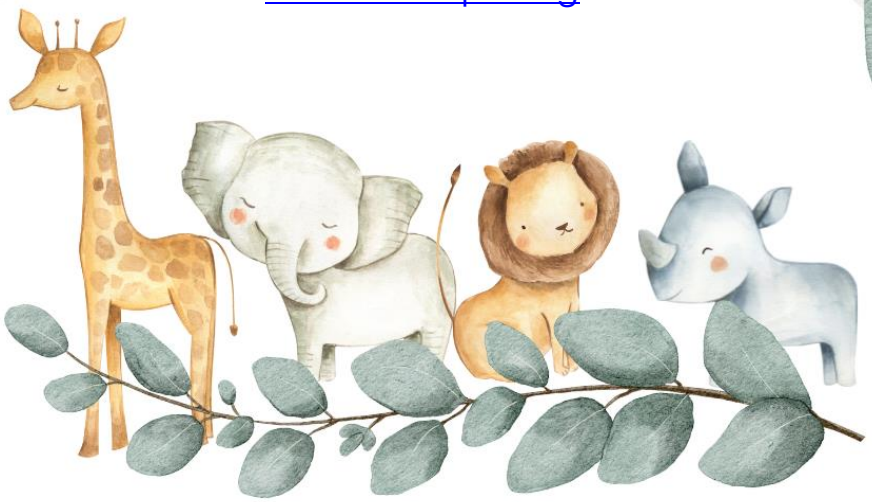
Ventura County
Special Education Local Plan Area
www.vcselpa.org



EARLY START OPERATIONS MANUAL FOR SCHOOL-BASED EARLY START PROGRAMS AND SERVICES

Serving Infants/Toddlers 0 – 36 months

December 2023

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INTRODUCTION

Welcome to Ventura County SELPA Early Start Program. Adopted in 1991 in the state of California, Early Start is an innovative, visionary program that provides family-focused services to infants and toddlers with disabilities. The goal of the program is to provide early intervention to assist children in developing their fullest potential.

Early Start is a program unlike any other public school, special education program. It requires ongoing collaboration with the Regional Center for intake, assessment, service delivery and transition. It utilizes a planning process (Individualized Family Service Plan - IFSP) and a service delivery model that is home-based and unique.

In addition, every local education agency in California has developed their own working system with their local regional center. Therefore, what we do in Ventura County SELPA is different than other places in the state.

All IFSP forms and most other documents to be used with families are also available in Spanish. See the SELPA website for all IFSP forms at www.vcselpa.org.

This manual was designed to assist you as you enter our program.

Original Editors: Fran Arner-Costello and Launice Walker

Thanks to the following staff for the 2023 revisions:
Regina Reed, Director, VC SELPA
Keisha Carroll and Rama Dasu, Simi Valley USD, Early Childhood Special Educators
Jaime Harris, Conejo Valley USD, Early Childhood Special Educator
Karly Stern, Ventura USD, Early Childhood Special Educator
Natalie Locacciato and Briseida Favela, Oxnard School District, Early Childhood Special Educators

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ROLES AND RESPONSIBILITIES OF SCHOOL DISTRICT ECSE

ROLES AND RESPONSIBILITIES OF SCHOOL DISTRICT EARLY CHILDHOOD SPECIAL EDUCATOR (ECSE)

Roles and responsibilities include the following but are not limited to:

SERVICE COORDINATOR:

- Develop IFSP
- Initiate referrals for other specialized assessments
- Coordinate services listed on IFSP
- Referral to community resources
- Adhere to State and Federal laws including timelines
- Coordinate Transition Planning and Referral to school district of residence at age three

*Service Coordinators within the schools may also serve as Service Providers.

SERVICE PROVIDER:

- Complete developmental assessment
- Attend IFSP
- Assist in developing appropriate measurable outcomes with the family
- Provide special instruction, family training, counseling, and home visits
- Develop reports of progress

The Early Start Program in the public schools provides services to children **200 days per year (Budget Act of 2008-09 Provision 8)**. In addition, the school district ECSE must be available to receive and act upon referrals of Solely Low Incidence children **12 months per year, each business day**.

Each Early Start program will serve eligible Infants/ Toddlers according to the "minimum" number on the attached chart, as per the October pupil count (first Wednesday in October).

Early Start Program
Allocation Formula

		Units	(Growth)* Eligible for more funding Units x 16 children[1]	(Average) Units x 14	(Recapture) At risk of losing funding Units x 12
Simi	32%	2.61	41.76	36.54	31.32
Ventura	19%	1.48	23.68	20.72	17.76
Oxnard	30%	2.42	38.72	33.88	29.04
Conejo	19%	1.53	24.48	21.42	18.36
		8.04		112.56	

*Growth and recapture are figured on the SELPA totals.

[1] Each child served is considered to use one slot, except children with unilateral hearing loss being seen only once a month, who are considered to use .25 of a slot

Revised 9.2022

REFERRAL

REFERRAL

Infants and toddlers can be referred to the Early Start program by any interested individual. This is typically done by a parent or guardian, doctor or other medical personnel, therapist, day care provider or education staff.

In Ventura County, the Early Start Program has a "*single point of entry*," which is Tri-Counties Regional Center (TCRC, phone (800) 664-3177). Children from Los Angeles County, residing in Ventura County SELPA school districts are referred to North LA County Regional Center (NLARC, phone (818) 778-1900).

TCRC staff will complete an Early Start Inquiry page (Attachment A), acquiring important information about the child and the concerns. The referral date is the date on which the Inquiry Sheet was completed. TCRC will assign an Interim Service Coordinator for the child.

TCRC will forward the Early Start Inquiry page to the appropriate school district program immediately. The school district ECSE is responsible for children within the cachement of the school districts they serve. (Attachment B)

The process for intake is known as Dual Agency Review Team (DART). During the DART process, infants will be considered for one of the following service coordination options:

Solely Low Incidence (SLI)
The school district ECSE is responsible to serve all infants/ toddlers with solely a vision impairment, hearing impairment, or orthopedic impairment, or any combination of those disabilities. These infants / toddlers are not served by TCRC and will receive services from the school district even if their caseload is full. The school district ECSE is the Service Coordinator.

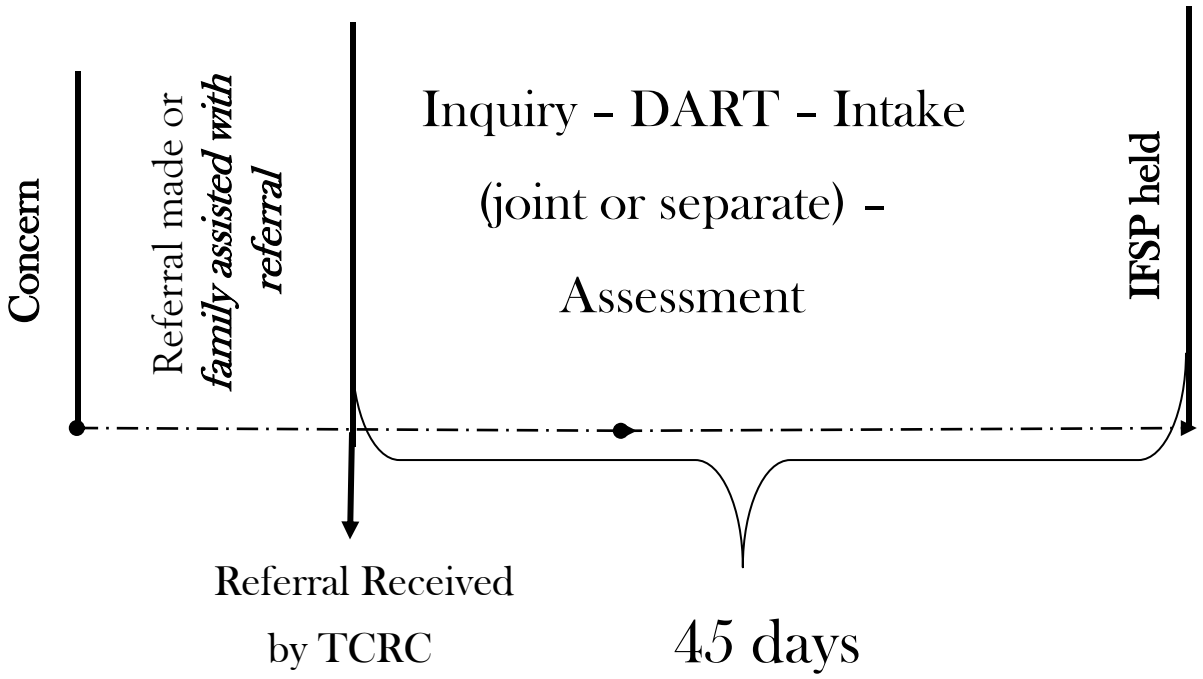
Regional Center Services only
TCRC is responsible for all eligible infants/ toddlers who will not be served by the school district ECSE at all.

Dually Served
If the school district ECSE has openings in their caseload, they can provide special education services to the child, with TCRC retaining service coordination responsibilities. According to the Memorandum of Understanding (MOU) between TCRC and Ventura County SELPA, the following infants / toddlers are priorities for dual service delivery:

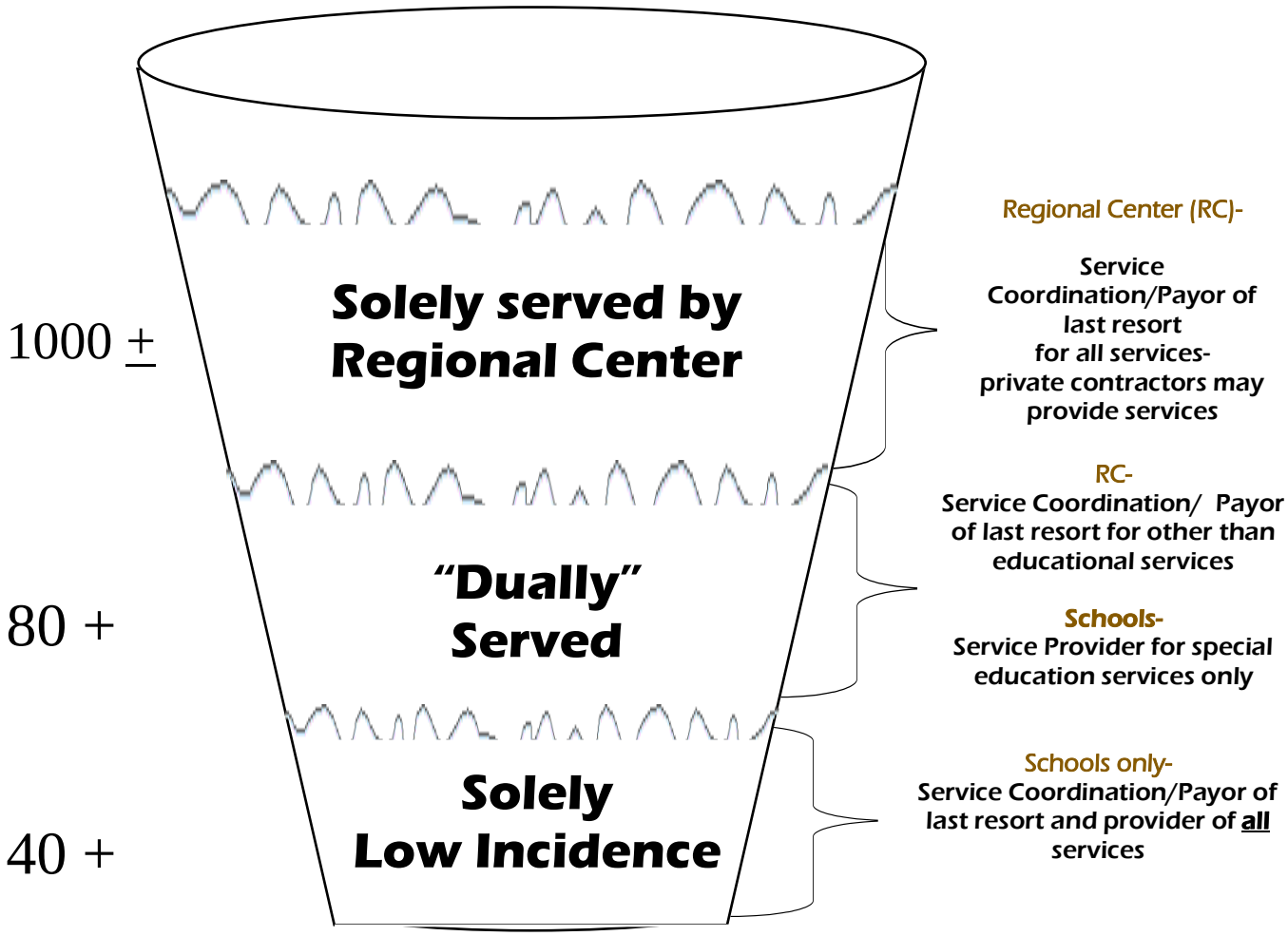
Children who would benefit from vision or hearing services; or
Children with orthopedic impairments
Children who exhibit multiple handicaps, especially those with cognitive impairments and other disabilities.

It is important to note that a child's initial service coordination status (SLI, RC services only or dually served) may change when the intake team meets the child and completes the assessment process. In that case, the child is referred back to the DART team to reconsider agency services.

The school district ECSE will respond to DART by 5:00pm next business day via phone, email. Once a referral is received by TCRC, the 45 day timeline begins. During the 45 day time line the following must occur: intake interview, assessment and Initial IFSP.



The following graphic demonstrates proportional numbers of children served by the various service delivery options.



EARLY START INQUIRY

Ventura County SELPA Early Start Program IFSP
Condado de Ventura SELPA *Programa de Servicios de Intervención Temprana IFSP*

Initial Intake Date: _____ **IFSP Due Date:** _____ **SSN#**_____ **UCI#**_____

Child's name: _____ Date of Birth: _____ Age: _____ Gender: _____
Last First MI

Mother/Guardian: _____ Maiden Name: _____ Father: _____

Parent Consent to Referral: ❑ Yes ❑ No Do Parents live together? _____ Primary Language: _____ Interpreter? _____

Mailing/Home Address: _____

Phone: _____ Message Phone: _____ School District of Residence: _____

Inquirer's Name: _____ Relationship to the Family: _____ Contact Phone _____

Has applicant ever applied for services from any regional center? ❑ Yes ❑ No Where? _____

Primary physician: _____ Telephone: _____

Other agencies involved: _____ Medical Info Attached: _____

Parent was informed that Early Start is a partnership between DDS and Dept of ED and information will be shared between TCRC and the LEA, and parents agreed to proceed. ❑ Yes ❑ No

HISTORY AND CONCERNS:

Birthplace: _____ Hospital: _____ Gestational Age: _____ Birth weight: _____

Present weight: _____ Medications and Equipment: _____

Medical Confirmation/Diagnosis: _____ Specialist(s) Involved: _____

Developmental Concerns	Description of Concerns:
☐ Vision	
☐ Hearing * *see checklist*	
☐ Physical * *see checklist*	
☐ Self-Help * *see checklist*	
☐ Behavioral	
☐ Social	
☐ Communication	
☐ Cognitive	

***Physical Checklist:** (*Circle all that apply*): rolls tummy to back, sits unsupported, belly crawls, crawls, pulls to stand, cruises furniture, walks, grasps toy, releases toy

***Self Help Checklist** (*Circle all that apply*) : holds a bottle with both hands, finger feeds, drinks from open cup, uses a spoon to feed

***Newborn Hearing Screening Passed**: ☐ Yes ☐ No

Inquiry taken by: _____ Phone #: _____ Ext: _____

Regional Center Service Coordinator assigned: _____ Phone #: _____ Ext: _____

Date of follow up – phone call to family (if appropriate): _____ How did you hear about Early Start: _____

Actions taken: ❑ Appears SLI-sent to LEA ❑ Faxed to LEA for consideration for dual Date _____

School District Response: _____ **Possible Dates for Joint Intake:** _____

LEA Early Start Coordinator:	**LEA Response Date:**
☐ **Yes**- agree to serve as SLI (Pending evaluation results)	☐ **No-** does not appear appropriate for dual/no available openings at this time
☐ **Yes**- agree to dual intake	☐ **No**- reconsider at later date when more information is available
Concerns/ Need More Info:	

SERVICE COORDINATION REGION	Speech/Language	Assistive Technology Assessment	Audiological Services (for a fee)	Orientation & Mobility	Nutrition*	Respite*	Transportation to educational services	Physical Therapy*	Occupational* Therapy	Vision Services	Counseling and Guidance Services	Parent training	Health and Nursing	Social Emotional Services	Recreation Services	Deaf	Hard of Hearing Services
Conejo Valley USD (**C**)	C	SELPA	VC	SELPA	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	C	C/BH	SELPA/ FRC	C	C/BH/RC/ SELPA	RD	SV	SV
Oxnard Elementary SD (**OE**)	OE	SELPA	VC	SELPA	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	OE	OE/BH	SELPA/ FRC	OE	OE/BH/RC/ SELPA	RD	OE	OE
Ventura Unified SD (**V**)	V	SELPA	VC	SELPA	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	V	V/BH	SELPA/ FRC	V	V/BH/RC/ SELPA	RD	V	V
Simi Valley Unified SD (**SV**)	SV	SELPA	VC	SELPA	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	SV	SV/BH	SELPA/ FRC	SV	SV/BH/RC /SELPA	RD	SV	SV

Hueneme **(H)**

California Children Services (**CCS**)

City Recreation Department (**RD**)

Family Resource Center (**FRC**)

Regional Center **(RC)**

Ventura County Special Education Local Plan Area (**SELPA**)

Ventura County Office of Education **(VC)**

DISTRICTS EACH REGION SERVES

Conejo

Las Virgenes Unified School District
Oak Park School District

Oxnard Elementary

Hueneme Elementary School District
Ocean View School District
Oxnard School District

Simi Valley

Moorpark Unified School District
Pleasant Valley School District
Simi Valley Unified School District
Somis School District

Ventura Unified

Briggs School District
Fillmore Unified School District
Mesa School District
Mupu School District
Ojai Unified School District
Rio School District
Santa Paula Unified School District
Ventura Unified School District

INTAKE

INTAKE

After an infant is referred to the Early Start program and has gone through the DART process, the Service Coordinator contacts the family to arrange an intake interview. (Attachment D) If the child may be dually served, the intake interview with the family will include a representative from TCRC and the school district. The representative from TCRC and the school district will make every effort to go out together to complete the intake interview.

Parent Consent will be obtained to gather information from medical practitioners or other providers. (Attachment E)

All children will be given vision and hearing screening.

All families will be given a referral to the Rainbow Connection Family Resource Center upon intake. (Attachment F)

INTAKE INTERVIEW WORKSHEET

Ventura County SELPA Early Start Program IFSP
Condado de Ventura SELPA *Programa de Servicios de Intervención Temprana IFSP*

Date of Report: _____
Dual case: ❑ Yes ❑ No

Name: _____ DOB: _____

IDENTIFYING INFORMATION:

Age: _____ Sex: _____ Ethnicity: _____

Address: _____

Phone Number: _____

Who does the child reside with? Biological Parents: ❑ Yes ❑ No _____

Foster Parents: ❑ Yes ❑ No _____ CPS Worker: ❑ Yes ❑ No _____

By whom referred: _____

Risk Factors: _____

Reason for concern (*congenital anomalies, prematurity, diagnosis, etc*): _____

_____

Location of interview: _____

Persons attending intake: _____

Health Insurance: _____

FAMILY SITUATION:

Mother: _____ Maiden Name: _____ DOB: _____

Age: _____ Educational Background_____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

_____

Father: _____ DOB: _____ Age: _____

Educational Background_____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

_____

Siblings

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

Name _____ DOB _____ Grade _____ School _____ ☐ Lives with child

MOTHER'S PRENATAL HISTORY:

Mother's medical history

Mom's health during pregnancy: _____

Due Date: _____ Maternal age at time of birth: _____ Prenatal Care: ❑ Yes ❑ No At

what month received: _____ Who provided care: _____

Problems during pregnancy

☐ Chronic Disease	☐ Rh Incompatibility	☐ Hypertension	☐ Trauma
☐ Viral Infection	☐ Vaginal Bleeding	☐ Toxemia	☐ Diabetes
☐ UTI	☐ Miscarriages	☐ Other	

Comments: _____

_____

Substance exposure

One month prior- What was your use of alcohol? _____

What was your use of tobacco? _____ Wa

was your use of recreational drugs? _____ Wa

was your use of prescriptions? _____

During pregnancy- What was your use of alcohol? _____ Wa

was your use of tobacco? _____ Wa

was your use of recreational drugs? _____ Wa

was your use of prescriptions? _____

What was your use of prenatals/folic acid/iron? _____

BIRTH HISTORY:

Fetal Movement: _____ At what month: _____

Hospital of birth: _____ Length of labor: _____

Gestational Age (*<32 weeks*): _____

Apgars (*5 minutes between 0-5*): _____1 minute _____5 minutes_____10 minutes

Birth Weight (*1500 grms/3 lbs 5 oz*): _____ Length: _____

Delivery

☐ Normal ☐ C-Section ☐ Induced Labor ☐ Premature (_____weeks)

☐ Breech ☐ Jaundiced ☐ Cord Around Neck ☐ Transfused

☐ Fever ☐ Twin (1st or 2nd) ☐ Rh-incompatible ☐ Baby Rotated

☐ Transverse ☐ Abruption ☐ Placenta Previa ☐ Meconium Aspiration/Stained

☐ Other Comments: _____

_____

NURSERY COURSE:

Regular nursery course:_____NICU: _____

Transport to other hospital: ❑ Yes ❑ No Name: _____

Reason: _____

☐ Oxygen/Ventilator ☐ Respiratory Distress Syndrome ☐ Bronchio-Pulmonary Disease ☐ Apnea and Bradycardia

☐ Intracranial Hemorrhage (*grade*): _____ ☐ Other: _____

Surgeries: ❑ Yes ❑ No Seizures: ❑ Yes ❑ No Congenital Anomalies: ❑ Yes ❑ No

Patent Ductus Arteriosus: ❑ Yes ❑ No Retinopathy of Prematurity: ❑ Yes ❑ No Genetic Syndrome: ❑ Yes ❑ No

Comments: _____

_____

HOSPITAL STAY:

Length of stay- Mom: _____ Baby: _____

Equipment Needed: _____ Tube/Gavage Feedings: _____

Test/Evaluation: _____

Discharge instructions (*equipment, medication, etc.*):

Comments: _____

_____

BABY/CHILD CURRENT STATUS:

Current Health:_____ Current Weight: _____ Height: _____

Vitamins: ☐ Yes ☐ No Medications: ☐ Yes ☐ No Type: _____ Dosage/Frequency: _____

Reason: _____ Dr. who prescribed medications: _____

MEDICAL FOLLOW UP:

Pediatrician:_____ Last Visit: _____ Next: _____

Specialist:_____ Appointment: _____

Specialist:_____ Appointment: _____

Follow-up Clinic: _____

Immunizations Up-to-Date: ☐ Yes ☐ No Explain: _____

_____

Medical problems

Tone Issues: ☐ Hypo? ☐ Hyper? ☐ Upper Extremities ☐ Lower Extremities

Re-hospitalizations: ☐ Yes ☐ No What Hospital: _____

Length of each: _____ _____ _____

Illness: _____ Surgeries: _____ Seizures: _____ Allergies: _____

Nutrition

Breast Feeding: ☐ Yes ☐ No How Much: _____ How Often:_____

Formula: ☐ Yes ☐ No Which: _____ How Much: _____ How Often: _____

Other Foods/Supplements (*types, amount, frequency*): _____

How Often: _____

Hearing

Formal hearing evaluation: ☐ Yes ☐ No When: _____ Where: _____

Results: _____

☐ Referred to Hearing Conservation: (805) 388-4438 on _____

Vision

Formal vision evaluation: ☐ Yes ☐ No When: _____ Where: _____

Results: _____

☐ Referred to: _____

Adaptive equipment

☐ Yes ☐ No Reason: _____ Type: _____

Comments: _____

OTHER AGENCIES INVOLVED:

WIC: ☐ Yes ☐ No Medi-cal: ☐ Yes ☐ No CPS: ☐ Yes ☐ No SSI: ☐ Yes ☐ No CCS: ☐ Yes ☐ No

Other: _____

_____

ADVANCED SCREENING:

Sensory issues

Is s/he sensitive to: Sounds: ❑ Yes ❑ No Touch: ❑ Yes ❑ No Brightness: ❑ Yes ❑ No Other:

_____

Regulation issues

Daily Schedule: Sleeping (*including naps*) _____

Eating: Picky Eater ❑ Yes ❑ No How Often: _____ Size of Serving: _____

Transition issues

Does s/he have difficulty with changes?: People: ❑ Yes ❑ No Places: ❑ Yes ❑ No

Daily Schedule: ❑ Yes ❑ No Going from one activity to the next: ❑ Yes ❑ No

Attention

Is s/he: Over focused on one thing at a time: ❑ Yes ❑ No Not able to focus: ❑ Yes ❑ No

Other: _____

Behavior issues (*consider age appropriateness and extent and frequency of behavior*)

Is s/he: Too Passive: ❑ Yes ❑ No Overwhelmed: ❑ Yes ❑ No Easily Upset: ❑ Yes ❑ No

Angers Quickly: ❑ Yes ❑ No Bites, Pinches others: ❑ Yes ❑ No Screams: ❑ Yes ❑ No

Throws Things: ❑ Yes ❑ No Excessive Irritability: ❑ Yes ❑ No

FAMILY STRENGTHS AND ROUTINES

(OPTIONAL FOR SCHOOL DISTRICTS**)**

Daily Schedule/Routines/Activities

●Home Activities

Naps _____ Bed time _____Rise time _____

Sleeps through night Y☐ N☐ _____ Child sleeps in own bed ☐ parent bed ☐

_____

●Bathing

Does child like to bathe? Y☐ N☐ Does soap on head bother him/her? Y☐ N☐

Does water bother him/her? Y☐ N☐ Does he/she allow scrubbing? Y☐ N☐

Challenges/Comments:_____

●Clothing

What clothing item can he/she take off? _____

What clothing item can he/she put on? _____

Challenges/Comments:_____

●Brushing

Does he/she allow you to brush/wipe teeth? Y☐ N☐ Does he/she brush/wipe own? Y☐ N☐

Challenges/Comments:_____

●Toileting

Potty trained? Y☐ N☐ Potty Routine? Y☐ N☐ Discomfort when wet/soiled? Y☐ N☐

Signs: Crying Y☐ N☐ Pointing Y☐ N☐ Tugging Y☐ N☐

Challenges/Comments: _____

●Community Activities

Walking ☐ Watching TV ☐ Park ☐ Shopping ☐ Movies☐ Playing ☐

Grocery Store ☐ Swap meet/flea market☐ Other ☐

Challenges/Comments: _____

●Family Resources

Transportation: _____ Daycare: _____ Religious Support: Yes☐ No☐

Bus ☐ Car ☐ Taxi ☐ Access ☐ Other ☐

Challenges/Comments: _____

●**Sensory Issues**

Is he/she sensitive to: Sounds Y☐ N☐ Touch Y☐ N☐ Brightness Y☐ N☐

Other: _____

●**Transition Issues**

Challenges during routine / activity? Y☐ N☐

Does she/he have difficulty with changes? Y☐ N☐ People? Y☐ N☐

Places? Y☐ N☐ Daily schedule? Y☐ N☐

Going from one activity to next? Y☐ N☐

●**Attention**

Is s/he: Over focused on one thing at a time? Y☐ N☐ Not able to focus? Y☐ N☐

Other: _____

●**Behavior Issues** (consider age appropriateness and extent and frequency of behavior)

Is he/she: Too Passive: Y☐ N☐ Overwhelmed Y☐ N☐ Pinching Y☐ N☐

Angers Quickly Y☐ N☐ Screams Y☐ N☐ Throws things Y☐ N☐

Head banging Y☐ N☐ Hitting Y☐ N☐ Bites Y☐ N☐

Tantrums Y☐ N☐ **How many per day? _____**

●**Communication**

Is your child communicating? Y☐ N☐

How is your child communicating? verbal_____ sign_____ gesture _____

How many of the words your child says are understood by others?_____

by parent/s only? _____.

What does your child do if you are unable to understand what s/he is trying to communicate?

_____

Does your child respond to her/his name? Y☐ N☐ _____

Does your child play with other children? Y☐ N☐ _____Adults? Y☐ N☐ _____

What type of social opportunities does your child have?_____

_____

Does your child look at you when you are talking to him/her? Y☐ N☐ with others Y☐ N☐

_____

_____

_____

PARENT CONSENT

Ventura County SELPA Early Start Program IFSP

FOR ASSESSMENT/EVALUATION, RELEASE/EXCHANGE OF INFORMATION, REQUEST FOR SERVICE

Child's Name: _____ DOB: _____

With your written consent, community agencies and the persons who represent them may share information with one another. Evaluation for the Early Start Program includes: finding out if your child is eligible for services, talking about what services are available, matching services to your child and family needs.

You need to know that:

- Your child may receive a developmental assessment.
- The information obtained is voluntary and will only be used to evaluate your child to determine his/her eligibility and need for services and provision of an Individual Family Service Plan.
- You may request copies of all records pertaining to your child.
- This consent for exchange is good for one year; you may withdraw your permission at any time by writing a note to your primary service coordinator. However, revocation of your permission will not apply to records already released.
- A photocopy of this document is as valid as the original.
- Sharing information helps agencies coordinate services for your child. You may choose which agencies shall exchange information.
- Information about your child and family is strictly confidential and will only be released to agencies and/or persons whom you choose in writing.
- You may refuse to sign this exchange form.
- You must be informed of the contents of this document in language you clearly understand.
- Information to be exchanged includes medical and health, developmental, speech and language, educational, hearing/vision and/or psychological.
- A copy of your parental rights which includes information regarding services which may be offered to the child and/or the family as part of the Early Start services, is attached.

I request coordination of Early Start services and agree to the exchange of information among the agencies checked below and the persons who represent them.

- ❑ Tri-Counties Regional Center (TCRC)
- ❑ Local Education Agency/Vendor

  _____

  _____
- ❑ County Health Department including Public Health Nursing and California Children's Services (CCS)
- ❑ Family Resource Center
- ❑ Primary Care Physician, Clinic please specify

  _____

  _____
- ❑ Hospital _____
- ❑ Other _____

I understand that I may limit what information is exchanged. List any limitations: _____

_____

I acknowledge that I have received a copy of the Parents' Rights & Responsibilities Regarding Evaluation and Assessment in the Early Start Program under IDEA.

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date

Rainbow Connection Referral Form

DATE _____

☐ I would like to talk to another parent.
Me gustaría recibir una llamada de otro padre o madre.

☐ Please email me information on trainings and activities for families.
Por favor envíe por correo electrónico información sobre entrenamientos y actividades para familias.
Email address/Correo electrónico _____

☐ Other _____
Otro_____

☐ I have been given information on Rainbow, I do not wish for a call at this time.
Yo tengo información de Rainbow. En este momento no deseo una llamada.

Child's Name:_____
Nombre del niño/a

Diagnosis:_____ D.O.B:_____ Age:_____ Sex: M☐ F☐
(If known) Diagnóstico (si lo sabe): fecha de nacimiento edad Sexo:

Parent's Name:_____
Nombre del padre o madre:

Address: _____
Domicilio:
_____Zip:_____

Family Language is: _____
Idioma de la familia:

Daytime Phone: _____ Evening Phone: _____
Numero de teléfono de día: de Noche:

Parent Signature: _____
Firma del padre:

Service Coordinator: _____
Nombre del coordinador de servicios:

(Mail to: Rainbow 2401 E. Gonzales Road #100 Oxnard, CA 93036 or fax 278-9056)

ASSESSMENT

ASSESSMENT

The assessment process must be multidisciplinary, and both agencies should collaborate together to assess potential dually served infants. The parents must give consent to assessment using the Parent Consent form (Attachment E). The assessment may be completed in conjunction with the Early Start Intake Interview Worksheet.

The school district ECSE may include as part of their multidisciplinary team a school nurse, psychologist, speech therapist, vision or hearing specialist. Additional assessments may be conducted by specialized staff as recommended by the ECSE. Proof that a multidisciplinary team was used is demonstrated by:

- Signatures on Summary of Assessment report
- A separate report submitted by a team member(s)
- Names listed on Family Approval page of the IFSP

Assessments must be completed within the 45-day timeline, and an IFSP meeting held.

The Assessment report will include:

- Family/Child Information
- Background Medical Information
- Assessment Purpose and Location
- Assessment Information – Indicate assessment tools used. Also include a statement regarding validity and cultural appropriateness of assessment tool(s) and if the infant/ toddler's response is a reliable predictor of his/ her development.
- Assessment results – must address these areas:
  - Gross Motor Skills
  - Perceptual/ Fine Motor Skills
  - Cognitive Development
  - Communication Development (Receptive and Expressive)
  - Adaptive/ Self-help Development
  - Social/ Emotional Development
- Summary
- Recommendations (including statement of eligibility)

When choosing an assessment tool consider the following:

- Use of a normed or standardized tool
- Assessment procedures that are not racially or culturally discriminatory
- Tool(s) that are considered to be valid for the suspected disability of the child

ELIGIBILITY

ELIGIBILITY

Eligibility for Solely Low Incidence (SLI):

1) Meets one or any combination of the following per Cal. Gov. Code sec. 95014 (a)(1):

- Hearing Impairment- A pupil has a hearing impairment, whether permanent or fluctuating, which impairs the processing of linguistic information through hearing, even with amplification, and which adversely affects educational performance. Processing linguistic information includes speech and language reception and speech and language discrimination.

- Deaf/Blind- A pupil has concomitant hearing and visual impairments, the combination of which causes severe communication, developmental, and educational problems.

- Visual Impairment- A pupil has a visual impairment which, even with correction, adversely affects a pupil's educational performance.

- Orthopedic Impairment- A pupil has a severe orthopedic impairment which adversely affects the pupil's educational performance. Such orthopedic impairments include impairments caused by congenital anomaly, impairments caused by disease, and impairments from other causes.

– and –

2) Is identified as requiring intensive special education and services by meeting one of the following CCR Title 5 Section 3031 criteria and who are not eligible for services under the Lanterman Development Disabilities Act:

(A) The child has a developmental delay as determined by a significant difference between the expected level of development for their age and their current level of functioning in one or more of the following five developmental areas:
1. cognitive development
2. physical and motor development, including vision and hearing
3. communication development
4. social or emotional development or
5. adaptive development.

A significant difference is defined as a 33 percent delay in one or more developmental areas

- or -

(B) The child has a disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education and services.

Eligibility for dually served:

Children served by both schools and TCRC must meet eligibility criteria for both agencies.

Infants and toddlers are eligible for Early Start services through TCRC if they have:
1. Established risk conditions w/conditions of known etiology or conditions, including fetal alcohol syndrome, w/established harmful developmental consequences
2. Developmental delay: The eligibility criteria for deciding if an infant or toddler has a developmental delay are as follows:
    - 0 - 36 months, 25% delay in one or more areas

The areas of delay are:
- Cognitive development
- Physical and Gross motor development
- Expressive language
- Receptive language
- Social or emotional development
- Adaptive development.

Eligibility for TCRC services will be determined by TCRC once the assessment report has been reviewed by their team.

Children who are eligible for Early Start services through TCRC may be dually served with the school district program if they also meet school district eligibility criteria:

1. Meet CCR Title 5 Section 3030 eligibility for any one of the following:
    - Hearing Impairment
    - Deaf
    - Deaf/ Blind
    - Orthopedic Impairment
    - Visual Impairment
    - Speech & Language Impairment
    - Autism
    - Intellectual Disability
    - Emotional Disturbance
    - Other Health Impairment
    - Multiple Handicaps
    - Traumatic Brain Injury

See **Statement of Eligibility for Early Start** form and sample (Attachment I).

VENTURA COUNTY SELPA
EARLY START PROGRAM
SOLELY LOW INCIDENCE ELIGIBILITY CHECKLIST
FOR CHILDREN WITH ORTHOPEDIC IMPAIRMENT

☐ Does the child have a severe orthopedic impairment which adversely affects performance, including impairments caused by congenital anomaly, impairments caused by disease, and impairments from other causes? (Does not require a medical diagnosis.) [CCR 3030(e)]. ***If so, child may qualify if other conditions are met.***

☐ Is there another Early Start eligible condition such as cognitive impairment, speech-language delay, prenatal substance exposure, prematurity, failure to thrive, etc? ***If so, child may not qualify as solely low incidence.***

☐ Does the child present with delays in his development?

If yes, note areas & percent delay:

- ☐ Cognitive _____
- ☐ Physical & Motor (including vision & hearing) _____
- ☐ Communication_____
- ☐ Social or Emotional _____
- ☐ Adaptive _____

Child must present with at least a 33%delay (under 24 mos. in order to qualify under low incidence/orthopedic impairment.

☐ Do the delays appear to be directly attributed to the orthopedic impairment? If yes, ***child would qualify for low incidence/orthopedic impairment***. Are delays part of a separate condition or impairment? ***Child would NOT qualify for solely low incidence and would need to be Re-DARTed.***

Provide rationale:

☐ Describe how the delays require special education services. [CCR 3030-first paragraph]. ***If not, child would not be eligible.***

After the initial evaluation, you may contact the physical or occupational therapist for a consultation and/or assessment in order to assist the team in deciding whether or not the child is eligible for the Early Start program as a child with a solely low incidence eligibility - orthopedic impairment.

INDIVIDUALIZED FAMILY SERVICE PLAN

INDIVIDUALIZED FAMILY SERVICE PLAN

The Individualized Family Service Plan (IFSP) is a legal document developed by the family, Service Coordinator, and service providers to initiate and facilitate requested services to the infant/ toddler and family. This paperwork will be reviewed every six months or at family request. Each review must include a new Information and Service page.

The IFSP must include:

- Name of Service Coordinator. Person responsible for facilitating implementation and coordination of the IFSP.

- Early Intervention services. Statement of the frequency, amount, location, and method of delivering the services.

- Agency responsible for providing each service.

- Dates. Initiation of services, duration of services, anticipated review date. Use M/D/Y format.

- Justification if services will not be provided in the natural environment. The "natural environment" is defined as the environment the family and child would be accessing if the child did not have a disability, including the home and community locations which typically developing children may access. Examples of rationales for providing services in more specialized settings only accessed by children with disabilities and their families include "access to specialized professionals," "access to specialized equipment not available in the home," "parent does not want services in the home."

- Family strengths, priorities, concerns and resources related to enhancing the development of their infant (only with family permission).

- Present levels of development including hearing, vision, health, gross or fine motor, cognitive, communication, social skills, and self-help skills. There must be evidence of input from all service providers, by participation or report.

- Outcomes: Major outcomes for the family and/or infant related to the special developmental needs of the infant. Outcomes must be measureable and stated in the parent's terms. Consider the infant's pre-literacy and language skills when writing outcomes. There must be an Outcomes and Services page for each service listed on Summary of Service page of the IFSP.

- Criteria, procedures, and timelines used to determine the degree of progress the child or family has made, and if changes are necessary.

- If the IFSP is a review, a statement of progress toward outcomes, in parent's words.

- Transition. Steps to be taken towards transition to appropriate services when infant is three years old. Transition may begin as early as 2 years 3 months.

For solely low incidence children, the school district ECSE is responsible for the IFSP. For dually served children, the school district ECSE completes a developmental assessment which includes present levels of development and participates in the development of the appropriate measureable outcomes. Ideally, the paperwork is completed when the Service Coordinator, parents, and school district ECSE are all together.

The school district ECSE will receive a copy of all paperwork generated by Regional Center, including Statement of Eligibility and Rainbow Referral. Parents receive a copy of "*Parent's Rights*" (in booklet or single page form) at all IFSP meetings(Attachment K).
ECSE will document that parent has received a legible copy of the IFSP and it has been fully explained. See Checklist for Student File (Attachment L)

The school district ECSE will forward a copy of each completed IFSP to the child's school district of residence. The ECSE will also forward information to the district CALPADS clerk for each Solely Low Incidence and Dually served child. This information is collected by the California Department of Education for pupil count and funding purposes in December and June each year.

See IFSP forms attached:

- Information and Services page and sample
- Strengths, Priorities and Concerns and sample
- Outcomes & Services and sample
- Family Approval and sample
- IFSP Semi-Annual Review and sample

PARENTS' RIGHTS AND RESPONSIBILITIES IN THE EARLY START PROGRAM UNDER IDEA

EVALUATION AND ASSESSMENT

The determination of eligibility for Early Start in California includes a timely, comprehensive, multidisciplinary evaluation and assessment of every child under three years of age who is suspected to be in need of early intervention services. If no parent or guardian is available or the child is a ward of the court, a knowledgeable surrogate parent who has no conflicting interest will be appointed by a regional center or LEA, under Title 17, Section 52175. Procedural safeguards ensure that families are provided their rights under the law.

As a parent, you have the right to:

1. be fully informed of your rights under Early Start;
2. refer your child for evaluation and assessment, provide information throughout the process, make decisions, and give informed consent for your child's early intervention services;
3. understand and provide voluntary written permission or refusal before the initial evaluation and assessments are administered; Consent for evaluation and assessment is required only at the time of initial evaluation and assessment to receive services. (If consent is refused, the regional center or LEA may take steps to obtain an initial evaluation without parental consent.);
4. participate in the initial evaluation and assessment process including eligibility determination;
5. receive a completed initial evaluation and assessment within 45 days after the referral of your child to a regional center or an LEA;
6. participate in a meeting to share the results of evaluations and assessments; and
7. participate in all decisions regarding eligibility and services.

THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) REQUIRES THAT:

1. Evaluation and assessment materials are administered in the language of the parents' choice or other mode of communication, unless it is clearly not feasible to do so.
2. Evaluation and assessment procedures and materials are selected and administered so as not to be racially or culturally discriminatory.
3. Evaluation and assessment materials are appropriate to assess the specific areas of developmental need and are used for the specific purposes for which they were designed.
4. Evaluations and assessments are conducted by qualified personnel.
5. Evaluations and assessments administered to children with known vision, hearing, orthopedic, or communication impairments are selected to accurately reflect the child's developmental level.
6. Evaluations and assessments are administered in the five developmental areas, which include physical development (motor abilities, vision, hearing, and health status); communication development; cognitive development; adaptive development; and social or emotional development. Assessments and evaluations are ongoing while your child is in Early Start.
7. Evaluations and assessments shall be conducted in natural environments whenever possible.
8. Pertinent records relating to your child's health status and medical history are reviewed.
9. No single procedure is used as the sole criterion for determining your child's eligibility for early intervention services.
10. Interviews to identify family resources, priorities, and concerns regarding the development of your child and your family's needs are voluntary.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

An Individualized Family Service Plan (IFSP) is a written plan for providing early intervention services to an eligible child and the child's family. For an infant or toddler who has been evaluated for the first time, a meeting must take place within 45 days of the referral to the regional center or LEA to share the results of the evaluation, to determine eligibility, and, for children who are eligible, to develop the initial IFSP. Evaluation results and determination of eligibility may be shared with families prior to the first IFSP meeting.

A periodic review of your child's IFSP must take place at least every six months. A review may occur more frequently if there are any changes to the IFSP or if you request a periodic review with the regional center or LEA. The IFSP must also be reviewed annually to evaluate how your child is doing and to make any needed changes to the IFSP.

During the development and implementation of an IFSP, you have the right as the parent to:

1. attend the IFSP meetings and participate in developing the IFSP;
2. invite other family members to attend IFSP meetings;
3. invite an advocate or persons other than family members to attend and participate in the IFSP meetings;
4. have a copy of the complete IFSP;
5. have the contents of the IFSP fully explained in the language of your choice;
6. give consent to services listed on the IFSP. If you do not give consent to a service, it will not be provided. You may withdraw consent after initially accepting or receiving a service;
7. have services provided in the natural environment or an explanation of why that is not possible;
8. exchange information about your child among other agencies;
9. be notified in writing before any agency or service provider proposes or refuses to initiate or change your child's identification, evaluation, assessment, placement, or the provision of appropriate early intervention services to your child or your family. The notice must contain:
   - the action that is proposed or refused,
   - reasons for the action, and
   - all available procedural safeguards.

   The notice must be presented in the language of your choice, unless it is clearly not feasible to do so, and may be translated so that you understand its contents; and
10. voluntarily use private insurance to pay for evaluation, assessment, and required early intervention services on the IFSP.

MEDIATION CONFERENCES, DUE PROCESS HEARINGS, AND STATE COMPLAINTS

In Early Start, parents have rights and protections to assure that early intervention services are provided to their children in a manner appropriate to their needs, in consideration of family concerns, and in compliance with applicable federal and State statutes and regulations. The following procedures are only for children under the age of three years.

As a parent, you have the right to:

1. request a due process hearing any time a regional center or LEA proposes or refuses to initiate or change the identification, evaluation, assessment, placement, and/or provision of appropriate early intervention service(s);
2. be informed of your right to file a complaint or a request for mediation and/or due process;
3. file a complaint if you believe there has been a violation of any federal or state statute or regulation governing early intervention services under Early Start including eligibility and services;
4. request a mediation conference immediately, prior to a complaint or due process hearing request, or at any time during the complaint/due process hearing processes to resolve a dispute related to any matter concerning federal or state statute or regulation governing early intervention services under Early Start; and
5. file a complaint if a due process decision fails to be implemented.

Mediation Conference

Mediation is a voluntary, non-binding, confidential process in which a neutral mediator facilitates settlement negotiations between you and another party. Voluntary mediation conferences are an informal way to resolve disagreements with early intervention service agencies or to address alleged violations of any state and federal statutes or regulations.

As a parent you have the right to:

1. file a request for mediation as the initial option for resolving a dispute or any time during the due process hearing or complaint process,
2. request a due process hearing or file a state complaint if the disagreement is not resolved,
3. refuse to participate in mediation.
4. have an impartial person facilitate the mediation conference,
5. require that the mediation conference is carried out at a time and in a location that is reasonably convenient for you,
6. have all personally identifiable information maintained in a confidential manner, and
7. receive a written document outlining the agreements reached as a result of the mediation conference.

Requests for mediation are filed with the:
Office of Administrative Hearings
Attention: Early Start Intervention Section
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
(916) 263-0654 Fax: (916) 376-6318

Due Process Hearings

All parents are encouraged to resolve differences at the lowest administrative level possible. When differences between you and a regional center or LEA cannot be resolved, due process hearings are available. You, as a parent, are encouraged to seek assistance from your child's service coordinator, the regional center, or the Special Education Local Plan Area (SELPA) office.

Circumstances leading to a due process hearing may be disagreements related to a proposal or refusal for identification, evaluation, assessment, placement, or services.

Your child will continue to receive the early intervention services identified on the IFSP that he/she is currently receiving unless you and the regional center or LEA otherwise agree to a change. If your disagreement involves a new service that has not started, your child will receive all services identified on the IFSP that are not in dispute. This does not include your regional center providing early intervention

services after your child has reached 36 months of age, as federal law and regulations do not allow states to pay for early intervention services under any circumstances once your child transitions from Early Start. The program or programs your child enrolls in subsequent to transition from Early Start is responsible for providing you and your child services for which he or she is eligible to receive.

Requests for a due process hearing are filed at the following address:
Office of Administrative Hearings
Attention: Early Start Intervention Section
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
(916) 263-0654 Fax: (916) 376-6318

**The due process hearing request form may be obtained from your service coordinator, the regional center, the LEA, and the Department of Developmental Services (DDS) website: www.dds.ca.gov/Forms/pdf/DS1802.pdf*

The due process hearing must be completed within 30 days of receipt of the request by the Office of Administrative Hearings. The timely issuance of the written decision may not be delayed by any concurrent voluntary local efforts to resolve the matter. The decision will be final unless appealed.

As a parent, you have the right to:
1. have the due process hearing conducted by an impartial person, not employed by an agency serving your child, who is knowledgeable in the laws relating to early intervention and the service needs of infants, toddlers, and families;
2. require that the proceeding is carried out at a time and in a location that is reasonably convenient for you;
3. have all personally identifiable information maintained in a confidential manner;
4. bring a civil action against the other party following completion of the proceeding if you disagree with the results;
5. receive services identified on the IFSP that are not in dispute; and
6. have mediation discussions kept confidential and not used as evidence in any subsequent due process or civil proceedings.

During a due process hearing, you also have the right to:
1. be accompanied and advised by counsel and/or by individuals with special knowledge with respect to early intervention services for children under age three years;
2. present evidence, confront, cross-examine, and compel the attendance of witnesses;
3. prohibit the introduction of any evidence at the proceeding that has not been disclosed to you at least five days before the proceeding begins;
4. obtain a written or electronic verbatim transcription of the proceeding; and
5. obtain written findings of facts and decisions within 30 days from the date the request is filed.

State Complaints

Any individual or organization may file a signed, written complaint against the DDS, the California Department of Education (CDE), or any regional center, LEA, or private service provider that receives Part C funds alleging violation of any state or federal early intervention statute or regulation. However, even though DDS is mandated to investigate any complaint it
receives, state law does not allow disclosure of the Early Start recipient's personally identifiable information without written parental consent, other than authorized employees specified by the regional center or LEA.

Information or assistance in filing complaints is available from your child's service coordinator, the regional center office, or the SELPA. DDS and CDE are available for consultation regarding the filing of a complaint. Additional assistance is available from advocacy organizations such as the State Council on Developmental Disabilities or Disabilities Rights California.

Complaints are filed directly with the:
Department of Developmental Services
Office of Human Rights and Advocacy Services
Attention: Early Start Complaint Unit
1600 9th Street, MS 2-15
Sacramento, CA 95814
(916) 654-1888 Fax: (916) 651-8210

Any individual or organization who files a complaint has the right to:
1. receive assistance in filing the complaint from a service coordinator, regional center, and/or LEA;
2. not be compelled to use any other procedures under the Education Code or the Lanterman Developmental Disabilities Services Act to resolve the complaint;
3. submit additional information to DDS that may be helpful to the investigation;
4. receive a final written decision within 60 days of the date DDS receives the complaint;
5. receive appropriate remedies that may include monetary reimbursement or other corrective action, and assurance that services will be provided appropriately in the future if the decision of DDS includes remedies for denial of appropriate services;
6. have any issue in a complaint that is not part of a due process hearing be resolved by DDS within 60 days of the receipt of the complaint;
7. be notified by DDS that the hearing decision is binding if an issue is being raised in a complaint that had previously been decided in a due process hearing involving the same parties; and
8. have any complaint resolved that alleges the failure of a public agency or private service provider to implement a due process decision.

The complaint must:
1. be in writing and contain a signed statement alleging that DDS, CDE, the regional center, LEA, or other service provider involved with Early Start has violated a federal or state law or regulation;
2. provide the name, address, and phone number of the complainant;
3. contain a statement of facts upon which the violation is based;
4. include the name of the party against whom the complaint is being filed;
5. have occurred not more than one year before the date the complaint is received by DDS unless a longer period is reasonable because the alleged violation continues for the child or other children, or
6. have occurred not more than three years before the date on which the complaint is received by DDS if the complainant is requesting reimbursement or corrective action as remediation of the complaint;
7. the complaint may also include, if applicable, a description of the voluntary steps pursued at the local level to resolve the complaint; and

8. be withdrawn if the Complainant elects to participate in mediation within the 60 day complaint investigation.

CHECKLIST FOR STUDENT FILE

Student Name:
45 Day Timeline End Date:

1. DART
____ Response by 5:00pm next business day to TCRC
Comments:

2. INTAKE
____ Schedule meeting with TCRC if Dual. Date: _____
____ Give Parent Rights
____ Give information on CCS if applicable
____ Give information to family about Rainbow Referral (or receive copy from TCRC)
Comments:

3. ASSESSMENT/REPORT
____ Report sent/faxed/emailed to TCRC, if Dual. Date: _____
Comments:

4. IFSP
____ IFSP scheduled Date: _____
____ Take to IFSP:

- All About Me binder
- Enrollment Packet
- Assessment Report
- School calendar
- IFSP paperwork (if SLI)

Comments:

5. OFFICE
____ Complete CALPADS page and give to CALPADS clerk in district
____ Send IFSP and report to District of Residence, if applicable
____ Copy of IFSP, Assessment Report and school calendar mailed/emailed/faxed/given to parents
____ If any contracts needed, send paperwork to SELPA
____ Send initial and transition IFSP to Hearing Conservation.
Comments:

INFORMATION AND SERVICES / INFORMACIÓN Y SERVICIOS

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

MEETING TYPE: (*tipo de plan*) _____ : _____ **DATE:** _____

IDENTIFYING INFORMATION (*INFORMACION*)

Child's name / *Nombre*_____ Gender (*Género)* _____
First (*primer)* Middle (segundo) Last (*apellido)*

SSID _____ Birth date (*fecha de nacimiento*) _____

Home language (*Idioma usado en casa*) _____ Interpreter needed? (¿*Necesita interprete*?) □ yes (*sí*) □ no

Translated IFSP needed? (¿*Necesita traducción del plan*?) □ yes (*sí*) □ no Language (*idioma)*_____

Parent/Guardian (*padre/tutor*)_____

Street address (*dirección*)_____

Home phone (*teléfono*) _____ Work phone_____ Email _____
(*de casa*) (*del trabajo*)

Parent/Guardian (*padre/tutor*)_____

Mailing address (*domicilio*)_____

Home phone (*teléfono*) _____ Work phone_____ Email _____
(*de casa*) (*del trabajo*)

Projected review (*revisión*) _____ Projected annual review_____
6 months or before (*6 meses o antes*) *(revisión annual proyectada)*

Service Coordinator _____ Agency _____ Case Number _____
(*cordinador/a de servicios)* (*agencia*) (*número de caso*)

Summary of early intervention services (RS=required service; NRS=Non required service; O=Other services)
Resumen de los servicios de intervención temprana (RS=servicios requeridos, NRS=servicios no requeridos, O=otros servicios)

Service or Activity [Designate type of service] (*servicio o actividad- designar un tipo*)	Frequency & Amount **Intensity** (*frecuencia y cantidad- **Intensidad***)	Individual or group (*individuo o grupo*)	Agency and/or Provider (*agencia y/o proveedor*)	Start/end Dates (*fechas de comienzo / fin)*	Location* (*localidad*)
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				
	Duration *Duración:*				

*Justification if not in natural environment (*Justifique el porqué de no en un ambiente natural)*

STRENGTHS, PRIORITIES AND RESOURSES / FORTALEZAS, PRIORIDADES Y RECURSOS

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

Child's Name/Nombre _____ DOB/FDN _____ Date/Fecha _____

TO HELP IN ASSESSING YOUR CHILD'S NEEDS
(Para ayudar a evaluar las necesidades de su nino/a)
(voluntary on part of family)
(voluntario por parte de la familia)

What are your child's **strengths**? *(¿Cuales son las **fortalezas** de su nino/a?)* (What does he/she do best?) *(¿Que es lo que hace su niño/a mejor?)*

What are your **concerns** and **priorities** about your child's health and/or development?
*(Cuales son sus **preocupaciones** y **prioridades** sobre la salud y/o el desarrollo de su nino/a?)*

Please list family **resources** (example: community, insurance, friends & family help, transportation, church, child care) *(Por favor liste los recursos familiares (por ejemplo: comunidad, seguro, ayuda de amistades y familiares, transportación, iglesia, guardería)*

What other things would you like to discuss? *(Otra cosa que quiera discutir)*

PRESENT LEVELS OF DEVELOPMENT
NIVELES DE RENDIMIENTO ACTUALES

Ventura County Special (SELPA) Early Start Program (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención plan individualizado de servicios familiar (IFSP)***

For Initial and Annual IFSPs, this form must be completed and attached to the IFSP.
If a separate report form is used, it must address all elements below.

Child's Name/*Nombre*: _____ DOB/*FDN*: _____

Address/*Domicilio*: _____ Chronological Age/*Edad Cronológico*: _____

Adjusted Age/*Edad ajustada*: _____

Phone/*Teléfono*: _____ Date of Assessment(s)/*Fecha de evaluación(es)*:

HEALTH/*SALUD*:

Health Status/*Salud*_____ Vision/*Visión*_____ Hearing/*Audiencia*_____

GROSS MOTOR/*MOTORA* (*large movement/movimiento amplio*):

PERCEPTUAL/FINE MOTOR/*PERCEPTUAL/MOTRIZ FINA* (*small movement/movimiento chico*):

COGNITIVE DEVELOPMENT/*DESARROLLO COGNITIVO* (*how child responds to environment, solves problems/como el niño responde al ambiente, resuelve problemas*):

COMMUNICATION DEVELOPMENT/*DESARROLLO DE LA COMUNICACION* (*language and speech/habla y lenguaje*)
Receptive/*Receptivo* (*understanding Comprensión*):

Expressive/*Expresiva* (*making sounds/haciendo sonidos, talking/hablando*):

SOCIAL/EMOTIONAL DEVELOPMENT/*DESARROLLO SOCIAL/EMOCIONAL* (*how child relates to others/cómo el niño se relaciona con otros*):

ADAPTIVE/SELF-HELP DEVELOPMENT/*ADAPTACION/DESARROLLO DE AUTO-AYUDA* (*sleeping, eating, dressing, toileting/durmiendo, comiendo, vestirse, ir al baño*):

ADDITIONAL COMMENTS/*COMENTARIOS ADICIONALES*:

ELIGIBLE under California Code of Regulations, Title 5, Sections 3030 and/or 3031
Reasons (*describe*):

IFSP ADDITIONAL PAGE / IFSP PÁGINA ADICIONAL

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

Child's Name/Nombre _____ DOB/FDN _____ Date/Fecha _____

FAMILY UPDATE or ADDITIONAL INFORMATION/*ACTUALIZACION DE LA FAMILIA o INFORMACION ADICIONAL*:

(including current resources, priorities and concerns/*incluyendo recursos actuales, prioridades y preocupaciones*)

: **OUTCOMES RESULTADOS** :

Ventura County SELPA Early Start Program IFSP
Condado de Ventura SELPA *Programa de Servicios de Intervención Temprana IFSP*

Child's Name: _____ DOB: _____ Date: _____

OUTCOME (in parents own words) ☐ 6 Month Review for _____

Area
Criteria 1:
Criteria 2:
Criteria 3:
Monitored by Target Date
Progress Criteria 1: _____ Comment:
Progress Criteria 2: _____ Comment:
Progress Criteria 3: _____ Comment:
Outcome Annual Review: _____ Outcome Met? ☐ Yes ☐ No

OUTCOME (in parents own words)

Area
Criteria 1:
Criteria 2:
Criteria 3:
Monitored by: Target Date:
Progress Criteria 1: _____ Comment:
Progress Criteria 2: _____ Comment:
Progress Criteria 3: _____ Comment:
Outcome Annual Review: _____ Outcome Met? ☐ Yes ☐ No

PROGRESS ASSESSMENT METHOD

Report Provided: ☐Parent Reports ☐ Observation ☐ Other:_____

FAMILY APPROVAL PLAN / PLAN DE APROBACIÓN FAMILIAR

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

Child's Name/Nombre _____ DOB/FDN _____ Date/Fecha _____

MEDICAL SERVICES (*servicios médicos*):

Assistive technology has been considered for this child (*Ayuda tecnológica ha sido considerada para este niño/a*):

FAMILY SERVICES (*servicios familiares*)**:**

OTHER IFSP PARTICIPANTS (*otros participantes del plan*):
The following individuals/agencies participated in the development of the IFSP either by attending the meeting or giving input and agree to carry out the plan as it applies to their role in the provision of entitled Early Intervention Services. (*Los siguientes individuos/agencias participaron en el desarrollo de este plan ya sea asistiendo a las juntas o proveendo información y acuerdan de llevar a cabo el plan como se aplica a sus cargos escrito en el suministro de servicios autorizados de intervención temprana*)

Name/ Title (*nombre/título*)	Agency/ Phone (*agencia/teléfono*)	Date (*fecha*)

Person providing input by telephone or writing: _____
(*persona dando información por teléfono ó por escrito*)

IFSP FAMILY APPROVAL (*aprobación de la familia*)

☐ _____I had the opportunity to help develop this Individualized Family Service Plan (IFSP) of _____(total) pages.
(*Tuve la oportunidad de ayudar con el desarrollo de este plan de _____páginas.*)

☐ _____**I have received a copy of my rights under this Early Start program at this meeting.**
(*He recibido una copia de mis derechos en esta junta.*)

☐ _____I understand my rights, the plan, and give permission of the service providers listed to carry out the plan with me, leading toward the agreed upon outcomes.
(*Entiendo mis derechos, el plan y doy permiso a los proveedores de servicios mencionados para desempeñar el plan conmigo, llegando a los resultados de común acuerdo.*)

☐ _____**A copy of the program calendar has been provided which shows breaks in service for holidays or vacations.**
(*He recibido una copia del calendario mostrando las fechas de descanso referente a los días festivos y vacaciones.*)

_____ _____
Parent/ Guardian Signature (*firma del padre/tutor*) Date (*fecha*)

_____ _____
Parent/ Guardian Signature (*firma del padre/tutor*) Date (*fecha*)

CHANGES OR ADDITIONS / CAMBIOS O ADICIONES

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

Child's Name/Nombre _____ DOB/FDN _____ Date/Fecha _____

Amends IFSP of: _____
Cambios o adiciones- enmienda del IFSP de

IFSP TYPE: (*TIPO DE PLAN*)

- ☐ Periodic Review(*Revisión periódica*)
- ☐ Information Change(*Cambio de información*)
- ☐ Parent Request (*Petición del padre*)
- ☐ Other (*Otro*):_____

STATUS: (*SITUACIÓN*)

- ☐ Continue IFSP(*Continuar con el IFSP*)
- ☐ Modify IFSP(*Modificar IFSP*)
- ☐ End IFSP(*Terminar IFSP*)

This IFSP meeting(*Esta reunion*) (date): _____
Projected Review: 6 months or before _____
(*Revisión proyectada: 6 meses o menos)*
Annual(*Anual*) _____
Projected IFSP Exit(*Término proyectado del IFSP*) _____

Translated IFSP needed?(*¿Necesita traducción del plan?*) ☐ yes*/ sí* ☐ no Language(*Idioma*) _____
Service Coordinator(*Coordinador/a de servicios*) _____ Agency(*Agencia*) _____ Phone(*Teléfono*) _____

IDENTIFYING INFORMATION(*DATOS DE IDENTIDAD***)**

Child's name(*Nombre*) _____
First *(primer)* Middle *(segundo)* Last *(apellido)*
Birth date (*Fecha de naciminto*) _____ Age (*Edad*) _____ Gender (*género*) _____
Home Language (Idioma usado en casa)_____ Interpreter needed? *(¿Necesita interprete?)* ☐ yes (*sí*) ☐ no
Parent/Guardian (*Padre/tutor*) _____
Street address (*Dirección*) _____
Mailing address (*Domicilio*) _____
Home phone (*Teléfono*) _____ Work phone (*del trabajo*) _____Message phone (*para mensajes*) _____
Parent email _____

CHANGE TO PLAN *(Cambio de Información)*

(check areas revised, added, or deleted and attach new pages)
(indique las areas modificadas, añadidas, tachadas y adjunte las páginas nuevas)

- ☐ Identifying Information (*Record changes above*) *Información de identidad (registre cambios de arriba)*
- ☐ Information and Services (*Información y servicios*)
- ☐ Family Concerns, Priorities, Resources (*Preocupaciones familiar, prioridades, recursos*)
- ☐ Assessment, Present Levels of Performance (*Medical, niveles actuales de desarrollo*)
- ☐ Outcomes *Resultados y servicios*)
- ☐ Other, specify (*Otro, especifique*)_____

CHILD STATUS CHANGE (*Cambio de la Situación del Niño/a*)

(*check those that apply*) *(marque los que correspondan)*

- ☐ No longer eligible (*Ya no es elegible*)
- ☐ Agency withdrawal (*Retiro de la agencia*)
- ☐ Parent withdrawal (*Retiro por parte del padre*)
- ☐ Transition to (*Transición a*):_____
- ☐ Other, specify (*Otro, especifique*)_____

Comments (*Comentarios*):

MODIFIED BY (*to include parent*): **Modificado por** (*incluir a un padre*):

Name/Title *Nombre / título*	Signature/or Other Verification of Authorization *Firma / otra forma de verificación*	Agency *Agencia*	Phone *Teléfono*	Date *Fecha*
Name-Parent(s) *Nombre-padre(s)*	Signature/or Other Verification of Authorization *Firma / otra forma de verificación*		Phone *Teléfono*	Date *Fecha*

cc: _____ _____

TRANSITION

TRANSITION

One of the major responsibilities of the Early Start Program is the transition from the Infant/ Toddler Program to services at age three. In addition to assistance with referral to public school special education services, Early Start Service Coordinators may provide resources for community recreation, day care, and other programs. The following tools are utilized:

- **Transition Meeting**

When the child is between age 2 years 3 months and 2 years 9 months, the school district ECSE convenes a meeting which must include the child's parent or guardian and a representative from the child's district of residence if agreed upon by parent. Any direct service providers and agencies serving the family may be invited, based on the parents' preference. Please see the attached SELPA list of Part B Preschool contacts for district contacts in each district. If the child is dually served, TCRC Service Coordinator takes the lead in coordinating the meeting.

- **Transition Plan Form**

During the Transition Meeting (which should also serve as a semi-annual review), the Transition Plan form is completed (see attached). The participants agree to complete their tasks towards the child's successful transition from Early Start. The school district of residence will collaborate with the Early Start team to coordinate the timing of the referral, which must be made no later than 2 years 9 months. The Early Start Service Coordinator will make the referral at the agreed upon time to include most recent IFSP and all assessment reports. (See attached Referral Cover sheet and checklist). S/he will also assist the family in the transition process, including completing and returning required paperwork and attendance at appointments. (See attached Transition timeline.)

- **"What's Next After Early Start?" booklet**

This booklet is available for all ECSEs to share information about transition with families. It is ideal to leave it in the home and then discuss it at periodic intervals. It is available in English and Spanish. Call the SELPA for free copies.

- **Transition Timelines and Options**

If the parents wish a referral to be made for assessment for special education, the ECSE will forward to the district, on the agreed upon date:

- Referral Cover Sheet
- Most recent IFSP
- Progress Reports
- Most recent assessments
- Parent Consent

This is known as a "Standard" referral.

If the parents do not want a referral to be made, the ECSE will forward to the district the Referral Cover Sheet only. This is known as a "Notification Only" referral.

For children found ES eligible within 90 days of child's 3rd birthday, a representative from the school district of residence will be invited to the initial IFSP meeting. The initial IFSP meeting will include the Transition Plan. The referral will be made immediately. This is known as an "Intake Referral".

For children from whom the Initial Inquiry is received between 60-46 days prior to the 3rd birthday, an Intake Referral will be made immediately after the ES Intake Interview is completed. The school district may choose to begin the assessment process immediately.

REFERRAL FROM EARLY START PROGRAM TO SCHOOL DISTRICT FOR SPECIAL EDUCATION ASSESSMENT

Ventura County Special Education Local Plan Area (SELPA)
Early Start Program Individualized Family Service Plan (IFSP)

☐ TCRC Oxnard ☐ TCRC Simi Valley ☐ North LA County ☐ School District Early Start

To: _____ School District: _____

Name of Early Start Service Coordinator: _____

Name of Child: _____

Date of Birth: _____

Family's primary language: __ _____

Interpreter needed? ☐ Yes ☐ No

Parent Name(s): _____

Address: _____

City: _____ Zip: _____

Home phone: _____ Cell phone: _____ E-mail address: _____

Did School District representative attend Transition IFSP?

☐ Yes Name: _____

☐ No explain why: _____

Date sent: _____

For School District use only: Date received: _____

PLEASE INDICATE TYPE OF REFERRAL PACKET:

☐ **Standard Referral**	☐ **Notification only referral**	☐ **Intake referral**	☐ **Inquiry referral**
Attach:	**Attach:**	**Attach:**	**Attach:**
* IFSP	* This cover sheet only	*ES Inquiry	* ES Inquiry
* Progress notes		*ES interview	
* Current assessments		*Consent Form	
* Transition plan			

TRANSITION PLAN / PLAN DE TRANSICIÓN

Ventura County Special Education Local Plan Area (SELPA) Early Start Program Individualized Family Service Plan (IFSP)
Área del Plan Local de Educación Especial del Condado de Ventura (SELPA) ***Programa de Servicios de Intervención Temprana plan individualizado de servicios familiar (IFSP)***

This form is used to facilitate discussion of each child's unique needs and to review options for services that may be necessary and appropriate when the child turns age three. (Esta forma es utilizada para facilitar información acerca de las necesidades individuales de cada niño/a y para discutir opciones de servicios que sean necesarias y apropiadas cuando el hijo/a cumpla tres años de edad).

Date/Fecha_____ DOB/FDN: _____ SSID #: _____

Child's Name/Nombre del hijo/a: _____: _____ Gender/ *Género:*_____

Address/Domicilio: _____

Phone/Numero telefónico: _____ Alternate phone/Numero alterno: _____

Parent email _____

Parent/Guardian/Surrogate/Padres/Guardián/Padre de crianza: _____

Home Language/Idioma de la familia: _____ School District/Distrito Escolar: _____

Service Coordinator/Agency/Coordinador de Servicios/Agencia: _____ Phone/teléfono: _____

Transition booklet provided/Folleto de trancision proveido: ☐Yes ☐No Date of Initial IFSP/Fecha del plan inicial: _____

☐ Parent declined school district attendance at transition IFSP/Padre rechazo la asistencia del distrito escolar durante la reunión de transición.

1. Summary of child's progress/Resumen del progreso del hijo/a

2. Areas of concern related to your child's development/Las áreas de procuración con respecto al desarrollo su hijo/a:

3. Special health care needs (medications, equipment, vision and hearing)/necesidades medicas (medicamentos, equipo medico, visión y audición):

4. What are your plans to continue supporting your child's development after the Early Start program ends? /¿Cuales son sus planes para continuar apoyando el desarrollo de su niño/a después de que el programa del Comienzo Temprano termine?

5. Program options described/discussed: eg: community programs, public school, etc./Opciones de programas descritas/discutidas, por ejemplo: programas de la comunidad, escuelas publicas, etc.:

Does family want a referral for consideration for special education eligibility at age 3?/ ¿La familia quiere una referencia para considerar elegibilidad de servicios especiales a la edad de 3 años?

☐ Yes Si Complete box (See #6)/Complete la caja (vea #6)

☐ No No Family was notified that Regional Center is obligated under 34 CFR 303.209(b) to provide identifying information only to the school district no later than 90 days prior to child's 3rd. birthday/La familia fue notificada que el Centro Regional esta obligado bajo el reglamento 34 CFR 303.209(b) a proveer información de identificación solo al distrito escolar a mas tardar 90 días antes del 3er cumpleaños de su hijo/a.

6. Based on the areas of concern described in question #2, what are the potential areas of assessment for school district to consider?/Basado en las áreas de preocupación descritas en la pregunta #2, ¿cuales son las posibles áreas de evaluar para que el distrito escolar considere?

School District/distrito escolar _____ Contact person/persona a quien contactar: _____

Phone/teléfono: _____ Email address/correo electrónico: _____

Referral to school district made today/Referencia al distrito escolar hecha hoy dia: _____

Referral to be sent to school district no later than/Referencia al distrito escolar se enviara a mas tardar: _____

Individualized Education Program (IEP) team meeting to review assessment results and discuss special education eligibility to be held by (no later than 3rd birthday/La reunión del plan individualizado de educación (IEP) para repasar los resultados de la/s evaluación/es y discutir la elegibilidad para el programa de educación especial se realizara (a más tardar el 3er cumpleaños): _____

Anticipated times when family/child may not be available/Tiempo anticipado cuando la familia/o el niño/a no estarán disponibles:

_____

Additional follow-up steps/Medidas de seguimiento adicionales: _____

7. Does the family want assessment for Regional Center eligibility at age 3? / ¿La familia quiere una evaluación de elegibilidad por medio del Centro Regional a los tres años de edad? ☐ Yes ☐ No

Potential Areas of assessment/Áreas potenciales a evaluar: _____

Who will contact parent/Quien contactara al padre: _____ Phone/telefono: _____ By When/Para cuando: _____

Individual Program Plan (IPP) meeting to be held by/Reunión del Plan Individualizado de Educación (IEP):_____

Additional follow-up steps/ Medidas de seguimiento adicionales:_____

8. Agreement to proceed, please initial/Acuerdo para proceder, por favor ponga sus iniciales:

_____ I have participated in developing this IFSP Transition Plan/He participado en el desarrollo de este Plan de Transición.

_____ I agree with the steps outlined in this plan/Estoy de acuerdo con los pasos descritos en este plan.

_____ I give my permission for the individuals and agencies indicated to carry out the plan with me/Doy mi permiso al personal y agencies indicadas para que sigan adelante con este plan conmigo.

_____ I give permission for the schools and Regional Center to share pertinent Early Start records, including assessments that are needed to consider school district eligibility as age 3/Doy permiso a las escuelas y al Centro Regional para que compartan información y evaluaciones que sean necesarias para determinar la elegibilidad de mi niño/a a la edad de 3 años.

_____ I understand that if I do not give permission, Regional Center is obligated under 34 CFR 303.209(b) to provide identifying information only to the school district no later than 90 days prior to my child's 3rd. birthday/Entiendo que si yo no autorizo, el Centro Regional esta obligado bajo el reglamento 34 CFR 303.209(b) a proveer información de identificación solo al distrito escolar a mas tardar 90 días antes del 3er cumpleaños de su hijo/a.

9. Signed/Firma:

Parent/Guardian/Surrogate Parent/Padre/Guadian/Padre de crianza: _____ Date/Fecha: _____

Early Start Service Coordinator/Coordinador de Centro Regional: _____ Date/Fecha:_____

School District Representative/Representante del Distrito Escolar: _____ Date/Fecha:_____

Present ☐ Participated via telephone

Participant/Participante: _____ Title/Agency/Titulo/Agencia: _____

Family would like a referral to Rainbow Connection Family Resource Center/La familia gustaría una referencia al Centro de Conexión de Recursos Familiares: ☐Yes ☐No

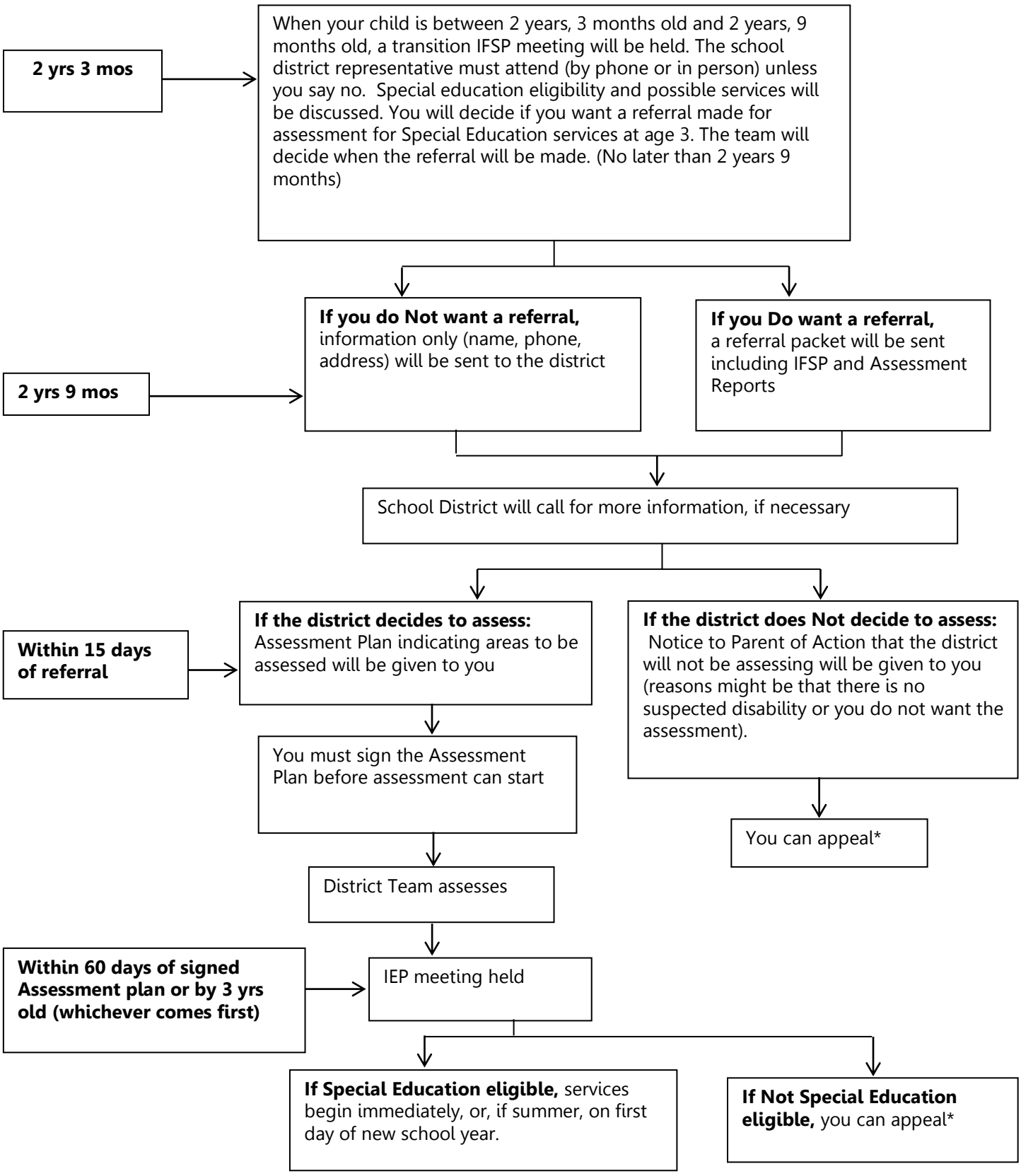
PLEASE INDICATE TYPE OF REFERRAL:

☐ **Standard Referral Attach:**
*IFSP
*Progress notes
* Current assessments
*Transition plan

☐ **Notification only referral Attach:**
*This cover sheet only

Your Child's Transition from

the Early Start Program to Public School Services



*See page 38 – Parents Rights for "Due Process"

Ventura County SELPA
Preschool Referral Contacts

ATTENTION	DISTRICT	SITE	ADDRESS	CITY/ZIP	PHONE	FAX	EMAIL
BIJI KOVOOR	BRIGGS	OLIVELANDS SCHOOL	12465 FOOTHILL RD	SANTA PAULA 93060	933-2254	933-1111	BKOVOOR@VCOE.ORG
SHANA GRUDSKY, COORDINATOR	CONEJO VALLEY USD	UNIVERSTIY CENTER	2801 ATLAS AVE.	THOUSAND OAKS 91362	492-4051	241-4346	SGRUDSKY@CONEJOUSD.ORG
SUSAN HERSH, PSYCHOLOGIST	FILLMORE USD		PO BOX 697	FILLMORE 93016	524-6029	524-6081	SHERSH@FILLMOREUSD.ORG
JOY EPSTEIN, (IFP'S ONLY) PROGRAM SPECIALIST	HUENEME SD	DISTRICT OFFICE	205 N VENTURA RD	PORT HUENEME 93041	488-3588 x 9244		JEPSTEIN@HUENEME.ORG
VALERIE LOUTHIAN	LAS VIRGENES SD	BUTTERCUP SCHOOL	6098 REYES ADOBE RD	AGOURA HILLS 91301	818-597-2153	597-2156	VLOUTHIAN@LVUSD.ORG
	MESA UNION SCHOOL DISTRICT		6098 REYES ADOBE RD	SOMIS, CA 93066	485-1411	445-4387	
ALANA STOTTS, SCHOOL PSYCHOLOGIST	MOORPARK USD	EARLY CHILDHOOD CTRQ	240 FLORY AVE	MOORPARK 93021	531-6466 x 7095	530-3885	ASTOTTS@MRPK.ORG
JENNIFER GOLDEN, PROGRAM SPECIALIST	OAK PARK USD	DISTRICT OFFICE	5801 E CONIFER ST	OAK PARK 91377	818-735-3224	818-735-3243	JGOLDEN@OPUSD.ORG
HEATHER HENDRIX, DIRECTOR	OCEAN VIEW SD	DISTRICT OFFICE	4200 OLDS ROAD	OXNARD 93033	488-4441	986-6797	HHENDRIX@OCEANVIEWSD.ORG
EMILY OTELSBERG, PSYCHOLOGIST	OJAI USD		PO BOX 878	OJAI 93024	640-4300	640-4447	EOTELSBERG@OJAIUSD.ORG
MARY TRUAX, MANAGER, SPED	OXNARD ELEMENTARY SD	EDUCATION SERVICE CTR	1051 SOUTH A ST.	OXNARD 93030	385-1501 x 2174	487-9648	MTRUAX@OXNARDSD.ORG
LAURA SCHUSSMAN, PROGRAM SPECIALIST	PLEASANT VALLEY SD	DISTRICT OFFICE/PEEP	600 TEMPLE AVE.	CAMARILLO 93010	389-2100 x 1326	445-8808	LSCHUSSMAN@PLEASANTVALLEYSD.ORG
MARIO TORRES, DIRECTOR	RIO SCHOOL DISTRICT	DISTRICT OFFICE	1800 SOLAR DR.	OXNARD 93035	485-1442		MTORRES49@RIOSCHOOLS.ORG
	SANTA CLARA		20030 E. TELEGRAPH RD	SANTA PAULA 93060	525-4573	525-4985	
ANDRES SANTAMARIA, PROGRAM ADMINISTRATOR	SANTA PAULA USD	DISTRICT OFFICE	221 W. STECKEL DR.	SANTA PAULA 93061	368-3700	933-8024	ASANTAMARIA@SANTAPAULAUSD.ORG
ERIN MACINTYRE, PSYCHOLOGIST, PROGRAM SPECIALIST	SIMI VALLEY USD	JULSTIN ELA	101 W. COCHRAN ST	SIMI VALLEY 93065	520-6619 x 3105	520-6586	ERIN.MACINTYRE@SIMIVALLEYUSD.ORG
KIM CHARNOFSKY	SOMIS UNION	SOMIS ELEM	5268 NORTH ST	SOMIS, CA 93066	386-5711	386-2324	KIM.CHARNOFSKY@STAFF.SOMISUSD.ORG
MARCEL HARNER, COORDINATOR	VENTURA USD	EARLY INTERVENTION CENTER	10731 DARLING RD	VENTURA 93004	672-2705 x 2206	672-0427	MARCEL.HARNER@VENTURAUSD.ORG

SUBMISSION OF DATA

SUBMISSION OF DATA

After the IFSP is complete, the ECSE must submit required data to the school district office for mandated reporting to (CALPADS). Use the attached form.

If the child has transferred in from another SELPA and/or district in California, he/she will already have an SSID (State Student Identification) number. Otherwise, your district will assign a new number.

CALPADS information should be forwarded to the district CALPADS staff person within one week of completing the IFSP.

If any CALPADS data changes (ie, level of service, primary disability) a CALPADS Data Update form must be submitted as soon as possible. This is important data for both compliance and fiscal accountability purposes.

Ventura County SELPA Early Start (Infant) Program – SIRAS Data Input Form
(attach IFSP documents and assessments)

- Moved in from out of SELPA
- Dually served

Student Name		**Home phone**
Address **City** **Zip**		
Father (First, Last)	**Employer**	**Cell Phone**
Mother (First, Last)	**Employer**	**Cell Phone**

LEA Identification

SELPA From _____
(children transferring in with active IFSPs from outside of SELPA only)

Reporting LEA/District Attending will default to your District when you start record

District of SPED Accountability _____

School Type No school (0-5 only) – 00

School Attending Marina West Oxnard ATLAS EIC Ventura Justin Simi University Preschool Conejo

Referral Information

Referral Date _____
(date of Early Start Inquiry)

Referral By Other-90 for TCRC referrals

Parental Consent Date _____
(date of written parent consent)

Initial Evaluation Date _____
(date of initial IFSP meeting)

Student Demographics

First Name _____

Middle Name _____

Last Name _____

SSID _____
(LEA Infant Program must request SSID for infants who do not yet have one in CALPADS)

Birthdate _____/_____/_____
mm dd yyyy

Grade Infant

Gender Male Female

Home Language Survey (HLS) will not be given until student enters TK/K, therefore EL type= TBD and Native Lang= Unknown UU

EL Type To Be Determined (TBD

Native Language Unknown

Federal Ethnicity Hispanic Not Hispanic

Race (number from 1 up to 4 on list below)- only first 3 will be entered into SIRAS

_____	100	Native American	_____	299	Other Asian
_____	201	Chinese	_____	301	Hawaiian
_____	202	Japanese.	_____	302	Guamanian
_____	203	Korean	_____	303	Samoan
_____	204	Vietnamese	_____	304	Tahitian
_____	205	Asian Indian	_____	399	Other Pacific Islander
_____	206	Laotian	_____	400	Filipino
_____	207	Cambodian	_____	600	African-American
_____	208	Hmong	_____	700	White

The following is not entered into MIS, but will be needed for the DRDP.
Language other than English spoken in the home Yes _____ No
(from Early Start Inquiry)

Migrant Yes No

Special Ed. Information

Plan Type IFSP – 150 Not eligible – 900 Eligible, no IFSP– 800

Special Ed Initial Entry Start Date _____
(date of initial evaluation- first IFSP date)

Last IEP Date (date of last IFSP meeting) _____

Last Evaluation Date _____
(date when IFSP Eligibility form was determined- Initial Evaluation Date)

Primary Residence
140 Parent or legal guardian
140 Homeless
210 Foster family home (FFH)
220 Licensed children´s institution (LCI)
240 Hospital

Disability (put 1 for primary, 2 for secondary)

_____	200	None	_____	270	Orthopedic Impairment
_____	210	Intellectual Disabilities	_____	280	Other Health Impairment
_____	220	Hearing Impairment	_____	290	Specific Learning Disability
_____	230	Deafness	_____	300	Deaf-Blindness
_____	240	Speech or Language Impairment	_____	310	Multiple Disabilities
_____	250	Visual Impairment	_____	320	Autism
_____	260	Emotional Disturbance	_____	330	Traumatic Brain Injury

Program Setting (circle one only)	Home-200	Community Setting-103 (daycare)	Other Setting-104 (playgroup)
Infant Setting	DIS	RSP	SDC
Special Transportation (to Early Start services)	Yes	No	
Parent Input	Yes		

Student Services Data (use codes from next page)

Service	Provider	Location	Frequency	Minutes	Start Date	End Date

Services:

210 Family training, counseling, and home visits (*0-2 only*)
220 Medical services (*for evaluation only*) (*0-2 only*)
230 Nutrition services (*0-2 only*)
240 Service coordination (*0-2 only*)
250 Special instruction (*0-2 only*)- **playgroup**
260 Special education aide in regular development class, childcare center or family childcare home (*0-2 only*)
270 Respite care services (*0-2 only*)

415 Language and speech
425 Adapted physical education
435 Health and nursing – specialized physical health care services
436 Health and nursing – other services
445 Assistive technology services
450 Occupational therapy
460 Physical therapy

520 Parent counseling
525 Social work services
535 Behavior intervention services

610 Specialized services for low incidence disabilities

710 Specialized deaf and hard of hearing services
720 Audiological services
725 Specialized vision services
730 Orientation and mobility
735 Braille Transcription
740 Specialized orthopedic services
760 Recreation services, includes therapeutic recreation (34 CFR 300.24)

900 Other special education/related service

Locations:

210 Home instruction based on IEP Team determination (*not medical*)
220 Hospital
320 Child development or childcare facility
350 Extended day care
360 Residential facility
510 Regular classroom/public day school
520 Separate classroom in public integrated facility
540 Separate school or Special Education Center or facility
890 Service provider location
900 Any other location or setting

Providers:

100 District of service
110 County office of education
120 SELPA
130 Another district, county, or SELPA
220 Regional Center
320 Department of Social Services
400 Nonpublic agency (NPA) under contract with SELPA or district
600 Other private program

SERVICE GUIDELINES

EARLY INTERVENTION SERVICES PROVIDED BY THE EARLY CHILDHOOD SPECIAL EDUCATOR VIA THE IFSP

A variety of Early Intervention services are available to all children and families, depending on their needs, and as specified in the IFSP. Services may include Home Based, Group, and Family Involvement activities.

Home based services are provided once or twice a week, depending on the needs of the infant and family. Home visits provided in conjunction with group services range from one to eight times per month, depending on the needs of child and family. Family involvement activities are offered at least once per month.

Other professionals will provide services as specified on the IFSP which may include Speech-Language Therapy, Occupational Therapy, Physical Therapy, Deaf/Hard of Hearing Services, Vision Services, Health and Nursing Services, or Orthopedic Impairment Services.

New intakes to Early Start must have both vision and hearing screening. See vision screening tool in this section.

SERVICES WHICH MAY BE PROVIDED BY SCHOOL DISTRICT TO CHILDREN WITH SPEECH AND LANGUAGE DELAYS

A. DEFINITIONS

1. Communication:
   Information which is transmitted or conveyed from one person to another, and the method used to convey it. Can be accomplished in many ways: visual (signing, gesture), body position, auditory, tactile, and olfactory.

1. Language:
   The organized set of symbols we use to communicate meaning about objects and relationships in our world. These symbols are combined according to rules that govern language. Symbols can be spoken, gestures, or written.

   a. Receptive language refers to the skills involved in understanding language, including:
      - The ability to hear differences in sounds and assign different meanings
      - Being able to remember what is heard (e.g. following a 3-step direction)
      - Understanding vocabulary and concepts
      - Understanding grammatical forms, such as plurals, negatives, etc.

   b. Expressive language refers to the skills involved in communicating one's thoughts and feelings to others, answering questions, relating events, and carrying on a conversation. These include:
      - Combining sounds within a language to convey meaning
      - Choosing word forms and word order appropriately
      - Choosing the best words to express a thought

3. Speech:
   The physical ability to make sounds and to pattern these sounds into words to communicate a message. There are three major aspects of speech:

   a. Voice: vibration of the vocal cords caused by the air stream passing through the larynx (voice box). The components of voice include quality (hoarse, weak, breathy), loudness, pitch, and resonance (vibration of air in the oral or nasal cavities).

   b. Articulation: the physical production of sounds in speech. The voice generated by the vocal cords is shaped into sounds by the palate, tongue, lips and teeth.

   c. Fluency (rhythm): sounds, words, and phrases flowing together smoothly during speaking, with pauses and stress to express meaning.

4. Pragmatics:
   Social and behavioral awareness of non-verbal communication skills, including visual contact, turn taking and body language.

5. Oral-Motor Skills:

The complex muscle task which requires coordination between the cognitive and the central nervous system to produce speech and feeding skills.

B. METHODS OF DELIVERY:

These services may be provided individually or in small groups by an Infant Specialist in consultation with a Speech/ Language Specialist, **or** directly by a Speech/ Language Specialist. Methods of delivery to be determined by the IFSP team based on assessment results and recommendations.

C. INTERVENTION AVAILABLE:

1. Assessment:
   a. Receptive/ Expressive
   b. Pragmatic skills
   c. Oral-Motor skills

2. Consultation Services:
   Speech/ Language specialist to assist Infant Specialist in determining appropriate goals and activities. Can be an occasional or an on-going service.

3. Early Communication Skills:
   Language-based and cognitive-based skills for pre-verbal children. Play skills, social intervention, early pragmatic and behavioral skills.

4. Articulation Therapy:
   To include breath support, positioning of body, use of articulators for sound production. Children with structural anomalies, hearing loss, neuro-muscular involvement may be candidates for this intervention.

5. Augmentative Communication Systems:
   Giving the child a means to interact with his environment to enhance learning and functional communication. Includes adaptive switch plates, communication boards (pictures, eye gaze, photos), gestural and sign language. Signing may be appropriate for children with a hearing loss, and for other children with expressive delays. Parent involvement is very important in this area.

6. Parent Education and Modeling:
   Providing activities of developmentally appropriate speech and language skills and play skills. Modeling interactions specific to the child's needs.

GUIDELINES FOR DIRECT SPEECH THERAPY

Readiness Skills:

- Intent to communicate
- Ability to imitate
- Ability to attend to age-appropriate tasks
- Understands cause and effect

Likelihood of Needing Speech Therapy:

- Discrepancy between expressive and receptive language skills
- Discrepancy between communication skills and other developmental areas
- Children with hearing loss
- Children with Down, Kleinfelter, Cleft Palate, Cerebral Palsy, Prader-Willi, Williams, Turner, Fragile X, Angelmann, may need consultation or direct therapy depending on underlying physiological conditions, such as low or high tone, absence of structure, cranial/facial anomalies, neurological issues, poor motor planning, etc.
- Children with autism

Other Points:

- Children with DHH may or may not need direct speech therapy depending on other professionals and what they are doing in terms of language development

Areas that an SLP should work on:

- Speech and language assessment (receptive, expressive, pragmatic and oral motor skills)
- Voice
- Articulation therapy
- Fluency
- Oral motor language
- Augmentative communication systems
- Parent education and modeling

Areas that the Early Childhood Special Educator should work on:

- Pragmatics
- Early communication skills (pointing, gesturing, imitating)
- Functional communication
- Listening and following directions
- Parent education and modeling

GUIDELINES FOR SCHOOL DISTRICT CONSIDERATION OF VISION SERVICES FOR CHILDREN SERVED SOLELY BY REGIONAL CENTER

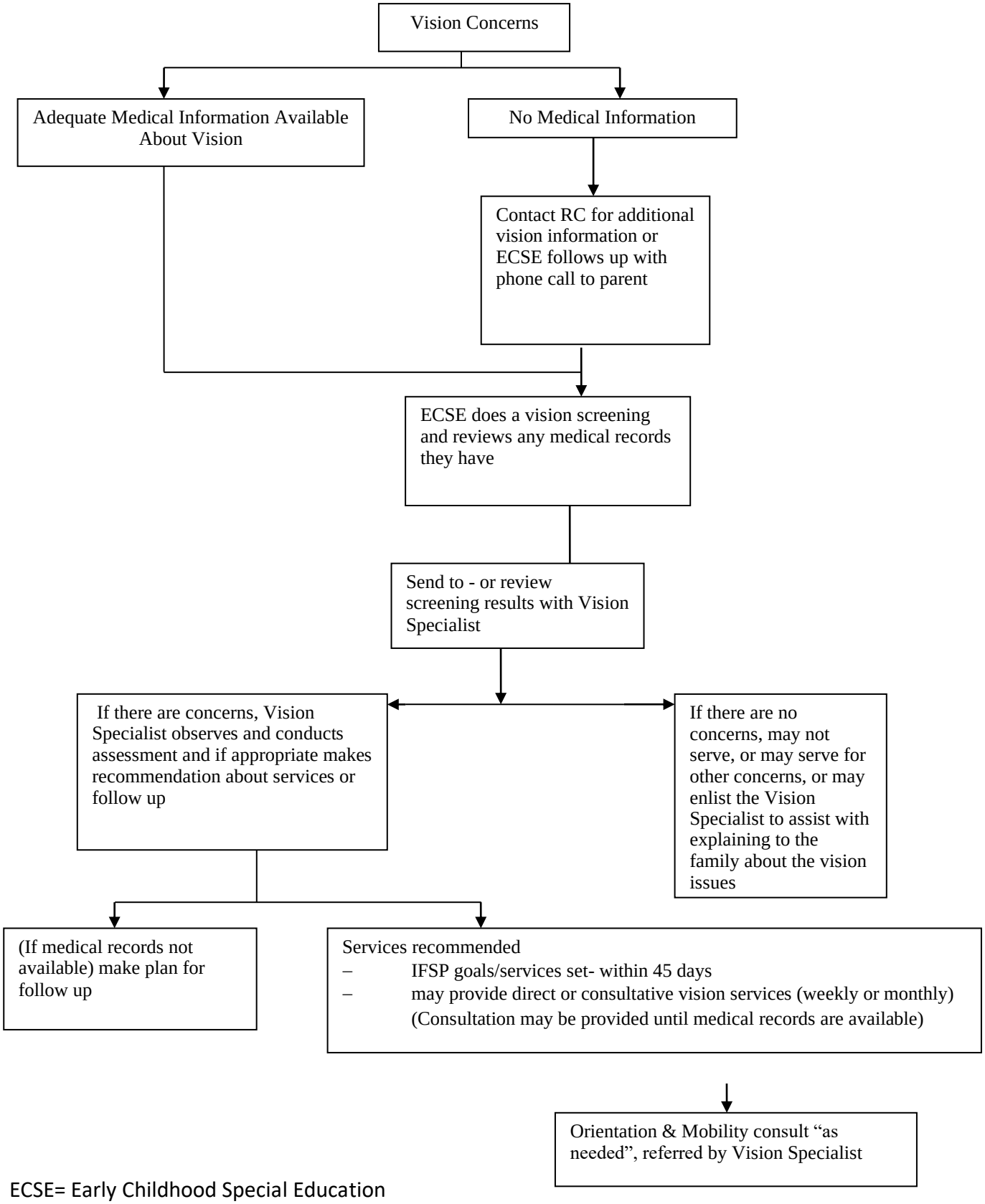
IF THERE APPEARS TO BE A NEED FOR VISION SERVICES:

- Awareness of need for vision services (in addition to another ES eligibility)
- IFSP amendment – medical vision assessment, arranged by Regional Center
- Vision assessment yields a vision diagnosis:
  - Child Re-DARTed to schools
  - Schools review case
  - If there is space available, the receiving district will consider the child as a priority for dual service delivery
  - IFSP held to revise service plan
  - If they choose to serve, districts would require that all special education services be transferred to the school district.

VC SELPA

Flowchart for Evaluating Vision Concerns

Inquiry received from Regional Center



ECSE= Early Childhood Special Education

RC= Regional Center

VENTURA COUNTY SELPA
EARLY START PROGRAM
VISION SCREENING

Instructions

Guidance for presenting and noting responses to each of the tasks:

1. Orients Centrally- Observe whether the head is in a center position looking at an object in the middle. Indicate approximate distance that the object was held, and the size of the object. Note how many seconds the student looked at the object.

2. Orients peripherally- Observe whether the child looks at items presented to left or right, even with a head turn.

3. Tracks horizontally- Use a light or other stimulating object and observe if child will track to either side, ok if they move their head. Indicate distance and the object. Also note whether student crosses midline.

4. Tracks vertically- Do same as above, tracking up and down (No midline).

5. Reaches on visual cue- Note which side, and size of object and distance. Note if child over- or under-reaches.

6. Shifts gaze- Using two stimulating objects, observe whether the child looks from one object to the other and back.

7. Blink Reaction/Rapid Eye Movement- Clap hands and observe whether or not the child blinks. Indícate whether they blink just once or multiple times.

8. Nystagmus- Note whether the eyeballs shake.

9. When looking at a light or object straight ahead, indicate whether any of the elements are observed. Give any explanatory comments which may be helpful to the Vision Specialist.

10. Does child turn/tilt head when looking at objects- Indicate the angle that they bring the object to the eye.

11. How does child look at objects they hold- Give the child an object, and observe the distance that they look at the object, and eye preference if any, and the angle.

12. Has child's vision been tested- If yes, indicate name and title of specialist, and date.

13. Is child taking any medications- If yes, please describe.

14. Vision records- Indicate whether or not they have been obtained, and the source (doctor, clinic, etc) if available.

15. Other medical concerns- Indicate any concerns expressed by parents or other professionals.

16. Parental concerns- Indicate any concerns the parents may have, particularly regarding the eyes and vision.

17. Put any other comments that you think the observer may wish to note. Forward to the Vision Specialist to review.

VENTURA COUNTY SELPA
EARLY START PROGRAM
VISION SCREENING

Name of Child_____Date of Birth_____

	TASK	OBSERVATION	COMMENTS
1	Orients centrally	Yes/No	
2	Orients peripherally without	Right/Left/ Not at all	
3	Tracks horizontally	Right/Left/ Not at all	
4	Tracks vertically	Up/Down/Not at all	
5	Reaches on visual cue	Right/Left/Not at all Over reach/Under reach	
6	Shifts gaze	Right/Left/Not at all	
7	Blink reaction/Rapid Eye Movement	Fast/Slow/Not at all	
8	Nystagmus	Yes/No	
9	When looking at a light or object straight ahead, are child's eyes: • Even and symmetrical, not cross eyed or exotropic • Droopy • Red • Excessive tearing • Constant rubbing • Excessive sensitivity to light	Yes/ No Yes/ No Yes/ No Yes/ No Right/Left/Both/No Yes/ No	
10	Does child turn/tilt head when looking at objects	Yes/ No	

11	How does child look at objects they hold • At what distance • Eye preference • At what angle does he/she bring objects to the eye	_____" Right/ Left/ Both/Neither _____^{o}	
12	Has child's vision been tested	Yes/ No	
13	Is child taking any medications	Yes/ No	
14	Medical records obtained	Yes/No	
15	Other medical concerns		
16	Parental concerns:		

Other Comments:

Date:_____
Signature of Interviewer:_____
Title:_____

Vision Specialist Review

☐ No apparent concern at this time
☐ Monitor for _____
☐ Will follow up
Comments:

_____ _____
Signature Date

MOU