Advocates for Children of New York

Protecting every child's right to learn

# Early Intervention

November 2025

# Agenda



- Introduction
- Early Intervention Overview
- Getting Services
- Service Delivery
- Transition to Preschool Special Education
- Your Rights
- Resources
- Questions

**Advocates for Children (AFC) is an independent agency that protects the rights of all NYC students.**

Helpline: **1-866-427-6033**
(Mon-Thurs, 10am – 4pm)

Free legal services to low-income families

Guides and resources:
www.advocatesforchildren.org

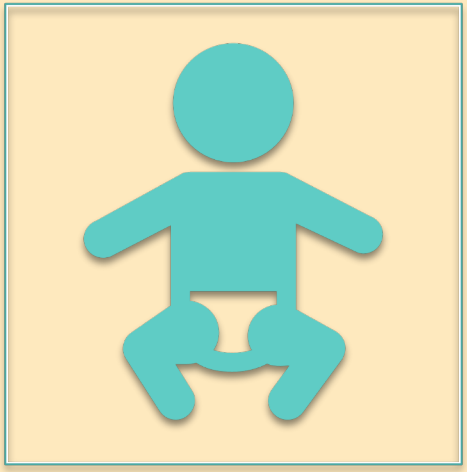
Workshops and trainings

Policy Advocacy and Impact Litigation

# What is Together Growing Strong?

# What is Early Intervention?





A free program that provides services to infants and toddlers with developmental delays or disabilities and their families

Run by the New York City Department of Health and Mental Hygiene (DOHMH)

# Trivia

Only a pediatrician can tell you if a child needs Early Intervention services.

True or False

# Who is Eligible?

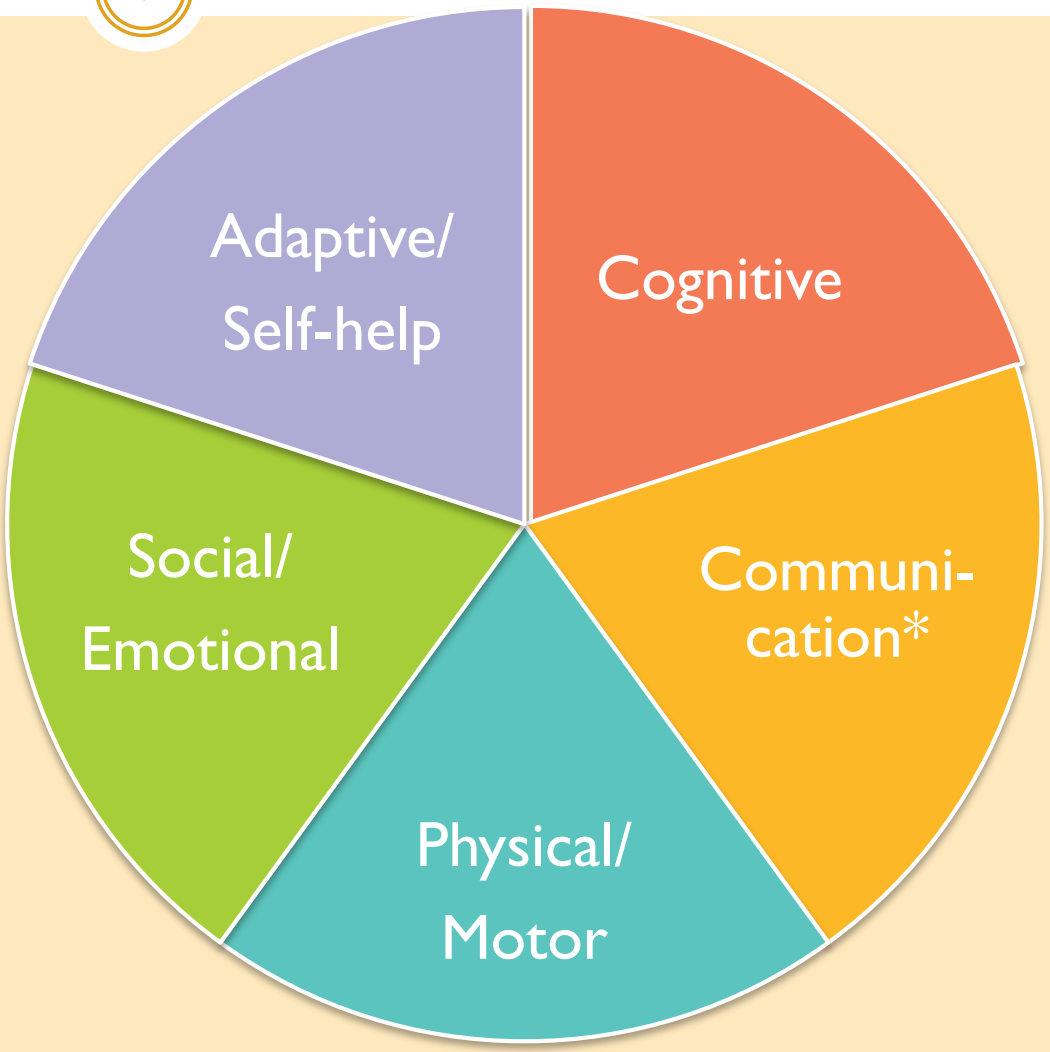


A child from birth to three who has:

Delay in 1 or more area:

12 months or
33% in 1

25% in 2



# Who is Eligible?



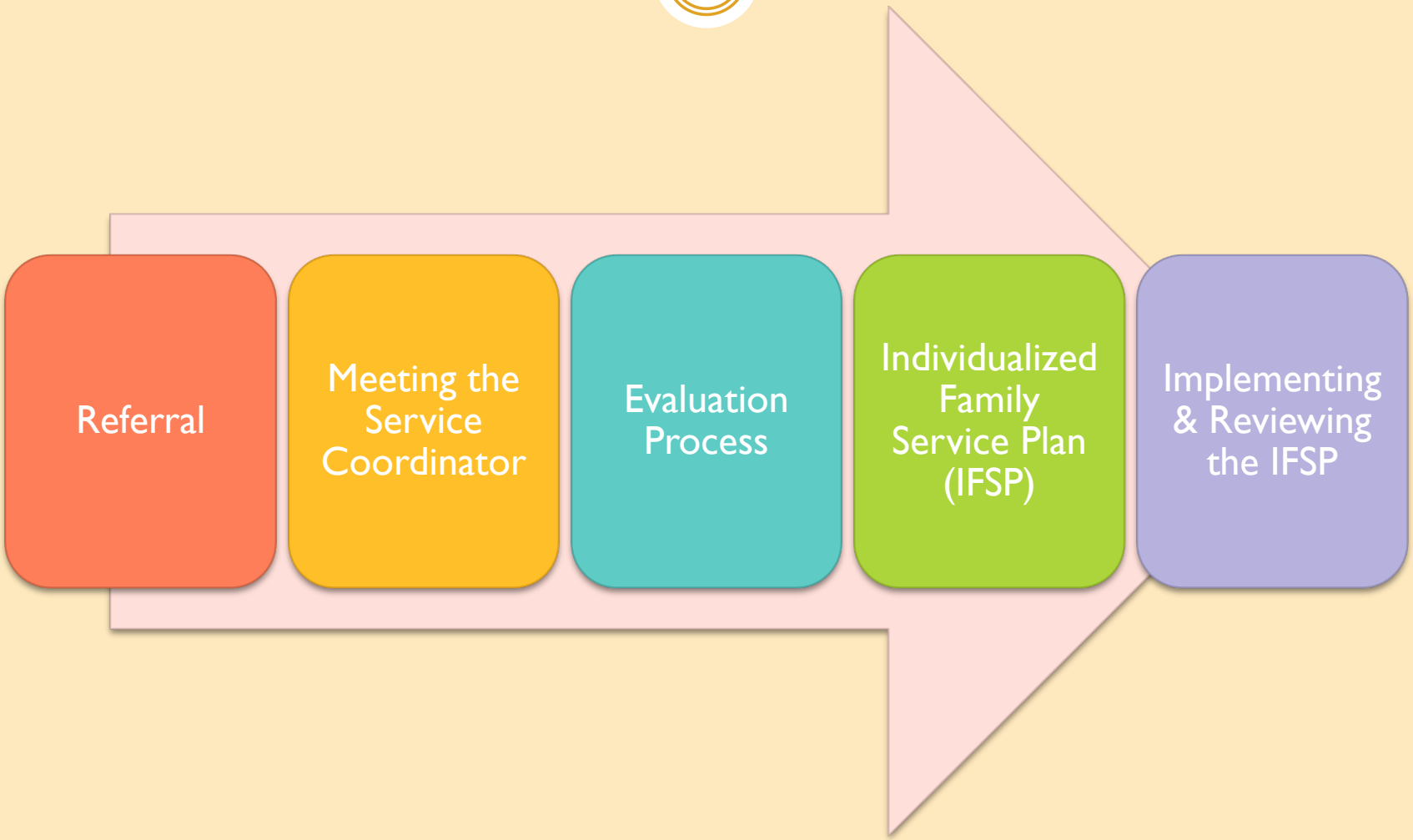
… or a diagnosis likely to lead to developmental delay

- Down Syndrome
- Cerebral Palsy
- Genetic disorders

List of Diagnosed Conditions

# Early Intervention Process





# Step 1: Referral



## WHO

Parent

Professionals like doctors, nurses, staff at childcare centers and shelters

## HOW

Call 311

Referral Portal: nyc.gov/health/ei-referral

# Step 2: Meeting the Service Coordinator



- Inform parents of their rights
- Discuss the evaluation process
- Help choose an evaluator and make an appointment
- Explain that EI is free
- Discuss health insurance and Medicaid
- Explain the Individualized Family Services Plan (IFSP)

# Step 3: Evaluations



Evaluations must be done by at least *two professionals* and must include:

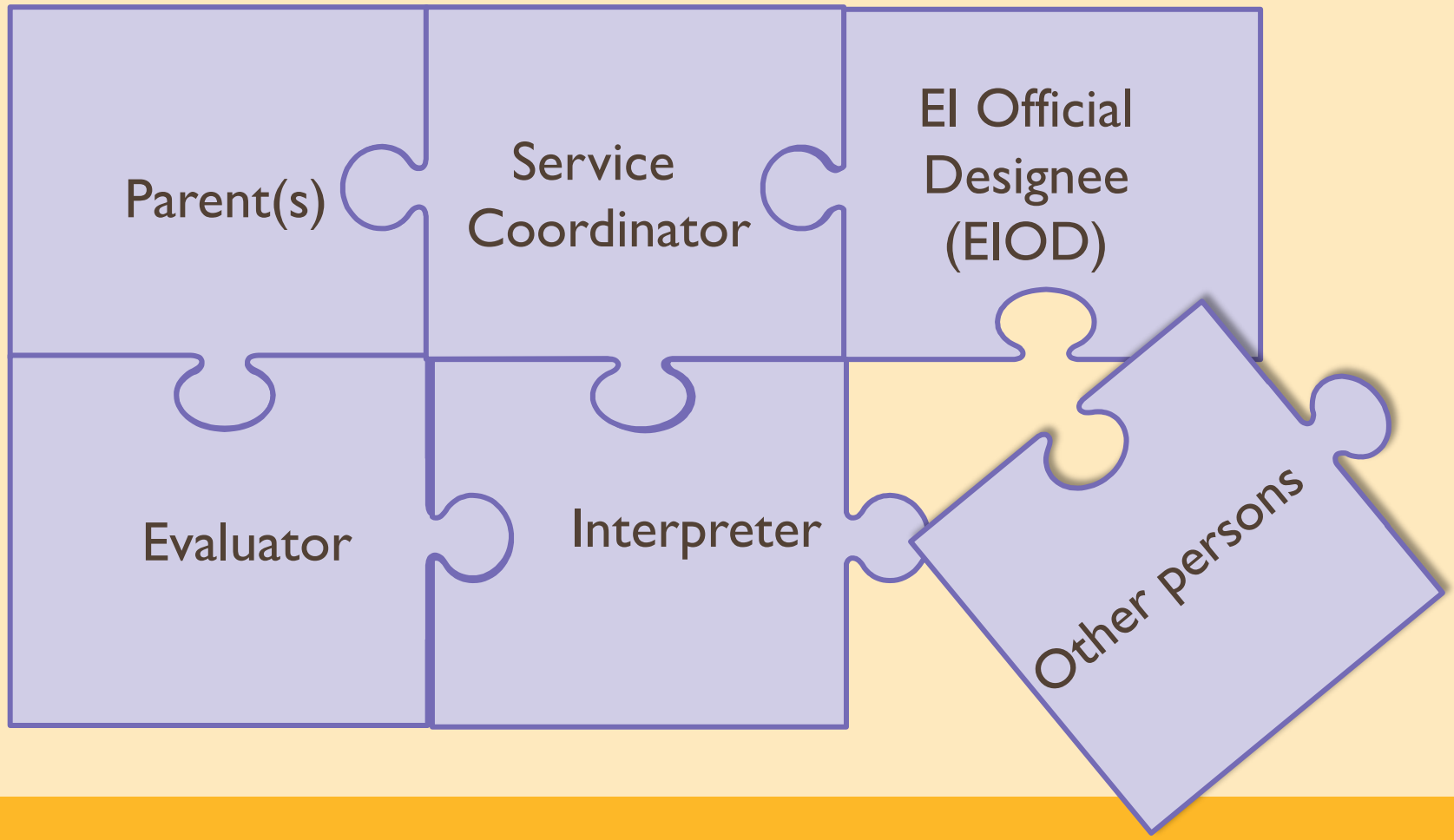
- Child Assessment- in all areas of development
- Health Assessment
- Parent Interview
- Review of Records
- Family's priorities, resources, and concerns
- Transportation Assessment
- Voluntary Family Assessment

# Questions?

# Step 4: IFSP Meeting



IFSP team must include:



# Step 4: Individualized Family Service Plan



Current Levels of Functioning

Services, including frequency, length, start date

Location for Services

Outcomes & Objectives

Transportation

# The IFSP

**INDIVI**
**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: _____/_____/_____

Meeting type and date

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 Meeting Participants

**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*

Parent concerns and evaluation results

*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_____

**<u>If child attends Daycare/ Child Care Program/ Babysitter, please fill out the following</u>:**
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: Goals & Objectives |
| 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 |

Service recommendation, frequency and location

*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?**

Transition planning

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: _____ / _____ / _____

# Step 4: IFSP Available Services



- Speech therapy
- Occupational therapy
- Physical therapy
- Special instruction
- Respite services
- Applied Behavior Analysis
- Family training, counseling, and home visits
- Transportation
- Assistive technology

*This is a partial list.

# Step 5: Starting Services



Service Coordinator will identify providers and arrange services

| Within 30 days | Natural Environment | Only with parent consent |
| --- | --- | --- |

# IFSP Timeline



## 45 Days

- IFSP must be completed within 45 days of referral

## 30 Days

- Services must start within 30 days of signing consent

## 6 Months

- IFSP reviewed every 6 months

## One year

- Re-evaluated annually by the IFSP team

# Trivia

On September 1st, you refer your child Amanda to EI.

When should you have an IFSP meeting?

a) By September 15th
b) By October 15th
c) By November 1st
d) Within a year

# Trivia

On October 15th, you sign consent for Amanda to receive services.

When should services begin?

a) By November 15th
b) By November 30th
c) By December 15th
d) By December 30th

# Questions?

# Transition from EI to Preschool Special Education



**3rd Birthday**

- Eligibility for EI ends
- EISC should help begin the transition at least 6 months before birthday
- Preschool Special Education eligibility starts

# EI Transition:
# When Can Preschool Services Begin?



If eligible:

## January 2nd

- If child turns 3 from Jan 1st - June 30th

## July 1st

- If child turns 3 from July 1st - December 31st

# EI Transition: Extending Services



If eligible, you can extend EI services until:

## August 31st

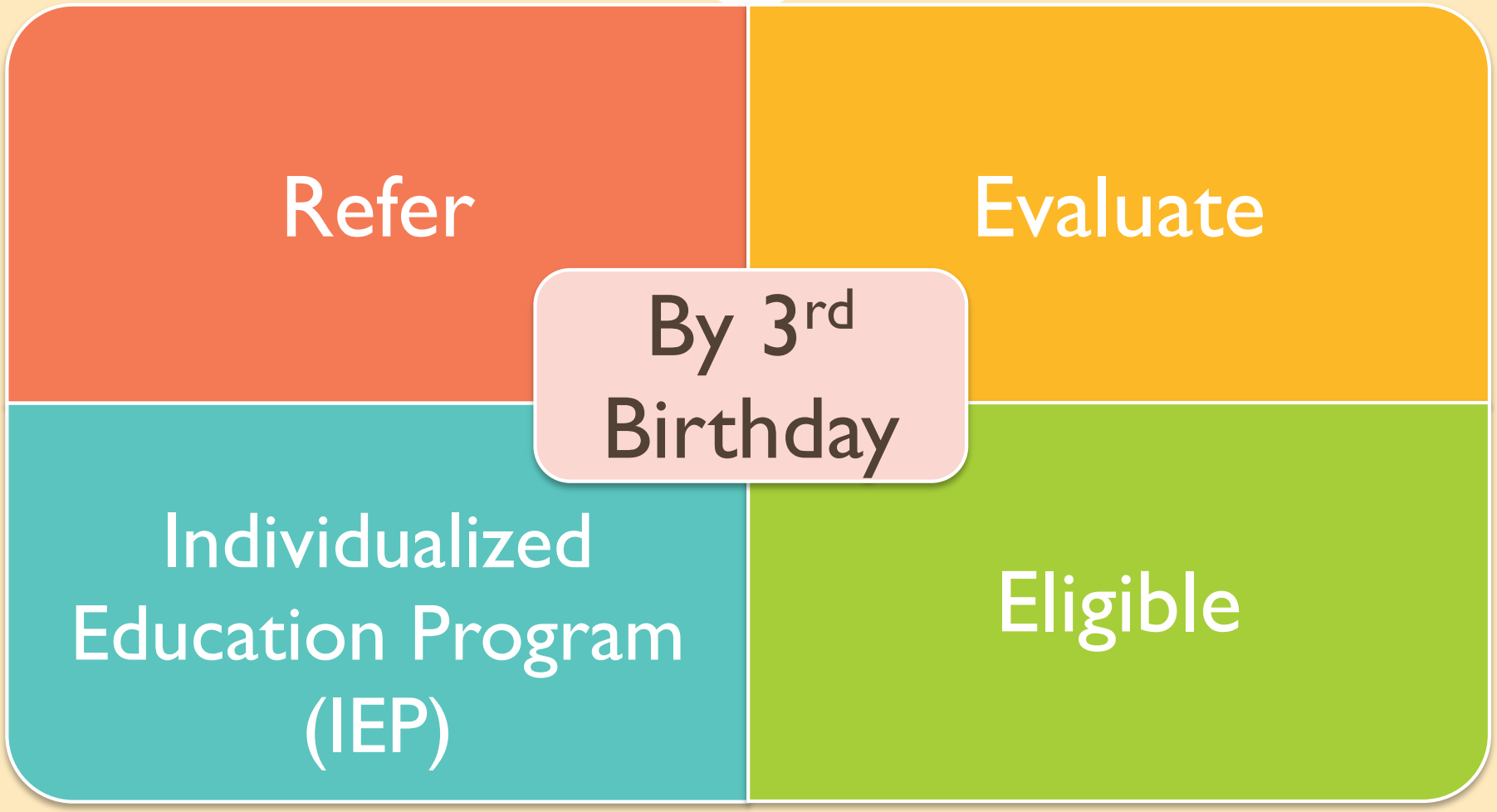
- If child turns 3 from Jan 1st - August 31st

## December 31st

- If child turns 3 from September 1st - December 31st

# EI Transition: Eligibility to Extend





# Trivia

Dillon receives EI services.

He turns three on February 21st.

**If found eligible, how early can Dillon start preschool special education?**

a) January 2nd
b) February 21st
c) February 22nd
d) July 1st

# Trivia

Dillon receives EI services.

He turns three on February 21st.

**If found eligible, how long can Dillon remain in Early Intervention?**

a) Until February 21st
b) June 30th
c) August 31st
d) December 31st

# Trivia

Dillon receives EI services.

He turns three on February 21st.

**If Dillon is not found eligible for Preschool Special Education, when will his EI services end?**

a) February 21st
b) February 28th
c) March 1st
d) June 30th

# Know Your Rights: Overview



- Be involved in all stages of the EI process.
- Refuse to consent or withdraw at any point in the process.
- Request full evaluations, in all areas of development.
- Choose the evaluation agency and service coordinator.
- Receive copies of evaluations, IFSPs and other documents in your language.
- Request new evaluations if you disagree with findings.
- Refuse any specific service without losing the right to other services.
- Confidentiality
- Due Process

# Know Your Rights: Resolving Issues



## EI Service Coordinator

## Regional Offices

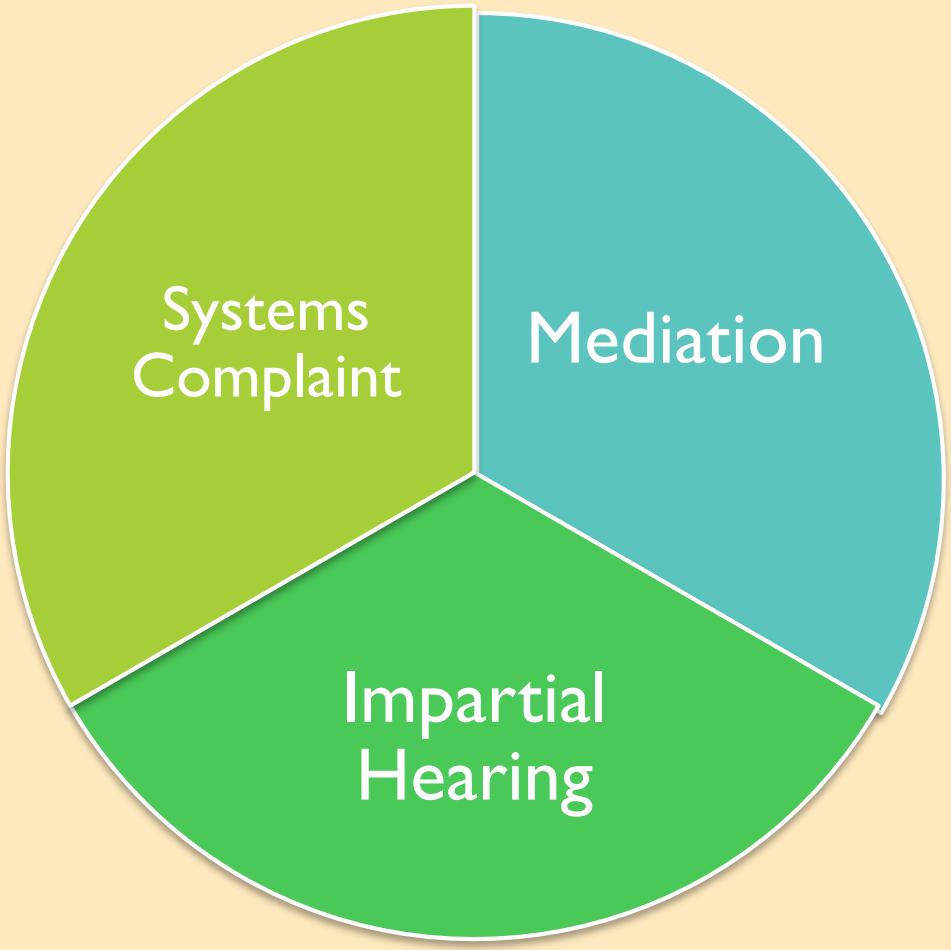
- Bronx: 718-838-6887
- Brooklyn: 718-694-6000
- Manhattan: 212-436-0900
- Queens: 718-553-3954
- Staten Island: 718-568-2300

## EI Consumer Affairs

- Call 347-396-6828
- Email EIConsumerAffairs@health.nyc.gov
- Copy* EarlyIntervention@afcnyc.org

# Know Your Rights: Due Process





# AFC Resources



Developmental Milestones

Guide to Early Intervention

Guide to Preschool Special Education Services

Early Intervention Brochure

Applying to 3-K & Pre-K

Preschool Related Services

Visit Our Website!

# Other EI Resources



CDC Resources

State EI Website

City EI Website

EI Program: A Parent's Guide

DOH EI Facebook

# DOE Contacts



| | |
|---|---|
| The transition from Early Intervention | eitopreschool@schools.nyc.gov |
| Committee on Preschool Special Education | Click to find by Region |
| DOE early childhood programs | ESEnrollment@schools.nyc.gov |

Advocates for Children of New York

Protecting every child's right to learn

# Call us with questions!

**Helpline: 866-427-6033 (toll free)**

**Monday-Thursday, 10am-4pm**

**info@advocatesforchildren.org**

# Questions?