WEST CENTRAL EARLY STEPS OPERATIONS HANDBOOK
2018-2019

West Central Early Steps Program
at Johns Hopkins All Children’s Hospital – Department 6500006005
501 Sixth Avenue South - St. Petersburg, FL 33701
Phone (727) 767-4403 - Fax (727) 767-4715

Table of Contents

Agency/Provider Personnel Development & Standards
Progress Monitoring Data
Services and Supports
Agency Child Record Standards
Agency/Provider Fiscal Compliance
Verification of Qualifications
WCES Provider Enrollment Application
Quarterly Progress Monitoring Update
Your Child’s Assessment Information
Participant Documentation of Initial and Follow-Up Eval/Assess/IFSP Form
Instructions: Participant Documentation of Initial and Follow-Up
30 Day Start Form
Consultation Documentation
Instructions: Consultation Documentation
Natural Environment Travel Log
Early Intervention Session Note
Travel Policy and Reimbursement Rates
INTRODUCTION
This handbook is a guidance document specific to West Central Early Steps (WCES) for agencies and providers who work with children and families. The Children’s Medical Services Early Steps Policy Handbook and Operations Guide (PHOG) at http://www.cms-kids.com/home/resources is the final guidance document.

1. AGENCY/PROVIDER PERSONNEL DEVELOPMENT & STANDARDS

A. Prior to providing services, each Agency must ensure that each provider within their agency be approved to provide services through West Central Early Steps.

B. The process for licensed and non-license providers who wish to enroll with West Central Early Steps is as follows:
   1. Verification of Qualifications - for West Central (attached)
   2. Once verified, completion of WCES Provider Enrollment Application (attached).

C. Evidence of the following must be present before each licensed and non-licensed professional can be credentialed with West Central Early Steps
   1. Providers must credential with Community Care Plan via this link www.ccpcares.org.
   3. Be enrolled in Medicaid as an Early Interventionist.
   4. Be enrolled as a Therapist (PT, OT, SLP) in Medicaid in their specific disciplines and provide services as authorized on the IFSP.
   5. WCES Provider Enrollment Application is completed for each provider.
   6. For individual liability insurance, submit one of the following:
      • An Individual Provider Professional Liability Certificate of Insurance (COI)
      • An Agency Company Certificate of Insurance with a list directly on the COI of those providers covered.
      • A list on the insurance agent’s letterhead of those providers covered under a current Agency’s Company Certificate of Insurance.
   7. Has completed the three (3) CMS Early Steps Orientation Training Modules prior to providing services as a WCES Provider.
   9. Receives authorization to provide services from WCES administration.
   10. Documentation of utilization of the e-verify system for EACH individual Provider.

D. The Agency/Provider will maintain the following documentation of each Provider:
   1. ITDS waiver approval and six (6) ITDS modules completion if applicable.
   2. Completion of three (3) Orientation Training Modules.
   3. WCES New Provider Orientation Training Attendance.
   4. BDI-2 and BDI-2 Screener Trainings if applicable (BDI-2 review training is required bi-annually).
   5. 36 hours of continuing education related to infants and toddlers with disabilities required for CMS/ES re-enrollment.

E. To maintain professional liability insurance coverage in the following amounts: $1,000,000 each claim and $3,000,000 per aggregate as described in ACH Policy, “Certificate of Coverage Program” and to provide evidence of such insurance to WCES annually or upon any change in coverage. Agency coverage must name personnel covered by the policy.
F. An active list of Agency/Provider personnel who serve WCES families must be on file with WCES. Should a Provider resign or terminate employment with the Agency, the WCES Provider Liaison and Service Coordinator (SC) must be notified within 2 business days. To notify WCES in the event the Provider is suspended or other action is taken which could result in loss of privilege to provide service.

G. The Agency/Provider agrees to utilize the U.S. Department of Homeland Security's E-Verify system, https://e-verify.uscis.gov/emp, to verify, in accordance with applicable laws, the employment eligibility of all new employees hired for the period July 1, 2018 - June 30, 2019 by the provider to perform work pursuant to the contract with the State of Florida Department of Health. Providers meeting the terms and conditions of the E-Verify System are deemed to be in compliance with this provision.

Attachments:
WCES Provider Enrollment Application

2. PROGRESS MONITORING DATA

A. Evaluation(s) and Assessment(s) Requirements:

1. The Battelle Developmental Inventory, 2nd edition (BDI-2) is used only upon entry into WCES and exit from WCES. If the BDI-2 is not sufficient for determining eligibility, then the Development Assessment for Young Children (DAYC) or another approved evaluation tool can be used for eligibility determination. In such cases, the BDI-2 will be completed within 30 days to meet requirements for the Early Steps Child Outcome Study. WCES will provide the scoring record. Completed Scoring Records must be returned to the assigned Service Coordinator upon completion of evaluation.

2. The (HELP, ELAP and AEPS), and discipline specific tools can be used for on-going assessments. These tools are the responsibility of the Provider.

3. On-going progress documentation must address any changes in the child’s development, learning, or behavior, and show progress toward achieving outcomes on the Initial Family Support Plan (IFSP) (PHOG 3.1).

4. The Primary Service Provider (PSP) will complete a Quarterly Progress Report and submit to the WCES Service Coordinator quarterly. If a Periodic Review of the IFSP is being requested/scheduled, the quarterly progress report for that period should be updated and submitted to the Service Coordinator at least 10 days prior to the meeting.

5. The PSP will complete an assessment of all 5 domains at least once annually and document results on the IFSP Assessment page of the child’s most recent IFSP. This must be completed and submitted to the Service Coordinator along with the Quarterly Progress Report within 10 business days of the Annual Review IFSP meeting.

6. The PSP and other IFSP team members must participate in Periodic and Annual IFSP meeting reviews.

7. Initial, periodic and annual redetermination of eligibility meetings will be documented on Participant Documentation of Initial and Follow-up Evaluation/Assessment/IFSP form.

B. Federal Child Outcome Measurement Study participation requirements:

1. Full training is required for performing the full BDI-2 and BDI-2 Screener prior to administering. Documentation must be submitted to WCES showing the training received, including date, location of the training, and name of trainer.

2. Proficiency to administer the BDI-2 will be determined by WCES. Errors in administration or scoring may require that the Provider complete an individualized mentorship.

3. Providers who are determined to be proficient may be asked by WCES to complete an EXIT for the child they are serving. The WCES Service Coordinator will provide the EXIT scoring record which must be returned to the SC within 2 days from completion of an EXIT.

4. Providers who administer the BDI-2 and BDI-2 Screener must participate in a BDI-2 review training bi-annually.

6. A BDI-2 must be completed on children exiting the program due to meeting their IFSP outcomes prior to age 3, moving out of state, being withdrawn by the family and/or turning 3.

7. Children who will remain in WCES until the day before their 3rd birthday should have an EXIT evaluation completed during the child’s 33rd month of age (no sooner than 90 days prior to the child’s third birthday).

8. For children exiting into their respective school systems:

   A. The BDI-2 screener can be used as an Exit evaluation for children who reside in Pinellas County.

      If results from the screener indicate delays in personal-social, communication, or adaptive, then
the full BDI-2 must be completed for those areas by Early Steps or by the LEA.

**B. Pasco, Hernando, and Citrus counties require a full BDI-2 at Exit**

9. Children who transfer from another Florida Early Steps district will not be included in the Child Outcomes Measurement Study. A BDI-2 or Screener may be needed if the child is transitioning to their respective school systems.

10. BDI-2 full kits or screeners may be loaned by WCES to agencies or teams of providers who routinely administer entry and exit BDI-2s

**Attachments:**

Quarterly Progress Report  
IFSP Assessment page  
Participant Documentation of Initial and Follow-up Evaluation/Assessment/IFSP

### 3. SERVICES and SUPPORTS

**A. Services** are provided using the Team-based Primary Service Provider (PSP) approach which includes:

1. A PSP, supported by a team of other professionals, who is identified to assist the family in achieving outcomes identified on the IFSP. Those who conduct the initial Eligibility Eval/Assessment/Initial Psych and Developmental Evaluation by Early Interventionist (IPDEI) should identify the PSP and other team members recommended to support the child and family in achieving identified IFSP outcomes.

2. Interventions that are embedded in the child’s and family’s daily routines, activities and places in the child’s natural environment.

3. Strategies and implementation plans outlined in the child’s IFSP. Supports and services should address the family’s functional goals and outcomes specified by the IFSP team.

4. An individualized treatment plan that enhances the child’s natural learning opportunities identified and available to the child during the course of the child and family’s routine daily activities.

5. Coaching and consultation to the family and other caregivers to enable them to implement activities and strategies to address the family’s concerns and IFSP outcomes.

**B. Requests to the provider for direct services** are made by the WCES Service Coordinator or via the E-Blast system.

**C. Providers who are enrolled in the child’s insurance will receive priority consideration.**

**D. Providers must initiate services (ST, PT, OT, EI) within 30 days** of the IFSP date and document the start date on the Service Initiation Report, forwarding it to the WCES Service Coordinator. If services cannot be initiated within this time period, the Provider will notify the WCES Service Coordinator of barriers preventing the initiation of services and document all attempts to contact and schedule on the Service Initiation Report. Efforts must be made by the WCES Service Coordinator to locate a Provider to be able to meet the 30 day requirement. Early Steps' children cannot be placed on a waiting list for services.

**E. Providers may conduct an assistive technology assessment with prior approval from the child’s IFSP team and report results on the Quarterly Progress Monitoring Reports.** Natural supports must be explored and used first. Any assistive technology purchased with Part C funds must meet an established developmental outcome on the IFSP.

**F. WCES Service Coordinators must be contacted by the provider when:**

1. The Provider is aware of a need for a change or modification in the service being provided to the child. If a provider recommends an increase in services, a written justification may be submitted to the Service Coordinator.

2. The Provider becomes aware of problems or concerns regarding the child’s services.

3. An IFSP outcome is not being met or progress is not being made .

4. An outcome on the IFSP has been achieved.

5. There are changes in family demographics.

6. Changes in insurance coverage.

**G. When the Provider participates in Initial, Periodic and Annual IFSP meetings, and Transition Conferences, a direct service (ST, PT OT, EI) cannot be billed.** Documentation will be on the Participant Documentation of Initial and Follow-up Evaluation/Assessment IFSP form and kept in the child’s record.
H. Other IFSP team members will be consulted as authorized on the IFSP. The Consultation Documentation form will be completed and submitted to the Service Coordinator when any IFSP team member provides consultation as on the IFSP.

I. Medicaid Policies and procedures will be followed as stated in the most current Therapy Services handbook and Early Intervention Services Coverage and Limitations handbook available at:
https://ahca.myflorida.com/medicaid/review/Specific/CL_07_070801_EIS_ver1_3.pdf

J. All other documentation will be provided to WCES as deemed necessary.

Attachments:
Service Initiation Report
Consultation Documentation

4. AGENCY CHILD RECORD STANDARDS

A. The Agency will maintain a child’s record to include a copy of the IFSP, each WCES authorized session note, all Progress Monitoring Data Updates and Reports, and other relevant documentation needed to provide services to the child and his family.

B. Early Intervention sessions must be documented. Early Intervention Session Note is available for use. Session notes should include:
   1. Date with start and end time
   2. Location(s)
   3. Narration of activities to address IFSP outcomes
   4. Family/caregiver participation in coaching activities
   5. Provider and family/caregiver signatures
   6. Family and/or Provider cancellation of session

C. To ensure that all Licensed Early Intervention Professionals incorporate all components and requirements of the Plan of Care (POC) from the current Medicaid Early Intervention Services Coverage and Limitations Handbook.

D. If an ITDS is the PSP for the child, the identification and signature of a Licensed Health Care Provider (LHCP) who is providing direction and support is required on the IFSP.

E. The State requires retention of records for a period of six (6) years after termination of the State contract. For services provided during the period of July 1, 2018 through June 30th, 2021, provider records must be retained until July 1, 2027, unless notified by the State of Florida or Johns Hopkins All Children's Hospital, Inc. in writing to the contrary.

5. AGENCY/PROVIDER FISCAL COMPLIANCE:

A. Individuals with Disabilities Education Act (IDEA)-Part C funds are always accessed as payer of last resort.


C. To provide WCES funded services only when authorized by WCES on the IFSP. Verbal authorization is not compliant.

D. To retain all pertinent documents that determine accuracy of claims submitted, adjudicated and reimbursed which includes:
   - Services/Contact notes
   - Travel Log
   - Consultation Forms
   - Explanation of Benefits
E. To bill all known and available third party resources for services to WCES where third party responsibility is denied. An explanation of benefits (EOB) must be included with the billing to WCES.

F. To submit ALL claims for cost reimbursement to the WCES Fiscal Coordinator:
   - Within 60 calendar days from date of service, or submit claims that have been submitted to a third-party payor in a timely manner and denied by the third-party payor within 60 calendar days after the service provider receives notice of denial.
   - In an Excel file formatted as specified by the WCES Fiscal Coordinator
   - Via an encrypted/password protected email

NOTE: WCES in not responsible for payment when the Provider did not comply with the third party agent’s or WCES billing requirements. Acknowledgement that third-party payor’s denial of payment for failure of the service provider to follow proper billing procedures, incorrect diagnosis code, or other correctable reasons will NOT constitute grounds for payment from WCES.

G. To accept WCES/Part C reimbursement rate as payment in full.
   Reference: Early Steps Service Taxonomy (http://peds.ufl.edu/es/Documentation/Codes/)

H. To inform the WCES Service Coordinator if the Provider identifies any changes in funding sources for services listed on the IFSP.

I. Travel is paid only in conjunction with an authorized and delivered Early Steps service (See attached Travel Policy). To document and maintain Early Intervention Professionals’ travel on the Natural Environment Travel Log.

J. To provide a copy of the compliance audit package, as required under OMB Circular A-133, if a Provider or agency is subject to OMB A-133 and receives $500,000 or greater in federal funds or state financial assistance during its fiscal year.

Attachments:
   Early Intervention Session Note
   Travel Reimbursement Policy
   Natural Environment Travel Log
West Central Early Steps
Verification of Qualifications

- Copy of current Form W9
- Work History, documenting in a month/year timeline for last five (5) years, with explanation of any gaps longer than 90 days in employment
- Documentation of appropriate professional Early Intervention experience
- Copy of Professional License; if applicable
- Copy of College/University Transcript (all degrees earned)
- Copy of Social Security card
- Copy of Individual National Provider Identification (NPI) number
- Copy of current liability insurance coverage
- Summary of professional liability claim(s) pending or filed against you within the past five (5) years
- Summary of Medicaid and Medicare sanctions within the past five (5) years. Provide date of occurrence, amount paid and brief summary of events for each sanction
- Current malpractice coverage in accordance to your specific Florida Statute Practice Act or bond that complies with the provider’s relevant practice act in the Florida Statutes; if applicable
- Level II Security Background Screen. Active/eligible Medicaid providers are exempt from submitting a Level II Security Background Screen if an eligible screen has been conducted within the past 5 years as evidenced by AHCA.
- Documentation of Infant Toddler Developmental Specialist Training Modules complete; (Non-licensed only).
- Documentation of Early Steps Orientation Training Modules completed (Copies of 3 Certificates)

Submit to:
Victoria Manzaroli, Fiscal Coordinator
West Central Early Steps - Johns Hopkins All Children’s Hospital
Ph: 727-767-6826, Fax: 727-767-6721
Vmanzar1@jhmi.edu

*Please note: Providers will still need to follow procedures to enroll separately with Medicaid managed care plans, including the CMS plan.
WEST CENTRAL EARLY STEPS PROVIDER ENROLLMENT APPLICATION

Agency Name: 

Doing Business As: 

Physical Address: 

City: ___________________ State: ___________________ Zip Code (with ext): ___________________ 

Mailing Address (if different than physical address): 

City: ___________________ State: ___________________ Zip Code (with ext): ___________________ 

Phone Number: (_____) __________ Extension: ___________ FAX Number: ___________________ 

Cell Phone number: (____) __________ E-Mail: ___________________ 

Tax ID: ___________________ Medicaid Group Number(s): ___________________ 

Administrative Contact: ___________________ Fiscal Contact: ___________________ Service Contact: ___________________ 

Date Liability Insurance Expires: ______________ NPI Number: ___________________ 

Are you a Minority Business Provider? ______ Are you certified? ______ CMBE Number: ___________________ 

Provider Name: ___________________ Title: ___________________

Completed CMS/ES Orientation Training Modules 1, 2, and 3 (Dates): 

Social Security Number: ___________________ NPI Number: ___________________ 

Individual Medicaid Provider Number: ______________ Date Eligible To Bill Medicaid: ______________ 

Individual El Medicaid Number: ______________ Date Eligible to bill Medicaid: ______________ 

License Number: ______________ License Expiration: ______________ Liability Insurance Expires: ______________ 

Area of Specialty (e.g., feeding, sensory integration, autism): 

Languages Spoken

Counties Served

__________________________

__________________________

__________________________

__________________________

BDI-2 Training Yes________ No__________ (If you have training, please provide documentation) 

For Early Steps Use Only: Date Application Received: ______________
West Central Early Steps
Quarterly Progress Report / IFSP Review Request

This form must be prepared by the provider and submitted to the family and service coordinator at least quarterly and prior to each IFSP review.

<table>
<thead>
<tr>
<th>Child’s Name: __________________</th>
<th>DOB: ______</th>
<th>SC: ______________</th>
<th>Service Period: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sessions provided (#): ______</td>
<td>Reason for missed sessions: ______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>_______________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>_______________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose:  ___Quarterly Progress Monitoring  ___ Request for IFSP Periodic Review  ___ Request for IFSP Annual Review*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*HELP and IFSP Assessment page must be completed for all domains and submitted to the service coordinator 10 days prior to the IFSP Annual Review.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress toward meeting IFSP Outcomes: ______________________</td>
<td>____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestions/Activities: ____________________________________</td>
<td>____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations:  ___No Changes  ___Discharge  ___ Update Outcomes  ___ Update Services  ___ Other: ______________________</td>
<td>____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Signature: ______________________________________</td>
<td>Caregiver Signature: ______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Print Name/Credentials: ______________________</td>
<td>Date Completed: ______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Submitted to Service Coordinator: ______________________</td>
<td>Service Coordinator Name: ______________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Your Child’s Assessment/Eligibility Determination Part I

For children to be active and successful participants at home and in the community, they need to develop skills in the three functional areas described below. We use this information about your child’s abilities and your concerns and priorities to understand your child’s progress.

### Date of evaluation/assessment: ___________________  
Chronological Age: ___________________ Months

### Instruments/Sources Used:

<table>
<thead>
<tr>
<th>Functional Areas</th>
<th>Activities Your Child Does Well</th>
<th>Activities Your Child Finds Difficult</th>
<th>Your Child’s developmental levels based on the evaluation and assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This includes your child’s ability to engage others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>including developing relationships, self-soothing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>strategies for becoming and remaining calm,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>getting along with others, and expressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>feelings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ACQUIRING AND USING KNOWLEDGE AND SKILLS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This refers to your child’s ability in areas such</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as thinking, reasoning, remembering, problem solving,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number concepts, and counting. It also includes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>skills related to language and literacy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>USING APPROPRIATE ACTIONS TO MEET NEEDS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This includes your child’s ability to take care of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>basic needs such as getting from one place to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>another, dressing, feeding, toileting, and using</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tools (forks, toothbrushes, crayons).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Review</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information Regarding Eligibility/Assessment:

- Social/Emotional: Score  
  Indicates an area of delay as defined by Early Steps
- Communication: Score  
  Indicates an area of delay as defined by Early Steps
- Cognitive: Score  
  Indicates an area of delay as defined by Early Steps
- Gross Fine Motor: Score  
  Indicates an area of delay as defined by Early Steps
- Self Help: Score  
  Indicates an area of delay as defined by Early Steps
Your Child’s Assessment/Eligibility Determination Part II

<table>
<thead>
<tr>
<th>Vision and Hearing Status:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Observations/Comments:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Eligibility:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Additional information regarding eligibility:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessors</th>
<th>Disciplines</th>
<th>Signatures</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor 1</td>
<td>Discipline 1</td>
<td>Signature 1</td>
<td>Date 1</td>
</tr>
<tr>
<td>Assessor 2</td>
<td>Discipline 2</td>
<td>Signature 2</td>
<td>Date 2</td>
</tr>
<tr>
<td>Assessor 3</td>
<td>Discipline 3</td>
<td>Signature 3</td>
<td>Date 3</td>
</tr>
<tr>
<td>Assessor 4</td>
<td>Discipline 4</td>
<td>Signature 4</td>
<td>Date 4</td>
</tr>
<tr>
<td>Assessor 5</td>
<td>Discipline 5</td>
<td>Signature 5</td>
<td>Date 5</td>
</tr>
</tbody>
</table>

*Indicates the appropriate license professional member(s) of the IFSP team providing support and direction, if applicable.
Participant Documentation of Initial and Follow-up Eval/Assess/IFSP - IFSP Meeting - Transition Conference

This form must be completed by team members participating in a required IFSP meeting/Transition Conference. (Team members conducting IPDEI/IPDEF may use this form to record start and end time.)

- Initial Evaluation/Assessment/IFSP Meeting (IPDEI)
- Follow-up Evaluation/Assessment/IFSP Meeting (IPDEF)
- IFSP Meeting
- Transition Conference
- COIFF (Face to Face)
- COIFP (Phone)

[check appropriate choices above]

Child’s Name:__________________________________ DOB:________________________________________

Date of Meeting/Conference:______________________ Location:______________________________________

Start Time:____________________________________

Team Members Present:___________________________

(Family) (Service Coordinator)

End Time:____________________________________

Activities:

- Initial or Follow-up Evaluation/Assessment/IFSP activities.
- Review and revisit family concerns, priorities, resources, routines and activities.
- Trans-disciplinary approach to the development of integrated outcomes and intervention strategies within the family's everyday routines, activities and places.
- Identification of PSP and appropriate team members to meet the specific family outcomes.
- Documentation of above on IFSP
- Transition activities
- Other (specify):

End Time:____________________________________

Provider Name: ________________________________(Print)

Provider Signature:___________________________

Copy to: Billing with monthly invoice.
PARTICIPANT DOCUMENTATION OF INITIAL AND FOLLOW-UP EVAL/ASSESS/IFSP - IFSP MEETING - TRANSITION CONFERENCE INSTRUCTIONS

This form is required for IFSP meetings and transition conferences, but optional for initial and follow-up evaluations.

IPDEI/IPDEF Documentation

LES have the option of using this form or another mechanism to record the time each team member who bills IPDEI/IPDEF spends conducting initial and follow-up evaluations.

Under Activities, check only the “Initial or Follow-up Evaluation/Assessment/IFSP activities” box and record the time YOU spent in the activity. On the bottom print your name and sign. The form is submitted with the invoice to the Local Early Steps to document IPDEI/IPDEF time billed.

IFSP meetings and transition conferences

For IFSP meetings and transition conferences, each team member must have a form completed for each IFSP meeting / transition conference in which he/she participates. During IFSP meetings/transition conferences, the members participating should appoint a recorder to LEGIBLY complete the form from Child’s Name to End Time. Each participating, billing provider should receive a copy. Each provider checks whether their participation was face to face or by phone at the top, and on the bottom prints their name and signs their copy. The form is submitted with the invoice to the Local Early Steps to document IFSP time billed.

Field Entry Guidance:

Child’s Name and DOB: = Child’s name whose IFSP/transition is being discussed and their Date of Birth.

Date of Meeting/Conference: = The date of the scheduled IFSP meeting/transition conference.

Location: = The actual location of the IFSP meeting/transition conference.

Start Time: = The time the IFSP meeting/transition conference began. For IPDEI/IPDEF the time should reflect each individual's Start Time.

Team Members Present = All the people participating in the IFSP meeting/transition conference. Professionals on the team indicate their credentials after their name, i.e. OT, PT, SLP, ITDS, etc.

Post evaluation and assessment IFSP activities: = Check the box for each activity that is part of the IFSP meeting/transition conference discussion. If there is an activity that is not listed check “Other” and describe the activity.

End Time: = The time the IFSP meeting/transition conference ends. For IPDEI/IPDEF the time should reflect each individual's End Time

ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS’ FORMS

When each participant receives their copy of the completed form, they will complete the remaining fields.

Initial Evaluation/Assessment/IFSP Meeting (IPDEI)
Follow-up Evaluation/Assessment/IFSP Meeting (IPDEF)
IFSP Meeting Transition Conference
COIFF (Face to Face) □ COIFP (Phone)

[check appropriate choices above]

Provider Name (Print) LEGIBLE name of provider Provider Signature Provider signature

Each individual provider submits their signed copy to the Local Early Steps with their invoice to document Initial and Follow-up Eval/Assess/IFSP/IFSP/transition conference time billed.
West Central Early Steps
Service Initiation Report

Part C requires services be started within 30 days of authorization on Form G of the IFSP

PLEASE RETURN THIS FORM TO THE SERVICE COORDINATOR WITHIN 10 DAYS OF START OF SERVICE

Agency Name: ______________________________________________

Service Authorized:   [ ] EIIF   [ ] SLP   [ ] OCCT   [ ] PHY

IFSP Authorization dates: _____________________________________

Service must begin no later than (date): _________________________

To be Completed by Provider

Above Services Started on (date): _____________________________

Provider: _________________________________________________

Documentation of Contact Attempts:

[ i.e. Reason for Delay in Initiation of Service ]

Date:

Return to:

Service Coordinator: _________________________________

Phone Number: _________________________________

E-mail:____________________________________

Fax: (727) 767-4715

Johns Hopkins All Children’s Hospital
West Central Early Steps
501 Sixth Ave. South, Dept.6500006005
St. Petersburg, FL 33701

Child Name/ MR #

or (Early Steps Label)
Consultation Documentation
(To be completed by those participating in consultation session)

Parent was notified and invited to participate on ___________________ by (method)____________________________

If the consultation meeting will potentially result in change of outcomes or services, the Primary Service Provider will contact Service Coordinator prior to meeting. Service Coordinator contacted on ___________________ by (method) ____________________________

Child’s Name: ____________________________  DOB: __________________________________________

Service Coordinator: ____________________________  Date of Consultation: ____________________________

Start Time: ____________    End Time: ____________    Location: ________________________________________

Consultation is to discuss/coach team members in addressing family/ caregiver’s:

• Challenges to implementing strategies and achieving goals for Outcome # _____
  ___________________________________________________________
  ___________________________________________________________
  ___________________________________________________________

• Successes to implementing strategies and achieving goals for Outcome # _____
  ___________________________________________________________
  ___________________________________________________________
  _________________________________________________________

The team (family, caregivers, primary service provider and supporting providers) will continue or modify the following strategies to achieve goals for Outcome # _____

  ___________________________________________________________
  ___________________________________________________________
  __________________________________________________________

IFSP Team meeting is needed to discuss recommended changes in services, frequency, and/or duration of services:

☐ YES  ☐ NO

Participating Team Members/Signatures:  (PSP indicated with *)

<table>
<thead>
<tr>
<th>Parent/ Guardian:</th>
<th>OT</th>
<th>SLP</th>
<th>Service Coordinator:</th>
<th>ITDS</th>
<th>PT</th>
<th>EI</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Face-to-Face</td>
<td>Phone</td>
<td>Face-to-Face</td>
<td>Phone</td>
<td>Face-to-Face</td>
<td>Phone</td>
<td>Face-to-Face</td>
</tr>
</tbody>
</table>

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)
Consultation Documentation, Continued

Child’s Name: ____________________________  DOB: __________________________
Service Coordinator: ______________________  Date of Consultation: ____________

Consultation is to discuss/coach team members in addressing family/caregiver’s:

- Challenges to implementing strategies and achieving goals for Outcome # ______

---

- Successes to implementing strategies and achieving goals for Outcome # ______

---

The team (family, caregivers, primary service provider and supporting providers) will continue or modify the following strategies to achieve goals for Outcome # ______

---

- Challenges to implementing strategies and achieving goals for Outcome # ______

---

- Successes to implementing strategies and achieving goals for Outcome # ______

---

The team (family, caregivers, primary service provider and supporting providers) will continue or modify the following strategies to achieve goals for Outcome # ______

Copy to: Family/Guardian
        Early Steps Service Coordinator within 5 business days
        Team Providers (whether present or not)
CONSULTATION DOCUMENTATION FORM INSTRUCTIONS

This form serves two primary purposes:
- Statewide uniform documentation of Consultation services paid for by contract funds
- Statewide uniform billing documentation for providers participating in Consultation

Each team member must have a form completed for each Consultation in which they participate. During consultation sessions, the members participating should appoint a **recorder** to LEGIBLY complete the form from *Child’s Name* to *IFSP Team Meeting Yes No*. Copies should then be made for each participant and the family. The original goes to the Service Coordinator to place in the child’s file. Consultation is typically between the Primary Service Provider and other team members. Each enrolled Early Steps provider can bill for Consultation using the form as invoice documentation. Although they may participate in the consultation, professionals and providers who are not enrolled would not be able to bill. If any team provider did not participate in the Consultation session, a copy should be provided to them so they can be informed.

**Field Entry Guidance:**

**Child’s Name:** *Full name of child*  
**DOB:** *Date of birth of child*

**Service Coordinator:** *Name*  
**Date of Consultation:** *MM/DD/YYYY*

**Start Time:** *Beginning time of consultation session*  
**End Time:** *End time of consultation session*

**Location:** *This is the location where the meeting was scheduled to be. If face-to-face, enter the location as i.e. Home, Local Early Steps, Playpen Therapy; if scheduled to be by phone, enter the location as Phone.*

Challenges and Successes to implementing strategies and achieving goals: Narrative of the discussion, by individual outcome.

The team (*family, caregivers, primary service provider and supporting providers*) will continue or modify the following strategies to achieve goals: Narrative of the recommendation(s) resulting from the consultation, by individual outcome.

**PSP:** *Name and credentials of the current Primary Service Provider*

**Consulting Team Members:** List all members participating in the consultation and check Face-to-Face or Phone and obtain signatures of those present.

**Family Participation:** *The name(s) of the family member(s) and check Phone, Face-to-Face or Declined Invitation*

**ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS’ FORMS**

When each provider receives their copy of the completed form, they will complete the remaining fields before billing.

**Provider/Participant Name (Print):** *LEGIBLE name of provider/participant*  
**Signature:** *Provider/Participant signature*

*(Each participant should find their designation and sign, if face-to-face. Provider signature lines should include the code signifying if participation was Face-to-Face or Phone)*

<table>
<thead>
<tr>
<th>Provider</th>
<th>Face-to-Face</th>
<th>or</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>CONOF</td>
<td></td>
<td>CONOP</td>
</tr>
<tr>
<td>PT</td>
<td>CONPF</td>
<td></td>
<td>CONPP</td>
</tr>
<tr>
<td>SLP</td>
<td>CONSF</td>
<td></td>
<td>CONSP</td>
</tr>
<tr>
<td>ITDS or OTHER EI PROVIDER</td>
<td>CONIF</td>
<td></td>
<td>CONIP</td>
</tr>
</tbody>
</table>

Billing is based on the *scheduled* location of the Consultation session. If the meeting is scheduled at the family’s home and some of the participants are at the home and others are participating by phone, those participating by phone must bill the Phone code. Those participating at the home bill the Face-to-Face code.

If the Consultation session is *scheduled* as a phone conference, then everyone participating must bill Phone codes, even if some participants are face-to-face.

Consultation time must be authorized on the Individualized Family Support Plan (IFSP). Consultation should all be authorized as Face-to-Face for purposes of entering it in the Early Steps Data System, Family Support Plan Service Authorization (FSPSA) component. It can be billed as either Face-to-Face or Phone when entered in the data system as an intervention.
# Natural Environment Travel Log

**Provider Name**

**Provider Signature**
I attest that the following information is true and accurate.

Entries must be clearly written and legible to be reimbursed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Point of origin Address</th>
<th>Time of Departure/Odometer</th>
<th>Destination Child’s Name &amp; Address</th>
<th>Time of Arrival/Odometer</th>
<th>Minutes Spent In Travel (1 unit = 1 minute) / Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>/</td>
<td></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td>Enter SAME if Point of Origin is same as previous Point of Destination</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td>Enter SAME if Point of Origin is same as previous Point of Destination</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td>Enter SAME if Point of Origin is same as previous Point of Destination</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td></td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

Copy to: Billing with Monthly Invoice
Child’s Name: __________________________  DOB: / /  Age: ___ months
Date of Session: ______________________  Procedure Code: ________  Diagnosis: __________
Time In: __________  Time Out: __________  Units: __ .25 units = 15 min
__ .50 units = 30 min
__ .75 units = 45 min
__ 1.0 units = 60 min

__ 1 evaluation Type:

Travel Time (in minutes): ______

Location: ___ Home  ___ Childcare Center  ___ Other: ________________________________
Participants: ___ Mom / Dad present / participated
___ Grandparent present / participated
___ Sibling present / participated
___ Childcare provider present / participated
___ Other: _________________________

Goals:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Parent/Caregiver Update:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Progress Toward Goals: __ Regression __ No Improvement __ Continuing Improvement __ Significant Improvement

Session Notes:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Goals Met: ________________________  Goals Ongoing: ________________________

Communicate with Service Coordinator:  NO  YES
for the following concern(s):
_____________________________________________________________________________________
_____________________________________________________________________________________

Notes For Next Visit:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Interventionist/Therapist Signature: __________________________________________

Parent/Caregiver Signature: __________________________________________
TRAVEL REIMBURSEMENT

The Local Early Steps (LES) offices have the following options in reimbursing providers for travel when they provide direct service in the natural environment. An exception is Consultation, as it may be held in a location other than the natural environment.

Options:

- No Reimbursement
- Reimburse $10 only Natural Environment Support Fee (NESF)
- Reimburse both the $10 and .445 cents per mile (NESF and Mileage)

Because travel is automatically included with authorized services provided in the natural environment, (along with consultation), it is not required that it be authorized on the IFSP.

WCES Reimbursement is as follows:

- $10 automatically (Does not matter how far the distance is)
- Additional .445 cents per mile (From 31 miles and up to 100 miles = 70 maximum)*

* NOTE: A provider may apply for an exception to the 100 mile cap
  - Via the Service Coordinator, the Provider must submit to WCES Fiscal Coordinator, Vicky Manzaroli, a printout from MapQuest that shows the mileage from the provider’s starting point address, to the patient’s location address, and to the provider’s ending point address.
  - WCES administration will review each request on a case-by-case basis.
  - The WCES Fiscal Coordinator will notify the Service Coordinator to inform the Provider of the decision

To receive reimbursement for travel, the following MUST be met:

- Service(s) MUST be Authorized on the IFSP
- Service(s) MUST be in the natural environment setting (With the exception of Consultation)
- Service(s) MUST be provided (If you travel and the family cancels, you are not able to bill)
TRAVEL REIMBURSEMENT (Contd)

Examples of reimbursement:

Trip # 1: Provider travels 30 miles round trip to home visit:  $10 Total for Trip # 1

Trip # 2: Provider travels 65 miles round trip to home visit: $10 plus $15.57 (65-30=35 miles x .445) = $25.57 Total for Trip #2

Trip # 3: Provider sees 3 children during the day (One after the other):
   Travels 25 miles to Client “A” = $10,
   then from “A” to “B” is 3 miles = $10,
   then from “B” to “C” and returning to the office is a total of 45 miles = $10 visit, plus $6.67 (45-30 =15 miles x.445) = $16.67. Total for Trip # 3 $36.67

Trip # 4: Provider travels 125 miles round trip to home visit: $10 visit plus $31.15 (100-30=70 miles x .445) = $31.15 Total for Trip #4 $41.15

Billing & Documentation

The service and CPT codes to use are:
NESF/99600 (Natural Environment Support Fee) Bill as 1 Unit for each event
TRAV/TRAVS (Mileage @ .445 cents per mile) Bill each mile as 1 unit

Travel will be included on the monthly invoice you submit to WCES. You WILL NOT submit mileage logs to the LES for billing, but you MUST maintain documentation in the child’s chart of the service(s) provided and the distance(s) traveled. This can be in the form of a mileage log or Mapquest printout. If WCES performs an audit, and documentation is not provided, you will be required to reimburse West Central for the amount that your agency was paid.