Educational and Developmental Intervention Services
EDIS Early Intervention
Policy and Practice Questions & Answers
Tri-Service Guidance
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EDIS Process Q&A

Family Rights	
Is it necessary to document when parents decline actually taking a copy of their rights?	*No. Parents sign that they have been provided a copy. Service coordinators are responsible for ensuring that families understand their rights. Additional documentation is not necessary.*
If parents decline early intervention services for a child with severe disabilities, can EDIS providers ask for mediation in order to ensure the child gets services? At what point does refusal for services constitute medical neglect?	*Building relationships with families from the beginning and helping families understand how early intervention supports families is very important. EDIS early intervention is strictly a voluntary service. EDIS does not treat life threatening conditions and refusing early intervention is not medical neglect. However, if a provider is concerned that a family's disinterest further support or services may have impact on the child's physical or emotional health, then EDIS must report the suspicion to the appropriate point of contact. Suspected neglect must also be referred to the appropriate local reporting point of contact. EDIS providers are mandatory reporters of any and all suspected abuse or neglect. Other agencies have the responsibility to conduct an investigation to confirm or refute the suspicion. EDIS must work with the appropriate community agencies if this is a concern.*

Referral	
From whom can EDIS accept direct early intervention referrals? Is it just the Military Treatment Facility (MTF)?	*EDIS can accept direct referrals for early intervention from agencies that are part of the Military Treatment Facility (MTF) or other entities of the DoD medical system. This includes but is not limited to physicians, nurse practitioners, nutritionist, social work services, psychology, etc... It does not include family support type agencies on the installation side such as Army Community Services, Airman & Family Readiness Center, Fleet and Family Services, Women Infants and Children, Child Development Services, other family support services. However, if any of these agencies have a concern about a child, they should provide the EDIS contact information to the family and help them contact EDIS.*
Can EDIS accept direct referrals from Family Advocacy Program (FAP)?	*Yes, in fact we must. The Individuals with Disabilities Education Act (IDEA) requires a referral for early intervention "of a child under the age of three who--(A) is involved in a substantiated case of child abuse or neglect; or (B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure" (Sec. 637.6.A.B.).* *EDIS will accept referrals for children referred to Family Advocacy Program for suspected child abuse or neglect. This requirement is for a referral and screening, and evaluation if needed.*

	Essentially, the early intervention process starts when the referral is received. A referral must be made for all children with substantiated abuse (as in A and B above). This is a requirement because the highest rates of abuse and neglect occur in infants and toddlers and there are high rates of developmental delay in this population.
How should EDIS respond to referrals from doctors that direct specific services (e.g., speech therapy 2 times a week)?	*This is a twofold question – how to respond to doctors and how to respond to parents. Educating doctors about the legal requirements of IDEA is important to ensure a common understanding of the benefits for children and families. It is important to educate the medical community that the IDEA directs service decisions based upon the unique needs of the child and family – not specific doctor's orders. Similarly, when a doctor refers a child for a speech evaluation or services, for example, early intervention does not just conduct a speech evaluation. Rather, a complete multidisciplinary evaluation of all domains of development is administered. If the child does not qualify for services through EDIS, it is still possible the child may benefit from "speech therapy" for medical reasons, and the physician's referral must be re-routed to appropriate resources.* *With regard to parents, it is important to discuss how service decisions are based upon their priorities for their child and family, not simply the child's medical diagnosis. Reinforce how young children learn in the context of day to day activities and how early intervention works with families to identify and enhance those learning opportunities. Help the family understand that this approach ultimately equates to more intervention compared to, for example, the two times a week of medical therapy the doctor recommended.* *In the end, all decisions about service must be family-centered taking into account the unique and dynamic circumstances including family concerns, priorities, and resources.*
When exactly does the 45 days start?	*The 45 days starts when early intervention receives the referral. For example, if a parent calls early intervention with concerns about their child, the referral date is the day early intervention receives the phone call from the parent. If a referral is received from Well Baby Clinic (WBC), the referral date is the day early intervention receives the referral from WBC. If a mass child find screening was done by early intervention, concerns were identified during the screening, and plans were made for further evaluation (i.e., referral to early intervention), the referral date is the day early intervention makes plans with the parent to conduct further evaluation. If a referral shows up electronically on a weekend or holiday – the referral date is the next business day.*
EDIS is to contact the family within 7 days of the referral. Who at EDIS can make this contact with the family?	*The intent of contacting the family within 7 days of the referral is to ensure timely action on the referral. At EDIS a trained administrative assistant (i.e., trained to contact families and briefly explain the program and confirm if the family elects to continue with the referral), EDIS Manager, or EDIS early intervention provider can be the one to contact the family and confirm the family's interest in moving forward with the process. EDIS personnel should document every attempt to contact the family (this can be done on the Entry/Entitlement form) to ensure that every effort was made to respond to the referral in a timely manner. If a parent contacts EDIS directly and talks with a trained EDIS administrative assistant/EDIS manager/EDIS provider, that constitutes the required contact.*

Screening	
When doing mass child find screenings is the EDIS permission to screen/evaluate form used to get parent permission?	*No. The EDIS Permission to Screen/Evaluate form is used for formal referrals and evaluations as part of the IDEA process. A child find screening is a non-IDEA function until the team decides to make a formal referral to EDIS early intervention. Permission may be documented on program level forms. If the event is sponsored by another agency such as Pediatrics, Child Youth Services, or other family support agencies, they may require specific forms.*

How often can you re-screen a child?	*There is no limit on the number of times or frequency of re-screenings for a child. With that said, typically re-screening would not occur more often than one month from the prior screening. It is also recommended that if there is still some question after a second re-screening the team should seriously consider evaluation. Also, if the child is older than two the team should seriously consider evaluation rather than continuing with re-screening.*

Evaluation	
Children with biological risks, that have a high probability of resulting in developmental delay, automatically qualify for early intervention. Can the doctor who diagnosed the condition be considered the second discipline on the team for evaluation?	*No, it must be two providers from the early intervention team. The physician's input is critical, but he/she cannot be considered the second evaluator on the multidisciplinary team. A child that is eligible due to biological risks requires a physician's statement that the medical condition has a high probability of resulting in developmental delay. That being said an evaluation is required to help determine where the child is developmentally. SNPMIS also requires that the "areas of delay" be entered when entering eligibility. The physician is not administering developmental assessments for determining present levels of development.*
Do children eligible under biological risk need to have an evaluation completed prior to service delivery?	*Yes, however a formal standardized evaluation (i.e., using a norm referenced instrument) is not necessary. An assessment of the child's present levels of development must be included and documented on the Individualized Family Service Plan (IFSP). Criterion-referenced instruments may be helpful in completing this as well as professional observation, developmental milestone checklists, and parent report.*
What is done if the standardized instrument does not provide an overall language score?	*An overall communication score is needed for evaluation as part of determining eligibility. If the standardized evaluation instrument does not provide an overall communication score, another standardized instrument, which provides an overall communication score, would have to be administered as part of the evaluation. The total score (including sub-tests of expressive and receptive) in the area of communication is used to assist with eligibility determination.*

Informed Opinion Process	
Can eligibility be based on clinical judgment?	*Yes, **informed opinion** can be used as the basis for determining eligibility. **Informed opinion** is the correct terminology (over informed clinical opinion or clinical judgment) because both parents and professionals contribute information needed in the decision-making process. Informed opinion as a basis for determining eligibility under developmental delay should be used **only** when team members believe that the child's performance on standardized measures is at odds with their own ongoing observations and assessment of the child's abilities. For example it may be that the child's abilities are demonstrated at extreme low frequencies and inconsistently exhibited and observed across settings, thereby affecting the child's functioning.*
When using the Informed Opinion process, how many additional tests must be administered?	*The Informed Opinion process requires the use of at least one measure in addition to the norm-referenced testing that was initially administered. The additional measures need only address the domain(s) in which the team suspects a delay.*
Do I need to use the Informed Opinion process for determining a child eligible based upon articulation?	*For children over 30 months of age, if you administer a norm-referenced test of articulation and the child demonstrates a score of -2.00 standard deviations below the mean score, then the Informed Opinion form and process is not needed, as the child's eligibility can be determined under developmental delay. Remember that as part of the evaluation process all five areas of development must be evaluated, not just articulation.*

Eligibility	
If a child, initially eligible under biological risk due to extreme prematurity, does not demonstrate delays at the time of re-evaluation do we continue to provide services?	*Prematurity is not a permanent condition and would not be the basis for continued biological risk without evidence of delay or other complications. A child initially determined eligible under the biological risk category, based on extreme prematurity, who demonstrates skills within normal limits at the time of re-evaluation would no longer be considered eligible. This is because the initial biological risk factor is no longer an issue impacting the child's development. However, if the re-evaluation does not indicate delays in development, but a biological risk factor is still an issue (e.g., Down syndrome, deafness, cerebral palsy etc.), then eligibility continues. Remember too that tracking is an option for children that do not meet eligibility criteria.*
Can a child remain eligible under biological risk until they turn three and exit from the program?	*Yes. There are essentially two categories of eligibility, (1) developmental delay and (2) biological risk –having a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay. Biological risk is not solely reserved for infants under a certain age. For example, a child older than 6 months who has a diagnosed physical or mental condition (e.g., Down syndrome, Fragile X…) may continue to be eligible for early intervention services under the biological risk category, if the condition is shown to have a high probability of resulting in delayed development.*
How many EDIS early intervention providers must be present at the meeting to determine eligibility?	*The eligibility meeting must include the initial service coordinator and at least one other professional involved with the evaluation. However, if a provider who evaluated the child cannot attend the meeting, he/she may be represented by a knowledgeable individual or a written report or even participate via phone. Whenever possible, teams are encouraged to discuss and determine eligibility immediately following the evaluation. Under such circumstances both evaluators would likely be present.*
Please clarify atypical phonological processes as they are used to determine a child's eligibility for early intervention.	*Phonology refers to the rules for producing and combining sounds within a language. A phonological disorder is characterized by the inaccurate production of sounds past the age at which correct production should occur. A phonological process disorder involves patterns of sound errors. Children over 2 ½ years of age (30 months) may be eligible for early intervention if they have fewer than 65% of their consonants correct or they use phonological processes that are abnormal or should have resolved. For children in a home where* ***English is not the primary language,*** *the evaluator must be able to demonstrate that the child has a* ***significant delay*** *in communication in his/her* ***primary or dominant language.*** *An interpreter in the child's primary language shall be used in the evaluation. For those children who* ***do not have an appropriate interpreter*** *in the child's primary language, but the evaluators suspect there is an actual developmental delay, then they should use* ***Informed Opinion*** *process to determine if the child meets the EDIS eligibility criteria for early intervention.*
Would a 20% delay in articulation combined with a 20% delay in one additional domain qualify a child for early intervention?	*No. Articulation is specifically addressed as a stand-alone criterion for determining EDIS early intervention eligibility for children over 2 ½ years of age (30 months). It is not an additional domain of development in and of itself, and therefore when the delay in articulation is not 2 standard deviations below the mean (e.g., 1.5 up to 2 SD below the mean) it cannot be combined with another domain that is not quite 2 standard deviations below the mean (e.g., 1.5 up to 2 SD below the mean).*
Are any of the following automatically eligible conditions: congenital hip dysplasia; feeding difficulty with diagnosis of feeding disorder in infancy; unilateral hearing loss; autism; anxiety disorder; failure	*Eligibility under biological risk requires a diagnosed physical or mental condition which has a high probability of resulting in developmental delay. Determination of biological risk must be based on a physician's diagnosis. When there is question about the probability of the condition resulting in a developmental delay the team must consult a physician to help determine if the individual child's condition has a high probability of resulting in a developmental delay, and include that documentation in the EDIS record.* ***NOTE:*** *The process of informed opinion is not applicable for determining eligibility under biological risk.* *Regarding the specific conditions included in this question…*

to thrive; thyroid disorder?	• *Diagnosed conditions with a high probability of developmental delay (automatic eligibility) include but are not limited to the following:*
	  ○ *Autism/PDD*
	  ○ *Down syndrome*
	  ○ *Angelman syndrome*
	  ○ *Fetal alcohol syndrome*
	• *Other health impairments that **may** qualify for eligibility under biological risk include but are not limited to the following: [Note that these conditions do not result in automatic eligibility, but require further exploration with a physician. Also keep in mind that EDIS does not classify a short-term medical problem as health impairment.]*
	  ○ *Feeding difficulty with diagnosed feeding disorder in infancy*
	  ○ *Congenital Hip Dysplasia*
	  ○ *Thyroid Disorder*
	  ○ *Unilateral hearing loss*
	  ○ *Failure to thrive*
	NOTE: The severity of the condition must be considered as well as any other conditions the child may have.
	When preparing for a determination of eligibility under biological risk it is helpful to consider the following information:
	○ *The names of all the diagnoses, conditions or disorders from the physician. Having all the information is important to get a complete picture of the child when making the eligibility determination.*
	○ *Do some research on the condition, review the literature available.*
	○ *Verbal confirmation of the diagnosis/condition/disorder from the physician is required prior to determining eligibility. Documented confirmation must be included in the EDIS record.*
	○ *Consult a physician to confirm that the condition/s has/have a high probability of resulting in a developmental delay.*
	
	Social/Emotional Conditions from the Diagnostic Classification 0-3 (as diagnosed by a licensed clinical psychologist) including anxiety disorders and adjustment disorders can be used supportively when looking at developmental delay and informed opinion.

Is torticollis and/or plagiocephaly a diagnoses with a high probability of resulting in a developmental delay? Is torticollis and/or plagiocephaly considered automatically eligible for EDIS early intervention?	*Torticollis is a condition caused by damage or a shortening of the Sternocleidomastoid muscle in the baby's neck causing the baby to twist its neck to one side.* *Plagiocephaly is a condition characterized by a persistent flattened spot on the back or side of the head. Both are medical conditions that require attention. However, torticollis and/or plagiocephaly are **not** considered conditions that have a **high** probability of resulting in delayed development and therefore are not routinely considered an automatically eligible condition for EDIS early intervention. However, children with either or both of these diagnoses may be demonstrating significant delays in development that could qualify them for early intervention services. Care should be taken to ensure thorough evaluation and assessment to determine if the child meets EDIS eligibility criteria.*
Does a cleft palate alone meet eligibility criteria for biological risk?	*Cleft palate is a congenital condition that has a high probability of later delay if early intervention services were not provided. A child would be eligible under biological risk provided the condition is severe enough to impact the child's development. However, early intervention services alone do not adequately address this condition. It is critical to have the medical community also address this condition.* ***NOTE:** EDIS is not a payment source for the medical treatment necessary to address this condition.*

What are the eligibility considerations for a child with feeding issues?	*If the child has a diagnosed feeding/swallowing disorder with a high probability of resulting in a developmental delay, he/she could be eligible under biological risk. However, if there is no diagnosis the team should determine if there is a significant delay in the adaptive domain of development. If there is not a significant measurable delay using a standardized instrument, but the team has concerns, then gather more information and determine if a significant delay in development is present using the informed opinion process. Remember though that the informed opinion process guides the process for gathering and considering additional information; it alone is not the "ticket" to eligibility. Considering all the information available there has to be a significant delay before a child is determined eligible using the informed opinion process. If the child is not eligible tracking is always an option.*
Can the ITSEA and/or TABS be used for evaluations to assist with determining eligibility?	*Best practice indicates that evaluation should rely on multiple informants, using multiple methods, and occur in multiple settings for assessment of young children. The ITSEA and TABS are tools that can be used to assist teams with determining a child's eligibility for EDIS early intervention services.*
Are standard deviation scores needed for determining eligibility under developmental delay or can percentage of delay be used?	*When working with a team to determine if a child meets the eligibility criteria for developmental delay in EDIS early intervention a norm-referenced test must be used initially to evaluate all five areas of development. It might be one full tool or a mix of tools. If using one tool that addresses all 5 domains of development (e.g., Battelle Developmental Inventory [BDI], Developmental Assessment of Young Children [DAYC]) it is best practice to administer the full tool. When using norm-referenced measures the standard scores should be used in accordance with the instrument.* *Although some norm-referenced tests provide "developmental age" or "age equivalency" scores these scores are considered imprecise. With norm-referenced tests "developmental age" or "age equivalency"* ***should not be used*** *for eligibility determination. Rather, use standard scores.*
When calculating a DQ score to a z-score *[with a standard deviation of 15 and a mean of 100],* what is -1.5 SD from the norm? Is it 77 or 78?	*The actual formula is:* *Standard score (DQ) minus the mean (100) divided by the standard deviation (15).* *So using a DQ of 78 (with a mean of 100 and standard deviation of 15):* *78-100/15 = -1.466 [-1.466 is the Z score – rounded up this is 1.47 and not -1.5)* *77-100/15= -1.533 [-1.533 is the Z score and the cut off score]* *So for tests using a mean of 100 and standard deviation of 15, like the DAYC, a DQ of 77 is equivalent to a Z score of -1.5. If the DQ is 78 (or higher for that matter) and the team continues to have concerns then consider gathering more information and using the informed opinion process.* *NOTE: When calculating z-scores from DQ be sure to look at the test manual to determine the standard deviation and mean.*

Tracking	
When is tracking an option?	*When the child is not eligible for early intervention services (i.e., does not meet eligibility criteria) but the team and family want to more formally keep an eye on the child's progress by checking in to see how the child is doing. In essence, tracking is a safety net.*
If tracking, can make a visit to the family or is it done telephonically?	*Tracking can occur as face-to-face visits or by phone. Tracking visits should not occur more frequently than every other month unless contacted by the parent.*
How long can a child be in tracking? Do they have to be re-evaluated after a period of time?	*It is recommended that tracking not occur longer than one year unless there are extenuating circumstances. If there are continued concerns beyond a year of tracking then further evaluation should be seriously considered.* *Children must also be discharged from tracking when they turn three or move to another location.* ***NOTE:*** *Re-evaluation is not necessary before discharge from tracking.*

IFSP Development	
When does the 45 day timeline end?	*The 45-day timeline ends when the all sections of the IFSP are completed and the family signs the form.*

Annual IFSPs	
At annual re-evaluation, must a standardized instrument be used or can a criterion-referenced measure to update the child's developmental levels?	*If there are questions about the child's continued eligibility status, then standardized instrument(s) assessing all 5 areas must be used. If there is a high degree of certainty that the child's eligibility status will remain the same, and information gathered from standardized instrument(s) will not be value added, then standardized instruments to assess all 5 areas of development are not required. However, developmental levels must be determined (i.e., assessment of all five domains must be administered). This can be done using a criterion-referenced instrument/s or standardized instrument/s if desired.*
Is it necessary to ensure a physical is completed as part of the annual re-evaluation?	*At annual re-evaluation a review of the child's medical history must occur. If the child has not received a medical evaluation or physical exam within the last 6 months, then EDIS should request that the family make an appointment for the child to have a physical exam as part of the re-evaluation. Re-evaluation is a comprehensive evaluation and must include all 5 areas, as well as the child's vision, hearing and health status. However, waiting for a physical exam should not hold up the process.*
Does an evaluation completed as part of the annual reassessment count as service delivery or should it be entered as evaluation session?	*The annual re-evaluation does not take the place of service delivery, but much information is learned/gathered through ongoing service delivery visits with the family.* *The re-evaluation and time associated with it is documented in SNPMIS as an "evaluation session." A new evaluation needs to be entered into SNPMIS and associated notes would be entered the same as an initial evaluation.* ***NOTE:** If additional time is taken during the same visit to provide services, then you also document that as a service session.*

Transition	
How is transition documented when no transition is anticipated at the time of IFSP?	*Teams must **always** address transition as part of every IFSP, regardless of the child's age. Transitions extend beyond the transition to preschool at the age of three and include family relocation and transition from hospital to home. In the event that no type of transition is anticipated, the team can write indicate that no transition is anticipated at this time. For example, this may occur when a very young child is determined eligible and the family has no anticipated transition or re-location.*
What part of the IFSP goes to the school for preschool transition?	*The entire IFSP can go to the school. However, local schools may not need all the information an entire IFSP contains, and may only request portions of the IFSP. Under such circumstances EDIS need not send the entire IFSP. EDIS and the local school must outline the transition process, including the identification of the information that EDIS will share with the school.*
Is it necessary to enter the end dates on the service page when a child transitions (to school) before the end date of services listed on the IFSP?	*The service end dates on the IFSP for a child approaching the age for transition to school should be the child's third birthday. On occasion the services may extend briefly (i.e., a week or two) beyond the child's third birthday, to accommodate junctures in the school year. If the child has a summer birthday the services might extend 3 months (maximum) past his/her birthday. Under these circumstances it is not necessary to enter end dates on the IFSP as the services are ending as part of the organized transition plan. However, if services are discontinued before the planned transition, then the discontinued dates must be entered and the reason for discontinuing service must be documented on the IFSP Change/Review form.*
If a plan ends and the child a month or less before turning three and transitioning, can the plan be extended?	*Yes. However, a Change/Review form must be completed and it must document why and how the extension is to occur. Such an extension must never go more than 3 months. The team must also consider the need for new outcomes as part of the transition plan.*

A child has an active IFSP and will be turning 3 shortly. The EDIS team completes an updated transition evaluation for DoDEA and scores indicate child is not eligible. Does EDIS continue with services?	*If the team feels the testing truly represents the child's abilities and he is functioning within normal limits across all developmental domains, the team may decide to discharge the child and celebrate the progress made. If, however, the team continues to have concerns and the child continues to have an active IFSP they may continue with services and initiate the transition process. This ensures that the decision of continued services through preschool is made with the involvement and input from the school Case Study Committee.*

Discharge	
Do you discharge for a new referral when the family chooses to postpone the process (e.g., until husband returns for R&R)? Is greater than 30 days a good bench mark to decide to discharge or remain open?	*The nature of the family's interest in postponing their involvement in the decision to proceed or not will help determine whether the referral should be discontinued. It is always best to have the discussion with the family so they can make an informed decision about how to proceed. If the family wants to postpone the process for 30 days, it would be reasonable to discharge the child from the referral process and start up again when the family is ready to proceed; this will initiate a new 45 day timeline.*
In suspending services what constitutes "for extended periods of time?" When do we need to complete a Review/Change form?	*In general, an extended period of time is anything over 30 days. Best practice is to complete the Review/Change form documenting the need to suspend services at the earliest possible point. As soon as it is known that a family will be away, the team should make the necessary arrangements to suspend services during their absence. If a family consistently "no-shows" for an extended period the team may suspend services, but keep the IFSP active. The service coordinator/providers must document all attempts to contact the family and send a letter to the family before suspending services. When sending the letter, a copy of Due Process/Procedural Safeguards pamphlet should be included.*
Is a team decision necessary for discharge? Can a child be discharged if the outcomes on the IFSP are met?	*Yes, a team decision is required for discharging a child/family from early intervention services. The only exception is if the family decides, for whatever reason, to discontinue early intervention services. Just meeting IFSP outcomes alone does not guarantee that the child no longer meets early intervention eligibility criteria and no longer requires early intervention services. To discharge a child/family from early intervention (in this scenario) the team must determine that the child no longer has a significant delay in development (i.e., meets EDIS eligibility criteria). To do so the team may administer another standardized evaluation or use criterion referenced instruments addressing all five domains. Alternately, if based upon ongoing assessment the child has been performing within normal limits, a screening instrument may be used in preparation for the team meeting to confirm whether the child remains within normal limits or whether there are new developmental concerns, which warrant further assessment.*