educate . innovate . advocate
Westchester Institute for Human Development
Cedarwood Hall, Valhalla, NY 10595
914.493.8202 . www.wihd.org

Fecha:

Queridos Padres:

Bienvenido al programa de Intervencion Temprana (EIP) del Departamento de Salud del Condado de Westchester.

En respuesta al referido de su hijo(a) para los servicios de Intervencion Temprana, yo he sido asignado(a) como su Coordinador(a) de Sevicio Inicial (ISC), para trabajar con su familia durante la primera face de su entrada al programa. La ISC le ayudara en la seleccion de la agencia mas apropiada para evaluar a su nino(a), responder a cualquier pregunta que usted tenga, atender sus inquietudes y ofrecer informacion adicional.

Necesito programar una visita inicial dentro de los proximos dias con el fin de repasar el paquete de referencia y completer los formularios, que deven ser completados por usted o su doctor. En ese momento seran obtenidos los siguientes formularios:

*Prueba de residencia (facture de telephone, electricida o cable)
*Copia de la tarjeta del seguro medico (frente y dorso)
*Carta de sus derechos de Privacidad
*Authorizacion para dar informacion sobre el seguro medico
*Consentimiento para facturar el seguro medico no-regulado
*Consentimiento de los padres para dar y recibir informacion
*Seleccion de la agencia evaluadora
*****Formulario medico para ser llenado por el medico de su hijo(a)*****
POR FAVOR devuelva el formulario medico lleno a la agencia evaluadora tan pronto le sea possible.
*Consentimiento para dar informacion medical al EIP
*Consentimiento a WIHD para destruir los registros de EIP
*Consentimiento a de los padres a WIHD para utilizar el correo electronic para intercambiar informacion de identificacion personal

Espero trabajar con su familia.

Atentamente,

Coordinadora de Servicio Inicial

Telefono#:_________________________________
Fax#:_______________________________________

Westchester Institute for Human Development
University Center for Excellence in Developmental Disabilities

Westchester County Department of Health

Services for Children with Special Needs

EARLY INTERVENTION PROGRAM INTAKE

CHILD'S NAME:____ DOB:____________________

AGENCY:____ INTAKE DATE:______________

INTIAL SERVICE COORDINATOR:__________________________ IFSP DATE:_______________

EIOD:____ Projected IFSP DATE:___________

THE INTAKE SHOULD ADDRESS THE FAMILY'S CONCERNS, PRIORITIES, and RESOURCES:

Concerns: Family concerns is defined as those areas that the parent identifies as needs, issues or problems that the family wishes to have addressed in the IFSP.

Priorities: Family priorities refers to those areas that the parent selects as essential targets for early intervention services to be delivered to their child and family unit.

Resources: Family resources refers to the strengths, abilities and formal and informal supports that can be accessed to address family concerns, needs or desired outcomes.

1. Has your child been previously referred to the Early Intervention Program?
   Previous Evaluations, EI, Private? ____

2. What was happening with your child that bought you to Early Intervention? Family concern.
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

CHILD'S NAME: ____ DOB:_____________

3. Tell me about your child? What does your child enjoy?
   PROMPT: What are the typical activities and routines of the day for you and your child?
   ____
   ____
   ____
   ____
   ____

4. Tell me about your family? (siblings, extended family, caregivers)
   PROMPT: Who is involved with your child and who can you call on for support for you and your family? ____
   ____
   ____
   ____
   ____

5. Are you looking for information or resources outside of the Early Intervention Program?
   PROMPT: Does your family need help finding community services? _________________
   ____
   ____
   ____
   ____

6. Do you have insurance? What type of coverage do you have?
   PROMPT: Do you have Medicaid, SSI, Child Health Plus, Commercial Insurance?
   ____

7. Does your child have a Pediatrician, Neighborhood Health Center?
   Physician's name and telephone number:_____________________________________
   ____
   Neighborhood Health Center Physician's name and telephone number: ____________________
   ____

8. In order for me to assist you in selecting an evaluator, does your child have an existing medical condition or special needs? ____
   ____
   ____
   ____
   ____

CHILD'S NAME: ____ DOB: __________________

9. Discuss EI process, refer to the Parent Guide to Early Intervention.
   - timeline, 45 day, eligibility
   - selection of evaluator, multidisciplinary evaluation
   - IFSP meeting, role of EIOD
   - selection of the Ongoing Service Coordinator
   - due process rights

____
____
____
____

10. Discussion on family responsibilities and participation in the Early Intervention Program.
PROMPT: If child is eligible, discuss with parent what their role is in the intervention process. i.e. Family Centered Intervention. ____
____
____
____
____

Westchester gov.com

WESTCHESTER COUNTY DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM

PARENTAL CONSENT TO INITIATE SERVICE COORDINATION

Child's Name: ____
Last First

Child's DOB: ______/______/________

I have been informed by the Early Intervention Initial Service Coordinator (ISC) of the various programs and services the Early Intervention Program (EIP) can provide to my child. I have also been informed that in order to provide such services it will be necessary for the Program to coordinate and exchange information with appropriate service providers.

☐ I consent to the planning and coordination of services for my child.

____ Date______/______/_______
Signature of Parent/Guardian

____ Date______/______/________
Signature of Initial Service Coordinator

Service Coordinator Must Complete:

Date ISC agency received assignment from WCDOH: ______/______/_______

Date ISC provided parent(s) the EIP Parent's Guide: _____/______/_______

Date ISC reviewed "Your Parent's Rights in the EI Program": _____/______/_______

Date ISC reviewed list of evaluation sites and discussed choice of evaluation site with parent: ____/____/_____

Name of evaluation site selected by parent: ____

Date referral made to evaluation site: ______/______/______

Westchester gov.com

WESTCHESTER COUNTY DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM

PARENT SELECTION OF EVALUATION AGENCY

Child's Name:____
Last First MI

DOB: _____/_________/___________ Date of Referral: _____/_____/______

My initial service coordinator has reviewed all options for evaluations and provided me with a list of NYSDOH approved evaluation agencies in Westchester County.

I have been informed that I will be involved in my child's evaluation, I will receive the results of all evaluations, and that a copy of all evaluations will be forwarded to ___________________________________, my assigned Early Intervention Official Designee (EIOD). If my child is eligible for the Early Intervention Program, the evaluations will assist in developing my child's Individualized Family Service Plan (IFSP).

I choose ____ as the evaluation agency that will determine my child's eligibility for the Early Intervention Program. In the event that this evaluation agency does not have availability I choose _________________________________, ______________________________.
(Evaluation Agency 2nd choice) (Evaluation Agency 3rd Choice)

____ Date: ____/____/_____
Signature of Parent/ Surrogate Parent

Revised 6/11/14

Kenneth W. Jenkins
Westchester County Executive

Department of Health
Sherlita Amler, M.D.
Commissioner

Westchester County Department of Health
Children with Special Needs

Patient Bill of Rights/Notice of Privacy Practices

I have been provided the opportunity to review the Westchester County Department of Health's Notice of Privacy Practices and Patient Bill of Rights prior to signing this document. The Notice of Privacy Practices for the Westchester County Department of Health is also provided on the Westchester County Department of Health's website at http://health.westchestergov.com/

Record Retention Policy

In accordance with the State Archives and Records Administration, Early Intervention records are maintained by Westchester County until the child turns 21 years old, at which time the record will be destroyed. The county may however maintain a permanent record of the child and family's name and address, and the types and dates of services received without time limitation.

I acknowledge that Westchester County's Notice of Privacy Practices and Record Retention Policy have been reviewed with me.

______________________________	______________________	________________
Signature of Parent/Guardian	Relationship to Child	Date

WCD11 0513

Department of Health
145 Huguenot Street
New Rochelle, New York 10801 Telephone: (914) 813-5080 Fax: (914) 813-5093

Westchester County Department of Health
Early Intervention Program Medical Form

Child's Name: ________________________ Date of Birth: ____________

Parent's Name: ____

Address: ____

Immunization History:

	Birth – 2 Months	4 Months	6 Months	12-18 Months	18-24 Months	24-30 Months	30-36 Months
(DtaP) Diphtheria, Tetanus, Pertussis							
(IPV) Polio							
(Hib) Haemophilius Influenzae type b							
(Hep B) Hepatitis B							
(MMR) Measles, Mumps, Rubella							
(PCV) Pneumococcal Conjugate							
Chickenpox) (Varicella)							

Testing: Lead: ___________ **Results:** ___________ **TB:** ____________ **Results**: ___________
Date of Last Physical Exam: _______ **(Ht.)** ______**inches**_______**% (Wt.)** _____**lbs.**_____**%**
Ophthalmology: ____________________________**Results:** ____________________________
Audiology: ______________________________ **Results:** ____________________________
Referrals to other physicians: ____
____

Please describe below or attach description of child's medical history that has an identified or potential impact upon his developmental growth: Birth defects, prematurity, addiction, respiratory/cardiac compromise, seizure activity, feeding difficulties, other pre-natal or neo-natal difficulties or history of accidents, injuries, hospitalization, etc.

Please describe child's current medications, medical needs or concerns including allergies, if any:

Please describe any emotional, social or behavioral problems of which you are aware:

I hereby recommend that this child receive services from Early Intervention that may include occupational therapy, physical therapy, speech, social work, and/or assistive technology services; if found eligible as per EI NY State Regs. and as per the IFSP.

Physician's Name: ____

Address: ____

____ Phone #: ______________

Signature: ____ Date: ______________________

Revised.2/11

Westchester Institute for Human Development
Notice and Consent for Destruction of Early Intervention Records

Early Intervention (EI) records are considered educational and are governed by the following regulations related to the retention and destruction of records containing personally identifiable information.

- Federal family Educational Rights and Privacy Act (FERPA)
- Title II-A of Article 25 of Public Health Law
- Intervention Program regulations in 10 NYCRR 69-4.17 (c)
- Title 34 of the code of Federal Regulations (CFR)

Personally Identifiable Information (PII), as used in information security, refers to information that can be used to uniquely identify, contact, or locate a single person or can be used with other sources to uniquely identify a single individual.

The Federal Government defines PII as "*Information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name*"

The records created for your child throughout the Early Intervention process will be retained by WIHD until they reach the age of 21 at which time they will be destroyed by us in a manner consistent with all Federal, state and local regulations and laws in effect at that time.

<u>The process used for destruction of these records may include the use of an outside record disposal company that Westchester Institute for Human Development contracts with specifically for this purpose. The company provides us with a certificate of destruction which is kept on file at WIHD in the Office of Corporate Compliance and Regulatory Affairs. Companies who contract to provide this service will be in full compliance with all Federal, state and local regulations in effect at the time the records are destroyed.</u>

<u>**You**</u> may request that the documents be destroyed earlier by submitting a request in writing to:

Westchester Institute for Human Development
Manager of the Early Intervention Program
Cedarwood Hall
Valhalla, New York 10595

Please be aware that you or your child may need the Early Intervention records for future purposes including determination of Social Security Benefits.

By signing this document, I acknowledge that the Policy of WIHD for retention and destruction of Early Intervention records has been explained to me and I consent to the destruction of these records including the use of an outside record destruction company who will be fully compliant with all federal, state and local regulations regarding destruction of personally identifiable information.

Child's Name	Child's Date of Birth
Name of Parent or Guardian	Signature of Parent or Guardian
Relationship to Child	Date

Reviewed 4/2016

Consentimiento de los Padres para Intercambiar Información Personal Identificable a través del Correo Electrónico

Nombre del Padre(s): ____

Dirección de correo electrónico (email): ____

Nombre del Menor: __________________________________ Fecha de nacimiento__________

A petición del interesado, usted ha escogido comunicar información personal identificable respecto al tratamiento de intervención temprana de su hijo(a) via correo electrónico (email) sin el uso de codificación de seguridad. Deseamos notificarle que enviar información personal identificable presenta varios riesgos de los que usted debe estar informado antes de darnos su consentimiento o permiso. Los riesgos incluyen, pero no se limitan a los siguientes:

- El email puede ser remitido y almacenado fácilmente en formato electrónico y en papel sin previo conocimiento del padre.
- Los remitentes pueden usar una dirección de email equivocada y la informacion personal identificable puede enviarse accidentalmente al destinatario equivocado.
- El email enviado via internet sin codificación de seguridad no es seguro y puede ser interceptado por terceros.
- El contenido del email puede ser cambiado sin conocimiento del remitente o del destinatario
- Pueden existir copias de seguridad del email aún después de que el remitente y el destinatario hayan borrado el mensaje.
- Los empleadores y proveedores de servicio en linea tienen derecho a checar los emails que se envian usando sus sistemas
- El email puede contener viruses y otros programas dañinos.

Reconocimiento y consentimiento de los padres

Yo reconozco que he leido y entiendo los artículos antes mencionados, los cuales describen los riesgos inherentes del uso del email para comunicar información personal identificable. No obstante, Yo, __________________ autorizo _____________________ con dirección de correo electrónico (email) _________________________ a que se comunique conmigo a mi dirección de correo electrónico (email) _______________________________________, con respecto a la participación de mi hijo(a) en el programa de intervención temprana (EIP por sus siglas en inglés), incluyendo, pero no limitado a la comunicación respecto a la obtención del servicio, su progreso en el EIP y cualquier otro asunto relacionado. Entiendo que el uso de email sin codificación contiene los riesgos como consta más arriba y puede resultar en una revelación imprevista de esa información.

(Opcional) Además, doy permiso a los miembros del equipo de tratamiento de mi hijo(a) para que entre ellos se comuniquen información personal identificable con respecto a mi hijo(a), usando correo electrónico sin codificación de seguridad. Los miembros del equipo de intervención temprana a quienes doy permiso para que se comuniquen entre ellos acerca de mi hijo(a) usando correo electronico sin seguridad son los siguientes:

(1) _________________________ con correo electrónico (email) ________________________

(2) _________________________ con correo electrónico (email) ________________________

(3) _________________________ con correo electrónico (email) ________________________

(4) _________________________ con correo electrónico (email) ________________________

(5) _________________________ con correo electrónico (email) ________________________

Firma del Padre ___________________________________ Fecha ________________________

PROGRAMA DE INTERVENCION TEMPRANA DEL NYS
CONSENTIMIENTO PARA EL USO DE TELESALUD (TELEHEALTH) DURANTE EL ESTADO DE EMERGENCIA PARA COVID-19

Nombre del niño:	No. De EI:	Fecha de nacimiento: / /
Dirección:		No. de apartamento:
Ciudad / Pueblo:	Estado: Nueva York	Código Postal:
Tipo de Servicios Que Se Prestaran Mediante Telesalud:	No. de Autorización del Servicio de NYEIS:	
Nombre del terapeuta/maestro:	No. de teléfono:	
Agencia Proveedora de Servicio:	No. de teléfono:	
Coordinador de Servicio:	No. de teléfono:	
Agencia del Coordinador de Servicio:	No. de teléfono:	

Instrucciones: Se debe completar un formulario de consentimiento como esta muestra para el uso de Telesalud como método de prestación de servicios de intervención temprana para cada tipo de servicio autorizado para el niño, incluyendo servicios de evaluación antes de que se puedan iniciar los servicios de telesalud. La telesalud como método de prestación de servicios de intervención temprana solo está disponible durante el estado de emergencia declarado para COVID-19 (hasta el 6 de abril de 2020). Se puede devolver un formulario de consentimiento para el uso de telesalud por correo electrónico si el padre / tutor también firma y devuelve el formulario de Consentimiento de los Padres Para Usar el Correo Electrónico Para Intercambiar Información de Identificación Personal, disponible aquí: https://www.health.ny.gov / community/infants_children/early_intervention/memoranda/docs/early_intervention_parent_consent_to_use_email.pdf
El formulario de consentimiento para el uso de Telesalud debe adjuntarse al caso integrado del niño en NYEIS.
Se requiere un formulario de consentimiento por separado para cada servicio de intervención temprana.

Yo, (Nombre completo del padre / tutor) ____, doy mi consentimiento para que se entregue el servicio (ingrese el tipo de servicio) ________________________ de mi hijo utilizando Telesalud como método de prestación de servicios de intervención temprana. Entiendo que los servicios de telesalud que recibirá mi hijo cumplirán el mandato de servicio en el (IFSP) Plan de servicio familiar individualizado de mi hijo y no se prestarán en adición de los servicios que mi hijo está autorizado a recibir en el hogar / servicios con base en la comunidad.

Entiendo que Telesalud como un método de prestación de servicios de intervención temprana solo está disponible durante el estado de emergencia declarado para COVID-19 y que los servicios de mi hijo se entregarán utilizando el método autorizado en el IFSP de mi hijo después del 6 de abril de 2020.

Entiendo que Telesalud significa que los servicios de intervención temprana se brindarán utilizando audio y video al mismo tiempo durante la sesión. La telesalud no significa tener una llamada telefónica con el terapeuta / maestro de mi hijo.

Entiendo que tendré acceso a todos los informes de intervención temprana resultantes de esas sesiones realizadas a través de telesalud en forma de notas de sesión y notas de progreso si las solicito al coordinador de servicios de mi hijo.

He recibido una copia de "Sus Derechos Familiares en el Programa de Intervención Temprana".

____
Nombre del Padre (letra de imprenta)

____ ________________________________
Firma del Padre Fecha

Insurance
Tool Kit Item 3
Form A

NYEIS Child Reference#:

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

COLLECTION OF INSURANCE INFORMATION

DATE INSURANCE INFORMATION COLLECTED/UPDATED:	*Is the Insurance Plan Regulated by New York State? Yes ☐ No ☐ If no, has the parent consented to use of their insurance benefits? Yes ☐ No ☐	Is the Insurance Plan: Primary ☐ or Secondary ☐
Child's Name:	Child's Date of Birth:	Child's Gender:
Parent/Guardian Name:	Parent/Guardian Date of Birth:	Parent/Guardian Phone No.:
Insurance Company Name:	Insurance Company Phone No:	**Insurance Company Billing and Claiming Address:
	Insurance Plan/Policy Name:	Type of Insurance Plan:
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder Gender:
Policy Holder Address:	Policy Holder Phone Number:	Policy Holder Relationship to Child:
Policy Holder Employer Name:	Employer Address:	Employer Phone No.:
Policy No. for Billing:	Child's Member Identification No:	Group Number (if applicable):
	Policy Effective From Date:	Policy Effective To Date:
Is the Plan Child Health Plus? Yes ☐ No ☐	Is the Plan Medicaid Managed Care? Yes ☐ No ☐	Is the Plan a self-funded plan? Yes ☐ No ☐
***Medicaid CIN Number (2 alpha, 5 numeric, 1 alpha):	CIN Effective From Date:	CIN Effective To Date:
Service Coordinator Name:	Service Coordinator Phone No: 914-493-8719	Service Coordinator Fax No.: 914-493-8066
Municipality Name: Westchester	Service Coordinator Agency: Westchester Institute for Human Development	Service Coordinator Address: Cedarwood Hall, Rm 338, Valhalla, NY, 10595

Insurance Information reviewed at 6 month IFSP: date_________ initials ________ no changes ________ new form ________
Insurance Information reviewed at 12 month IFSP: date_________ initials ________ no changes ________ new form ________
Insurance Information reviewed at 18 month IFSP: date_________ initials ________ no changes ________ new form ________
Insurance Information reviewed at 24 month IFSP: date_________ initials ________ no changes ________ new form ________
Insurance Information reviewed: date_________ initials ________ no changes ________ new form ________

NYEIS Child Reference #:

Insurance Tool Kit Item 4
Form B

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CHILD INSURANCE INFORMATION

Child's Name/Date of Birth: ______________________ **Child's Gender:** male ☐ female ☐

Primary Insurance Information:

Insurance Company/Plan Name: ______________________

Insurance Company Billing address: ______________________

Policy/Identification (ID) Number: ______________________

Child's Member ID (if different): ______________________

Group #: ______________________

Policy Holder Name: ______________________ Policy Holder Gender: male ☐ female ☐

Policy Holder Date of Birth: ______________________

Policy Holder Address: ______________________

Policy Holder Phone Number: ______________________

Policy Holder relationship to child: ______________________

Other Insurance (if applicable):

Insurance Company/Plan Name: ______________________

Insurance Company Billing address: ______________________

Policy/ID Number: ______________________

Child's Member ID (if different): ______________________

Group #: ______________________

Policy Holder Name: ______________________ Policy Holder Gender: male ☐ female ☐

Policy Holder Date of Birth: ______________________

Policy Holder Address: ______________________

Policy Holder Phone Number: ______________________

Policy Holder relationship to child: ______________________

Medicaid Client Identification Number (CIN) (if applicable): __ __ __ __ __ __ __ __
(2 letters, 5 numbers, 1 letter)

______________________ ______________
Parent/Legal Guardian Signature Date

Parent signature confirms that the insurance information on file is correct.

Insurance Information reviewed at 6 month IFSP: date________ no changes ____ parent signature ______________

Insurance Information reviewed at 12 month IFSP: date________ no changes ____ parent signature ______________

Insurance Information reviewed at 18 month IFSP: date________ no changes ____ parent signature ______________

Insurance Information reviewed at 24 month IFSP: date________ no changes ____ parent signature ______________

Insurance Information reviewed (other): date________ no changes ____ parent signature ______________

PARENT ATTESTATION OF NO INSURANCE (if applicable)

Child's Name: ______________________ **Child's Date of Birth:** ____________

I ______________________ (please print name) the parent and/or legal guardian of the child whose name is above, attest that as of today's date such child does not have health insurance coverage. I understand that the assigned Early Intervention Program service coordinator must assist me with the identification of and application for health insurance for which such child may be eligible. I also understand that such child is not required to have health insurance in order for Early Intervention Program services to be provided.

______________________ ______________
Parent/Legal Guardian Signature Date

Revised May 2017

NYEIS Child Reference#:

Insurance Tool Kit Item 5 **Form C**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

AUTHORIZATION TO RELEASE HEALTH INSURANCE INFORMATION

Pursuant to Section 2559(3)(d) of NYS Public Health Law and
Section 3235-a(c) of the Insurance Law

Insured's (Child's) Name:	Date of Birth:
Parent/Legal Guardian's Name:	Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name and Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Service Coordinator Name:	Service Coordinator Agency: Westchester Institute for Human Development
Service Coordinator Address: Cedarwood Hall, Room 338, Valhalla, NY 10595	Service Coordinator Phone No.: 914-493-8719
Municipality: Westchester	Date Sent to Insurer:

I request and authorize the release of health insurance coverage information for the insured named above to my child's and family's early intervention service coordinator, provider(s), the municipality which administers the local Early Intervention Program, and the NYS Department of Health and/or its early intervention fiscal agent.

I authorize the exchange of information between these parties and the insurer named above for the purposes of facilitating claiming and assisting in the adjudication of claims for services rendered under the Early Intervention Program:

I further consent and authorize providers who submit claims to the above referenced insurer to provide such information as may be required by the insurer to facilitate claiming and payment for services rendered under the Early Intervention Program.

This request applies only to health insurance coverage under the insured's policy, plan or benefit package for the purposes of facilitating payment from the insurer for services rendered under the Early Intervention Program.

Parent/Guardian's Signature: ____

Date Signed: ____

Revised 2/14

NYEIS Child Reference#:

Insurance Tool Kit Item 11 **Form F**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CONSENT TO BILL NON-REGULATED INSURANCE

TODAY'S DATE:	*Is the Insurance Plan Regulated by New York State: Yes ☐ No ☐
Child's Name:	Child's Date of Birth:
Insurance Company Name:	Insurance Plan Name/Type:
Insurance Company Address:	Insurance Company Phone No:
Policy Holder's Name:	Policy Holder's Relationship to Child:
Policy Holder's Address:	Policy/ID No.: Child's Member ID No.: Group No. (if applicable):
Name of Service Coordinator:	Service Coordinator's Phone Number: 914-493-8719
Consent Effective From Date:	Consent Effective To Date:

Please Read

I understand that I can decide if I wish to give my permission for my health insurance plan, which is not regulated by New York State Insurance Law, to be billed to help pay for the Early Intervention Program services my child and family receive.

I understand that my consent is voluntary, that I can revoke my consent at any time, and that the revocation of consent will not be retroactive.

I understand that if I give this permission, my insurance benefits may not be protected by State Insurance or Public Health Law and that my insurer may not be prohibited from:

- Applying the early intervention services to the policy's lifetime or annual monetary or visit limits.
- Discontinuing or not renewing my insurance coverage because my child receives early intervention services.
- Increasing my insurance premiums because my child is receiving early intervention services.

Consent to Bill Non-Regulated Insurance

☐ **I give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

☐ **I do NOT give my consent** to my Early Intervention Program providers to access benefits through my health insurance plan, which is NOT regulated by New York State Insurance Law, to help pay for the early intervention services my child and family receive.

Parent Name　　　　Parent Signature　　　　Date

NYEIS Child Reference#:

Insurance Tool Kit Item 6 **Form D**

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

REQUEST FOR COVERAGE INFORMATION
Pursuant to Section 3235-a(c) of New York State Insurance Law

Child's Name (First/MI/Last):	Child's Date of Birth:
Municipality:	Date Sent to Insurer:
Name of Parent/Legal Guardian:	Phone No.:
Insurance Company/Plan Name:	Insurance Company Address:
Policy Holder Name and Address:	Policy Holder Relationship to Child:
Policy Holder Date of Birth:	Policy No. for Billing:
Policy Holder Employer Name:	Policy Holder Employer Address:
Child's Member Identification No.:	Group No. (if applicable):
Early Intervention Service Coordinator:	Service Coordination Agency: Westchester Institute for Human Development
Service Coordinator Phone No.: 914-493-8719	Service Coordinator Fax No.: 914-493-8066
Service Coordinator Address: Cedarwood Hall, Room 338, Valhalla, NY 10595	

Dear Insurer:

This form requests information about the above named child's insurance coverage. The parent/guardian of the above named child has authorized release of this information (authorization form enclosed). As per requirements in Section 3235-a(c) of the New York State Insurance Law, we request that you complete and return this form to the Early Intervention Program at the address provided above. Section 3235-a(c) of the State Insurance Law requires this information to be returned within 15 days of request. Provision of this information will assist both the authorized providers and the insurer in claims processing.

Please provide the following requested information regarding the above named child's benefits as the insured.

Is the child's health coverage:

a) A health insurance policy, plan or benefit package regulated under New York State Law — Yes☐ No☐

b) Child Health Plus — Yes☐ No☐

c) Other government plan (e.g., Medicaid Managed Care) — Yes☐ No☐

d) A self-insured plan governed by ERISA or other plan not subject to regulation under New York State Insurance Law? — Yes☐ No☐

Please indicate the effective dates of coverage for this policy: ______________________________

Revised 2/14

NYEIS Child Reference#:

Child's Name (First/MI/Last):	Child's Date of Birth:

Visit Limit Information

If the child's insurance policy, plan or benefit package **IS** a policy regulated by New York State Insurance Law and **IS NOT** Medicaid, Champus, or a self-insured plan or other plan not subject to New York State Insurance Law, please indicate the number of annual visits available for the covered services identified below (if no coverage is available, please indicate by placing a 'N' in the second column and a '0' in the third column).

Service	Covered (Y/N)	Number of Annual Visits
Applied Behavior Analysis		
Assistive Technology/Durable Medical Equipment		
Audiology Services		
Nursing Services		
Diagnostic and Evaluation Services		
Nutrition Services		
Occupational Therapy		
Physical Therapy		
Psychological Services		
Social Work Services		
Special Instruction		
Speech Language Therapy		
Vision Services		

Is prior authorization for covered services required? **Yes☐** **No☐**

Are there specific referral procedures that must be followed? **Yes☐** **No☐**

If yes, please describe the procedures that must be followed:

____

____

Please provide the name, telephone number, and email address of an appropriate contact person for questions about the information on this form:

______________________ ______________ ______________

Name Phone E-mail

Please return completed form to the Early Intervention Service Coordinator at the address on the first page of this form. Thank you for your assistance.

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Cedarwood Hall, Valhalla, NY 10595
914.493.8202 . www.wihd.org

CONFIRMACION DE LA REUNION INICIAL DE IFSP

FECHA:_________________

RE:____
Niño(a)

ESTIMADO(a):____:

Esta es para confirmer que el Plan de servicio Personalizado para la familia (IFSP) esta fijado como sigue:

FECHA:__________________________
HORA:___________________________

☐ The Family Connection
WIHD/Cedarwood Hall
Room 338
Valhalla, NY 10595

☐ Westchester County Dept of Health
145 Huguenot Street, 7th Floor
New Rochelle, NY 10801

☐ Other:____________________
____
____

En la reunion, nosostros discutiremos sus preocupaciones y prioridades, asi como las destrezas de su hijo(a). La evaluacion sera explicada y revisada. Un plan sera desarrollado para su familia. Por favor asegurese de que el seguro social de su hijo(a) sera requerido, si usted no lo ha proporcionado anterior a la reunion, asi como el seguro social de la persona bajo la cual esta la poliza de seguro medica de su hijo(a), si usted no lo ha proporcionado anterior a la reunion.
Usted puede invitar a cualquier persona a participar en la reunion.
Esperamos contar con su presencia en la reunion.

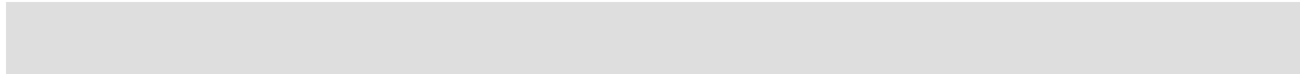
Sinceramente,

____
Servidora de Coordinadora Inicial
Telefono: ____________________________
cc: ( ) EIOD___________________________________
( ) Evaluador______________________________
( ) Otros___________________________________

Westchester Institute
for Human Development

Family Connection – Early Intervention Services
Cedarwood Hall, Room 338
Valhalla, New York 10595

914-493-1343 (p)
914-493-8066 (f)
914-493-2639 (alternate f)



facsimile transmittal

To:	**From:**
To Fax:	**Phone # for follow-up:**
Pages:	**Date:**

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Fecha:

Queridos Padres:

Bienvenido al programa de Intervencion Temprana (EIP) del Departamento de Salud del Condado de Westchester.

En respuesta al referido de su hijo(a) para los servicios de Intervencion Temprana, yo he sido asignado(a) como su Coordinador(a) de Sevicio Inicial (ISC), para trabajar con su familia durante la primera face de su entrada al programa. La ISC le ayudara en la seleccion de la agencia mas apropiada para evaluar a su nino(a), responder a cualquier pregunta que usted tenga, atender sus inquietudes y ofrecer informacion adicional.

Necesito programar una visita inicial dentro de los proximos dias con el fin de repasar el paquete de referencia y completer los formularios, que deven ser completados por usted o su doctor. En ese momento seran obtenidos los siguientes formularios:

*Prueba de residencia (facture de telephone, electricida o cable)
*Copia de la tarjeta del seguro medico (frente y dorso)
*Carta de sus derechos de Privacidad
*Authorizacion para dar informacion sobre el seguro medico
*Consentimiento para facturar el seguro medico no-regulado
*Consentimiento de los padres para dar y recibir informacion
*Seleccion de la agencia evaluadora
*****Formulario medico para ser llenado por el medico de su hijo(a)*****
POR FAVOR devuelva el formulario medico lleno a la agencia evaluadora tan pronto le sea possible.
*Consentimiento para dar informacion medical al EIP
*Consentimiento a WIHD para destruir los registros de EIP
*Consentimiento a de los padres a WIHD para utilizar el correo electronic para intercambiar informacion de identificacion personal

Espero trabajar con su familia.

Atentamente,

Coordinadora de Servicio Inicial

Telefono#:___________________________________
Fax#:____

The goal of the Early Intervention Program is to help families help their children learn and develop.

If your child is eligible for the program, we will assign a team to your child that will include teachers, therapists, a service coordinator, and an Early Intervention Official Designee.

Together, your team will develop a plan and identify services based on your concerns, priorities, and resources. They will work with you to meet your child's and your family's goals.

What is Telehealth?

Telehealth is when **evaluations** and **therapies** are provided online, through a live video session. It is like receiving an in-person evaluation or therapy session. You can see, hear, and talk to the teacher/therapist/evaluator about your child.

- You will need a smartphone or a laptop/computer and the internet.
- All Early Intervention services are confidential and live telehealth video sessions must meet privacy rules.
- Research shows that telehealth can be as helpful as in-person services for children with different types of developmental delays.

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Telehealth In The Early Intervention Program

Do Not Wait!

Consider Telehealth Evaluations or Services:

- ✓ It will give you greater scheduling flexibility.
- ✓ It is as effective as in-person therapy and has been used in other States for many years.
- ✓ It increases positive child outcomes.
- ✓ It increases parent involvement, a feeling of competence, and empowerment.

What to Expect:

- Telehealth and EI supports the parents in a child's life.
- The teacher and therapist will coach you working to support your family during daily routines.
- Babies and toddlers need lots of practice and, when parents receive coaching, their children get more practice and learning with their family in between therapy sessions.
- The teacher or therapist pays close attention to the family's learning style and cultural beliefs to help support your family.
- More frequent and quality back-and-forth interactions between children and their parents help lay the foundation for learning and health, for now and in the future.

Have Questions or Want More Information?

Please contact the Westchester County Department of Health Early Intervention Program at 914 -813-5090

To make a referral to the Early Intervention Program, please call 914 813-5094- English/Spanish

For information regarding Child-Find at Risk Program, please call 914-813-5328

For information regarding community resources, please call Children and Youth with Special health Care needs- CYSHCN- 914-813- 5076

Westchester County

George Latimer, County Executive
Sherlita Amler, MD, Commissioner
Department of Health

Questions And Answers For Families About Telehealth In Early Intervention

Q: What is telehealth?
A: Telehealth (or teletherapy) is the way for your child to get Early Intervention (EI) evaluations or services without an evaluator or therapist coming in person to your home, and it works. Research shows it can be as helpful as in-person services for children with different types of developmental delays.

Q: What do I need in order to receive EI services by telehealth?
A: You and the evaluator or therapist will each use a tablet, smartphone, or laptop computer so that you can see and hear each other. You will each need a reliable Internet connection.

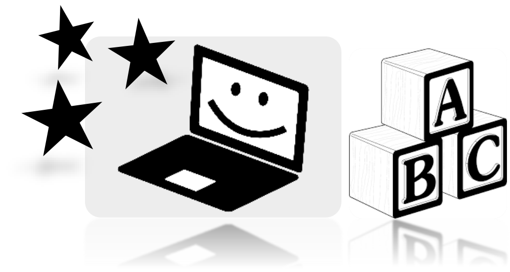
Q: Does telehealth work?
A: Both telehealth and in-person are ways that work well to provide services or evaluate your child. Some states have been offering telehealth as a way to get Early Intervention services for many years. Research shows that telehealth offers more flexibility with scheduling and increases parent engagement in their child's therapy or evaluation session. Parents say that they feel re empowered to help their child make progress when their child gets teletherapy sessions.

Q: I'm not a therapist. How am I supposed to do the therapy activities with my child?
A: Early Intervention has always had a family-centered approach that uses embedded coaching, where the Early Intervention evaluator/therapist coaches *you* in ways to work with your child. When receiving services by telehealth, you only use toys and other items you have at home.

Q: My child is young. How are they going to pay attention to the therapist on the screen?
A: You're the one who will see on the screen what the therapist/teacher is explaining. Then you try it with your child and the therapist/teacher sees what you're doing. This way, the therapist/teacher can see what typically occurs during your family's routine activities, the skills your child uses to carry out those routine activities with your help, and how your child interacts with others including you!

Q: What if I want in-person but there are no available service providers?
A: Give telehealth a try. If you've told your IFSP team that you prefer in-person services, they'll keep looking for an in-person service provider while you accept telehealth for the time being. It's much better for your child to receive some of their services by telehealth than to not receive those services at all while you're waiting for in-person services to be found.

Q: I accepted telehealth and we did a few sessions, but I don't feel my child is making progress. What should I do?
A: Give it a little more time. You can also ask your therapist to schedule a few in-person sessions so you can look together for new ways to address a functional outcome without the limits of a screen. This way, the therapist can see your child in-person in their natural environment and may have some new ideas about how to make telehealth work better for you and your child.



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