered services.
  - Addressing program-related issues or supporting the development of foundational skills to promote early identification, intervention, screening, and referral for mental health Medicaid services for young children and their families.
  - Program mentoring or reflective supervision for child care staff and other direct service providers to enhance their understanding of and skill in addressing factors within their programs to support children's healthy social, emotional, and behavioral health and development.
  - Identifying opportunities to improve collaboration on the early detection of mental health problems and to expand young children's access to mental health Medicaid services.
  - Responding to identified opportunities for community resource development through program planning, policy development, and interagency coordination.
- Education services may include:
  - Training for the community mental health center staff or other CIS and community early childhood professionals about the benefits of participating in medical/Medicaid-related services, assisting families in accessing such services, and more effectively referring children and their families to such services.
  - Training of foundational skills for families, community-based groups, and early childhood professionals to support children's social, emotional, and behavioral health and development.
  - Learning about the paperwork necessary for documenting consultation. However, education services do not include the day-to-day supervision of community mental health center staff (or contractors) or internship students.

Therapeutic Child Care Services

Therapeutic child care services are intended to provide outcome-based, planned combinations of consultation, education, and intervention services within high-quality child care settings. Therapeutic child care services funded through CIS supports:

- Children to develop their social and emotional skills
- Parents to develop their knowledge and skills on how to support their children's social and emotional needs
- Child care staff to develop their ability to support children's healthy social and emotional development

Therapeutic child care services are outlined within a formal agreement between a regional CIS ECFMH service provider and the specialized child care provider in which these services will be based. The Agreement is available to a region's specialized child care providers that:

- Have a quality factor of 3 STARS or greater, and who have attended advanced trainings intended to enhance program quality and delivery of services to support children's healthy development (ex. Fundamentals of Early Learning).
- Have a demonstrated high need for this service due to the identified needs of enrolled children or other documented[1] circumstance(s).
- Have a demonstrated commitment to accommodating the individualized needs of the children served.
- Have a balanced enrollment of children with typical development[2], children potentially at risk[3], and children with identified specialized needs[4] within the fiscal agent's region. For programs not meeting this standard, the fiscal agent will provide the State with a plan for achieving a balanced enrollment of children. The plan must be submitted to the Child Development Division, 280 State Drive, NOB 1 North, Waterbury, VT 05671-1040, by December of each contract year.

In addition, it is expected that specialized child care providers:

- Support the Division for Early Childhood and the National Association for the Education of Young Children's joint position statement, which identifies early childhood inclusion as "the values, policies, and practices that support the right of every infant and young child and his or her family, regardless of ability, to participate in a broad range of activities and contexts as full members of families, communities, and society."
- Participate in the State's Child Care Financial Assistance Program (CCFAP) and are committed to enrolling children supported by the CCFAP as 30% enrollment census.
- Accept the State's CCFAP Maximum Rate as full payment for child care services provided to families receiving 100% of CCFAP benefit.
- Provide full-day/full-year services; after school programs must provide full-year services and be available for full-day when schools are not in session. If the fiscal agent wishes to serve part-day/part-year programs, the 12-month agreement must include a provision for providing continuity of CIS ECFMH services for child care program-enrolled children/families so those services will be maintained during the times when the child care program is not operating.
- Provide continuity of care for children and families who are currently receiving services in the program and actively support regular attendance for enrolled children.
- When needed, refer families to the local CIS team to access CCFAP benefits to ensure continuity of child care enrollment.

---

[1] Documented is defined as: the program has written a proposal document that includes quantitative and qualitative data that identifies the particular circumstances they are using to justify the need for therapeutic child care within the child care program.

[2] Typical Development is defined as: at the time of enrollment, the child has no current diagnosis of a health or developmental condition that might cause them to be identified as needing services, supports or interventions.

[3] Potentially at Risk is defined as: at the time of enrollment, the program having some information that suggests risk factors that might impact the child such as the child: having a specialized service need identified through the child care financial assistance program; being referred to or assessed by the local CIS program; being referred for a special education services evaluation or a coordinated services plan; the child's family being assessed by the FSD, etc.

[4] Identified specialized needs is defined as: at the time of enrollment, the child having a current diagnosis of a health or developmental condition that requires the child to need services, supports or interventions, or an open case with the FSD, or an active CIS One Plan for family support through the family's child care financial assistance benefit that has goals directly involving the child or addressing risk factors that have a direct impact on the child.

- Provide a range of services to benefit children and families' health and development, including nutrition services, inclusive care and education services, and support for children's health and mental health through ongoing professional development of staff, and the program's continuous improvement plan.
- Ensure families are active participants in the program; and that the program's policies, values, and practices empower families as informed caregivers and advocates for their children.
- If eligible, the program participates in the Child and Adult Care Food Program.
- Have documented evidence of regular, ongoing collaboration with local resources that provide supportive health, development, and child care services to children, families, and child care programs.
- Operate with up to a 12-month agreement between a regional CIS ECFMH service provider.

The agreements must include, at a minimum:

- Evidence of support for this therapeutic service agreement from the local CIS Administrative Team documented by team members signatures on the agreement.
- The provision of regularly scheduled mental health support to promote the healthy social and emotional development of at-risk populations of children enrolled in the child care program by providing:
    - Consultation by a qualified, supervised mental health professional to child care staff
    - Training related to social, emotional, behavioral and/or challenging family issues provided to child care staff, parents, or others associated with the child care program
    - Support with children's healthy social and emotional development
    - Positive behavioral support
    - Modeling of effective strategies/interventions for child care staff
    - Contact/availability of a mental health professional to families of enrolled children (ex. families invited to trainings or made aware of mental health staff on-site during drop-off/pick up times, or during open houses/parent-teacher conferences, etc.)
    - Regularly occurring, practice-related supervision coordinated by the regional CIS ECFMH service provider with the on-site clinical and child care staff

Agreements may also include direct therapeutic services provided within the child care setting to individuals or groups of children in order to support children's inclusion in the daily program activities.

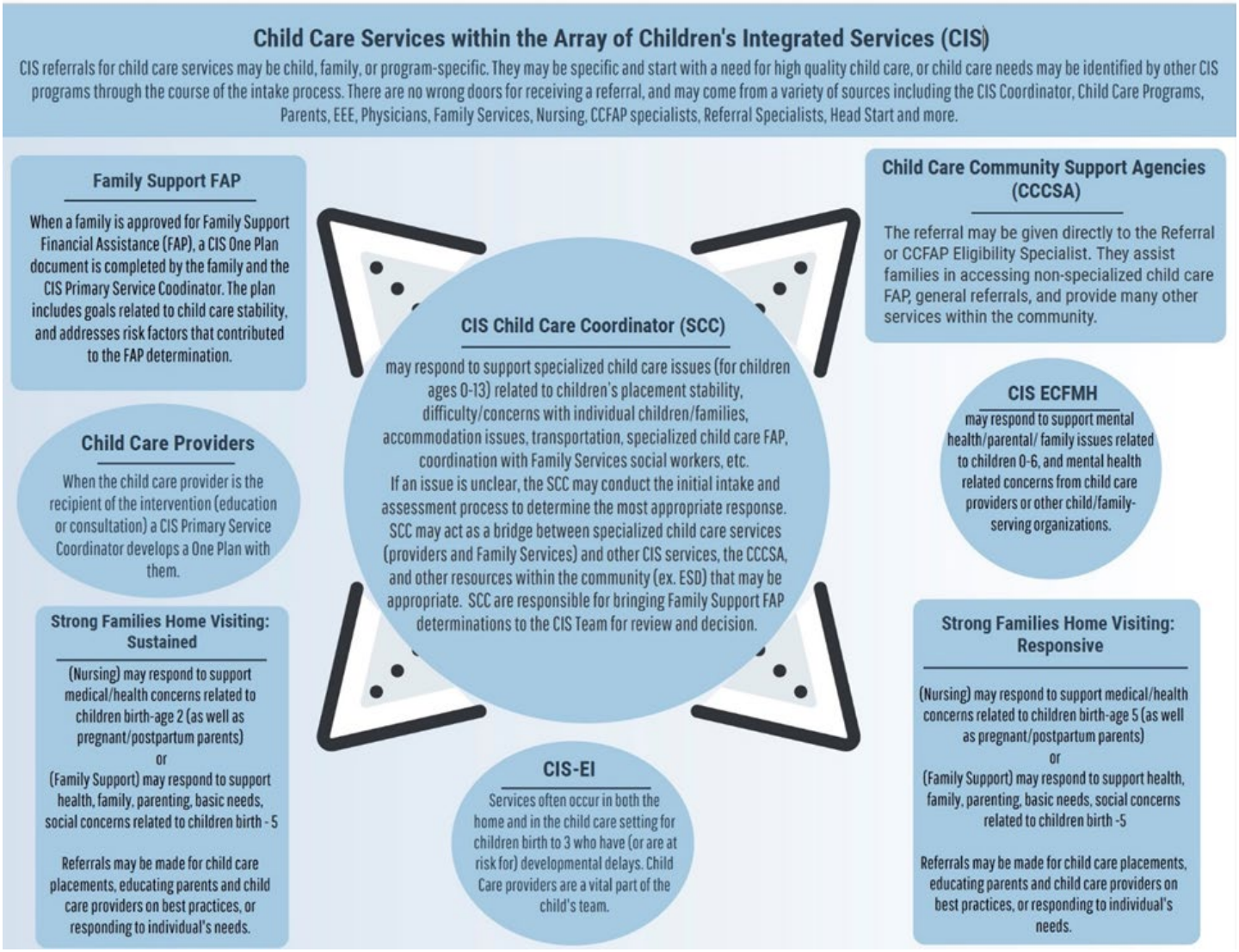
- A need for direct therapeutic services must be identified by using at least one evidence-based assessment tool administered and documented by a qualified practitioner.
- Goals for direct therapeutic services will be documented using the CIS One Plan when provided to individuals, or through an amendment or addendum to the above referenced 12-month agreement when provided to a group or the program as a whole.

Specialized Child Care

Specialized Child Care Coordinators (SCCC) are versed in all systems within the CDD and serve children, families, and child care programs through the following efforts:

- **Eligibility:** SCCCs provide eligibility determination for all SCC service needs, including CCFAP, family support service needs, Children with Special Health Needs (CSHN), and Protective Services Authorizations with the FSD.

- **Case Management:** SCCCs work with families, caseworkers, and child care providers to find eligibility determination, enhanced child care placements and supports, and individualized service planning and collaboration with the FSD and the CIS multidisciplinary team.
- **Program Capacity Building:** SCCCs work to build the capacity and quality of high-quality child care programs. They provide ongoing technical assistance to increase the capacity of specialized child care programs, supporting the program's ability to care for children with special needs. SCCCs work with licensing, referral, eligibility, and Northern Lights at Community College of Vermont (CCV) to ensure child care programs access high-quality professional development, increasing STARS, Special Accommodation Grants (SAG), and managing transportation. They also support a family's access to the necessary resources and supports they need for their children with special health needs.



Child Care Financial Assistance Program – Service Needs

The SCCC is responsible for case management and oversight of the following service needs under the CCFAP Regulations:

- **Family Support Child Care** is a prevention and early intervention service designed to reduce stress for families and their children and promote positive child development. The child care financial assistance may be authorized after a confidential application and risk assessment have been completed and

reviewed. Generally authorized as part-time or may be authorized as full-time. Program duration is generally one year.

- **Special Health Need – C (Child)** is established when the primary caretaker(s) can demonstrate that their child has a significant health or specialized developmental need as documented by a licensed physician and/or licensed psychologist or by the assessment determining eligibility for special education or early intervention services that includes child care as part of the child's development plan (IEP or IFSP). Child care hours will be determined based on the days and hours per week documented in an individualized plan for the child. Families accessing the CCFAP for a Special Health Need - Child must meet income guidelines on the sliding fee scale.
- **Protective Services Child Care** is personalized child care that includes a planned child development intervention strategy authorized by the FSD Social Worker and must be part of the family plan as a safety strategy. The child care provider is an active participant on the Family Services team for children receiving protective services child care. This specialized care may only be given by a provider that has submitted a provider rate agreement in the Child Development Division Information System and has a signed and filed current Specialized Provider Agreement (Part III) and is in compliance with all requirements.

Family Support Child Care

The intent of Family Support Child Care (FS) is to support families while they address the stressors that qualified them for the benefit. The financial assistance enables children up to age 13 to be safely and consistently cared for in a high-quality child care setting while their parents/guardians work on a plan that addresses and mitigates their family's risk factors/stressors.

CIS Teams, led by the SCCC, will approve FS financial benefits for a 12-month period unless the parent/guardian requests a shorter amount of time. If a parent/guardian requests a shorter time or the child/ren leaves child care, CIS teams will need to document this in writing for CCFAP auditing purposes.

Case Management

The SCCC is the case manager for families receiving FS and supports families to reach the goals they set using the following benchmarks:

- Strengthen family and community connections and support.
- Establish links with community support systems.
- Respect the integrity of the family.
- Create opportunities for parents to feel empowered to act on their own behalf.

Information for CIS Teams

The application process for FS can be found here:

The SCCC presents the FS applications at the weekly CIS Referral and Intake Team Meeting. The team will use the information to discuss the family's risk factors and determine if the family is eligible for FS.

The SCCC will facilitate and review the process with the CIS Team. During the review process, each CIS support team member will:

- Respect the family's dignity, and consider their strengths and resources along with their needs and difficulties.

- Keep in mind that the primary goal is keeping children safe, now and in the future.
- Create specific, measurable, attainable, relevant, and timely goals (SMARTIE) with the family.
- Decrease risk and increase protective factors.
- Maintain confidentiality.

Tools for Determining Eligibility for Family Support Child Care

The SCCC will use the Family Support Child Care Score Sheet (Word) to document the score of each indicator and/or notes that are directly related to the conversation that supports the eligibility determination, the date of the meeting, and a list of all the participants involved in the eligibility determination process. The completed score sheet must be included in the family's FS CCFAP file.

The SCCC will facilitate the FS determination meeting with the CIS Team using the "A Measure of How Families are Doing" rubric to determine the right score for each item. The score is determined along the continuum based on the family's individual needs and the resources available within the community.

Family Support Next Steps

Once a determination for FS has been made, the SCCC will notify the family of the decision first by phone, and then they will notify the family and the primary service coordinator in writing. The team's decision must be recorded in the CDDIS.

The SCCC will work with the eligible family to develop a One Plan. The One Plan defines how the parent/guardian(s) will address the risk factors. The One Plan must document the frequency and method by which the SCCC will be connecting with the family to review their progress on their plan. The SCCC will meet with the family to review the plan at a minimum of every three (3) months.

The CIS One Plan is the preferred planning document, but if the family is actively working with a provider who is helping them to address their primary risk factors (ex. Head Start Home Visitor, the Refugee Resettlement Project, therapist, or housing support services) a copy of that plan will be included in the file.

If a copy of the other service provider's plan (ex. mental health) cannot be included in the client's file, then the SCCC is responsible for creating a CIS One Plan with, at a minimum,

- the client consent page,
- service grid, and
- the outcome page(s), which include the activity(ies) and services/resources that the family will be accessing to achieve their goal(s).

Example of Working with Other Service Providers:

A housing specialist was recently at the staff meeting where the SCCC provided information about family support child care. The housing specialist is going to work with the parent/guardian to apply for FS child care. The SCCC is assisting the housing specialist in completing the necessary paperwork to submit the FS application.

The housing specialist is already working with the parent/guardian, and will help them complete:

- CCFAP Application
- CIS-Referral
- CIS – Family Support Intake Supplemental
- CIS- 03 Authorization Form completed and signed with child care and housing specialist listed

If the housing specialist does not have a plan to share or the plan does not currently include child care as a goal for the family, the following documentation should be completed by the SCCC for the file.

- Summary Report Page: Summarizes all the information gathered about the referral and eligibility.
- Outcome Page: A family may be working with a housing provider to secure a safe place to live that they can afford. This activity may be recorded using the outcome page

The SCCC outcome grid illustrates how the parent/guardian will follow the plan developed with the housing specialist.

We want:	**So that:**
To work with our housing specialist and follow their plan.	We have a safe and secure place to live
Strategies: • Parent/guardian and the housing specialist Rita will meet weekly. • Parent/guardian and Rita will schedule a meeting with the financial planner at Head Start next month. • Parent/guardian will save money weekly towards a deposit on the house/apartment • Melissa will attend child care 3 days a week. Parent/guardian and the housing specialist Rita will meet weekly. • Parent/guardian and Rita will schedule a meeting with the financial planner at Head Start next month. • Parent/guardian will save money weekly towards a deposit on the house/apartment • Melissa will attend child care 3 days a week.	**How will we know when we are successful?** We will have safe and affordable housing.

Eligibility Period

In 2014, the Child Care Block Grant established a minimum 12-month eligibility and redetermination period for eligible CCFAP families. To meet these requirements, CIS teams will need to approve FS financial assistance for a 12-month period unless the parent requests in writing a shorter amount of time. If a parent requests a shorter time or termination of the child care, the SCCC will document this in writing for CCFAP auditing purposes.

Six-Month Plan Review

The six-month plan review involves discussing how the family is doing with their identified goals, reviewing available resources or services, and discussing the transition from FS at the end of 12 months.

- The SCCC must complete a six-month plan review to access or change the outcomes or goals with the family. If applicable, the Primary Service Coordinator needs to be involved with the reviews.

- If another service provider holds the One Plan, the SCCC is still responsible for completing a six-month plan review form. The six-month review can be completed during a co-visit with the SCCC and service provider, through a telephone conversation, or solely by the SCCC or the service provider.
- Store completed six-month plan review forms in the family's file.
- The CIS Referral and Intake Team do not need to reapprove FS at six months.

Transitioning from Family Support Child Care

Transition planning should begin at the six-month review to ensure that the family remains stable when FS ends.

Reapplying for FS

FS applications beyond the initial 12 months should be considered the exception to the rule.

1. If a family needs an additional 12 months of FS, the discussion with the family or primary service coordinator should start 90 days prior to the initial authorization ending.
2. Assess, change, or update current goals and the service grid; the parent/guardian's signature is required. However, if the family did not meet with the SCCC to develop goals and/or meet to complete the six-month review, they cannot reapply for FS.
3. A new CCFAP application is required every 12 months with supporting documentation to continue FS.
4. The CIS Referral and Intake Team will determine eligibility for an additional 12 months. The team will formally review the necessary documentation to determine eligibility, including the ongoing One Plan. The CIS team should use the FS score sheet to determine eligibility. The score sheet must include the CIS team members, the score, resources or referrals, and the final decision made by the team.
5. Document the team's decision and the meeting date in CDDIS.
6. Requests to approve FS beyond 24 months must go through the CIS State Team for review and approval. The request must be received by the CIS Child Care Administrator 30 days prior to the end of the 12-month child care authorization and should include an updated review of the file by the CIS team, a new score sheet, a CCFAP application, and an updated one plan.

Child Care Program Capacity Building

Specialized Child Care (SCC) providers have committed to providing the best quality care to vulnerable children in their care. They agree to continuous professional development that targets children's social-emotional development to enhance and improve their skills in a safe and supportive environment.

The SCCC should be prepared to answer any questions the program may have related to becoming an SCC.

Specialized Child Care Agreement

The SCC Agreement is a legally binding document that lays out the requirements and expectations for an SCC program. The SCC Agreement status will be determined and approved by the CIS State Team based on the following:

1. The program meets all the requirements outlined in the SCC Agreement.
2. The SCCC has visited the owner or director of the program to review the SCC Agreement and completed the On-Site Consultation form.

3. The program owner or director signed the SCC Agreement, and the SCCC submitted the signed agreement to the CIS State Team.

Specialized Child Care Provisional Agreement

The SCC Provisional Agreement is for programs that do not meet the requirements under the SCC agreement to become specialized and are only for programs caring for a child with a CCFAP protective services need. Provisional agreements may be used in exceptional circumstances when no other SCC program is available or when a child is already attending a program when the child enters protective services.

The SCC Provisional Agreement differs from the SCC Agreement because it is time-limited and specific to the child identified on the agreement. If an SCCC receives information that a provisional SCC program has enrolled additional protective services need children, they should report that information to the CIS State Team as soon as possible.

The CIS State Team will determine the SCC provisional status based on the following:

1. The child care program is in good standing with CDD child care licensing regulations.
2. The SCCC has conducted an on-site visit with the owner or director of the program to ensure and discuss their willingness to meet the criteria to become a fully approved SCC program. The program will need to have a plan to meet the requirement to attain 3 STARS within a time-limited period.
3. The On-Site Consultation review form and SCC Provisional Agreement are signed by the program owner or director and the SCCC.

SCCCs must keep track of the SCC Provisional Agreements and notify the state when those children are no longer attending. The SCCC will ensure the FSD social workers do not place additional children with a provisional SCC provider. SCCCs will work closely with FSD social workers to support them in finding the right child care program.

Child Care Program Site Visits

Site visits for SCC applicants are required at least once before a program becomes specialized.

1. The SCCC must complete the On-site Consultation Review form at the visit and keep a copy for their records.
2. The SCCC will send the signed SCC Agreement and the On-site Consultation Review form to the CIS State Team.
3. The CIS State Team will review the SCC Agreement, the On-site Consultation Review form, regulatory history, and any other relevant information and decide on awarding status.
4. If approved, notification will be sent through the CDDIS, and an award letter emailed to the program and the SCCC. The letter will detail steps needed to maintain status, including annual professional development requirements.
5. CDD will verify that the provider continues to meet the requirements when their annual license is under review. If the program does not meet the standards and CDD removes their SCC status, the SCCC will be notified and will then work with the FSD to find alternate child care for the children with a Protective Services designation.

Out-Of-State Child Care Programs

Out-of-State child care providers are typically used when working with the Family Services Division to place a child. CDD is unable to approve payment for these services until the out-of-state child care program is formally approved by CIS and CDD licensing.

For CIS Child Care Coordinators requesting Out-of-State Specialized Child Care:

1. Please fill out the out-of-state provider packet and submit it to AHS.DCFCDDSCCServices@vermont.gov.
2. After CDD approves the out-of-state provider in CDDIS, communicate through a phone call and email to the program director:
    a. Provide the social worker's email and phone number to share relevant information as it pertains to the child in care.
    b. Provide your contact information if they have questions or need support to find additional resources for the child in care.
    c. Provide information on setting up a provider account with CDDIS and the attendance/payment process.

Helpful Links

- SCC FAQs
- SCC Case Management and Coordination Snapshot
- The CIS CCFAP FS Cheat Sheet
- FS Child Care Evaluation/Recommendation Sheet (Word)
- FS Supplemental Application – Parent Information
- FS For Refugee Families

Section Six – Referral and Intake

Types of Referrals

CIS works with many different community providers. Below are examples of the kind of referrals CIS receives:

- A pregnant or postpartum person who has questions or concerns about a condition or risk situation that impacts their health or safety
- A parent of a child aged three or younger who has questions or concerns about a suspected developmental delay or condition that would affect their child's development
- A family who has questions or concerns about how to help their family provide a stable and healthy environment for their child(ren)
- A child care program with questions or concerns about how to support a child's development and about available resources to maintain the child's placement
- A local OB/GYN with concerns about a pregnant or postpartum person

Referral Sources

Primary referral sources include but are not limited to:

- Physicians & other health care providers
- Hospitals

- Child care programs
- Early Head Start and Head Start
- Health Department programs (e.g., WIC, CSHN, Child Development Clinics)
- Mental Health & Developmental Disabilities agencies
- Schools
- Parent Child Centers
- Child and Family Service agencies and other early childhood practitioners
- FSD

Referral sources also include self-referrals from pregnant and postpartum people and parents/guardians of children birth to six years of age.

Communication about the Referral Outcome

CIS clients control how, when, and how much information is shared with a primary referral source. Authorization must be given to the CIS Referral and Intake Team rather than to an individual agency to share outcome information. (Example: A referral comes from a primary care provider, and ECFMH is identified as the intake coordinator. The parent/guardian must authorize the CIS Referral and Intake Team to share information with the primary care provider, rather than authorizing the ECFMH agency alone.)

Referral Process

The referral process must include:

- Assurance that the family's verbal consent is received and documented and that consent is documented on each separate referral.
- Assurance that there is coordination with the team and minimal duplication across CIS services.
- Management of incoming referrals, including:
    - With the regional CIS Referral and Intake Team, discuss and identify the appropriate CIS staff person who is initially assigned as the primary service coordinator to conduct the initial intake and screening.
    - Triaging urgent care (mental health, Neo-Natal Intensive Care Unit (NICU) or other medical, child protection, or any high-risk situation requiring immediate response).
    - Referring children birth to age three with developmental concerns who may be potentially eligible for a Part C Early Intervention evaluation within two business days.
    - Making referrals for pregnant and postpartum people eligible for Sustained Nurse Home Visiting to the home health agency by the end of the next business day or sooner.
    - Referring children who may or have qualified for specialized child care.

Initial Contact

- Contact with all referred pregnant or postpartum people, families, or child care programs must occur within five business days from the date of referral.
- Exceptions: referrals for children ages birth to three with a developmental concern require review by Part C Early Intervention and families contacted within five calendar days, which is the timeframe mandated under Federal law (34 CFR 303.303 (a)(2), Special Education Rule 2360.5.2 (a)(3)).
- Inform individuals about CIS services, the regional CIS processes, and what to expect.
- Document all attempts at contacting referred individuals.

- If unable to make contact after three attempts, CIS providers must follow the CIS Guidance regarding "Lost to Contact" as found in #11 of this Section.

Intake Process

The intake process must include:

- Obtaining appropriate written authorization using the CIS-03 Authorization form
- Obtaining information listed on the CIS-02 Intake Form
- Verifying the client's contact information
- Obtaining insurance information by completing the CIS-02 Supplemental Form and social security numbers, if applicable
- Obtaining consent for evaluation, if applicable
- Obtaining Family Support Child Care Financial Assistance Supplemental Form information, if applicable
- Getting a signed Consent for Services form before any CIS direct service is provided (home visiting, specialized instruction, developmental education, parent education, ECFMH services, consultation to families or child care providers, provider education)

Authorization Form

The purpose of the CIS Authorization Form is to obtain written authorization for the CIS Intake Team to:

- Review and triage referrals
- Obtain initial intake and further assessment/evaluation information as necessary to determine the services necessary
- Coordinate services across all Early Childhood providers based upon services determined necessary
- Consult with the CIS Early Childhood Consultation Team when needed

If a service plan is needed, written authorization specific to the services that use an authorization in the plan will need to be obtained.

For additional support with the Authorization Form, please review the instructions and guidance document.

Intake Form

The purpose of the form is to provide a tool to document more in-depth knowledge about the referred individual regarding their concerns, current support services, or reason for referral and to identify the next steps with that individual. Completing the form occurs after an initial referral is made and may be used by any member of the CIS Intake Team or a primary service provider.

Primary Service Coordinator

Assignment of the Primary Service Coordinator

- The primary service coordinator should be assigned from the community where the family anticipates their child will attend public school.
- In cases where parents/guardians have shared legal custody but live in different regions, the family should indicate in which region they anticipate the child will ultimately be enrolled in public school.

- One Plan direct services are sub-contracted by the primary service coordinator's region's fiscal agent to the designated co-serving region, which will provide these direct services (except for out-of-bundle services, which do not need a sub-contract).
- The regional fiscal agent hosting the primary service coordinator counts this child toward their monthly minimum caseload number for billing purposes

Primary Service Coordinator Responsibilities

The Primary Service Coordinator's responsibilities include:

- Promoting and facilitating communication among all team members
- Assuring coordination of services
- Serving as a single point of contact in helping CIS clients to obtain the resources and services they need
- Facilitating and/or performing screenings, initial evaluations, or ongoing assessments as needed for determination of eligibility, progress, and/or program planning within defined timelines:
    - The initial One Plan development meeting must occur within 45 days of assignment to the primary service coordinator.
    - Services identified in the One Plan must begin within 30 days of signed consent of the One Plan document.
    - Include the family's service providers on the individual child/family team (including school personnel, health care providers, juvenile justice, law enforcement, other AHS staff, and others at family request).
    - Ensure the provision of year-round services for pregnant people and children from birth to age six and their families through appropriate activities as indicated in the One Plan.
    - Consult with and provide interpretation/synthesis of the information to parents/caregivers.
    - Provide direct instruction/modeling of prevention/intervention techniques and strategies to families, caregivers, and other providers.
    - Design appropriate learning environments and activities that promote an individual or family's acquisition of skills that promote healthy development in all areas.
    - Utilize the CIS Consultation Team as family/individual needs are identified to help inform the One Plan.
- Identifying how services are delivered and/or supported within the child care setting when child care is part of a child/family's plan.
- Providing written notification to CIS clients of their exit from CIS services because of inability to contact.
- Reviewing and updating the One Plan at least every six months or more often as needed or when a change is identified.
- Submitting required documentation to the State, especially for out-of-bundle services (ex. POLR & nursing PA's).
- If the service intensity of a shared client has a significant negative fiscal impact on a region, the Primary Service Coordinator is responsible for notifying his/her CIS Technical Assistance Liaison. The TA Liaison will bring the information to the CIS State Team for review.

Sub-Contracts

The following are recommendations for inclusion in sub-contracts:

- Ensure representation of both regions at all One Plan team meetings (beginning with the initial meeting).
- Articulate a clear communication protocol between both regions.
- The service provider and location of service delivery are clearly identified.
- Identify how out-of-bundle CIS services will be delivered and how required documentation will be managed.
- Articulate how in-bundle payments for CIS services will be disbursed to the non-primary service coordinator region (ex. monthly invoices).

Unable to Contact Family/Guidance Communication Templates

- Child Care Unable to Contact at Referral
- Child Care Unable to Engage After Services Have Begun
- After a Family or Child's One Plan is Written but No Services Have Begun
- Lost Contact with Family After Services Have Begun

Section Seven – Developmental Screening, Evaluation, and Assessment

Children grow, develop, and learn throughout their lives, beginning in pregnancy. A child's development can be measured as they move, play, learn, speak, and behave in the context of their family and their community. These actions are indicators of their developmental milestones. When a child does not reach age-appropriate milestones at the same time as other children of the same age, this is considered a developmental delay. If a child is not developing as expected, steps can be taken to support a child in reaching their full potential. Parents'/guardians concerns are generally valid and are predictive of developmental delays.

CIS service providers conducting developmental screenings, evaluations, and assessments:

- Promote the importance of universal developmental screening (UDS) with families and providers and the utilization of the UDS registry.
- Refer to the CIS Approved Developmental Screening Tools document to identify State-approved comprehensive screening, evaluation, and assessment tools that address physical, psycho-social, developmental and environmental health, including protective and risk factors.
- Obtain consent from the client/parent/guardian before conducting a screening, evaluation, and/or assessment.
- Require that all evaluation and assessment activities include a review of and incorporation of relevant information such as observations, interviews, and information received from sources such as the family, health care provider, child care provider, other state agencies or programs, or others involved with the child and client/parent/guardian.
- If directed by the State, the Fiscal Agent shall bill Medicaid for initial evaluations for Medicaid-eligible children that are conducted to determine eligibility for EI services. Billing for these evaluations shall be done in accordance with guidance provided by the State. The Contractor shall not retain more than 10% of the funds from this billing for administrative fees. The Contractor shall ensure the entity/subcontractor who conducts these evaluations is remitted the remainder of the funds from the Medicaid billing.
- Communicate all screening, evaluation, and assessment results to the client/parent/guardian, the rest of the team, and the referral source when appropriate.

- Identify the need for any additional specialized assessment and ensure documentation of this on the client's One Plan.
- Schedule a multidisciplinary review by the client/parent/guardian.

Section Eight – One Plan

Fiscal Agent Responsibilities

The fiscal agent shall require the use of the One Plan as the single service plan for all CIS services and require that all client records at a minimum utilize the State-approved CIS documentation (or elements of that documentation if an electronic data system is used). For services delivered in three or fewer visits, the Service Grid, along with the Consent for Initiation/Change/Continuation of Services, and at least one Outcome Page (or equivalent electronic data sets) must be completed at a minimum.

The fiscal agent shall provide integrated services under this contract to clients with demonstrated need who are entitled to such services through Medicaid eligibility and/or IDEA Part C eligibility criteria. The fiscal agent may receive reimbursement for additional clients with demonstrated need within the extent of the General Funds available as specified in Attachment B in the CIS Contract. All contract requirements must be met for any cases billed to this contract, including but not limited to applicable staffing qualifications and service delivery timelines.

Service Provider and Primary Service Coordinator Responsibilities

Service providers should identify and work with the strengths and capabilities of the child care program, pregnant or postpartum person, or family and their children. Appropriate use of the One Plan requires partnering with pregnant or postpartum people, family, or child care program, and service providers to develop a plan and create goals that are specific, measurable, achievable, relevant and time-bound (S.M.A.R.T), and that are meaningful to the pregnant or postpartum person, family, or child care program. Activities and strategies to achieve the goals and outcomes define the work between the service provider(s) and the pregnant or postpartum person, family, or child care program.

The identified primary service coordinator is responsible for, at a minimum, the following:

- Serve as a single point of contact in supporting the pregnant or postpartum person, family, or child care program to obtain the resources and services they need.
- Facilitate team meetings that include all service providers working with the pregnant or postpartum person, family, or child care program to develop, review and evaluate the One Plan, which includes: coordinating and facilitating the initial meeting, annual review, 6-month reviews, and transition meetings. If requested by the client, the primary service coordinator shall invite other relevant individuals to meetings in order to provide support to the client; this may include the child care program a child is enrolled in, school personnel, health care providers, other community agency program staff, other AHS program staff, etc. (this is not intended to be an exclusive list).
- Promote and facilitate ongoing communication between all team members, including the pregnant or postpartum person, family, or child care program.
- Plan for transition for all clients, including:
    - People beyond two months postpartum, supporting transition in accordance with CIS guidance or applicable evidence-based home visiting model requirements
    - Children eligible for Part C Early Intervention in accordance with federal regulations

  - Children beyond age six years for other services supporting transition in accordance with CIS guidance or applicable evidence-based home visiting model requirements
  - Child care programs that may need ongoing support to provide quality child care facilitating transition to other community-based supports
- Coordinate services:
  - Coordinate and/or perform screenings, initial evaluations, or ongoing assessments as needed to determine eligibility, progress, and/or program planning.
  - Consult with and provide interpretation of information to parents/caregivers.
  - Ensure the provision of year-round services for child care programs, pregnant and postpartum people, and children from birth to age six years (up to age 13 years for Specialized Child Care) and their families through appropriate activities as indicated in the One Plan.
  - Monitor to ensure all planned services are delivered in accordance with the One Plan.
  - Utilize the CIS Consultation Team as needs are identified to help inform the One Plan as needed by service providers.
  - Identify how services are delivered and/or supported within the child care setting when child care is part of a child/family's plan.
  - Provide written notification to family's/child care programs/pregnant or postpartum people of their exit from CIS services because of inability to contact in accordance with CIS guidance.

Paperwork Guidance for a Child Care Program Client

Step	Process	Documentation
1	Phone call or in-person contact is made. Referral sources include: • Child Care Provider (either teacher or director) • EEE • Parent • CIS Provider • CDD Licenser • Community Agency staff Issues typically include: • Program-related issues (whole program or classroom-specific) • Child-related issues (either group or individual) • Incident focused (ex. licensing visit or biting)	**Referral** • CIS 01 Referral
2	Complete a warm call to the provider (Note: if it's a child-specific issue, you need parent/guardian permission to proceed. However, you can still proceed with programmatic issues without parental consent). Information gathered: • Contact info • Initial Contact date	**Initial Contact & Intake** • CIS 02 Intake • CIS 03 Authorization

Step	Process	Documentation
	• Discussion regarding issue	
3	Complete the initial site visit to the program. The intent is to gather more information about the need. The visit may be scheduled with the teacher or director. The visit may include: • Observations • Interviewing staff/director • Consultation • Meeting with staff to talk with them about what consultation can offer How you proceed with this visit is determined by: • How much information you gathered during the warm call • The content of the information you gathered during the warm call • Your prior relationship with the program (if any) **Note:** This process may take more than one visit. During this point or at a follow-up check-in, you may learn this will be more complex than giving one or two consultations.	**One Plan** • Your Resources and Supports • Evaluation Consent
4	Once you have enough information, you will plan to provide (or arrange to have provided) one or some of the following: • Observation targeted based on information gathered. • Consultation to address the issue identified during your screening/assessment. • Education to address an identified issue. You may provide the above to the following: • Director • Teacher(s) • Paraprofessionals • Parent/guardian **Note:** When developing the plan, you work with the identified individual(s) associated with the program to either be recipients of the service (clients) or deliver a service. You will: • Suggest things to try based on your assessment. • Help them prioritize what they want to improve. • Break it down into chunks (activities). • Identify a long-term goal (eye on the prize). • Include timelines!	**One Plan Development** • One Plan: o Summary Report o Your Concerns, Hopes & Priorities o Your Outcomes o Services o Your Teams Membership and Your Consent

Step	Process	Documentation
5	**Ongoing work with the program.** Follow up may include: • Phone check-in (you call them) • In-person check-in (you visit the program) • Consultation (on-going) • Observations (on-going) • Coaching • Assessing (ongoing) • Provide a training • Provide referral(s) to other resources	**Service Delivery** • Contact notes • Informal documentation of your work
6	**Plan Review** Once several activities are completed or well underway, or goals have been reached, you will return to step 4 (which may need to include additional information gathering if needed). **Note:** • At any time, for many reasons, you may have to hit the "reset" button! This brings you back to step 3 or 4, or you may have to exit the client. • Limitations to progress may include: o The provider doesn't have adequate time to complete the discussion/goal of a site visit or meeting (including anything described in steps 3 through 6). o The provider may have issues that arise that impact engagement. o Any issues that arise that interrupt the current plan (crisis that needs to be dealt with immediately versus an emerging issue that will be reviewed for plan development).	**Plan Review** • Revisit any necessary plan pages • One Plan: o Plan Review o Your Outcomes
7	**Disengagement:** • By the Director: Let the program know you are closing the case because of lack of engagement; this closing may be impacted by why you are there (ex., CIS child enrolled or a licensing issue). o May mean closing needs to include information shared with additional people. o Always leave the door open for them to contact you for help in the future. o The Director may be amenable to you remaining available to a teacher.	**Transition or Exit** You may transition the program to other supports (ex., resource development offered by the Community Agency or mentoring through Let's Grow Kids). Or you may exit sending an exit letter for failure to engage. Or you may just note on the plan review page your

Step	Process	Documentation
	○ If issues are really egregious, you may have to make a report to CDD licensing or Family Services. • By a teacher: Reconnect with the Director. You may: ○ Reset goal to being focused with the Director or another teacher. ○ If it is a 'light' issue, inform the Director you intend to close the case. • By a paraprofessional: ○ Talk to the paraprofessional's 'boss' (parent, teacher, or Director) and figure out what to do next. • By a parent: You may: ○ If they allow it, still be able to work with the program – though you will have to reframe the goals to be directed to the program. ○ Reconnect with the teacher/director and determine the next steps.	review with the program and decision to end services.

Section Nine – CIS Community Services Standard

Professional Standards

Professional standards or competencies are the foundation of the CIS professional system and are used:

- As the self-assessment in an IPDP (Individual Professional Development Plan)
- To provide common expectations and language
- To plan and assess professional development activities and curricula (our shared work)
- To develop job descriptions and performance evaluations
- To structure supervision and mentoring

The CIS professional standards recommended for all staff roles within the CIS program include the following knowledge areas:

- Philosophy and Professional Orientation – Professionals show knowledge of using a family-centered, strengths- and outcomes-based collaborative approach for delivering services and supporting children and families.
- Family Systems – Professionals, demonstrate knowledge of family characteristics, factors impacting family functions, and strategies for supporting families.
- Child Development – Professionals use their knowledge of child development and the factors affecting development in their work with young children and their families.
- Assessment – Professionals use their knowledge of assessment to inform the One Plan process.
- Addressing Challenges- Professionals demonstrate knowledge of risk and resiliency factors, the use of strategies for working with vulnerable populations, and ways to promote effective transitions.
- Systems Resources – Professionals have knowledge of resources, systems, laws, policies, and procedures.

See the Northern Lights at CCV website for more information on the early childhood core knowledge and competencies that provide a foundation for Vermont's early childhood field, including CIS professionals.

Job Descriptions

- Children's Integrated Services (CIS) Coordinator
- CIS Specialized Child Care Coordinator
- CIS Strong Families Vermont Nurse Home Visitor
- CIS Strong Families Vermont Family Support Home Visitor Master and Bachelor Prepared
- CIS Early Childhood and Family Mental Health
- Early Interventionist/Development Educator
- Early Interventionist Associate

Waiver Process for Hiring Staff Who Do Not Meet Minimum Job Qualifications

CIS has determined that a relevant bachelor's degree is required as the minimum qualification for all CIS providers. Occasionally, regional CIS agencies experience a gap in filling a position with a qualified individual. The agency may wish to employ someone who doesn't meet these educational requirements, but has other experience that suggests that they can succeed in a CIS position (e.g., in early childhood and family mental health, nursing, developmental education expertise, family support, child care, etc.).

The CIS State Team has adopted a waiver process for a regional agency/team to submit a request to hire a staff person who does not meet the minimum qualifications:

1. Before hiring someone who does not meet the minimum CIS job qualifications, the supervisor of the hiring agency must contact a CIS State Team member to request and receive a waiver. The waiver request must include the following information about the candidate for hire before the CIS State Team can approve or deny the request:
    a. Current degree(s) and field of study
    b. The scope and length of experience working with families with young children
    c. The focus of the bachelor program the individual has enrolled in and expected completion date; this requires a transcript or other institutional acknowledgment of student status
    d. A letter of intent from the applicant stating their interest, qualifications for the position, and relevant past experiences
2. If the waiver is approved, and the candidate for hire is chosen to fill the vacant CIS staff position, the following state and regional agency oversight will be in effect until the individual has completed their degree program:
    a. The appropriate scope of work is defined, with refinement, as the individual's knowledge and skill levels increase.
    b. Weekly supervision with the individual to provide orientation to CIS, including outreach and referral; engagement with families; home visiting; use of the One plan with goals and outcomes; coordination of services; reporting and quality requirements; ongoing mentoring and reflective practice; professional development; etc.
    c. A copy of their Individual Professional Development Plan (IPDP) is submitted to the CIS State Team and updated yearly.

Professional Development

- All staff new to CIS shall successfully complete (with an 80% or better quiz score) online CIS training modules within 30 days of hire. These include, but are not limited to:
    - CIS Orientation (3 modules)
    - One Plan Orientation (5 modules)
    - Online Mandated Reporter Training
    - Early Intervention Orientation (8 modules) – Required for EI providers only
    - Basic Specialized Care Training (6 hours) - Required for Child Care Coordinators only; recommended for all other CIS service providers.
- CIS community providers must:
    - Maintain professional development required by their specialty license or certification
    - Attend any trainings necessary to comply with Federal regulations and all State requirements
    - Complete at least 10 additional hours of professional development activities annually, which may include the following:
        - Scheduled CIS Conference/Institute. Note that the State may limit attendance
        - CIS Community of Practice Calls, which will be identified in advance as professional development by the State, and for which participants must complete an electronic evaluation after each call if requested by the State
        - Regional trainings provided by the State, with an electronic evaluation completed after the training
        - Other professional development required by CIS State staff based on contract monitoring activities
        - Other State-sponsored trainings, both core and discipline-specific trainings including, but not limited to:
            - Parents as Teachers (PAT)
            - Maternal Early Childhood Sustained Home-visiting (MECSH) and trainings related to the Early Intervention Certificate and IDEA Part C rules and regulations.

Section Ten – Annual Data Reporting and Billing Guidance

Encounter Data

Reporting encounter data is a requirement of the CIS contract from July 1st through June 30th each year (or until the State provides a different mechanism for reporting the data). These data are required to meet the Centers for Medicare & Medicaid Services (CMS) requirements, support the payment reform project, and promote data-informed decision-making.

- Effective October 1, 2020, services delivered after that date will be reported in accordance with the Guidance Manual.
- CIS clients who are privately insured and do not receive CIS-EI services will be reported using the template below.

Please submit your encounter data using the spreadsheet template provided here via GlobalScapes.

- Encounter Data Spreadsheet

- CIS Case Rate Billing Guidance

Semi-Annual Data

Semi-Annual data are due to the State on January 31st of each year. Below you will find the reporting templates and guidance to assist you with your reporting requirements in accordance with the current CIS contract. All Reports must be submitted via GlobalScapes.

- CIS Semi-Annual Performance Measure Template
- CIS Semi-Annual Performance Narrative Template
- CIS Semi-Annual Reporting Guidance

CIS-EI System of Payments

1. To be reimbursed for the provision of services, a service provider must have received the following from the child's Primary Service Coordinator:
    a. Children's Integrated Services Permission to Bill Private and Public Insurance form completed and signed by the family.
    b. Current CIS One Plan Service Grid with the family's consent to receive services; additionally, a service provider should also have a copy of all outcomes they are responsible for supporting through the services.
    c. EI Request for Financial Assistance Form (if applicable for the family).

    Note: If a service provider is not receiving these documents for each client they serve through CIS-EI, they need to reach out to the child's Primary Service Coordinator and request them.

2. Begin by determining the proper insurance to bill:
    a. If the family/guardian authorizes private insurance to be billed:
        i. Bill the private insurance first.
        ii. If the private insurance denies the full charge, seek a PA from CIS-EI, then bill through the Gainwell PES system.
        iii. If the private insurance pays in part, then see step 3 below.
        iv. If there is a patient share (co-pay or deductible) and the family has completed an EI Request for Financial Assistance Form, you can invoice the State. See step 2 below.
    b. If the family/guardian denies access to private insurance:
        i. If the client has Medicaid as secondary insurance, see step 2. c.
        ii. The State must receive a copy of the insurance form denying access to the client's insurance. The State uses this to enter a note into the Medicaid system for any PA's received, allowing the provider to be paid using Part C monies as the payor of last resort.
        iii. Submit a PA for services as needed: direct therapies that require PA, meetings (as needed), and travel. Be sure to attach all required documentation. See step 5 for information on submitting PAs.
        iv. Once you receive the Notice of Decision (informing you the PA was entered), submit your claim through the Gainwell PES system.
    c. The client only has Medicaid:
        i. Service provider bills for their services through the Gainwell PES system.

ii. If Medicaid denies the service provider's claim, or if the service provider knows it is not a service Medicaid will cover (ex. Travel and meetings), the service provider must submit a PA (following the guidance in step 5 below).
iii. Once the service provider receives the Notice of Decision (informing them the PA was entered), they would submit/resubmit their claim through the Gainwell PES system.

3. CIS-EI may also cover invoices for client co-pays and deductibles when a family/guardian requests it (see step 1):
    a. Invoices must be accompanied by:
        i. the RA/EOB from the insurance provider; and
        ii. the most recent service grid covering the dates of services listed on the invoice.
    b. Invoice amounts must equal (or be less than) the amounts on the RA/EOB for the client co-pay/deductibles.
    c. If the invoice is for a dollar amount greater than what the RA/EOB lists for the client co-pay/deductible, the State will deny the invoice, notify the service provider as such, and shred it. In this case, the service provider will need to submit a new invoice with the correct amount.

    Note: You can find the Medicaid reimbursement amount for this code at: http://www.vtmedicaid.com/#/feeSchedule or by contacting your Medicaid provider representative. Medicaid and Part C, as the payor of last resort, will reimburse the difference between what insurance covered/denied only up to this amount.

4. Costs above the amount private insurance will cover:
    a. If the client has Medicaid as secondary insurance, the service provider will submit a claim, accompanied by the RA/EOB, through the Gainwell PES system for the difference between what private insurance covers and what Medicaid would cover.
    b. If the client does not have Medicaid as secondary insurance, first submit a PA through CIS-EI for the service (see step 5 below).
    c. After completing step 5, submit a claim through the Gainwell PES system for the difference between what private insurance covers and what Medicaid would cover. This charge will be covered by CIS-EI as the payor of last resort.

    Note: CIS-EI will not pay amounts above the Medicaid rate for a service.

5. Prior Authorizations
    a. Prior Authorizations (PA) must be submitted through GlobalScapes, Vermont's secure document transfer system; if you need a GlobalScapes account, contact AHS.dcfcddcisei@vermont.gov.
    b. All PA's must be accompanied by a service grid that aligns with the service, service date(s), service frequency/month, and:
        i. In the case of an oral motor request, include the licensed physician's prescription/diagnosis.
        ii. In the case of autism/suspected autism, include the diagnosis/suspected diagnosis date and any documentation related to the autism.
        iii. PA's must be accurate and complete. If they are not accurate (ex., do not match services listed on the Service Grid) or are incomplete (ex., missing required accompanying

documents), they will be denied. Service providers will be notified of this denial via email from AHS.dcfcddcisei@vermont.gov.

iv. Once a service provider submits their PA request, it will be processed within ten business days. The service provider will receive a Notice of Decision from the Medicaid system once the PA is authorized. At that point, the service provider can begin billing against that PA.

6. PA's for services provided more than six months in the past may be denied. CIS follows Medicaid rules for the timely filing of claims.
7. If the service provider notices an error in their PA, they must email AHS.dcfcddcisei@vermont.gov right away, and the State will work to resolve the issue.
8. If a service provider has a PA and a claim is denied, they can contact their Medicaid provider representative to determine the reason for denial. Service providers can view the Provider Map to identify their Vermont Medicaid Provider Representative.
   Note: If a service provider received a denial for a speech code, they must submit a PA for this code, and the State will authorize it if it is on the child's service grid.

CIS-EI Initial Evaluation Billing Guidance

All children must have a 5 domain Initial Evaluation.

- If the child has Medicaid, and this is the first Initial Evaluation performed in their lifetime, then the Initial Evaluation claim should be submitted through Gainwell.
- If the child has Medicaid and this is not the first Initial Evaluation performed in their lifetime, then the CIS EI Initial Evaluation Invoice Form should be completed and sent via GlobalScape to the State. Additional Initial Evaluations should only be performed when the child has been out of the program for 6 months or more.
- If the child has private insurance, then the CIS EI Initial Evaluation Invoice Form should be completed and sent via GlobalScape to the State.
- If the child is auto-eligible and the Initial Evaluation is performed at a later date, then the State does not reimburse for this at this time.

Require fields for Filling out the CIS EI Initial Evaluation Invoice Form:

- Program Name
- Preparer
- Invoice Date:
  - Select the region code from the drop-down option Host Agency
  - Invoice Date- should be the date that the Initial Evaluation Form is submitted to the State. It should be written out Year, Month, Day. For example, an invoice submitted on January 1, 2022, would be 20220101
  - Sequence- this is if the region is sending in multiple invoices on the same date. This should be filled out on the subsequent invoices. '2' for the second additional invoice, 3 for the third, etc.
- Child Information
  - Child last name
  - Child first name
  - Child's date of birth

  - Select the type of insurance the child has
- Initial Eval.
  - Add in the Initial evaluation date.
  - Add in the cost- this should be $700.00
  - Blank Space- record any relevant note, such as If the child has Medicaid and this is a subsequent evaluation. An example would be '2nd Evaluation.'
  - Result- select if the child was eligible for EI or if they were not eligible (No One Plan Resulting, also known as NOPR)
- Screening Done- If the child was screened, select the outcome.
  - Enter the Screener's name
- Screening Not Done- If the child was not screened, select a reason.
- Certifying Signature – The invoice must be signed, or it will be denied.
- Total Requested- enter the total dollar amount requested for each child.

CIS-EI Obligation in Paying for Specialty Evaluations

The below situation frequently happens around the State, so to clarify: A private OT provider performed an evaluation to determine if a child was eligible. The child wasn't found eligible, so was a referral and a NOPR.

Below is what we sent out in the notes from the March and April EI Monthly Calls (3/24, 4/28) -- "**Specialty Evaluations are not used for finding eligibility** – first you screen, then do 5 domain evaluation to determine eligibility. Then, if needed to drill down to identify goals that will address the finer needs of a child, a specialty evaluation may be ordered. Specialty evaluations are not needed for determining Part C eligibility due to our broad standard of eligibility." **VT Spec. Ed. Rule 2360.5.4 Evaluation of the Child and Assessment of the Child and Family** (34 CFR 303.321); **VT Spec. Ed. Rule 2360.5.4.1 Procedures for Evaluation of the Child**

Fundamentally, CIS-EI pays for initial evaluations used to determine eligibility. Until a child is found eligible and a specialty evaluation ordered on the service grid with parent/guardian consent obtained, specialty evaluations should not be conducted and are not covered by Part C funds. Only with an 'active' record in Part C can we access Part C funds to pay for specialty evaluations. If the family is 'lost to contact' or declines services at any point after being made active and having a specialty evaluation performed, that is fine – during the period the child is 'active' with our program, Part C funds can be accessed to pay for services planned on the service grid and signed off on by the family. If the family desires a specialty evaluation and is not currently active with CIS-EI, they need to obtain a doctor's referral. That service is billed to their insurance (private/Medicaid).

A specialist serving a child not yet found eligible for Part C services needs to understand that Part C is not responsible for payment until eligibility is determined. In such cases, specialists need to seek reimbursement through the family's insurance provider through normal means.

If a specialty therapist is used as the 'second set of eyes' in conducting a 5 Domain assessment using one of the State approved tools, they would be reimbursed from the funds paid out to the EI Agency via that Agency's evaluation invoicing to the State (the State pays $700 through an invoice for two disciplines to conduct a 5-domain using one of the State approved tools).

Billing for Group Services

Under the fully integrated fiscal model, providing services in a group setting is an option and maybe an appropriate way of delivering services. CIS fiscal agents can use the T1024HU code to bill for each Medicaid-eligible client receiving services in a group setting.

These clients must have a completed One Plan that includes:

- Clearly articulated goals on the Outcomes page that relates to the activity of the group services provided
- The specific group services to be provided are detailed on the Service Grid pages
- Service notes that document date and client participation
- Consent
- Childbirth education is exempted from the One Plan requirement

Group Services

CIS or other contracted staff who provide group services must have the appropriate credentials and certifications to teach/lead the class (e.g., parenting/child development, nutrition/meal planning, etc.).

Service Notes

Progress notes need to be in compliance with AHS requirements. This format is ideal whether services are provided to individuals one-on-one or to groups. Notes should identify:

- Summary of major content or intervention provided during a visit consistent with treatment goals (outcomes)
- Observations made of the individual or responses to interventions provided during the visit
- Assessment of progress toward treatment goals (outcomes) based on observations and information gathered during the visit
- Plan for continued intervention and next steps that the client/family can work on between visits and that the provider can support at the next visit.

Children Co-Served by Different Regions with Single Fiscal Agent Contract

There are situations in which, because of shared legal parental custody or other arrangements (i.e., child care enrollment), a child spends equal amounts of time in two regions, resulting in the need for CIS services to be delivered in both regions. To facilitate the efficient delivery of services a CIS Primary Service Coordinator is assigned. Refer to Section Eight of this manual for more information about the responsibilities of the CIS Primary Service Coordinator.

Parents have choices when it comes to matching services with their needs, and it is important that the impact of their choices are understood fully (i.e., if they choose to go against the guidance/policies CIS sets regarding this topic, what impact, if any, might that have on the scope of their child's supports and their transition to services after exiting CIS).

CIS Case Rate Billing Guidance

CIS reimburses fiscal agents for service delivery using a bundled monthly case rate. To provide clarity of billing expectations, the guidance below details the criteria that must be met for a case to be "billable" to the CIS bundled contract, applicable to all CIS service types (CIS-EI, SCC, Home Visiting, and ECFMH). This is

intended to ensure fiscal resources are aligned with substantive service delivery and support clarity among providers to streamline billing and reimbursement processes. All services reimbursed through the bundled case rate must be delivered and billed in accordance with Medicaid requirements, which may be found in the General Provider Manual and see Children's Integrated Services Manual.

Initial Month of Services

Providers may bill the monthly case rate if in the first month of service delivery the only service provided is an initial assessment to determine eligibility for CIS services. [5]

A One Plan is not required to be in place for this initial claim, but the service must be reported via the encounter data spreadsheet or MMIS encounter data submission (when made available by the State). This may occur only once per client, with the exception of instances where a client re-engages with CIS services at least six months after exiting services.

Monthly Case Rate Billing

All criteria below must be met for the month and the client in question to bill the monthly case rate (with the exception of the initial month of service detailed above):

1. The client must have a One Plan that includes at a minimum the following elements:
    a. CIS-01 Referral Form
    b. CIS-02 Intake
    c. CIS-02 FS Supplemental (applicable for FS cases only)
    d. CIS-03 Authorization
    e. Insurance Authorization Form
    f. Minimum of 1 outcome
    g. Service Grid
    h. Consent to Receive Services

    Note: The above forms can be found on the DCF website.
2. A service provider must have had direct contact with, or on behalf of, the client through the delivery of a minimum of one unit of a billable service in accordance with the CIS bundled contract. [6] All billable services qualify for billing with the exception of unusual travel that does not accompany another case rate service [7].
    a. Direct contact may include, but is not limited to, in-person, allowable telehealth or telephonic activities with the client and/or their family; or in-person or telephonic activities between members of the care team with or without the client present.
3. The service delivery has been reported to the State using the encounter data spreadsheet or MMIS encounter claim submission (when made available).

---

[5] An initial assessment performed by an SCCC to determine FS eligibility meets this requirement.

[6] Please refer to the encounter data spreadsheet for a list of case rate services, including detailed code and unit definitions. Units of service vary by codes, and the minimum unit must be delivered to bill the bundle for that client. In many cases, this unit is 15 minutes (defined by Medicaid as 8+ minutes), but in instances where a code's unit of service for a code is longer than 15 minutes, this standard must be met to be considered "billable."

[7] Incidences of unusual travel that do not result in accompanying service delivery (i.e., client no show) are not considered case rate billable and therefore should not be reported as encounter data (either through the encounter data spreadsheet or MMIS encounter claim submission when made available).

4. Limitations
    a. Service delivery funded by mechanisms other than the CIS bundled contract are not case rate qualifying services and therefore do not qualify as billable to the bundle.
    b. Communication by email, text, voicemail, and postal mail does not qualify as direct contact with or on behalf of the client.

Appendix A – Resources and Forms

Resources

- AHS HIPAA Privacy and Security Officers Contact Information
- AHS HIPAA Training and Resources
- CIS Encounter Report Guidance Flow Chart
- Claim Adjustment Reason Code Cross Walk to Medicaid EOBVT Medicaid Provider Manual
- COVID-19 Resources for CIS Providers
- Early Head Start/Head Start Memorandum of Understanding
- Memo to the Field Re: Oral Motor Billing for Vermont CIS EI February 6, 2017

Forms

- CIS EI Initial Evaluation Invoice Form

Appendix B – Definitions

Adjusted Age reflects the age a premature baby would be if born on their due date.

Adoption Assistance is a financial assistance program for people who adopt children with special needs. It can include reimbursement of one-time adoption expenses, medical benefits, monthly payments, and the payment of special services.

Adoption Subsidy is a program that is designed to allow and encourage families to provide permanent homes for special needs children.

Agency of Human Services (AHS) was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within the state government.

Child Care Financial Assistance Program (CCFAP) (formally known as child care subsidy) helps eligible families pay for the cost of child care. Payments are made directly to child care providers on behalf of families.

Child Development Division (CDD) is a Division within the Department for Children and Families and provides direct oversight of services for children and families that include regulating early childhood and afterschool programs; early intervention services; information, resource, and referral for families; parent education and family support services.

Children's Integrated Services (CIS) is a resource for pregnant and postpartum people and families with children from birth up to age 13.

Child Safety Plan is a plan that is created to ensure a child's safety within their home as a result of a report made to the Family Services Division (FSD).

CIS client may be a child, pregnant or postpartum person, parent/caregiver, a child care program, or child-serving agency receiving consultation or education from CIS.

CIS Coordinator provides leadership to each region's CIS system of care in all aspects of the systems development, service delivery, professional development, financing, data collection and evaluation for the CIS the following services (Early Intervention, Family Support and Nurse Home Visiting, Specialized Child Care and Early Childhood and Family Mental Health).

Department for Children and Families (DCF) is a department within the Agency of Human Services. It provides a wide array of programs and services, including adoption and foster care, child care, child development, child protection, child support, disability determination, and economic benefits such as 3SquaresVT, fuel assistance, and health insurance.

Dr. Dynasaur is a State benefit program that provides free or low-cost health coverage for children under the age of 18 and pregnant women. Eligibility is based on household income and family size.

Early Childhood and Family Mental Health (ECFMH) program is prevention, promotion, and early intervention with a mental health focus on serving young children and families.

Early Intervention (EI) services are provided to children experiencing an observable and measurable delay in cognitive, physical, communication, social/emotional, or adaptive development, or who have a diagnosed medical condition that has a high probability of resulting in developmental delay.

Educational Services Surrogate is a surrogate parent who is appointed by the Agency of Education (AOE) to serve as a child's advocate in the educational or early intervention decision-making process in place of the child's parent or guardian.

Family Support Home Visiting is support for needed medical, social, educational, and other services to promote optimal maternal and early childhood health and development.

Gainwell is a contractor who processes Vermont's Medicaid claims, Part C, and Payor of Last Resort (POLR) payments/claims.

Housing Assistance is a benefit program run by the Department for Children and Families, Office of Economic Opportunity (OEO), which provides emergency housing and services for Vermonters who are homeless or at risk of homelessness.

Individuals with Disabilities Education Act (IDEA) was enacted by Congress in 1975 to ensure that children birth to age three with disabilities have the opportunity to receive developmental services and free appropriate public education for children ages three through twenty-one.

Individualized Education Plan (IEP) is part of Part B, special education school-based plan of service.

Jump on Board for Success (JOBS) is a program assisting youth and young adults ages 16 to 21 who suffer from mental health issues to secure employment and aid their transition into the workplace.

Local Education Agency/Supervisor Union (LEA/SU) is for all youth not in state custody, and the concerns are primarily educational.

Medicaid for Children and Adults (MCA) includes the Dr. Dynasaur program. These programs are run by the Vermont Health Connect and offer free or low-cost health coverage for eligible Vermonters. MCA is based on family size and household income.

Medicare is a national social insurance program administered by the United States federal government that guarantees access to health insurance for Americans ages sixty-five and older and younger people with disabilities.

Nursing Home Visiting is to support children birth to age six, as well as pregnant and postpartum people with medical/health/developmental issues.

One Plan is a document used to help determine the needs of the child and family, collaborate in setting goals and measure outcomes for children and families, and identify community resources. Vermont's CIS One Plan meets all of the requirements and is considered the Individualized Family Service Plan (IFSP) as defined within the IDEA Part C.

Part B of the Individuals with Disabilities Education Act (IDEA) provides services to students aged three up to 21 who meet the State's definition of a developmental delay or who have a diagnosed condition that might result in a developmental delay.

Part C of the Individuals with Disabilities Education Act (IDEA) provides services to children birth to three who meet the State's definition and who are experiencing a developmental delay or who have a diagnosed condition that may result in a developmental delay.

Payer of Last Resort (POLR) is Part C funding that pays for therapeutic Early Intervention services not covered by private insurance, Medicaid, or Children with Special Health Needs (CHSN).

Private health insurance is a type of plan that is either owned by the individual, offered through an employer, or as part of a government-sponsored program.

Reach Up is a benefit program run by the Department for Children and Families, Economic Services Division, which helps families with children by providing financial assistance for basic needs and services that support work and self-sufficiency.

Respite care is care by an individual or family who is not the child's regular caregiver, intended to provide caregivers with temporary relief from the demands of caring for a child with special needs.

Primary Service Coordinator provides development, oversight, and coordination of the One Plan, including the outcomes and services, for pregnant/postpartum people, families, children, and child care providers.

Service Provider is the individual(s) charged with a provision of service within the One Plan.

State Benefit Program is a variety of services and supports to help assist families. These include but may not be limited to; 3 Squares VT, Emergency/General Assistance, Energy Assistance, Reach-Up, Health Care, and Child Care.

Title IV-E is a Federal Adoption Assistance and Child Welfare Act (Public Law 96-272). The law created new sources of funding under Title IV-E of the Child Welfare Act for the placement of children from needy families. Title IV-E also guarantees Medicaid for all eligible children and requires certain protection for children, such as reasonable efforts to prevent placement and regular review of case plans.

Title V is supplemental security income benefits under title XVI of the Social Security Act or disability or blindness payments under titles I, II, X, XIV, or XVI of the Social Security Act.

Women, Infant, and Children (WIC) is a federal assistance program of the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA) for healthcare and nutrition of low-income pregnant women, breastfeeding women, and infants and children under the age of five.

Appendix C – Acronyms and Abbreviations

AHS – Agency of Human Services

AOE – Agency of Education

BFIS – Bright Futures Information System

CAPTA – Child Abuse Prevention Treatment Act

CCFAP – Child Care Financial Assistance Program

CDD – Child Development Division

CDDIS – Child Development Division Information System

CIS – Children's Integrated Services

COP – Community of Practice

CSNH – Children with Special Health Needs

CQI – Continuous Quality Improvement

CPT – Child Protective Team

DAIL – Disability, Aging and Independent Living

DE – Developmental Educator

DCF – Department for Children and Families

DVHA – Department of Vermont Health Access

ECFMH – Early Childhood and Family Mental Health Access

ECO – Early Childhood Outcomes (specific to CIS Early Intervention)

ECSE – Early Childhood Special Education

EDGAR – Education Department General Administrative Regulations

EI – Early Intervention

EMR – Electronic Medical Record

ESD – Economic Services Division

EFS – Enhanced Family Services

FAP – Financial Assistance Program

FERPA – Family Educational Rights and Privacy Act Regulations

FNS – Food and Nutrition Services

FTE – Full-Time Equivalent

FTP – File Transfer Protocol

FRC – Family Resource Coordinator

FSD – Family Services Division

GEPA – General Education Provisions Act

HIPAA – Health Portability and Accountability Act

HPES – Hewlett-Packard Enterprise System

ICO – Informed Clinical Opinion (specified to CIS Early Intervention)

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Plan, Part B Special Education

IFS – Integrated Family Services

IPDP – Individual Professional Development Plan

JOBS – Jump On Board for Success

LEA – Local Education Agency

LIT – Local Interagency Team

MCH – Maternal and Child Health

MECSH – Maternal Early Childhood Sustained Home-Visiting

MIECHV – Maternal Infant Early Childhood Home Visiting

NIST – National Institutes of Standards and Technology

OEO – Office of Economic Opportunity

PAT – Parents as Teachers

PII – Personally Identifiable Information

POLR – Payer of Last Resort

SFVT – Strong Families Vermont

SC – Service Coordinator

SCC – Specialized Child Care

SCCC – Specialized Child Care Coordinator

SMARTIE Goals – Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable

SU – Supervisory Union

SUD – Substance Use Disorder

VAHHA – Vermont Assembly of Home Health and Hospice Agencies

WIC – Women, Infants, and Children