Advocates for Children of New York

Protecting every child's right to learn

早期干预

流程

2

介绍 → 早期干预概述 → 获取服务 → 服务交付过程

↓

过渡到学前特殊教育 → 您的权利 → 资源 → 问题

儿童权益倡导协会(AFC)是一个保护所有纽约市学生权利的独立机构。

热线: 1-866-427-6033
(周一至周四, 上午10点 至 下午4点)

为低收入家庭提供
免费法律服务

指南和资源：
www.advocatesforchildren.org

讲座和培训

推动政策改革和公益诉讼

AFC

什么是“茁壮成长”？

Together Growing Strong
Juntos Florecemos
茁壮成长

纽约大学“茁壮成长”项目为日落公园零至七岁的儿童以及他们的家庭提供早期教育的支持与帮助。

纽约大学“茁壮成长” CARE 项目

COMMUNITY-BASED 基于社区
ACTIVITIES 活动
RESOURCES 资源
EDUCATION 教育

加入 茁壮成长 CARE 项目 来获取以下服务:

- 儿童亲子活动
- 儿童读书会
- 免费新年礼物领取
- 幼儿园预备系列讲座
- 网络和实体讲座
- 每周育儿贴士
- 免费儿童物品互换活动
- 免费食物领取

使用微信软件扫描以下二维码即可加入

也欢迎发送短信 "TGS" 到 (332) 733-3137 或 (347) 767-8230 报名加入我们的项目!

茁壮成长是纽约大学朗格尼医院的家庭健康中心、纽约大学格罗斯曼医学院和纽约大学朗格尼布鲁克林医院的合作项目。

Together Growing Strong
Juntos Florecemos
茁壮成长

什么是早期干预？

为发育迟缓或残疾的婴幼儿及其家庭提供服务的免费项目

由纽约市卫生与心理健康局 (DOHMH) 运营

问答游戏

只有儿科医生才能告诉你孩子是否需要早期干预服务。

对 还是 错？

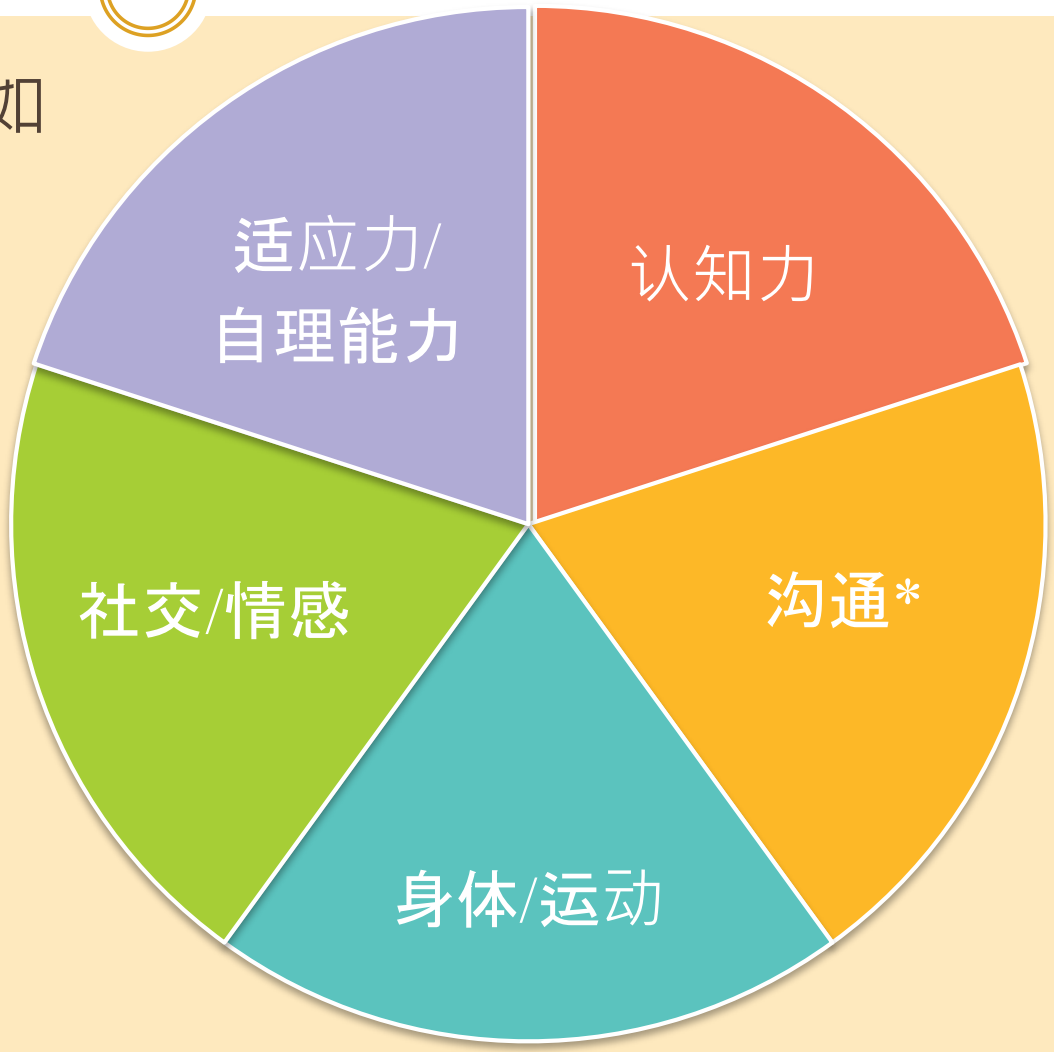
哪些人符合资格？

新生儿至三岁的儿童，如果：

在一个或多个领域出现发育迟缓：

在1个领域迟缓12个月或33%

在2个领域迟缓25%



哪些人符合资格？

……或可能导致发育迟缓的诊断

- 唐氏综合征
- 脑瘫
- 遗传性疾病

已确诊的疾病列表

早期干预过程

9

第 1 步：转介

谁

家长

专业人士，例如医生、护士、托儿中心和收容所的工作人员

如何

拨打311

转介门户网站：
nyc.gov/health/ciieferral

第 2 步：与服务协调员会面

- 告知家长他们的权利
- 讨论评估过程
- 协助选择评估师并预约
- 解释说早期干预是免费的
- 讨论保险和医疗补助计划(Medicaid)
- 解释个别化家庭服务计划（IFSP）

第 3 步：评估

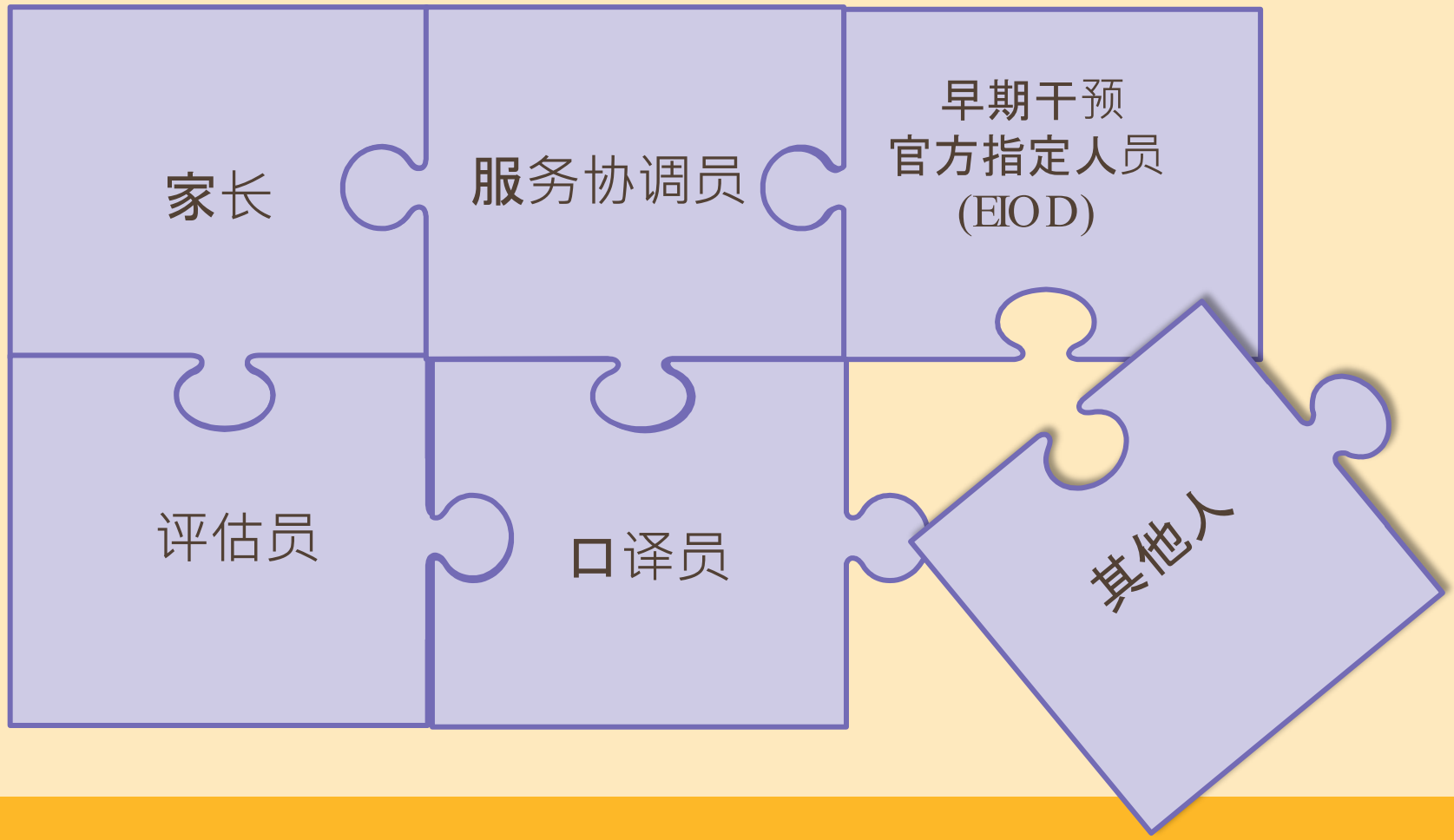
评估必须由至少**两名专业人员**进行，并且必须包括：

- 儿童评估——涵盖所有发展领域
- 健康评估
- 家长访谈
- 记录审查
- 家庭的优先事项、资源和顾虑
- 交通运输评估
- 自愿性家庭评估

问题？

第 4 步：IFSP会议

IFSP团队必须包括：



第 4 步：个性化家庭服务计划(IFSP)

当前能力水平

服务内容，包括频率、时长、开始日期

服务地点

成果与目标

运输

IFSP表格

INDIVIDUALIZED FAMILY SERVICE PLAN
IDENTIFYING INFORMATION (Page 1)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/____/____
Today's Date: _____/_____/_____ Gender: [ ] M [ ] F

IFSP meeting held within 45 days? [ ] YES [ ] NO
(If no, verify reason for delay on Transmittal Form)

IFSP Meeting (check as appropriate): ☐Interim ☐Initial ☐6 month ☐12 Month ☐18 Month ☐24 Month ☐30 Month ☐36 Month ☐Amended
(If this is an Amendment meeting, check *amended* and the IFSP period) ☐ Transition Conference ☐ Transition Plan (check the transition conf./plan box and the IFSP period)
Date of Initial IFSP :_____/_____/_____ At initial IFSP, write effective dates: 6 Month Review: _____/_____/_____ Annual IFSP: _____/_____/_____

会议类型和日期

Mother's/Guardian's Name: _____ Father's/Guardian's _____
Child's Address: _____ Apt. # _____ Zip Code_____ Parents' Language: _____
(Street) (Borough/City)
Home Phone #: (_____) _____ Alternate Phone #: (_____) _____ Cell Phone #: (_____) _____

Is child in foster care: ( ) No ( ) Yes **If yes, please fill out the following information:**
Foster Parent/Surrogate's Name: _____ Agency: _____ Caseworker's Name: _____

Agency Address: _____ Phone #: (_____)_____
Fax # : (_____)_____

Ethnicity: ☐Hispanic ☐Not Hispanic **Race**: ☐White ☐Black ☐Native American or Alaskan ☐Asian ☐Native Hawaiian/ Other Pacific Islander
NOTE: More than one racial category can be checked.

IFSP Participants:	**Print Name:**	**Agency:**	**Signature:**
☐ Parent ☐ Legal Guardian ☐ Foster Parent			
☐ Early Intervention Official Designee			
☐ Initial SC ☐ Ongoing SC ID #: Phone #: ( )			
☐ Evaluator ☐ Interventionist			
☐ Other			

IFSP会议
参会人员

Health/ Medical Information

Diagnosis: **Medical Alerts:**

INDIVIDUALIZED FAMILY SERVICE PLAN (Page 2)
CURRENT DEVELOPMENT, and FAMILY CONCERNS

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/____/____ Today's Date: ____/____/____

Concerns: What my (parent) concerns are: (Provide example(s) of how daily routines are affected/ when this concern is most noticeable to the parent/family.)

Motor: Ability to get around- gross motor (ex: sitting, rolling, standing, crawling, walking), handling small objects- fine motor, sensory skills) hearing, vision.
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Adaptive: Sucking, eating solid foods, drinking from a cup. Sleeping, dressing, toileting.)
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of*

家长关注的问题和评估结果

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Communication: Understanding what is being said, using sounds, words or gestures to let others know what he/she needs.
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern in attached MDE Summary):*

Cognitive: Thinking, Learning, Using Toys, Paying Attention, Controlling Environment
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples):*

MDE Results: ☐ There are no concerns at this time; the child is developing typically in this domain. ☐ The evaluation results indicate concerns *(Concern in attached MDE Summary):*

Social Emotional: Relating to and getting along with adults and children, getting used to new places and expressing emotions (self-calming)
Parent Concern: ☐ *I have no concerns in this area at this time.* ☐ *Parent is concerned about this area of development (provide examples)*

MDE Results: ☐ *There are no concerns at this time; the child is developing typically in this domain.* ☐ *The evaluation results indicate concerns (Concern attached in MDE Summary):*

INDIVIDUALIZED FAMILY SERVICE PLAN
DAILY ROUTINES, PARENT PRIORITIES and RESOURCES (Page 3)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____

When early intervention services are provided in places where your family typically lives, learns and plays, (family's daily routine/natural environment), progress is made more quickly. Young children learn best by socializing and playing with people they are close to(parents, family members, babysitters, childcare workers, and other children), and in places they know and like. The questions on this page will help families identify natural learning opportunities throughout the child's day and, how interventions can be made a part of your daily activities.

Priorities:

1. Based on our conversation, which of your child's daily routines and activities would you like Early Intervention to help you work with your child on (ex: **At home**: bath time, meal time, naps, dressing/ **Outside:** Shopping, attending childcare, visiting friends or family **Events**: Family get-togethers/ Places parent and child go together)?

2. Based on your answer(s) to the last question, which concern(s) would you like Early Intervention to focus on (if more than one, list them in order of priority)?

Resources: (This Section must be filled out by the ISC with the parent/guardian before the IFSP meeting)

1. Where does your child spend most of his/her time during a typical day? (Some of these places may be possible sites for early intervention activities)
   ☐ *Daycare/ Child Care Program/ Babysitter ☐ At home ☐ Other_____

If child attends Daycare/ Child Care Program/ Babysitter, please fill out the following:
Name of caregiver, or program: _____
Address_____ Phone #: (_____) _____

2. If your child is not in a Daycare/ Child Care Program/ Babysitter who assists you with childcare? ☐ Grandparent ☐ Friend ☐Other_____

3. What language does your child hear most of the day? _____

INDIVIDUALIZED FAMILY SERVICE PLAN
FUNCTIONAL OUTCOMES (Page 4)

Child's Name: (Last) _____ (First) _____ EI #:_____
DOB: / / Today's Date: / / Date of Review: / /

Functional Outcome: A practical result that your child will gain as a result of Early Intervention supports and services in the next 6 months
Note: Outcomes are not discipline specific. Interventionist must work together on all outcomes identified in the IFSP.

1. Functional Outcome:	**2.** Functional Outcome:
Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:	Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome: 目标与目的
Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐ Discontinue	Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐Discontinue
Progress Note Dates:	**Progress Note Dates:**
3. Functional Outcome:	**4.** Functional Outcome:
Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:	Objectives: Short term goals that should be achieved in order for the child to reach the functional outcome:
Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐ Discontinue	Six Month Review: Will this outcome: ☐ Continue ☐ Be Revised (Complete new outcome page) ☐Discontinue
Progress Note Dates:	**Progress Note Dates:**

Signature of Person Completing ☐6 ☐18 ☐30 mo Review | **Signature of Parent/Guardian (at Review)** | **Signature and Stamp of EIOD (at Review)**

INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICE AUTHORIZATION FORM Page 5a

CHILD INFO: Child's Name: (Last) _____ (First) _____
(Middle) _____ EI #: _____ DOB: ____/ ____/ ____
Effective Date of IFSP: ____/ ____/ ____ End Date of IFSP: ____/ ____/ ____

TYPE OF IFSP
❑ Interim ❑ Initial
❑ 6 Month
___6 ___18 ___30
❑ Annual
___12 ___24 ___36
❑ Amendment to IFSP
Dated:
____/____/____

PROVIDER INFORMATION (USE ONE SHEET PER SERVICE PROVIDER)
PROVIDER NAME:
_____
PROVIDER EI #: _____
CONTACT PERSON: _____
CONTACT PERSON'S PHONE: (____) _____
CONTACT PERSON'S FAX: (____) _____
SC: _____ SC #: _____
PHONE: (____) _____ FAX: (__)_____

Service Provider not identified at time of IFSP for the following services (Pended):
Service Type: Frequency/ Duration Authorized:
1. _____
2. _____
3. _____
4. _____
5. _____
OSC will identify provider by ____/____/____
NOTE: OSC must contact EIOD if provider is not identified within two weeks

EIOD Name _____ DATE: ____/____/____
EIOD Signature:

NOTE: The Service Authorization Form is only valid if signed by the EIOD. A separate Service Authorization Form must be completed for each service provider.

Insurance Information must be completed and updated at each IFSP, including amendments. If the child is enrolled in a Medicaid Managed Care Plan, include child's Medicaid number, as well as insurance Company Information.
Child Medicaid Eligible: □ Yes □ No
Child's Medicaid OR CIN #: ___/ ___/ ___/ ___/ ___/ ___/ ___/ ___
Ltr / Ltr / # / # / # / # / # / Ltr

Private Insurance Name (Do not write Child Health Plus)
Insurance Company Name: _____
Policy Holder Name: _____ DOB: ____/ ____/ ____
Relationship to Child: _____ Policy #: _____
Group Name: _____ Group #: _____
Effective Date: ____/ ____/ ____

1: SERVICE TYPE Use code letters for Service, Method and Location (See back for KEY)		2: Method	3: Location	4: Begin Date	5: End Date	6: Min per visit	7: Days per week	8: Weeks	9: Units	10: Waiver Code(s)		11: Status	Provider Instructions 12: Bilingual Request?	Provider Instructions 13: Prescription Needed?
1: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
2: TYPE SVC *Code Letter*										Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
3:TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
4: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing
5: TYPE SVC *Code Letter*	_____	_____	_____							Waiver Code(s)	_____ Initial Start date:	☐ ADD ☐ END	☐	☐ PT ☐ OT ☐ Nursing

服务推荐、频率和地点

Data Entry Name: _____ *Date:* ____/____/____

INDIVIDUALIZED FAMILY SERVICE PLAN
Transition Plan (Page 7b)

Child's Name: (Last) _____ (First) _____
EI #:_____ DOB: ____/ _____/ _____
Today's Date: _____/ _____/ _____ Child's Age: _____

TRANSITION PLAN:

1. What types of setting/services are being considered? Discuss various options for programs and/or services when the child exits EI, such as home, Early Head Start, Head Start, child care, private preschool, play group, preschool special education programs and services through CPSE, OMRDD, etc. **At this time we are interested in the following options:**

2. Date by which steps to prepare the child and family to adjust to a new setting should begin _____/_____/_____
(6 mo. prior to discharge or when child is leaving EI before his/her third birthday)

3. Describe steps to be taken to ensure a smooth transition? (Visit Early Head Start, day care centers, private preschools, etc.)

4. Who will assist?

过渡计划

My child is leaving EI before the third birthday for the following reason(s): _____.
I am aware that I may re-refer my child to EI before his/her third birthday if I have concerns about his/her development.
I am aware that I can refer my child to CPSE after his/her third birthday if I have concerns about his/her development.

Parent's Signature _____ Date _____/ _____/ _____

NOTE: Update this section at every IFSP meeting.

Notification sent to the CPSE on: _____/ _____/ _____
Transition conference was held on: _____/ _____/ _____
Child was referred to the CPSE on: _____/ _____/ _____
CPSE meeting is scheduled for: _____/ _____/ _____
CPSE meeting was held on: _____/ _____/ _____

Child was found **eligible** for preschool special education programs and services.
Last day of EI services: _____/ _____/ _____

Projected date of preschool services: _____/ _____/ _____

Child was found **not eligible**. Last day of EI services: _____/ _____/ _____

第 4 步：IFSP 可用服务

言语治疗（ST）

职业治疗（OT）

物理治疗（PT）

特别指示

喘息服务

应用行为分析

家庭培训、咨询和家访

交通服务

辅助技术（AT）

* 这是部分列表。

第 5 步：启动服务

服务协调员将确定服务提供商**并安排服**务。

30天内	自然环境	需经家长同意

IFSP 时间表

45 天

- IFSP 必须在转介后 45 天内完成。

30 天

- 服务必须在签署同意书后 30 天内开始。

6 个月

- IFSP 每 6 个月进行一次审查

1 年

- 由 IFSP 团队每年重新评估

问答游戏

9月1日，您将您的孩子小曼转介至早期干预计划。

何时应该召开IFSP会议？

a) 9月15日之前
b) 10月15日之前
c) 11月1日之前
d) 一年内

问答游戏

10月15日，您签署同意书，允许小曼接受服务。

服务何时开始？

a) 11月15日之前
b) 11月30日之前
c) 12月15日之前
d) 12月30日之前

问题？

从早期干预过渡到学前特殊教育

三岁生日

- 早期干预的资格结束
- 早期干预服务协调员应该至少在孩子生日前 6 个月就开始帮助他们进行过渡。
- 学前特殊教育资格开始

早期干预过渡：
学前服务何时可以开始？

如果符合条件：

1月2日

- 如果孩子在1月1日至6月30日期间年满3岁

7月1日

- 如果孩子在7月1日至12月31日期间年满3岁

早期干预过渡：延长服务

如果符合条件，您可以将EI服务延长至：

8月31日

- 如果孩子在1月1日至8月31日期间年满3岁

12月31日

- 如果孩子在9月1日至12月31日期间年满3岁

早期干预过渡：延长资格

转介

评估

3岁
生日前

个性化教育计划
（IEP）

符合资格

问答游戏

小迪正在接受早期干预服务。

他将于2月21日满三岁。

如果符合资格，小迪最早可以什么时候开始接受学前特殊教育？

a) 1月2日
b) 2月21日
c) 2月22日
d) 7月1日

问答游戏

小迪正在接受早期干预服务。

他将于2月21日满三岁。

如果符合延长资格，并且小迪的父亲决定延长早期干预服务，小迪可以继续接受服务到何时？

a) 截至2月21日
b) 6月30日
c) 8月31日
d) 12月31日

问答游戏

小迪正在接受早期干预服务。

他将于2月21日满三岁。

如果小迪不符合学前特殊教育资格，他的早期干预服务何时终止？

a) 2月21日
b) 2月28日
c) 3月1日
d) 6月30日

了解您的权利：概述

- 参与 EI 流程的各个阶段。
- 在整个过程中，您可以随时拒绝同意或退出。
- 要求对所有发展领域进行全面评估。
- 选择评估机构和服务协调员。
- 以您的语言接收评估报告、IFSP 和其他文件的副本。
- 如果您对评估结果有异议，请要求重新评估。
- 拒绝任何特定服务，不影响您获得其他服务的权利。
- 保密性
- 正当程序

了解您的权利：解决问题

EI 服务协调员

区域办事处

- 布朗克斯
  718-838-6887
- 布鲁克林
  718-694-6000
- 曼哈顿
  212-436-0900
- 皇后区
  718-553-3954
- 史泰登岛
  718-568-2300

EI 消费者事务

- 请致电
  347-396-6828
- 电邮至
  EIConsumerAffairs@health.nyc.gov
- 请抄送*
  EarlyIntervention@afcnyc.org

了解您的权利：正当程序

AFC 资源

发展里程碑

早期干预指南

学前特殊教育服务指南

过渡到幼儿园

申请3-K和Pre-K

学前教育相关服务

访问我们的网站！

其他 EI 资源

美国疾病控制与预防中心资源

早期干预计划：家长指南

卫生部早期干预项目 Facebook

州政府EI网站

市政府EI网站

教育局联系方式

从早期干预过渡	eitopreschool@schools.nyc.gov
学前特殊教育委员会	点击按校区查找
教育部 早期儿童项目	ESEnrollment@schools.nyc.gov

Advocates for Children of New York

Protecting every child's right to learn

如有疑问请致电我们！

热线：866-427-6033（免费）

周一至周四

上午 10 点至下午 4 点

info@advocatesforchildren.org

问题？