VENTURA COUNTY SELPA
EARLY START PROGRAM

www.vcselpa.org

OPERATIONS MANUAL FOR

School District
Early Childhood
Special Educators (ECSE)

Serving Infants/Toddlers 0 – 36 months

2020

“Baby Bootee Camp”

Guide

Contact:
Regina Reed
Director, Personnel Development
RReed@vcoe.org
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 service delivery model components (home-based services, nutrition and respite services) that are 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](http://www.vcselpa.org).

This manual was designed to assist you as you enter our program. Welcome to “Baby Bootee Camp”.

Original Editors: Fran Arner-Costello and Launice Walker
Thanks to the following staff for the 2010 revisions:
Keisha Carroll and Rama Dasu, Simi Valley USD, Early Childhood Special Educator
Raelynne Lorenz, Conejo Valley USD, Early Childhood Special Educator
Karly Stern, Ventura USD, Early Childhood Special Educator
Gina Villavicencio, VC SELPA, Secretary
2015 Revisions- Regina Reed, Director, VC SELPA
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<td>Intake</td>
<td>13</td>
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<td>Assessment</td>
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<td></td>
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<td></td>
<td>• Vision</td>
<td></td>
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<td></td>
<td>• Deaf/Hard of Hearing</td>
<td></td>
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<td>Purchases</td>
<td>93</td>
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<td>12</td>
<td>Memorandum of Understanding (MOU)</td>
<td>95</td>
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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 December 1 pupil count.
### Early Start Program Allocation Formula

<table>
<thead>
<tr>
<th></th>
<th>(Growth)*</th>
<th>(Recapture)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible for more funding</td>
<td>At risk of losing funding</td>
</tr>
<tr>
<td>Units</td>
<td>Units x 16 children</td>
<td>Average</td>
</tr>
<tr>
<td>Simi</td>
<td>32%</td>
<td>2.61</td>
</tr>
<tr>
<td>Ventura</td>
<td>19%</td>
<td>1.48</td>
</tr>
<tr>
<td>Oxnard</td>
<td>30%</td>
<td>2.42</td>
</tr>
<tr>
<td>Conejo</td>
<td>19%</td>
<td>1.53</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8.04</td>
</tr>
</tbody>
</table>

*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 June 2015
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 2017 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, or fax. 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.

Referral Received by TCRC 45 days

Inquiry - DART - Intake (joint or separate) - Assessment

Concern

Referral made or family assisted with referral

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

- **Solely served by Regional Center**: 1000+
- **“Dually” Served**: 80+
- **Solely Low Incidence**: 40+
The SELPA Early Start Secretary will forward to each infant/toddler program a list of all Inquiries (Attachment C) completed by TCRC each week.

The SELPA Early Start Secretary will forward to each school district in the SELPA a list of Early Start Intakes received for children residing in the district, on a quarterly basis.
# Ventura County Early Start Program

**EARLY START INQUIRY**

<table>
<thead>
<tr>
<th>Initial Intake Date:</th>
<th>IFSP Due Date:</th>
<th>SSN#:</th>
<th>UC#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Child's name:</th>
<th>Date of Birth:</th>
<th>Age:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last:</td>
<td>First:</td>
<td>MI:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother/Guardian:</th>
<th>Maiden Name:</th>
<th>Father:</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Mailing/Home Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Message Phone:</th>
<th>School District of Residence:</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Birthplace:</th>
<th>Hospital:</th>
<th>Gestational Age:</th>
<th>Birth weight:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Present weight:</th>
<th>Medications and Equipment:</th>
</tr>
</thead>
</table>

Medical Confirmation/Diagnosis:  
Specialist(s) Involved:

### Developmental Concerns

<table>
<thead>
<tr>
<th>Vision</th>
<th>Hearing * see checklist</th>
<th>Physical * see checklist</th>
<th>Self-Help * see checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral</td>
<td>Social</td>
<td>Communication</td>
<td>Cognitive</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>LEA Early Start Coordinator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yes- agree to serve as SLI (Pending evaluation results)</td>
</tr>
<tr>
<td>- Yes- agree to dual intake</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEA Response Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No- does not appear appropriate for dual/no available openings at this time</td>
</tr>
<tr>
<td>- No- reconsider at later date when more information is available</td>
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</table>

Concerns/ Need More Info:
<table>
<thead>
<tr>
<th>SERVICE COORDINATION REGION</th>
<th>Speech/Language</th>
<th>Assistive Technology Assessment</th>
<th>Auditory Services (for a fee)</th>
<th>Orientation &amp; Mobility</th>
<th>Nutrition*</th>
<th>Respite*</th>
<th>Transportation to educational services</th>
<th>Physical Therapy*</th>
<th>Occupational Therapy*</th>
<th>Vision Services</th>
<th>Vision Therapy</th>
<th>Counseling and Guidance Services</th>
<th>Psychological Services (Non Assessment)</th>
<th>Parent Training</th>
<th>Health and Nursing</th>
<th>Social Emotional Services</th>
<th>Recreation Services</th>
<th>Deaf</th>
<th>Hard of Hearing Services</th>
<th>Parent Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conejo Valley USD (C)</td>
<td>C</td>
<td>SELPA</td>
<td>VC</td>
<td>C</td>
<td>SELPA</td>
<td>SELPA</td>
<td>SELPA</td>
<td>CCS/SELPA</td>
<td>CCS/SELPA</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>SELPA/SELPA/SELPA/SELPA/SELPA/SELPA</td>
<td>C</td>
<td>C/BH/RC/S/SELPA/SELPA/SELPA/SELPA</td>
<td>RD</td>
<td>SV</td>
<td>SV</td>
<td>C/RC/BH/SELPA</td>
<td></td>
</tr>
<tr>
<td>Ventura Unified SD (V)</td>
<td>V</td>
<td>SELPA</td>
<td>VC</td>
<td>H</td>
<td>SELPA</td>
<td>SELPA</td>
<td>SELPA</td>
<td>CCS/SELPA</td>
<td>CCS/SELPA</td>
<td>V</td>
<td>V</td>
<td>V</td>
<td>SELPA/FRC/V/BH/SELPA</td>
<td>V</td>
<td>V/BH/RC/SELPA/SELPA/SELPA/SELPA</td>
<td>RD</td>
<td>V</td>
<td>V</td>
<td>V/RC/BH/SELPA</td>
<td></td>
</tr>
</tbody>
</table>

Hueneme (H)
California Children Services (CCS)
City Recreation Department (RD)
Family Resource Center (FRC)
Regional Center (RC)
Ventura County Behavioral Health (BH)
Ventura County Special Education Local Plan Area (SELPA)
Ventura County Office of Education (VC)

**DISTRICTS EACH REGION SERVES:**

**Conejo Valley Unified School District**
- Conejo Valley Unified School District
- Las Virgenes Unified School District
- Oak Park Unified School District

**Oxnard Elementary**
- Hueneme School District
- Mesa Union School District
- Ocean View School District
- Oxnard School District
- Pleasant Valley School District
- Somis Union School District

**Simi Valley**
- Moorpark Unified School District
- Simi Valley Unified School District
- Somis & Pleasant Valley (Deaf only)

**Ventura Unified**
- Briggs School District
- Fillmore Unified School District
- Mupu School District
- Ojai Unified School District
- Rio School District
- Santa Paula Unified School District
- Ventura Unified School District
## SAMPLE

**DART**  \(\text{SIMI OFFICE}\)  \(\text{DATE: Week of: April 29 – May 5, 2010}\)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>District</th>
<th>Service Coordinator</th>
<th>Dual</th>
<th>Priority</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MARGO, Baby</td>
<td>11/19/2008</td>
<td>Conejo</td>
<td>Pedro Mendoza</td>
<td>No</td>
<td>N</td>
<td>Speech Delay</td>
</tr>
<tr>
<td>2. EVAN, Baby</td>
<td>12/31/2009</td>
<td>Simi</td>
<td>Sheryl Gamble</td>
<td>No</td>
<td>N</td>
<td>Premature</td>
</tr>
<tr>
<td>3. GANO, Baby</td>
<td>10/31/2009</td>
<td>Simi</td>
<td>Gaby Fukunaga</td>
<td>yes</td>
<td>N</td>
<td>Developmental Delay</td>
</tr>
</tbody>
</table>
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. See guidelines for Vision and Hearing screening in “Service Guidelines” section.

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

Date Report: ____________________

Name: _______________________________ UCI: _____________  DOB: ____________
Assigned SC: _____________________               IFSP Due Date: ___________________
SSN: ____________________________               Dual case: Yes ☐ No ☐

Insurance Name: ___________________ Insurance # ____________________________

IDENTIFYING INFORMATION:
Age: __________ Sex: M ☐ F ☐ Language: ☐ Spanish ☐ English ☐ Other ___________
Address: ___________________________________________________________________
Home Phone #: _____________________ Cell Phone #:_______________________________
E-mail address: ___________________________________________________________________

By whom referred: ___________________________________________________________________

Reason for concern: (congenital anomalies, prematurity, diagnosis, etc.):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Location of interview: _____________________________________________________________
Persons attending intake: ___________________________________________________________

FAMILY SITUATION:

Mother/Foster: _________________________ Maiden name: ____________ DOB: ________
Age: ______ Educational background: ______________________________________________
Employment: ______________________________    Place of birth: ________________________

History of disabilities (i.e. learning, special needs CP, Autism, etc.):
_______________________________________________________________________________

Father/Foster: _________________________ DOB: _____________________
Age: __________ Educational background: __________________________________________
Employment: ______________________________    Place of birth: ________________________

History of disabilities (i.e. learning, special needs, CP, Autism, etc.):
_______________________________________________________________________________
**Siblings:**

Name: _____________________________ Age: ___ Lives w/parent: Yes □ No □
Name: _____________________________ Age: ___ Lives w/parent: Yes □ No □
Name: _____________________________ Age: ___ Lives w/parent: Yes □ No □
Name: _____________________________ Age: ___ Lives w/parent: Yes □ No □

**OTHER AGENCIES INVOLVED**

- WIC: Y □ N □ (Counseling Y □ N □ Housing Asst: Y □ N □)
- Medical: Y □ N □ (Cal-Fresh Y □ N □ Other: Y □ N □)
- Cash-Aid: Y □ N □ (CDR Y □ N □ Type: _____________________________)
- SSI: Y □ N □ (NFL Y □ N □ Hub: _____________________________)
- CPS: Y □ N □ (name: _____________________________)
- Public Health: Y □ N □ (name: _____________________________)

Foster Parents: Yes □ No □

Educational Rights: _____________________________ Date of Placement: ________________

Who does the child reside with? _____________________________ Biological Parents: Yes □ No □

**MOTHER’S PREGNATAL HISTORY:**

**Mother’s medical history**

Due date: _____________ Maternal age at time of birth: _________ Prenatal care: Y □ N □

At what month received? _____________________________ Who provided care? ________________

Specialist: _____________________________

Ultra sound □ Yes □ No ______ Prenatal Vitamins: Yes □ No □ Iron □ Folic Acid □

**Problems during pregnancy:**

□ Chronic disease □ Rh incompatibility □ Hypertension □ Trauma
□ Viral infection □ Vaginal bleeding □ Toxemia □ Diabetes
□ UTI □ Miscarriages □ Bed rest ________ □ Weight loss/gain
□ Preclampsia □ Amnio □ Anemia □ Other _____________________________

Comments: _____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
History of Drug Abuse and Domestic Violence:

Have you ever had substance abuse issues? Y □ N □

- Did you use any of the following substances during pregnancy;
  - Alcohol □ tobacco □ cocaine □ meth □ prescription drugs □ marijuana □ other □
- Have you suffered from Depression?
  - Before pregnancy □ during pregnancy □ after pregnancy □
- Have you taken depression medication?
  - Before pregnancy □ during pregnancy □ after pregnancy □
- Do you have a health condition?
  - Before pregnancy □ during pregnancy □ after pregnancy □
- Do you take medication?
  - Before pregnancy □ during pregnancy □ after pregnancy □
- Any history of domestic violence? Yes □ No □
- Are you interested in receiving additional information to help with domestic violence?
  - Yes □ No □

Comments: ________________________________________________________________
________________________________________________________________________

BIRTH HISTORY:

Hospital of birth: _________________________________ Length of labor: ______________

Gestational age: (<32wks?): ______________

Apgars: (0-5): ____1min. ___5min. ___10min.

Birth weight (1500grms/3lbs.5.oz?): ________________ Length: _________________

Delivery:

- Vaginal Delivery □ C-Section □ Induced labor
- Premature (___weeks) □ Breech □ Jaundiced
- Cord around neck □ Transfused □ Fever
- Twin (1st or 2nd) □ Rh negative □ Baby rotated
- Vacuum Extraction □ Transverse □ Abruption
- Meconium aspiration/stained □ Placenta previa: □ Other

Comments: __________________________________________________________________________
________________________________________________________________________
**NURSERY COURSE**

Number of Days in NICU: _________________________________________________

Transport to other hospital? Y □  N □  Name: _______________________________

Reason: _________________________________________________________________

□ Oxygen/Ventilator □ Respiratory Distress Syndrome □ Bronchio-Pulmonary Disease

□ Apnea and Bradycardia □ Intracranial Hemorrhage (Grade): _______ Other: ___________

Surgeries: Y □  N □  Seizures: Y □  N □  Congenital Anomalies: Y □  N □

PDA:        Y □  N □  ROP:     Y □  N □  Genetic Syndrome: Y □  N □

Additional tests and referrals: _______________________________________________

Comments: ________________________________________________________________________________

________________________________________________________________________

**BABY/CHILD CURRENT STATUS:**

Diagnosis: _____________________ Current weight: _______ Height: _________

Vitamins: Yes □ No □  Medications Yes □ No □

Type: _______________________ Reason:_____________ Dosage/Frequency:_______________

Type: _______________________ Reason:_____________ Dosage/Frequency:_______________

Dr. who prescribed Meds: ___________________________________________________________________

Immunizations up to date? Yes □ No □  Explain______________________________________________

**MEDICAL FOLLOW UP:**

Pediatrician: _________________________ Last visit: ___________ Next: ___________

Specialists: __________________________ Last visit: ___________ Next: ___________

Name: _________________________ Phone Number: _________________________

Specialists: __________________________ Last visit: ___________ Next: ___________

Name: _________________________ Phone Number: _________________________

Medical problems: _________________________________________________________________

Re-hospitalizations: Y □  N □  Hospital: ____________________________

Reason: _________________________ Number of days: ___________ Dates: ___________

**Hearing**

Formal hearing evaluation done? Y □  N □  Newborn hearing Y □  N □  Passed Y □  N □

When: _________ Where: __________________ Results: _______________________

Hearing Conservation (805) 437-1380  Referred date: ____________________________

**Vision**

Formal vision evaluation done? Y □  N □  Newborn vision Y □  N □  Passed Y □  N □
When: _________  Where: _______________________  Results: _________________

☐ Referred to: ____________________________________________________________

☐ Vision and hearing screening performed by SC______________________________

Adaptive Equipment? Y ☐  N ☐  Reason: ______________  Type: ______________
Comments: __________________________________________________________________

Nutritional
Breast feeding: Y ☐  N ☐  How much: ____________  How often: ____________
Formula: Y ☐  N ☐  How much: ____________  How often: ____________
Drink bottle Yes ☐  No ☐  if yes, how many per day __________________________

Pacifier: Yes ☐  No ☐
Eating Habits: Fruits ☐  Veggies ☐  Grains ☐  Meat ☐  Dairy ☐
Does child chew meat ☐  or spit out ☐
Does child eat independently using fork ☐  spoon ☐  finger foods ☐
Drink open cup ☐  sippy cup ☐  straw ☐
Does child mind getting dirty during feeding? Yes ☐  No ☐

Other foods/supplements: __________________________________________________

Special Diet, Allergies, Feeding problems ________________________________________
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 □
Ventura County Early Start Program
PARENT CONSENT
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)  ☐ Family Resource Center
☐ Local Education Agency/Vendor  ☐ Primary Care Physician, Clinic please specify
☐ County Health Department including Public Health Nursing and California Children's Services (CCS)  ☐ 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 ________________________
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 ☐
     Diagnóstico (si lo sabe):       fecha de nacimiento          edad                 Sexo:
     (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

Use the form “Summary of Assessment/ Present Levels of Development” (Attachment G) or the Assessment Report Template (Attachment H).
Ventura County Early Start Program
Programa de Servicios de Intervención del Condado de Ventura
Individualized Family Service Plan (IFSP)
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR (IFSP)
SUMMARY OF ASSESSMENT/PRESENT LEVELS OF DEVELOPMENT
RESUMEN DE EVALUACION/NIVELES DE RENDIMIENTO ACTUALES
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/FECHANACIMIENTO: __________________________
Address/Domicilio: __________________________ Chronological Age/Edad Cronológica: __________________________
Phone/Teléfono: __________________________ Adjusted Age/Edad ajustada: __________________________
Date of Assessment(s)/Fecha de evaluación(es): __________________________

Assessment Purpose & Location:
Assessments used/Evaluaciones utilizadas:
Assessor initials/iniciales del evaluador:
_____ Evaluation procedures were selected so as not to be racially or culturally discriminatory. (Los procedimientos de evaluación fueron seleccionados a fin de no ser racial o culturalmente discriminatorios.)
_____ The assessment tools used are considered to be valid for the suspected disability of this child. (Los instrumentos de evaluación utilizados se consideran válidos para la discapacidad que se sospecha de este niño.)
_____ Assessment results appear to be reliable indicators of child’s developmental abilities (or) Los resultados de la evaluación parecen ser indicadores fiables de las capacidades de desarrollo del niño (o)
_____ Although test reliability may have been affected to an unknown degree due to ________________, the results are as reliable as possible. Aunque la fiabilidad de la prueba puede haber sido afectado a un grado desconocido debido a ________________, los resultados son tan fiables como sea posible.

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

SOCIAL/EMOTIONAL DEVELOPMENT/DESARROLLO SOCIAL/EMOCIONAL (how child relates to others/como 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:

Assessor/Asesor: __________________________ Assessor/Asesor: __________________________
Title/Título: __________________________ Title/Título: __________________________
Agency/Agencia: __________________________ Agency/Agencia: __________________________
Child’s Name:  
Birthdate:  
Chronological Age:  
Assessor:  

Date of Report:  
Date of Assessment:  
Parent Name:  
UCI Number:  

Background/Medical Information

Assessment Purpose and Location

Assessment Information

Assessment Results

**Gross Motor:** Refers to large body movements, balance, and coordination. Coordinate motor tasks build the foundation for exploration and learning, and are crucial to the ability to vocalize and speak.

**Perceptual/Fine Motor:** Refers to small body movements, and ability to manipulate items in the environment.

**Cognitive Development:** Refers to the hierarchy of the child’s typical level of play to include attention and exploration, functional understanding of objects, awareness of routines and sequences.

**Communication Development:** Refers to responses and understanding demonstrated by a child to directions and requests that involve actions such as pointing, facial expression, tone of voice and words.

**Adaptive/Self Help:** Refers to the ability to initiate and perform age appropriate tasks moving to independence. This includes maintaining attention and the ability to determine what to attend to and what to screen out, eating patterns, sleeping patterns, self motivation and personal responsibility.

**Social/Emotional Development:** Refers to the ability to form attachment and interact with adults and peers, expression of feelings, affect self-concept, coping and awareness of social role.
Summary

Recommendations

Staff contributing to this report

Early Childhood Special Educator
Name: ___________________________ Phone Number: __________ Email Address: __________

School Psychologist
Name: ___________________________ Phone Number: __________ Email Address: __________

Occupational Therapist
Name: ___________________________ Phone Number: __________ Email Address: __________

Physical Therapist
Name: ___________________________ Phone Number: __________ Email Address: __________

Speech Language Pathologist
Name: ___________________________ Phone Number: __________ Email Address: __________

Deaf/Hard of Hearing Specialist
Name: ___________________________ Phone Number: __________ Email Address: __________

Teacher of Students with Visual Impairments
Name: ___________________________ Phone Number: __________ Email Address: __________

Teacher of Students with Orthopedic Impairments
Name: ___________________________ Phone Number: __________ Email Address: __________
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
2. Developmental delay. The eligibility criteria for deciding if an infant or toddler has a developmental delay are as follows:
   - 0-23 months, a 33% delay in one or more areas
   - 24-36 months, a 50% delay in one area or 33% in two or more areas

The areas of delay are:
- Cognitive development
- Physical and motor development
- Communication development
- 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
   - Mental Retardation
   - Emotional Disturbance
   - Other Health Impairment
   - Multiple Handicaps
   - Traumatic Brain Injury

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

See attached “pocket guide”
Ventura County Early Start Program
STATEMENT OF ELIGIBILITY FOR EARLY START

Name ____________________________ DOB _______________ UCI ____________

REGIONAL CENTER

ELIGIBLE under California Early Intervention Services Act
Reasons (mark and describe)

- Developmental delay:
  - Motor
  - Social/Emotional
  - Communication
  - Cognitive
  - Adaptive/Self Help

- Established risk: Dx _____________________________

  ICD-9 Codes ______________________________________

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<tr>
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<th>Date</th>
<th>Branch Manager or Designee</th>
<th>Date</th>
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<tr>
<td>Physician</td>
<td>Date</td>
<td>Psychologist</td>
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NOT ELIGIBLE
Reasons (describe):

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SCHOOLS

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

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<th>Administrator or Designee</th>
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NOT ELIGIBLE
Reasons (describe):

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<th>Administrator or Designee</th>
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SAMPLE - Only complete for SLI students.
Ventura County Early Start Program
STATEMENT OF ELIGIBILITY FOR EARLY START

<table>
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<tr>
<th>Name</th>
<th>Infant Baby</th>
<th>DOB</th>
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**REGIONAL CENTER**

**ELIGIBLE** under California Early Intervention Services Act

Reasons (mark and describe)

- Developmental delay:
  - ☐ Motor
  - ☐ Communication
  - ☐ Adaptive/Self Help
  - ☐ Social/Emotional
  - ☐ Cognitive

- Established risk: Dx __________________________

ICD-9 Codes __________________________

---

Service Coordinator __________________________ Date ____________
Branch Manager or Designee __________________________ Date ____________

Physician __________________________ Date ____________
Psychologist __________________________ Date ____________

---

**SCHOOLS**

**ELIGIBLE** under California Code of Regulations, Title 5, Sections 3030 and/or 3031

Reasons (describe): Check Handy Pocket Guide, for example: Infant Baby is eligible as a child with an orthopedic impairment and at risk for developmental delay.

---

Service Coordinator __________________________ Date ____________
Administrator or Designee __________________________ Date ____________

Physician __________________________ Date ____________
Psychologist __________________________ Date ____________

---

Sign Here __________________________
Service Coordinator __________________________ Date ____________
Administrator or Designee __________________________ Date ____________

---

NOT ELIGIBLE
Reasons (describe):

---

Service Coordinator __________________________ Date ____________
Branch Manager or Designee __________________________ Date ____________

Physician __________________________ Date ____________
Psychologist __________________________ Date ____________

---

NOT ELIGIBLE
Reasons (describe):

---

Sign Here __________________________
Service Coordinator __________________________ Date ____________
Administrator or Designee __________________________ Date ____________
1) Title 5 3030 disability: HI, VI, SLI, SLP, Autism, MR, ED, D/B, OHI, SOI
   – and –

2) Requires Special Education and services by meeting one of the following:
   a. Significant delay in:
      • cognitive development;
      • physical and motor development, including vision and hearing;
      • communication development;
      • social or emotional development; or
      • adaptive development.
      Significant delay is defined as:
      • Under 24 months: 33 percent delay in one developmental area
      • Over 24 months: either a 50 percent in one developmental area or a 33 percent delay in two or more developmental areas
      – or –
   b. A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

2) Requires Special Education and services by meeting one of the following:
   a. Significant delay in:
      • cognitive development;
      • physical and motor development, including vision and hearing;
      • communication development;
      • social or emotional development; or
      • adaptive development.
      Significant delay is defined as:
      • Under 24 months: 33 percent delay in one developmental area
      • Over 24 months: either a 50 percent in one developmental area or a 33 percent delay in two or more developmental areas
      – or –
   b. A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.
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 one area or 33% delay in 2 areas or 50% delay in one area (over 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 Summary of Services 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 measurable 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 measurable 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 the initial and annual IFSP (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 CASEMIS 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:
- Summary of Early Intervention Services 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 and Hearing Conservation, 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:
       o All About Me binder
       o Enrollment Packet
       o Assessment Report
       o School calendar
       o IFSP paperwork (if SLI)
   Comments:

5. OFFICE
   ____ Complete CASEMIS page and give to CASEMIS 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:
**Ventura County Early Start Program**

*Programa de Servicios de Intervención Temprana del Condado de Ventura*

**INDIVIDUALIZED FAMILY SERVICE PLAN**

*PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR*

**IDENTIFYING INFORMATION (INFORMACIÓN)**

Child’s name / Nombre: ____________________________

Male  |  Female
--- | ---
First (primer)  |  Middle (segundo)  |  Last (apellido)
(masculino)  |  (femenino)

SS# ____________________________  |  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) ____________________________

Mailing address (domicilio) ____________________________

Home phone (teléfono) ____________________________  |  Work phone ____________________________  |  Message phone ____________________________

(de casa)  |  (del trabajo)  |  (para mensajes)

**IFSP TYPE: (tipo de plan)**

☐ Initial (inicial)  |  ☐ Transition Planning (planeamiento de transición)

☐ Annual IFSP (plan anual)  |  ☐ Periodic Review (revisión periódica)

☐ Semi-Annual  |  ☐ Final

☐ [6 months or before]  |  Projected review (revisión proyectada)

☐ Projected annual review

**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)*

<table>
<thead>
<tr>
<th>Service or Activity (servicio o actividad)</th>
<th>Frequency &amp; Amount Intensity (frecuencia y cantidad-intensidad)</th>
<th>Individual or group (individuo o grupo)</th>
<th>Agency and/or Provider (agencia y/o proveedor)</th>
<th>Start/end Dates (fechas de comienzo/fin)</th>
<th>Location + (localidad)</th>
<th>Funding source (origen de financiamiento)</th>
</tr>
</thead>
</table>

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

______________________________
SAMPLE-
Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura
INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

IDENTIFYING INFORMATION (INFORMACION)
Child's name / Nombre

<table>
<thead>
<tr>
<th>Infant</th>
<th>Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>First (primer)</td>
<td>Middle (segundo)</td>
</tr>
<tr>
<td>Male</td>
<td>X</td>
</tr>
</tbody>
</table>

SS# ___________  Birth date (fecha de nacimiento) 5/19/08

Home language (idioma usado en casa)  English  Interpreter needed? (¿Necesita interprete?)  ☑ yes (sí)  ☐ no

Transcribed IFSP needed? (¿Necesita traducción del plan?)  ☑ yes (sí)  ☐ no  Language (idioma) ___________

Parent/Guardian (padre/tutor)  Mom and Dad Baby

Street address (dirección)  1234 Main St. Camarillo, CA 93012

Mailing address (domicilio)  Same as above

Home phone (teléfono)  805-555-1212  Work phone  Message phone

IFSP TYPE: (tipo de plan)  Check appropriate box (Use MM/DD/YY)

☐ Initial (inicial)  ☐ Transition Planning (planeamiento de transición)  This IFSP meeting (esta reunión)  5-19-10

☐ Annual IFSP (plan anual)  ☐ Periodic Review (revisión periódica)  Projected review (revisión)  11-19-10

☐ Semi-Annual  ☐ Final  [6 months or before] (6 meses o antes)

Projected annual review  5-19-11 (revisión anual proyectada)

Service Coordinator  Agency  Your school district  Case Number

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)

<table>
<thead>
<tr>
<th>Service or Activity [Designate type of service] (servicio o actividad-designar un tipo)</th>
<th>Frequency &amp; Amount Intensity (frecuencia y cantidad-intensidad)</th>
<th>Individual or group (individuo o grupo)</th>
<th>Agency and/or Provider (agencia y/o proveedor)</th>
<th>Start/End Dates (fechas de comienzo/fin) (M/D/YY)</th>
<th>Location * (localidad)</th>
<th>Funding source (origen de financiamiento)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Coordination</td>
<td>Ongoing</td>
<td>I</td>
<td>Your school district</td>
<td>5-19-10 – 11-19-10</td>
<td>Phone/ Home Group</td>
<td>Your school district</td>
</tr>
<tr>
<td>Specialized instruction</td>
<td>30 min. 1x a week</td>
<td>I</td>
<td>Your school district</td>
<td>5-19-10 – 11-19-10</td>
<td>Home</td>
<td>Your school district</td>
</tr>
<tr>
<td>Family, Counseling, and home visits</td>
<td>30 min. 1x a week</td>
<td>I</td>
<td>Your school district</td>
<td>5-19-10 – 11-19-10</td>
<td>Home</td>
<td>Your school district</td>
</tr>
<tr>
<td>Infant/Toddler playgroup</td>
<td>Your program time</td>
<td>I</td>
<td>Your school district</td>
<td>5-19-10 – 11-19-10</td>
<td>School Site</td>
<td>Your school district</td>
</tr>
<tr>
<td>Include any referrals made (CCS, Rainbow, Hearing Conservation)</td>
<td>One time only</td>
<td>I</td>
<td>Your school district</td>
<td>5-19-10 – 5-19-10</td>
<td>Home</td>
<td>Your school district</td>
</tr>
</tbody>
</table>

*Justification if not in natural environment (Justifique el porqué de no en un ambiente natural) Access to specialized equipment not available in the home Of parents do not want services in the home.
Child's Name: (Nombre) ____________________________

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

What are your child's strengths? ¿Cuales son las fortalezas de su niño/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 niño/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)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
OUTCOMES AND SERVICES

Child’s Name (nombre): ____________________________ Date of Birth (fecha de nacimiento): ______________

IFSP Type and date (tipo de plan y fecha):

- [ ] Initial (inicial) ______________
- [ ] Semi-Annual (semi-anual) ______________
- [ ] Annual (anual) ______________
- [ ] Transition Planning (plan de transición) ______________
- [ ] Other/Periodic (otro/enmienda) ______________

Note: Use as many copies of this page as necessary to complete all outcomes.

MAJOR OUTCOMES (in parents’ words) / Resultados Mayores (con las palabras de los padres)

ACTION PLAN / METHOD (Criteria, procedures, and time lines to determine progress) / Plan de acción/método (criterio, procedimiento y límite de tiempo para determinar el progreso)

Date (fecha): ______________
(update in parents’ words):
(revisa con las palabras de los padres)

Date (fecha): ______________
(update in parents’ words):
(revisa con las palabras de los padres)

Parent signature or initial (firma del padre ó inicial) ______________

Parent signature or initial (Firma del padre ó inicial) ______________
SAMPLE
Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura
INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

OUTCOMES AND SERVICES
RESULTADOS Y SERVICIOS

Child’s Name (nombre): Infant Baby

Date of Birth (fecha de nacimiento): 5/19/08

IFSP Type and date (tipo de plan y fecha): Check appropriate box and fill in meeting date (M/D/YY)

☐ Initial (inicial) ☐ Semi-Annual (semi-anual) ☐ Annual (anual)
☐ Transition Planning (plan de transición) ☐ Other/Periodic (otro/enmienda)

Note: Use as many copies of this page as necessary to complete all outcomes.

MAJOR OUTCOMES (in parents’ words) / Resultados Mayores (con las palabras de los padres)

We want Infant to play like his friends.

ACTION PLAN / METHOD (Criteria, procedures, and time lines to determine progress) / Plan de acción/método (criterio, procedimiento y límite de tiempo para determinar el progreso)

Infant Baby and family will receive home visits, one time per week to address the following outcomes:

Infant Baby will:

• Cooperatively play ball games with peers
• Engage in finger plays and nursery rhymes
• Propel self forward on tricycle or ride-on-toy

Progress determined by parent/teacher/therapist observation(s) by 11/19/10.

Date (fecha): (update in parents’ words):
(revísela con las palabras de los padres)

When reporting progress at each semi and annual review, copy each previous ‘Outcomes and Services’ page and complete this section using the parent’s words. Have parent sign or initial below. Attach copies to new IFSP.

Date (fecha): (update in parents’ words):
(revísela con las palabras de los padres)

Parent signature or initial (firma del padre ó inicial)

Parent signature or initial (Firma del padre ó inicial)
Child’s Name (Nombre) ___________________________ Birth date (Fecha de nacimiento) ________________________

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 proveiendo 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)

<table>
<thead>
<tr>
<th>Name/ Title (nombre/título)</th>
<th>Agency/ Phone (agencia/teléfono)</th>
<th>Date (fecha)</th>
</tr>
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<tbody>
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</tr>
</tbody>
</table>

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 ___________ pages.
(Tuve la oportunidad de ayudar con el desarrollo de este plan de _______ páginas.)

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

_____ 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) ___________________________
Child's Name (Nombre): Infant Baby
Birth date (Fecha de nacimiento): 5-19-08

MEDICAL SERVICES (servicios médicos):
Child's doctor, insurance provider, etc.

Assistive technology has been considered for this child (Ayuda tecnológica ha sido considerada para este niño/a):
Write N/A -or- if applicable include.

FAMILY SERVICES (servicios familiares):
WIC, church, extended family, etc.

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 proveiendo 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)
Include names of each service provider.

Name/ Title (nombre/título) | Agency/ Phone (agencia/teléfono) | Date (fecha)
--- | --- | ---
Parent(s) | | 5/19/10
Your Name/ SC/ ECSE | Your school district and phone | 5/19/10

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

IFSP FAMILY APPROVAL (aprobación de la familia) Have parent initial individual statements below.

_______ 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 the 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)
<table>
<thead>
<tr>
<th>Name/Nombre</th>
<th>Date/Fecha</th>
</tr>
</thead>
</table>

**FAMILY UPDATE or ADDITIONAL INFORMATION**
(including current resources, priorities and concerns)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
### IFSP SEMI ANNUAL/ANNUAL REVIEW

<table>
<thead>
<tr>
<th>Name</th>
<th>Infant Baby</th>
<th>Date</th>
<th>5-19-10</th>
</tr>
</thead>
</table>

**FAMILY UPDATE or ADDITIONAL INFORMATION**

(including current resources, priorities and concerns)

> Use this page at a review to update current family information, including but not limited to, medical, hearing and vision information.
Ventura County Early Start Program
Programa de Servicios de Intervención del Condado de Ventura
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR (IFSP)

CHANGES OR ADDITIONS
CAMBIOS O ADICIONES

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)
☐ Other:

This IFSP meeting (Esta reunión) (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) ______________________
Child Social Security Number (Número de seguro del niño/a) _________
Child Case Number, if applicable (Número de caso del niño/a, si aplica) _______

IDENTIFYING INFORMATION (DATOS DE IDENTIDAD)

Child’s name (Nombre) ______________________
First (primer) ______________________ Middle (segundo) ______________________ Last (apellido) ______________________
Birth date (Fecha de nacimiento) ______________________ Age (Edad) ______________________ Gender (género) ______________________
Home Language (Idioma usado en casa) ______________________ Interpreter needed? (¿Necesita intérprete?) □ yes (sí) □ no
Parent/Guardian (Padre/tutor) ______________________
Street address (Dirección) ______________________
Mailing address (Domicilio) ______________________
Home phone (Teléfono) ______________________ Work phone (del trabajo) ______________________ Message phone (para mensajes) ______________________

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

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

Comments (Comentarios): ______________________

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)
☐ Moved out of county to (Se mudó fuera del condado hacia): __________
☐ Agency withdrawal (Retiro de la agencia)
☐ Parent withdrawal (Retiro por parte del padre)
☐ Whereabouts unknown (Paradero desconocido)
☐ Transition to (Transición a): ______________________
☐ Other, specify (Otro, especifique) ______________________

Comments (Comentarios): ______________________

K) IFSP CHANGES OR ADDITIONS 2010
<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Signature/or Other Verification of Authorization</th>
<th>Agency</th>
<th>Phone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre / título</td>
<td>Firma / otra forma de verificación</td>
<td>Agencia</td>
<td>Teléfono</td>
<td>Fecha</td>
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</table>

<table>
<thead>
<tr>
<th>Name-Parent(s)</th>
<th>Signature/or Other Verification of Authorization</th>
<th>Phone</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Nombre-padre(s)</td>
<td>Firma / otra forma de verificación</td>
<td>Teléfono</td>
<td>Fecha</td>
</tr>
</tbody>
</table>

**CC:** ________________________________ ________________________________
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 the California Special Education Management Information System (CASEMIS). 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.

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

If any CASEMIS data changes (ie, level of service, primary disability) a CASEMIS 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 PROGRAM – CASEMIS DATA INPUT FORM

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Home phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Father (First, Last)</td>
<td>Employer</td>
</tr>
<tr>
<td>Mother (First, Last)</td>
<td>Employer</td>
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</table>

**LEA Identification**

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

<table>
<thead>
<tr>
<th>District Attending</th>
<th>will default to your District when you start record</th>
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<tbody>
<tr>
<td>District of Residence</td>
<td>________________________________________________</td>
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<table>
<thead>
<tr>
<th>School Type</th>
<th>School Attending</th>
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<tr>
<td>No school (0-5 only) – 00</td>
<td>Marina West Oxnard</td>
</tr>
<tr>
<td>Saticoy EIC Ventura</td>
<td>Justin ELA Simi</td>
</tr>
<tr>
<td>University Preschool Conejo</td>
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</tr>
</tbody>
</table>

**Program Information**

Infant Referral Date
(date of Early Start Inquiry)

<table>
<thead>
<tr>
<th>Infant Referral by</th>
<th>Parent - 10 Teacher-20 Other-90 _____________________</th>
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</thead>
</table>

Infant Parental Consent Date
(date of Parent Consent signed)

Infant Initial Evaluation Date
(date of Initial IFSP meeting)

Early Intervention will be No for all districts

Plan Type
IFSP – 10 Not eligible – 90 Eligible, no IFSP– 80

**Student Demographics**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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SSID (for students transferring in from out of SELPA)

Birthdate

<table>
<thead>
<tr>
<th>mm</th>
<th>dd</th>
<th>yyyy</th>
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</thead>
</table>

Gender
Male Female

Federal Ethnicity
Hispanic Not Hispanic
Race (number from 1 up to 4 on list below)

<table>
<thead>
<tr>
<th></th>
<th>100</th>
<th>Native American</th>
<th>299</th>
<th>Other Asian</th>
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<tr>
<td></td>
<td>201</td>
<td>Chinese</td>
<td>301</td>
<td>Hawaiian</td>
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<td></td>
<td>202</td>
<td>Japanese</td>
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<td>Guamanian</td>
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<td>203</td>
<td>Korean</td>
<td>303</td>
<td>Samoan</td>
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<td>204</td>
<td>Vietnamese</td>
<td>304</td>
<td>Tahitian</td>
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<td>205</td>
<td>Asian Indian</td>
<td>399</td>
<td>Other Pacific Islander</td>
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<td></td>
<td>206</td>
<td>Laotian</td>
<td>400</td>
<td>Filipino</td>
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<td></td>
<td>207</td>
<td>Cambodian</td>
<td>600</td>
<td>African-American</td>
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<tr>
<td></td>
<td>208</td>
<td>Hmong</td>
<td>700</td>
<td>White</td>
</tr>
</tbody>
</table>

EL Type      EO       EL (if Primary Language other than English)

Primary Language (from Early Start Inquiry)

Special Education

Migrant      Yes   No

Residential Status  Parent-10  LCI-20  Foster Family-30
                   Hospital-40  Other-90

Entry Date (date of Initial IFSP)

Last IEP Date (date of last IFSP)

Last Evaluation Date (date of last IFSP mtg. when Eligibility form was determined)

Disability (put 1 for primary, 2 for secondary)

<table>
<thead>
<tr>
<th></th>
<th>200</th>
<th>None (for secondary only)</th>
<th>280</th>
<th>Other Health Impairment (OHI)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>210</td>
<td>Intellectual Disability (ID)</td>
<td>281</td>
<td>Established Medical Disability (EMD) (3 and 4 year olds only)</td>
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<tr>
<td></td>
<td>220</td>
<td>Hard of Hearing (HH)</td>
<td>290</td>
<td>Specific Learning Disability (SLD)</td>
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<tr>
<td></td>
<td>230</td>
<td>Deafness (DEAF)</td>
<td>300</td>
<td>Deaf-Blindness (DB)</td>
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<tr>
<td></td>
<td>240</td>
<td>Speech or Language Impairment (SLI)</td>
<td>310</td>
<td>Multiple Disability (MD)</td>
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<tr>
<td></td>
<td>250</td>
<td>Visual Impairment (VI)</td>
<td>320</td>
<td>Autism (AUT)</td>
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<tr>
<td></td>
<td>260</td>
<td>Emotional Disturbance (ED)</td>
<td>330</td>
<td>Traumatic Brain Injury (TBI)</td>
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<td></td>
<td>270</td>
<td>Orthopedic Impairment (OI)</td>
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</tbody>
</table>

Solely Low Incidence Disability      Yes   No

Infant Setting  DIS-21  RSP-22  SDC-23

Federal Infant Setting (circle one only)  Home-100  Community Setting-200 (daycare)  Other Setting-900 (playgroup)

Percent of Time in Regular Ed Programs  Leave blank (for ages 3 to 22 only)

Grade  Infant – 16

Special Transportation (to Early Start services)  Yes   No

Parent Input  Participatio Field Names
      Yes   “Not to participate” for all areas
## Student Services Data

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Location</th>
<th>Frequency</th>
<th>Minutes</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
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</table>

See Chart on next page for options
### Options/Combinations for Infant Toddler Services

<table>
<thead>
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<th>Service</th>
<th>Provider</th>
<th>Location</th>
<th>Frequency</th>
<th>Minutes</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>(0-2 only) Family training, counseling, and home visits</td>
<td>District of Service</td>
<td>Home instruction based on IEP</td>
<td>Weekly</td>
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<td>Other public program</td>
<td>based on IEP</td>
<td>Monthly</td>
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<td>Team determination (not medical)</td>
<td>Yearly</td>
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<td>(0-2 only) Medical services (for evaluation only) - 220</td>
<td>Regional Center CCS</td>
<td>Service Provider location – 890</td>
<td>Weekly</td>
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<td></td>
<td>SELPA</td>
<td>Home - 210</td>
<td>Monthly</td>
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<td></td>
<td></td>
<td></td>
<td>Yearly</td>
<td></td>
<td></td>
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<td>(0-2 only) Nutrition services - 230</td>
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<td>Home - 210</td>
<td>Weekly</td>
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<td></td>
<td>Regional Center</td>
<td></td>
<td>Monthly</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Yearly</td>
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<td>(0-2 only) Service coordination - 240</td>
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<td>Weekly</td>
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<td>Regional Center</td>
<td></td>
<td>Monthly</td>
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<td></td>
<td></td>
<td>Yearly</td>
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<td>(0-2 only) Special instruction - 250</td>
<td>District of Service</td>
<td>Home – 210</td>
<td>Weekly</td>
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<td></td>
<td>Other public program</td>
<td>Service Provider location – 900</td>
<td>Monthly</td>
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<td>Any other location or setting - 900</td>
<td>Yearly</td>
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<td>(0-2 only) Respite care services - 270</td>
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<td>Home – 210</td>
<td>Weekly</td>
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<td>Regional Center</td>
<td>Service Provider location – 890</td>
<td>Monthly</td>
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<td>Any other location or setting - 900</td>
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<tr>
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<td>Weekly</td>
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<td>SELPA</td>
<td>Monthly</td>
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<td></td>
<td>Regional Center</td>
<td>Yearly</td>
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<td>Speech and Language – 415</td>
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<tr>
<td>Occupational therapy – 450</td>
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<tr>
<td>Physical therapy – 460</td>
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<td>Health &amp; Nursing - other services – 436</td>
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<td>Specialized services for low incidence disabilities – 610</td>
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<td>Specialized deaf and hard of hearing services – 710</td>
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<td>Audiological services – 720</td>
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<td>Specialized vision services - 725</td>
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</tbody>
</table>
**VENTURA COUNTY SELPA EARLY START PROGRAM – CASEMIS DATA UPDATE FORM**

Enter student’s name and DOB for all students. Enter other information only if changed.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>DOB</th>
<th>Home phone</th>
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<tbody>
<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Zip</td>
<td></td>
<td></td>
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<tr>
<td>Father (First, Last)</td>
<td>Employer</td>
<td>Phone</td>
</tr>
<tr>
<td>Mother (First, Last)</td>
<td>Employer</td>
<td>Phone</td>
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</table>

**LEA Identification**

<table>
<thead>
<tr>
<th>District Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Residence</td>
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<table>
<thead>
<tr>
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<th>Marina West</th>
<th>Saticoy EIC</th>
<th>Justin ELA</th>
<th>University Preschool</th>
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<tbody>
<tr>
<td>Oxnard</td>
<td>Ventura</td>
<td>Simi</td>
<td>Conejo</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Student ID # (if known)</th>
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</table>

**Program Information**

| Plan Type | IFSP – 10 | Not eligible – 90 | Eligible, no IFSP– 80 |

**Special Education**

<table>
<thead>
<tr>
<th>Migrant</th>
<th>Yes</th>
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<tr>
<td>Residential Status</td>
<td>Parent-10</td>
<td>LCI-20</td>
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<td>Hospital-40</td>
<td>Other-90</td>
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<table>
<thead>
<tr>
<th>Last IEP Date (date of last IFSP)</th>
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</table>

<table>
<thead>
<tr>
<th>Last Evaluation Date</th>
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</thead>
<tbody>
<tr>
<td>(date of last IFSP mtg. when Eligibility form was determined)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability (put 1 for primary, 2 for secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 None (for secondary only)</td>
</tr>
<tr>
<td>210 Intellectual Disability (ID)</td>
</tr>
<tr>
<td>220 Hard of Hearing (HH)</td>
</tr>
<tr>
<td>230 Deafness (DEAF)</td>
</tr>
<tr>
<td>240 Speech or Language Impairment (SLI)</td>
</tr>
<tr>
<td>250 Visual Impairment (VI)</td>
</tr>
<tr>
<td>260 Emotional Disturbance (ED)</td>
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<tr>
<td>270 Orthopedic Impairment (OI)</td>
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</table>

<table>
<thead>
<tr>
<th>Solely Low Incidence Disability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

| Infant Setting | DIS-21 | RSP-22 | SDC- 23 |

<table>
<thead>
<tr>
<th>Federal Infant Setting (circle one only)</th>
<th>Home-100</th>
<th>Community Setting-200</th>
<th>Other Setting-900</th>
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</thead>
</table>
Special Transportation (to Early Start services)  Yes  No

**Student Services Data**

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Location</th>
<th>Frequency</th>
<th>Minutes</th>
<th>Start Date</th>
<th>End Date</th>
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<td></td>
</tr>
</tbody>
</table>

See Chart on next page for options
### Options/Combinations for Infant Toddler Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Location</th>
<th>Frequency</th>
<th>Minutes</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0-2 only) Family training, counseling, and home visits - 210</td>
<td>District of Service</td>
<td>Home instruction based on IEP Team determination (not medical) - 210</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other public program</td>
<td></td>
<td>Monthly</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-2 only) Medical services (for evaluation only) - 220</td>
<td>Regional Center</td>
<td>Service Provider location – 890</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCS</td>
<td>Home - 210</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SELPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-2 only) Nutrition services - 230</td>
<td>SELPA</td>
<td>Home - 210</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-2 only) Service coordination - 240</td>
<td>District of Service</td>
<td>Home - 210</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-2 only) Special instruction - 250</td>
<td>District of Service</td>
<td>Home – 210</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other public program</td>
<td>Service Provider location – 900</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any other location or setting - 900</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-2 only) Respite care services - 270</td>
<td>SELPA</td>
<td>Home – 210</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Center</td>
<td>Service Provider location – 890</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any other location or setting - 900</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various related services as needed (see below)</td>
<td>District of Service</td>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SELPA</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Center</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Speech and Language – 415
Occupational therapy – 450
Physical therapy – 460
Health & Nursing - other services – 436
Specialized services for low incidence disabilities – 610
Specialized deaf and hard of hearing services – 710
Audiological services – 720
Specialized vision services - 725
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.
### Ventura County EARLY START PROGRAM

**TRANSITION PLAN**

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).

<table>
<thead>
<tr>
<th>Date/Fecha</th>
<th>DOB/FDN</th>
<th>UCI #</th>
<th>SSN#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Male/Masculino
- Female/Femenino

| Address/Domicilio: | |

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

| 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  
- 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?

____________________________________________________________________________________________________

____________________________________________________________________________________________________

School District/district 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 día: ____________________________

☐ 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 realizará (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/teléfono: ____________ 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/Yo 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 comparten 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: _________________

Regional Center 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/Título/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  ☐ Notification only referral

Attach:  * IFSP

* Progress notes

* Current assessments

* Transition plan

Attach:  * This cover sheet only
SAMPLE- Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura

TRANSITION PLAN
PLAN DE TRANSICIÓN

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 y para discutir opciones de servicios que sean necesarias y apropiadas cuando el niño(a) cumple tres años de edad.

Date/Fecha: 1/24/10  DOB/FDN: 5-19-08  UCI #:  SSN#:  Male/Masculino  Female/Femenino
Child’s Name/Nombre del Niño: Infant Baby
Address/Domicilio: 1234 Main St. Camarillo, CA 93012
Parent/Guardian/Padres/Guardian/Padre de Crianza: Mom and Dad Baby
Home Phone/Telefono del hogar: 805-555-1212  Work Phone/Telefono de trabajo: 
Home Language/Lenguaje de la familia: English
School District/Distrito Escolar: Your school district
Service Coordinator/Agency/Coordinadora de Servicios: Your name  Phone/Telefono: Your phone number
Transition booklet provided/Folleto de trancisión proveido:  Yes/  No
Date of Initial IFSP/Fecha de IFS Inicial

Give “What”s Next After Early Start”
☐ Parent declined school district attendance/Padre rechazo la asistencia del distrito escolar

1. Current Early Start services, including provider/Servicios de Comienzo Temprano actuales, incluyendo el proveedor: List current services and providers.

2. Child’s strengths/Fortalezas del niño: List the child’s strengths using parent input.

3. Areas of concern related to transition and where skills are needed (home, community, daycare/preschool)/Areas de preocupación relacionadas con la transición y habilidades necesarias (hogar, comunidad, guardería, preescola): List the concerns that the parent may have.

4. Family’s plans for age three services/activities/Planes familiares para servicios/actividades de tres años. Address any anticipated gaps in service (summer vacation, family trips)/Identifique cualquier intervalo anticipado en servicios (vacaciones de verano, viajes familiares): List child’s activities such as preschool plans, community plans (such as Park and Recreation, NFL, other activities). List any anticipated gaps if school is not in session when child is turning 3 or mention if family will be unavailable.

5. Special health care needs (medications, equipment, vision and hearing)/Necesidades medicas (medicamentos, equipo medico, vision y audición): Hearing/ vision results. List any medications. Discuss general health. Address any equipment that may be used.

6. Program options discussed/Opciones de programas discutidas: Any programs that are discussed at this meeting may be listed here.

7. Eligibility for age three services (Elegibilidad para servicios después de los tres años): Does the family want assessment for public school special education eligibility at age 3? (¿La familia quiere evaluación por medio de la escuela pública para elegibilidad de servicios especiales?)
School District of Residence (Distrito escolar en su área residencial): District in which child resides.
Select one:
☐ Referral to district made today  ☐ Referral to be sent to district no later than: Fill in if applicable
(Referencia al distrito hecha hoy)  (Referencia debe ser enviada al distrito antes de) 
School District Contact Person (Contacto del distrito escolar): Name of Contact

Phone (Teléfono): Contact’s phone number Email (Correo electrónico): Email of contact person

Individualized Education Program (IEP) team meeting to be held by: Child’s third birthday.

If parent wants the service coordinator to attend, please complete.

☐ Please invite my Early Start Service Coordinator to the IEP meeting. (Por favor de invitar a mi coordinadora de servicios a la junta del IEP)

Service Coordinator’s Email (Correo electrónico de mi coordinadora):

Additional follow-up steps (if any, i.e. other data to be gathered, immunization records, medical records, appointments, etc.)
Adicionales medidas de seguimiento (si algo. e.j. otra información que tiene que ser documentada, registro de vacunas, expediente medico, citas, etc.):

i.e. Need 2 forms of proof of residence (such as utility bills), Copy of birth certificate, etc.

If applicable, please complete.

Does the family want assessment for Regional Center eligibility at age 3? ☐ Yes ☐ No

(¿La familia quiere evaluación para elegibilidad de servicios por el Centro Regional después de los 3 años? ☐ Sí ☐ No)

Areas of Assessment (Áreas de evaluación):

Who will contact parent (Quien se pondrá en contacto con los padres):

Phone (Teléfono): By When (Antes de):

Individual Program Plan (IPP) meeting to be held by (La reunión del Plan Individualizado del Programa (IPP) será):

Additional follow-up steps (if any, i.e. other data to be gathered, immunization records, medical records, appointments, etc.)
Adicionales medidas de seguimiento (si algo. e.j. otra información que tiene que ser documentada, registro de vacunas, expediente medico, citas, etc.):

8. Referral to Multidisciplinary, Multiagency Team Assessment (MMTA) ☐ Yes ☐ No Discuss with SC, (Referencia al Equipo Multidisciplinario, Evaluación por Varias Agencies (MMTA) ☐ Sí ☐ No if appropriate.

9. General notes (Notas generales):

10. Agreement to proceed (Acuerdo para proceder): Parent to complete this section.

☐ I have participated in developing this 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 agencias indicadas para que sigan adelante con este plan conmigo.)
☐ I give permission for the schools and Regional Center to share information and assessments that are needed to determine eligibility of my child at age 3 (Doy permiso al 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.)

11. Signed (Firma):

Parent/Guardian/Surrogate Parent(s) Date (Fecha)
(Padres/Guardian, Padres de Crianza)

Regional Center Service Coordinator (Coordinadora de Servicios del Centro Regional):

School District Representative (Representante del Distrito Escolar):

Title/Agency (Título/Agencia):

☐ Present (Presente) ☐ Participated via telephone (Participo por teléfono)

Participant (Participante):

Title/Agency (Título/Agencia):

Family would like a referral to Rainbow Connection Family Resource Center ☐ Yes (Sí) ☐ No

(La familia gustaría una referencia al Centro de Conexión de Recursos Familiares) Check appropriate box.
VENTURA COUNTY EARLY START PROGRAM
Referral from Early Start Program to School District
for Special Education Assessment

From: Regional Center Office  □ TCRC Oxnard  □ TCRC Simi Valley  □ North LA County

To: ____________________________________  School District: ____________________________________

Name of Child: ___________________________________________________________________________

Date of Birth: __________________________

Name of Early Start Service Coordinator: ______________________________________________________

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 Attach:
  * IFSP
  * Progress notes
  * Current assessments
  * Transition plan

□ Notification only referral Attach:
  * This cover sheet only

□ Intake referral Attach:
  * ES Inquiry
  * ES interview
  * Consent Form

□ Inquiry referral Attach:
  * ES Inquiry
From: Regional Center Office  □ TCRC Oxnard  ☑ TCRC Simi Valley  □ North LA County

To:  _Program Specialist__________  School District:  _Your School District__________

Name of Child:  Infant Baby

Date of Birth:  5-19-08

Name of Early Start Service Coordinator:  _Your Name______________________________

Family’s primary language:  _English______________________________

Interpreter needed?  □ Yes  ☑ No

Parent Name(s):  _Mom and Dad Baby__________________________________________

Address:  1234 Main St._____________________________________________________

City:  _Camarillo_________________________  Zip:  93010_________________________

Home phone:  805-555-5555  Cell phone:  805-555-1212  E-mail address:  heyyou@email.com

Did School District representative attend Transition IFSP?

☑ Yes Name:  _School Psychologist____________________________________________

□ No explain why: _______________________________________________________________________

Date sent:  11-24-10

For School District use only: Date received: _________________________________

PLEASE INDICATE TYPE OF REFERRAL PACKET:

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

□ Notification only referral  Attach:  
   * This cover sheet only

□ Intake referral  Attach:  
   *ES Inquiry
   *ES Interview
   *Consent Form

□ Inquiry referral  Attach:  
   * ES Inquiry
Three Year Old Transition Checklist for School District “Part B” Preschool Assessment Staff

Child’s Name: ____________________________    DOB: _______________

TCRC Service Coordinator: ________________________________________________

Service Coordinator Phone: _______________    Email: ______________________

School district staff should carefully document the following important dates and retain copies of the forms noted:

1. Date contacted for a Transition IFSP meeting by Regional Center Service Coordinator: __________________________
2. Date of district attendance at Transition IFSP Meeting: ____________________
   (School district may participate by teleconference if parent agrees)
   (Copy of Transition IFSP Form with School District Signature)
3. Date referral received: _________________________
   (Copy of Referral Form with date received stamped or initialed)
4. Date of Notice of Special Education Referral Sent:____________________
   (Copy of Notice of Referral)
5. Date Assessment Plan sent and received from parents:
   Sent: ____________________    *Received: ____________________
   (Copy of signed Assessment Plan)
   or
6. Date Prior Written Notice sent: ______________________
   (Copy of Prior Written Notice)

Note reason timeline delayed (if any)

☐ Parent did not make child available for assessment
☐ School Holiday in excess of 5 days/Break between school sessions (only allowed if Intake Inquiry received by Early Start within 45 days of child’s 3rd birthday)
☐ Other ____________________________

7. Date IEP Meeting scheduled: __________________________
   (Copy of signed IEP Meeting Notice)
8. *Date IEP Meeting held: __________________________
   (Copy of Initial IEP)

Name and Title of person completing this form: ____________________________________________
Your Child’s Transition from the Early Start Program to Public School Services

When your child is between 2 years, 3 months old and 2 years, 9 months old, a transition IFSP meeting will be held. The school district representative must attend (by phone or in person) unless you say no. Special education eligibility and possible services will be discussed. You will decide if you want a referral made for assessment for Special Education services at age 3. The team will decide when the referral will be made. (No later than 2 years 9 months)

If you do Not want a referral, information only (name, phone, address) will be sent to the district

If you Do want a referral, a referral packet will be sent including IFSP and Assessment Reports

School District will call for more information, if necessary

If the district decides to assess: Assessment Plan indicating areas to be assessed will be given to you

You must sign the Assessment Plan before assessment can start

District Team assesses

If Special Education eligible, services begin immediately, or, if summer, on first day of new school year.

If Not Special Education eligible, you can appeal*

If the district does Not decide to assess: Notice to Parent of Action that the district will not be assessing will be given to you (reasons might be that there is no suspected disability or you do not want the assessment).

You can appeal*

Within 15 days of referral

Within 60 days of signed Assessment plan or by 3 yrs old (whichever comes first)
<table>
<thead>
<tr>
<th>ATTENTION</th>
<th>DISTRICT</th>
<th>SITE</th>
<th>ADDRESS</th>
<th>CITY/ZIP</th>
<th>PHONE</th>
<th>FAX</th>
<th>E-MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIJ KOVOOR</td>
<td>BRIGGS</td>
<td>OLIVELANDS SCHOOL</td>
<td>12465 FOOTHILL RD.</td>
<td>SANTA PAULA, CA 93060</td>
<td>933-2254</td>
<td>933-1111</td>
<td><a href="mailto:bkvoor@vcoe.org">bkvoor@vcoe.org</a></td>
</tr>
<tr>
<td>SHANE CRAVEN, COORDINATOR</td>
<td>CONEJO VALLEY UNIFIED SCHOOL DISTRICT</td>
<td>UNIVERSITY CENTER</td>
<td>2801 ATLAS AVE.</td>
<td>THOUSAND OAKS, CA 91362</td>
<td>492-4051</td>
<td>241-4346</td>
<td><a href="mailto:scraven@conejoysd.org">scraven@conejoysd.org</a></td>
</tr>
<tr>
<td>SUSAN HERSH, PSYCHOLOGIST</td>
<td>FILLMORE UNIFIED SCHOOL DISTRICT</td>
<td>P.O. BOX 697</td>
<td>FILLMORE CA 93016</td>
<td>524-6029</td>
<td>524-6081</td>
<td><a href="mailto:shersh@fillmoreusd.org">shersh@fillmoreusd.org</a></td>
<td></td>
</tr>
<tr>
<td>ESTELA MACIAS, PROGRAM SPECIALIST</td>
<td>HUENEME SCHOOL DISTRICT</td>
<td>DISTRICT OFFICE</td>
<td>205 NORTH VENTURA ROAD</td>
<td>PORT HUENEME, CA 93041</td>
<td>488-3588</td>
<td>X9243</td>
<td><a href="mailto:emacias@hueneme.org">emacias@hueneme.org</a></td>
</tr>
<tr>
<td>JOY EPSTEIN (IFSP’S ONLY), PROGRAM SPECIALIST</td>
<td>HUENEME SCHOOL DISTRICT</td>
<td>DISTRICT OFFICE</td>
<td>205 NORTH VENTURA ROAD</td>
<td>PORT HUENEME, CA 93041</td>
<td>488-3588</td>
<td>X9244</td>
<td><a href="mailto:jepstein@hueneme.org">jepstein@hueneme.org</a></td>
</tr>
<tr>
<td>VALERIE LOUTHIAN</td>
<td>LAS VIRGENES UNIFIED SCHOOL DISTRICT</td>
<td>BUTTERCUP SCHOOL</td>
<td>6098 REYES ADOBE RD.</td>
<td>AGOURA HILLS, CA 91301</td>
<td>818-597-2153</td>
<td>597-2156</td>
<td><a href="mailto:vlouthian@lvusd.org">vlouthian@lvusd.org</a></td>
</tr>
<tr>
<td></td>
<td>MESA UNION SCHOOL DISTRICT</td>
<td>3901 NORTH MESA SCHOOL ROAD</td>
<td>SOMIS, CA 93066</td>
<td>485-1411</td>
<td>445-4387</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JAN VAN ATTA, PSYCHOLOGIST</td>
<td>MOORPARK UNIFIED SCHOOL DISTRICT</td>
<td>EARLY CHILDHOOD CTR.</td>
<td>240 FLORY AVENUE</td>
<td>MOORPARK, CA 93021</td>
<td>531-6466</td>
<td>X7095</td>
<td><a href="mailto:ivanatta@mrpk.org">ivanatta@mrpk.org</a></td>
</tr>
<tr>
<td>CRISTINA IBARBARIA</td>
<td>MUPU</td>
<td>MUPU SCHOOL</td>
<td>4410 N. OJAI RD.</td>
<td>SANTA PAULA, CA 93060</td>
<td>525-6111</td>
<td></td>
<td><a href="mailto:cibarbia@vcoe.org">cibarbia@vcoe.org</a></td>
</tr>
<tr>
<td>JENNIFER GOLDEN, PROGRAM SPECIALIST</td>
<td>OAK PARK UNIFIED SCHOOL DISTRICT</td>
<td>DISTRICT OFFICE</td>
<td>5801 EAST CONIFER STREET</td>
<td>OAK PARK, CA 91377</td>
<td>818-735-3224</td>
<td>818-735-3243</td>
<td><a href="mailto:jgolden@opusd.org">jgolden@opusd.org</a></td>
</tr>
<tr>
<td>ALICIA PENA-ALCANTAR, PSYCHOLOGIST</td>
<td>OCEAN VIEW SCHOOL DISTRICT</td>
<td>LAGUNA VISTA</td>
<td>4200 OLDS RD.</td>
<td>OXNARD, CA 93033</td>
<td>488-3638</td>
<td>986-6797</td>
<td><a href="mailto:aalcantar@oceanview.org">aalcantar@oceanview.org</a></td>
</tr>
<tr>
<td>EMILY OTELSBERG, PSYCHOLOGIST</td>
<td>OJAI UNIFIED SCHOOL DISTRICT</td>
<td>P.O. BOX 878</td>
<td>OJAI, CA 93024</td>
<td>640-4300, 640-4447</td>
<td></td>
<td><a href="mailto:eotelsberg@ojaiusd.org">eotelsberg@ojaiusd.org</a></td>
<td></td>
</tr>
<tr>
<td>MARY TRUAX, MANAGER, SPECIAL EDUCATION</td>
<td>OXNARD ELEMENTARY SCHOOL DISTRICT</td>
<td>EDUCATION SERVICE CTR</td>
<td>1051 SOUTH ‘A’ STREET</td>
<td>OXNARD, CA 93030</td>
<td>385-1501</td>
<td>X2174</td>
<td><a href="mailto:mtruax@oxnardsd.org">mtruax@oxnardsd.org</a></td>
</tr>
<tr>
<td>LORI BOWE, PSYCHOLOGIST</td>
<td>PLEASANT VALLEY SCHOOL DISTRICT</td>
<td>DISTRICT OFFICE/ PEEP</td>
<td>600 TEMPLE AVENUE</td>
<td>CAMARILLO, CA 93010</td>
<td>445-8676</td>
<td>445-8808</td>
<td><a href="mailto:lbowe@pvhs.k12.ca.us">lbowe@pvhs.k12.ca.us</a></td>
</tr>
<tr>
<td>MEAGAN GUENTHER, PSYCHOLOGIST</td>
<td>RIO SCHOOL DISTRICT</td>
<td>2500 VINEYARD AVENUE</td>
<td>OXNARD, CA 93036</td>
<td>485-1442</td>
<td></td>
<td><a href="mailto:mguenther@rioschools.org">mguenther@rioschools.org</a></td>
<td></td>
</tr>
<tr>
<td>KRISTI GROOMS, STUDENT SUPPORT SERVICES SPECIALIST</td>
<td>SANTA CLARA</td>
<td>SANTA CLARA</td>
<td>20030 E. TELEGRAPH ROAD</td>
<td>SANTA CLARA, CA 93060</td>
<td>525-4573</td>
<td>525-4985</td>
<td><a href="mailto:kgrooms@santapaulaunified.org">kgrooms@santapaulaunified.org</a></td>
</tr>
<tr>
<td>ERIN MACINTYRE, PSYCHOLOGIST, PROGRAM SPECIALIST</td>
<td>SIMI VALLEY UNIFIED SCHOOL DISTRICT</td>
<td>JUSTIN ELA</td>
<td>101 W COCHRAN ST</td>
<td>SIMI VALLEY, CA 93065</td>
<td>520-6619</td>
<td>X3105</td>
<td><a href="mailto:erin.macintyre@simivalleysd.org">erin.macintyre@simivalleysd.org</a></td>
</tr>
<tr>
<td>KIM CHARNOFSKY</td>
<td>SOMIS UNION</td>
<td>SOMIS ELEM</td>
<td>5268 NORTH ST.</td>
<td>SOMIS, CA 93066</td>
<td>386-5711</td>
<td>386-2324</td>
<td><a href="mailto:Kim.charnofsky@staff.somisusd.org">Kim.charnofsky@staff.somisusd.org</a></td>
</tr>
<tr>
<td>KELLY MCNELIS SCHRODER, PROGRAM SPECIALIST/SCHOOL PSYCHOLOGIST</td>
<td>VENTURA UNIFIED SCHOOL DISTRICT</td>
<td>EARLY INTERVENTION CENTER</td>
<td>10731 DARLING ROAD</td>
<td>VENTURA, CA 93004</td>
<td>672-2705, X2206</td>
<td>672-0427</td>
<td><a href="mailto:Kelly.McnelisSchroder@venturasd.org">Kelly.McnelisSchroder@venturasd.org</a></td>
</tr>
</tbody>
</table>

**Ventura County SELPA Preschool Referral Contacts**
CONTRACTS

The school district ECSE can arrange for services such as respite, transportation, or nutrition for families of Solely Low Incidence children, if needed. See attached memos for guidelines for transportation and respite. The ECSE must submit the information in writing to the SELPA Secretary, so that a contract can be drawn up.

The information necessary for a respite, nutrition or transportation contract is:
1. Name and birth date of child.
2. Address and phone number of child/family.
3. Name of provider of service.
4. Address of provider.
5. For transportation: the anticipated number of miles per month, and the reimbursed cost per mile (based on SELPA rates).
6. For respite and nutrition: the approved number of hours per month, and the reimbursed cost per hour (based on SELPA rates).
7. A copy of the IFSP. The services must be listed on the Summary of Early Intervention Services page. The funding source will be the Ventura County SELPA.

In general, the standard of service for respite care is 4 to 8 hours per week, to be determined by the ECSE based on the child/family’s need. Respite may only be provided to free up the family to attend an Early Intervention Service such as parent education activities. The family will select the respite care provider and receive funds to reimburse him/her. A child with significant medical needs may require a skilled respite provider. The number of hours per week may increase or decrease, as would the rate. If the family does not have a skilled respite care provider in mind, one can be obtained through a contract that SELPA maintains with a nursing association. Certified nursing assistants and skilled nurses are available (check hourly reimbursement rate with SELPA).

The standard of service for transportation varies according to the child’s needs. Transportation reimbursement may only be applied toward costs related to the infant attending an Early Intervention service, which would include therapies provided by CCS or private agencies, play group, etc. The service must be listed on the Summary of Services page of the IFSP. Mileage reimbursement can be determined by estimating the number of miles the family travels each month to address the child’s needs, and reimbursed at the rate currently allowed by the Ventura County Office of Education.

When the contract is written, copies will be sent to the ECSE, the family, and the service provider. The service provider must submit a signed invoice stating the dates and hours that the service was provided (See sample). This invoice can be submitted once a month, and no later than the end of the contract period or June 10, whichever comes first. The ECSE must sign the invoice and have the School District Coordinator or Director sign it. The ECSE must make a copy to keep in the child’s file before sending the invoice to the SELPA Director for a signature.

Fingerprinting for service providers is mandatory, with the exception of parents who are being reimbursed for costs. Service providers who are already under contract to SELPA have complied with the fingerprinting requirements (nutrition, skilled nursing, respite). No contract funds will be paid until the fingerprinting process is completed and results are obtained.
May 20, 2010

To: Early Start Families being served by Ventura County SELPA School Districts

Subject: Changes in availability of transportation services as of July 1, 2010

This is to inform you of changes to availability of reimbursement for transportation services for Early Start families served by SELPA School Districts. Due to budgetary concerns at both the state and federal level, school districts and regional centers are required to be more careful about services that are to be legally provided. Two sources of law:

“Transportation and Related Costs includes the cost of travel (e.g., mileage, or travel by taxi, common carrier or other means) and other costs (e.g., tolls and parking expenses) that are necessary to enable a child eligible under this parent and the child’s family to receive early intervention services.” (Emphasis added)
34 Code of Federal Regulations Part 303 Section 303.12 (d)(15)

“An early intervention service is defined as (a service that) is provided or purchased through the regional center, local educational agency, or other participating agency. The State Department of Health Services, State Department of Social Services, State Department of Mental Health, and State Department of Alcohol and Drug Programs shall provide services in accordance with state and federal law...."
Title 14, California Early Intervention Services Act, Section 95020 (e) (1)

Therefore, starting July 1, 2010, your School District Service Coordinator will only be allowed to authorize transportation costs related to your child attending an Early Intervention Service, which would include therapies provided by CCS or private agencies, play group, etc. We will no longer be able to reimburse you for costs related to traveling to medical appointments.
This Services Agreement (the "Agreement") is made and entered into this ______ day of _________________, 20___, by and between Ventura County Office of Education (hereinafter referred to as "Superintendent") and Provider (hereinafter referred to as "Provider").

Provider desires to engage Provider services as more particularly described on "Statement of Work" which is attached hereto and incorporated herein by this reference ("Services").

Provider has the necessary qualifications by reason of training, experience, preparation and organization, and is agreeable to performing and providing such Services, upon and subject to the terms and conditions as set forth below in this Agreement.

NOW THEREFORE, for valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. CONDITIONS. Provider will have no obligation to provide Services until Superintendent returns a signed copy of this Agreement.

2. NATURE OF RELATIONSHIP. The parties agree the relationship created by this Agreement is that of independent contractor. In performing all of the Services, Provider shall be, and at all times is, acting and performing as an independent contractor with Superintendent, and not as a partner, coventurer, agent, or employee of Superintendent, and nothing contained herein shall be construed to be inconsistent with this relationship or status, and is not granted any right or authority to assume or create any obligation or responsibility, express or implied, on behalf of or in the name of Superintendent or to bind the Superintendent in any manner or for any purpose.

3. NON-EXCLUSIVITY.
   a. During the term of this Agreement, Provider may independently or in conjunction with any other entity, provide similar or comparable services to any third party.
   b. During the term of this Agreement, the Superintendent may, independent of Provider's relationship with the Superintendent, without breaching this Agreement or any duty owed to the Superintendent, act in any capacity, and may render services for any other entity.

4. SERVICES. Provider shall provide Superintendent with the Services, which are described on the "Statement of Work" (reference page 5). The Statement of Work shall set forth the mutually agreed schedule for providing such services. Provider shall use its best efforts to complete all phases of the Work according to such timetable.

5. STORED STUDENT DATA. Information Technology Requirements are described on Attachment A; attached hereto and incorporated herein by this reference. In the event an independent contractor or third party captures or stores student data, please review the attachment of the terms of service and provider documentation as to how either contractor or third party complies with Family Educational Rights and Privacy Act (FERPA) and AB1584.

6. TIME OF PERFORMANCE. The term of this Agreement shall commence on _____________, 20___, and terminate on _____________, 20___.

7. PAYMENT AND EXPENSES. All payments due to Provider are set forth in the "Schedule of Fees" attached hereto and incorporated herein by this reference. All payments due to Provider are set forth in "Schedule of Fees" and shall be paid by the Superintendent within 30 days of receipt of a proper invoice from Provider, which invoice shall set forth in reasonable detail the Services performed. The Superintendent reserves the right, in its sole and absolute discretion, to reject any invoice that is not submitted in compliance with the Superintendent’s standards and procedures. In the event that any portion of an invoice submitted by a Provider to the Superintendent is disputed, the Superintendent shall only be required to pay the undisputed portion of such invoice at that time, and the parties shall meet to try to resolve any disputed portion of any invoice. The rates set forth in "Schedule of Fees" are not set by law, but are negotiated between Superintendent and Provider whereby the Superintendent can evaluate whether Provider has satisfactorily completed the Work ("Performance Criteria"). Provider, at Provider's sole cost and expense, shall furnish all tools, equipment, apparatus, facilities, transportation, labor, and material necessary to meet its obligations under this Agreement. No substitutions of materials or Service from those specified in this section shall be made without the prior written consent of the Superintendent.

8. ASSIGNMENT AND SUBCONTRACTORS. Provider shall not assign, sublet, or transfer this Agreement or any rights under or in this Agreement without the prior written consent of the Superintendent.

9. TERMINATION OR AMENDMENT. This Agreement may be terminated or amended at any time by mutual written consent of all the parties hereto and may be terminated by either party for any reason by giving the other party 30 days advance written notice. In the event of cancellation prior to completion of the specified Services, all unfinished or unfinished projects, documents, data, studies, and reports prepared by the Provider under this Agreement shall, at the option of the Superintendent, become Superintendent property. The Provider shall be entitled to receive just and equitable compensation for any satisfactory Work completed on such items prior to termination of the Agreement.

10. NOTICE. Any notices required or permitted to be given under this Agreement shall be deemed fulfilled by written notice, demand or request personally served on (with proof of service endorsed thereon, or mailed to, or hereinafter provided to) the party entitled thereto or on its successors and assigns, and may be given by:
   a. Personal delivery;
   b. Overnight commercial courier;
   c. Certified or registered prepaid U.S. mail, return receipt requested; or
   d. Electronic mail or electronic facsimile transmission; provided that if given electronically, an additional copy shall also be delivered by a, b, or c, above.

Ventura County Office of Education
LONG FORM SERVICES AGREEMENT
If mailed, such notice, demand, or request shall be mailed certified or registered mail, return receipt requested, and deposited in the United States mail addressed to such party at its address set forth below or to such address as either party hereto shall direct by like written notice and shall be deemed to have been made on the third (3rd) day following posting; or if sent by a nationally recognized overnight express carrier, prepaid, such notice shall be deemed to have been made on the day following business day following deposit with such carrier. For the purposes herein, notices shall be sent to the Superintendent and the Provider as follows:

Ventura County Office of Education Provider Attn: 
VCOE Program Manager: Street 
City, State, Zip Code 

11. WARRANTY. Provider hereby warrants to Superintendent that the Work shall be performed in a professional and workmanlike manner consistent with the highest industry standards. For a period of one (1) year following completion of the Work, Provider shall correct or make arrangements to correct any breach of the warranty for the Work within ten (10) business days of notice from Superintendent of same.

12. ADDITIONAL WORK. If changes in the Work seem merited by the Provider or the Superintendent, and informal consultations with the other party indicate that a change is warranted, it shall be processed by the Superintendent in the following manner:
   a. A letter outlining the changes shall be forwarded to the Superintendent by the Provider with a statement of estimated changes in fee and/or time schedule.
   b. A written amendment to this Agreement shall be prepared by the Superintendent and executed by each of the parties before any performance of such Services or the Superintendent shall not be required to pay for the increased cost incurred for the changes in the scope of Work.

Any such amendment to the Agreement shall not render ineffective or invalidate unaffected portions of this Agreement.

13. COMPLIANCE WITH LAWS. Provider hereby agrees that Provider, officers, agents, employees, and subcontractors of Provider shall obey all local, state, and federal laws and regulations in the performance of this Agreement, including, but not limited to minimum wages laws and/or prohibitions against discrimination.

Provider, officers, agents, employees and/or subcontractors of Provider shall secure and maintain in force for the full term of this Agreement, at Provider’s sole cost and expense, such licenses and permits as are required by law, in connection with the furnishing of all the Services, materials, or supplies necessary for completion of the Services described.

Provider shall be responsible for all costs of clean up and/or removal of spilled regulated substances as a result of Provider’s Services or operations performed under this Agreement, including, but not limited to:

- Hazardous and toxic substances
- Medical waste
- Universal waste
- Biological waste
- Sharps waste

14. NON-DISCRIMINATION AND EQUAL EMPLOYMENT OPPORTUNITY. Provider represents and agrees that it does not and shall not discriminate against any employee or applicant for employment because of race, religion, color, sex, or national origin.

15. INDEMNIFICATION. Provider agrees to defend, indemnify, and hold harmless Superintendent, its officers, agents, employees, and/or volunteers from and against all losses, damages, and expenses, including legal fees and costs, or other obligations or claims arising out of any liability or damage to person or property, or any other loss, sustained or claimed to have been sustained arising out of activities of the Provider or those of its officers, agents, employees, or subcontractors of Provider, whether such act or omission is authorized by this Agreement or not. Provider shall also pay for any and all damage to the Real and Personal Property of the Superintendent, or loss or theft of such Property, done or caused by such persons. Superintendent assumes no responsibility whatsoever for any property placed on Superintendent premises by Provider, Provider’s agents, employees or subcontractors. Provider further hereby waives any and all right of subrogation that it may have against the Superintendent. The provisions of this Indemnification do not apply to any damage or losses caused solely by the negligence of the Superintendent or any of its officers, agents, employees, and/or volunteers.

16. INSURANCE. Provider and any and all vendors and subcontractors working for Provider shall provide, at their own expense, certificates of insurance to the Superintendent as evidence of the insurance coverage required below herein.

- Workers’ Compensation Insurance. Provider shall procure and maintain, during the term of this Agreement, Workers’ Compensation Insurance, as required by California law, on all of its employees engaged in Work related to the performance of this Agreement. Provider shall procure and maintain Employer’s Liability insurance coverage of $1,000,000. In the case of any such Work which is subcontracted, Provider shall require all subcontractors to provide Workers’ Compensation Insurance, and Employer’s Liability insurance for all of the subcontractor’s employees to be engaged in such Work unless such employees are covered by the protection afforded by the Provider’s Workers’ Compensation Insurance.

- Commercial General Liability Insurance. Provider shall procure and maintain, during the term of this Agreement, not less than the following General Liability insurance coverage:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Each Occurrence</th>
<th>Aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual, Sole Proprietorship, Partnership, Corporation, or Other</td>
<td>$1,000,000.00</td>
<td>$2,000,000.00</td>
</tr>
</tbody>
</table>

Commercial General Liability insurance shall include products/completed operations, broad form property damage, and personal and advertising injury coverage.

Any and all subcontractors hired by Provider in connection with the Services described in this Agreement shall maintain such insurance unless the Provider’s insurance covers the subcontractor and its employees.

Provider’s and any and all subcontractor’s Commercial General Liability Insurance shall name Ventura County Office of Education, its employees, and school board members as additional insureds.

- Automobile Liability. Provider shall procure and maintain, during the full term of this Agreement following Automobile Liability Insurance with the following coverage limits:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Each Occurrence</th>
<th>Aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal vehicles</td>
<td>$500,000.00 combined single limit</td>
<td></td>
</tr>
<tr>
<td>Commercial vehicles:</td>
<td>$1,000,000.00 combined single limit</td>
<td></td>
</tr>
<tr>
<td>Student Transportation</td>
<td>$5,000,000.00 combined single limit</td>
<td></td>
</tr>
</tbody>
</table>

Provider’s and any and all subcontractor’s Commercial Automobile Liability Insurance shall name Ventura County Office of Education, its employees, and school board members as additional insureds.

- Errors and Omissions Insurance. Provider shall procure and maintain, during the term of this Agreement, Professional Liability/Errors and Omissions Insurance in an amount of the following:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Each Occurrence</th>
<th>Aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education consultants, nurses, therapists</td>
<td>$1,000,000.00</td>
<td></td>
</tr>
<tr>
<td>Medical corporations</td>
<td>$5,000,000.00</td>
<td></td>
</tr>
</tbody>
</table>

- Other Coverage as Dictated by the Superintendent. Provider shall procure and maintain, during the term of this Agreement, the following other Insurance coverage:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Each Occurrence</th>
<th>Aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse and Molestation</td>
<td>$2,000,000.00</td>
<td></td>
</tr>
<tr>
<td>Cyber Liability</td>
<td>$5,000,000.00</td>
<td></td>
</tr>
</tbody>
</table>
Certificates of Insurance. Provider and any and all subcontractors working for Provider shall provide certificates of insurance to the Superintendent as evidence of the insurance coverage required herein, not less than fifteen (15) days prior to commencing work for the Superintendent, and at any other time upon request of the Superintendent.

Provider’s and any and all Provider subcontractor’s Commercial General Liability Insurance and Abuse and Molestation coverage shall be in the name of the Superintendent, its employees, and school board members as additional insureds, evidenced by an endorsement to the policy.

Failure to Procure Insurance. Failure on the part of Provider, or any of its subcontractors, to procure or maintain required insurance shall constitute a material breach of contract under which the Superintendent may immediately terminate this Agreement.

Certificates of Insurance. Provider and any and all subcontractors are required to comply with Education Code section 45125.1 regarding fingerprinting requirements. Certain entities that contract with a school Superintendent are required to comply with Education Code section 49406 regarding examination for tuberculosis unless the Superintendent determines that the Provider will not constitute a health hazard to students.

PROVIDER RETENTION. Provider must provide proof that fingerprint certification requirements have been fulfilled prior to commencing any services for the Superintendent under this Agreement.

Certain entities that contract with a school Superintendent may be required to comply with Education Code section 49406 regarding examination for tuberculosis unless the Superintendent determines that the Provider will not constitute a health hazard to students.

GOVERNING LAW AND VENUES. Provider hereby acknowledges and agrees that Superintendent is a public entity, which is subject to certain requirements and limitations. This Agreement and the obligations of Superintendent hereunder are subject to all applicable federal, state and local laws, rules, and regulations, as currently written or as they may be amended from time to time.

This Agreement shall be interpreted in accordance with the laws of the State of California. If any action is brought to interpret or enforce any term of this Agreement, the action shall be brought in state or federal court situated in the County of Ventura, State of California. Provider hereby waives and expressly agrees not to assert, in any way, any claim or allegation that it is not personally subject to the jurisdiction of the courts named above. Provider further agrees to waive any claim or allegation that the suit, action, or proceeding is either brought in an inconvenient forum or that the related venue is improper.

COPYRIGHT. Provider hereby agrees that Superintendent shall be the sole owner of the copyright for any publications, writings, materials or product developed by Provider under this Agreement. Provider shall maintain that copyright and shall not assign, transfer, mortgage or otherwise convey any portion of such copyright or any derivative work thereto.

DISPUTE RESOLUTION. The parties agree that, in the event of any dispute under the agreement in which the amount sought is $5,000.00 or less, any litigation to resolve the dispute shall be brought in the Ventura County Small Claims Court. If the amount in dispute exceeds $5,000.00, the parties agree that they will first submit the matter to a mutually agreed upon mediator. Notwithstanding section 22, Attorneys' Fees, the costs the mediator shall be borne equally by the parties.

This Agreement constitutes a binding expression of the understanding of the parties with respect to the services to be provided hereunder and is the sole contract between the parties with respect to the subject matter thereof. There are no collateral understandings or representations or agreements other than those contained herein. This Agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and is the sole contract between the parties with respect to the subject matter thereof. There are no collateral understandings or representations or agreements other than those contained herein.

Provider hereby agrees that Superintendent shall be the sole owner of the copyright for any publications, writings, materials or product developed by Provider under this Agreement. Provider shall maintain that copyright and shall not assign, transfer, mortgage or otherwise convey any portion of such copyright or any derivative work thereto. Provider hereby agrees that Superintendent shall be the sole owner of the copyright for any publications, writings, materials or product developed by Provider under this Agreement. Provider shall maintain that copyright and shall not assign, transfer, mortgage or otherwise convey any portion of such copyright or any derivative work thereto. Provider hereby agrees that Superintendent shall be the sole owner of the copyright for any publications, writings, materials or product developed by Provider under this Agreement. Provider shall maintain that copyright and shall not assign, transfer, mortgage or otherwise convey any portion of such copyright or any derivative work thereto.
29. **AUTHORITY.** Provider represents and warrants that Provider has all requisite power and authority to conduct its business and to execute, deliver, and perform this Agreement. Each party warrants that the individuals who have signed this Agreement have the legal power, right, and authority to make this Agreement and to bind each respective party.

30. **COUNTERPART EXECUTION: ELECTRONIC DELIVERY.** This Agreement may be executed in any number of counterparts which, when taken together, shall constitute one and the same instrument. Executed counterparts of this Agreement may be delivered by PDF email or electronic facsimile transmission, and shall have the same legal effect as an “ink-signed” original.

IN WITNESS WHEREOF, the parties have executed this agreement as of the date first written above.

<table>
<thead>
<tr>
<th>VCOE Authorized Representative</th>
<th>Provider/ Representative’s name and title (print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>By:</td>
<td>By:</td>
</tr>
<tr>
<td>Signature</td>
<td>Signature</td>
</tr>
</tbody>
</table>
STATEMENT OF WORK

DESCRIPTION OF WORK: ____________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

TIME SCHEDULE OF WORK: _________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

SCHEDULE OF FEES

FEES:
Compensation for Services $ ____________________________
* Please indicate Honorarium/Per-day/Hour/Session/Quarter/Lump sum

ACTUAL AND NECESSARY TRAVEL EXPENSES O Yes (Itemize Below) O No $ ____________________________
* Original itemized receipts required

TOTAL NOT TO EXCEED $ ____________________________

Proper invoicing is required. Receipts for expenses are required. Canceled checks are not accepted as receipts.

ADDITIONAL COSTS OF EXPENSES:
1. **DIGITAL STUDENT RECORDS AND PRIVACY.** [For providers of cloud-based services, for the digital storage, management, and retrieval of student records or digital educational software that authorizes a third-party provider of digital educational software to access, store, and use student records, or both].
   a. Student records continue to be the property of and under the control of the local educational agency. Student records include any information directly related to a student that is maintained by the District, and any information acquired directly from the student through the use of instructional software or applications assigned to the student by a teacher or other District employee.
   Provider will not use any information in the student record for any purpose other than those required or specifically permitted by this Agreement. Provider shall not use personally identifiable information in student records to engage in targeted advertising.
   b. Provider shall provide a description of the means by which students may retain possession and control of their own student-generated content, if applicable, including options by which a student may transfer student-generated content to a personal account. Such description shall be attached hereto and incorporated herein by this reference.
   c. Parent, legal guardian, or eligible student review.
      1) To inspect, review, or obtain copies of student records, authorized persons shall submit a request to the Provider. Prior to granting the request, the Provider shall authenticate the individual’s identity. For any individual granted access based on a legitimate educational interest, the request shall specify the interest involved.
      2) When prior written consent from a parent/guardian is required by law, the parent/guardian shall provide a written, signed, and dated consent before the district discloses the student record. Such consent may be given through electronic means in those cases where it can be authenticated.
      3) Provider shall maintain a record which lists all persons, agencies, or organizations requesting or receiving information for each student’s record and the legitimate educational interest of the requester.
      4) Only a parent/guardian having legal custody of a student or an adult student may challenge the content of a record or offer a written response to a record.
   d. Provider shall provide a description of the actions the Provider will take, including the designation and training of responsible individuals, to ensure the security and confidentiality of student records. Compliance with this requirement shall not, in itself, absolve the Provider of liability in the event of an unauthorized disclosure of student records. Such description shall be attached hereto and incorporated herein by this reference.
   e. Provider shall provide a description of the procedures for notifying the affected parent, legal guardian, or eligible student in the event of an unauthorized disclosure of the student’s records. Such description shall be attached hereto and incorporated herein by this reference.
   f. Notwithstanding Section 20, Document Retention, a certification that a student’s records shall not be retained or available to the Provider upon completion of the terms of the Agreement and description of how that certification will be enforced.
   g. The requirements provided above shall not apply to student-generated content if the student chooses to establish or maintain an account with the Provider for the purpose of storing that content pursuant to paragraph b.
   h. The District and the Provider will jointly ensure compliance with the federal Family Educational Rights and Privacy Act (FERPA) by doing the following:
      1) Use student data only for authorized evaluation, audit, or other compliance purposes;
      2) Protect the data from further disclosure or other uses; and
      3) Destroy the data when no longer needed for the authorized purpose.
IRS 20 FACTOR CHECKLIST

Below are the 20 factors used by the IRS to determine whether the control over a worker is sufficient to constitute an employer-employee relationship. If the relationship is an Independent Contractor, you should only be concerned with the results of the work, not the way in which it is performed. Though these rules are intended only as a guide (the IRS says the importance of each factor depends on the individual circumstances) they should be helpful in determining whether enough control is exercised to show an employer-employee relationship.

If you answer “Yes” to all of the first four questions, you’re probably dealing with an independent contractor: “Yes” to any of the questions 5 through 20 means your worker is probably an employee.

1. **Profit or Loss:** Can the worker make a profit or suffer a loss as a result of the work aside from the money earned from the project? *This should involve real economic risk - not just the risk of not getting paid.*

2. **Investment:** Does the worker have an investment in the equipment and facilities used to do the work? *The greater the investment, the more likely independent contractor status.*

3. **Works for More than One Firm:** Does the person work for more than one company at a time? *(This tends to indicate independent contractor status, but employees can also work for more than one business.)*

4. **Services Offered to the General Public:** Does the worker offer services to the general public?

5. **Instructions:** Do you have the right to give the worker instructions about when, where, and how to work? *This shows control over the worker.*

6. **Training:** Do you train the worker to do the job in a particular way? *(Independent contractors are already trained.)*

7. **Integration:** Are the worker's services so important to your business that they have become a necessary part of the business? *(This may show that the worker is subject to your control.)*

8. **Services Rendered Personally:** Must the worker provide the services personally, as opposed to delegating tasks to someone else? *This indicates that you are interested in the methods employed, and not just the results.*

9. **Hiring Assistants:** Do you hire, supervise, and pay the worker's assistants? *(Independent contractors hire and pay their own staffs.)*

10. **Continuing Relationship:** Is there an ongoing relationship between the worker and yourself? *(A relationship can be considered ongoing if services are performed frequently, but irregularly.)*

11. **Work Hours:** Do you set the worker's hours? *(Independent contractors are masters of their own time.)*

12. **Full-Time Work:** Must the worker spend all of his or her time on your job? *(Independent contractors choose when and where they will work.)*

13. **Work Done on Premises:** Must the individual work on your premises, or do you control the route or location where the work must be performed? *(Answering "no" doesn't by itself mean independent contractor status.)*

14. **Sequence:** Do you have the right to determine the order in which services are performed? *(This shows control over the worker.)*

15. **Reports:** Must the worker give you reports accounting for his or her actions? *(This may tend to show Lack of independence.)*

16. **Pay Schedules:** Do you pay the worker by the hour, week, or month? *(Independent contractors are generally paid by the job or on commission, although by industry practice, some are paid by the hour.)*

17. **Expenses:** Do you pay the worker's business or travel costs? *(This tends to show control.)*

18. **Tools and Materials:** Do you provide the worker with equipment, tools or materials? *(Independent contractors generally supply the materials for the job and use their own tools and equipment.)*

19. **Right to Fire:** Can you fire the worker? *(An independent contractor can't be fired without subjecting you to the risk of a breach of contract lawsuit, so long as the results meet specifications.)*

20. **Workers Right to Quit:** Can the worker quit at any time, without incurring liability? *(An independent contractor has a legal obligation to complete the contract.)*

By affixing my initials below, I certify I have reviewed the above "Checklist".

Program Manager       Contractor
TO:
Ventura County SELPA
Attn: Yanka Ricklefs, Director, Personnel Development
5100 Adolfo Road
Camarillo, CA 93012
(805) 437-1560

Date: ______________________________________

Name of Child: ______________________________________

Name of Transportation Provider: ______________________________________

Address: ______________________________________

I submit the following expenses for **TRANSPORTATION**:

<table>
<thead>
<tr>
<th>DATE</th>
<th>LOCATION TO</th>
<th>LOCATION FROM</th>
<th>ROUNDTRIP MILEAGE</th>
<th>CHARGES (485¢ P/MILE)</th>
<th>TOTAL</th>
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</table>

Provider signature: ______________________  Date: ________________

Infant Specialist signature: ________________  Date: ________________

Coordinator/Director signature: ________________  Date: ________________

SELPA signature: ______________________  Date: ________________
September 1, 2010

To: Early Start Families being served by Ventura County SELPA School Districts

Subject: Changes in availability of respite services as of September 1, 2010

This is to inform you of changes to availability of reimbursement for respite services for Early Start families served by SELPA School Districts. The following is excerpted from a March 2003 letter from Stephanie Lee, Director of the Office of Special Education Programs:

“The Code of Federal Regulations (CFR) §303.12(a) Part C regulations list 16 “types” of services included under “early intervention services”. The note following §303.12 indicates that the lists of services are not exhaustive. The note states “early intervention services may include such services as the provision of respite and other family support services.” The term “respite” as used in that note is not intended to mean “reprieve” or “rest” but rather a child care-type service provided to enable parent(s) to participate or receive other early intervention services in order to meet the outcomes on a child’s IFSP.

In order for a parent to develop the capacity to assist his/her child in meeting his/her developmental needs, the parent may need respite or other type of care for the child while the parent participates in appropriate early intervention activities. Families may need in-home or other care arrangements for their child in order for the family to participate in early intervention services that include a defined family component, i.e., family training or counseling services, psychological services, or social work. A family may need to participate in sign language classes in order to assist the child in developing communication skills or meet with a psychologist to design appropriate behavioral management strategies to use when the child engages in inappropriate behaviors. Although the provision of respite or other care arrangements may be necessary for some families to participate in appropriate early intervention activities, respite is not intended to serve as child-care or “baby-sitting” assistance in ordinary circumstances.”

Therefore, starting September 1, 2010, your School District Service Coordinator will only be allowed to authorize respite costs related to your child attending an Early Intervention Service, which would include participation in parent education activities or other parent support events.
TO:
Ventura County SELPA
Attn: Yanka Ricklefs, Director, Personnel Development
5100 Adolfo Road
Camarillo, CA 93012
(805) 437-1560

DATE: ________________

Name of Child: ________________________
Name of Parent: ________________________
Name of Care Provider: ____________________
Address of Care Provider: ______________________
Name of other Care Provider: ______________________
Other Care Provider Address: ______________________

I submit the following expenses for RESPITE CARE:

<table>
<thead>
<tr>
<th>DATE</th>
<th>RECEIPT NUMBER</th>
<th>HOURS</th>
<th>CHARGES (For each time, attach signed receipt)</th>
<th>TOTAL</th>
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</table>

Parent signature: ________________________ Date: ________________
Infant Specialist signature: ________________________ Date: ________________
Coordinator/Director signature: ________________________ Date: ________________
SELPA signature: ________________________ Date: ________________

CONTRACT #             ACCOUNT #
SERVICE
GUIDELINES
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. The SELPA has provided Oto-Acoustical Emission Screening (OAES) devices for each Early Start program to be able to conduct hearing screening.
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.

2. 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

Occupational Therapist:
- Oral motor feeding
- Assistive technology
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.
Inquiry received from Regional Center

Vision Concerns

Adequate Medical Information Available About Vision

No Medical Information

Contact RC for additional vision information or ECSE follows up with phone call to parent

ECSE does a vision screening and reviews any medical records they have

Send to - or review screening results with Vision Specialist

If there are concerns, Vision Specialist observes and conducts assessment and if appropriate makes recommendation about services or follow up

If there are no concerns, may not serve, or may serve for other concerns, or may enlist the Vision Specialist to assist with explaining to the family about the vision issue

(If medical records not available) make plan for follow up

Services recommended
- IFSP goals/services set- within 45 days
- may provide direct or consultative vision services (weekly or monthly)
  (Consultation may be provided until medical records are available)

Orientation & Mobility consult “as needed”, referred by Vision Specialist

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. Indicate 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

<table>
<thead>
<tr>
<th>TASK</th>
<th>OBSERVATION</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>1. Orient centrally</td>
<td>Yes/No</td>
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<tr>
<td>2. Orient peripherally without</td>
<td>Right/Left/Not at all</td>
<td></td>
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<tr>
<td>3. Tracks horizontally</td>
<td>Right/Left/Not at all</td>
<td></td>
</tr>
<tr>
<td>4. Tracks vertically</td>
<td>Up/Down/Not at all</td>
<td></td>
</tr>
<tr>
<td>5. Reaches on visual cue</td>
<td>Right/Left/Not at all</td>
<td></td>
</tr>
<tr>
<td>6. Shifts gaze</td>
<td>Right/Left/Not at all</td>
<td></td>
</tr>
<tr>
<td>7. Blink reaction/Rapid Eye Movement</td>
<td>Fast/Slow/Not at all</td>
<td></td>
</tr>
<tr>
<td>8. Nystagmus</td>
<td>Yes/No</td>
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<tr>
<td>9. When looking at a light or object straight ahead, are child’s eyes:</td>
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<tr>
<td>• Even and symmetrical, not cross eyed or exotropic</td>
<td>Yes/ No</td>
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<tr>
<td>• Droopy</td>
<td>Yes/ No</td>
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<td>• Red</td>
<td>Yes/ No</td>
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<tr>
<td>• Excessive tearing</td>
<td>Yes/ No</td>
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<td>• Constant rubbing</td>
<td>Yes/ No</td>
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<tr>
<td>• Excessive sensitivity to light</td>
<td>Right/Left/Both/No</td>
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<tr>
<td>10. Does child turn/tilt head when looking at objects</td>
<td>Yes/ No</td>
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<td></td>
<td>Question</td>
<td>Response</td>
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<td>11</td>
<td>How does child look at objects they hold</td>
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<td></td>
<td>• At what distance</td>
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<td>• Eye preference</td>
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<td></td>
<td>• At what angle does he/she bring objects to the eye</td>
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<td>Right/ Left/ Both/Neither</td>
<td>Right</td>
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<td>Left</td>
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<td>Both</td>
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<td>Neither</td>
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<td>12</td>
<td>Has child’s vision been tested</td>
<td>Yes/ No</td>
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<tr>
<td>13</td>
<td>Is child taking any medications</td>
<td>Yes/ No</td>
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<td>14</td>
<td>Medical records obtained</td>
<td>Yes/ No</td>
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<td>15</td>
<td>Other medical concerns</td>
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<td>16</td>
<td>Parental concerns:</td>
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<td></td>
<td>□ No apparent concern at this time</td>
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<td>□ Monitor for ________________</td>
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<td>□ Will follow up</td>
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<td>Comments:</td>
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</table>

Other Comments:

Date:________________________
Signature of Interviewer:____________________________________________
Title:___________________________________________________________________

Vision Specialist Review

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

____________________________    ____________________
**Services to Deaf/Hard of Hearing**

1. Results of Newborn Hearing Screening evaluations in Ventura County are forwarded by various medical facilities to the Southern California Hearing Coordination Center, then to the CA Department of Education, Deaf/Hard of Hearing department. In turn, CDE contacts Ventura County Office of Education Hearing Conservation (HC) (Leslie Comstock, Director). HC then continues the referral process to the VC Early Start Program, with a cc to the appropriate school district program as an advanced notice.

   In addition, infants who are suspected of having a hearing loss may be referred to the VC Early Start program by medical offices, family members, or other interested parties.

2. In the VC Early Start Program, Regional Centers are the ‘single point of entry’ for all infant referrals, 0-36 months. Infants who have, or are suspected of having, a hearing impairment should be referred to the appropriate Regional Center office (see appendix I for guidelines):

   - North Los Angeles County Regional Center  (818) 778-1900
   - Tri-Counties Regional Center East Office  (805) 522-8030
   - Tri-Counties Regional Center West Office  (805) 485-3177

3. The Regional Center office will complete an Early Start Inquiry Form, and send it by email (both names) or fax to the Early Start Service Area Program which serves the infant’s home school district (see appendix II for names and areas).

   - Conejo Valley USD Service Area   Fax (805) 241-4346   email:  iraplere@conejousd.org
   - Oxnard Elem SD Service Area   Fax (805) 984-1808   email:  sramirez@oxnardsd.org ngonzalez@oxnardsd.org
   - Simi Valley USD Service Area   Fax (805) 520-6107  email: keisha.carroll@simivalleyusd.org rama.dasu@simivalleyusd.org
   - Ventura USD Service Area   Fax (805) 672-0427email:  karly.stern@venturausd.org

4. Before responding to the RC inquiry, the home Service Area Early Childhood Special Educator (ECSE) will review the inquiry to determine the extent of the infant’s hearing impairment. If there is a bilateral moderate-severe-profound hearing loss (Deaf infant), the home Service Area ECSE will refer the infant to the appropriate Deaf/Hard of Hearing Service Area ECSE (see appendix III for guidelines), which becomes the designated school district of service to respond to the inquiry and follow up with the referral.

   If there is a unilateral hearing loss or a bilateral mild hearing loss, the home Service Area ECSE will respond to the inquiry and follow the referral. The DHH Service Area ECSE will provide consultation services to the home Service Area ECSE as specified on page 100.
5. The designated school district Early Start ECSE will respond to the Regional Center by email or fax by 5:00pm next business day. One of the following responses will be indicated:
   - Agrees to dual intake
   - Agrees to serve as solely low incidence
   - Declines to serve (not SLI, and no opening or not a priority for dual)
   - Agrees to reconsider at a later date when assessment report is available

Dual Intake: Infants who present with multiple concerns may be considered for 'dual' status, if the designated school district Early Start Program has openings. In dual status, the RC is the family’s Service Coordinator, and provides most Early Start services. The SD provides special education and related services (see MOU, Appendix B). If the SD has no openings, dual referrals may be declined and RC remains the interim Service Coordination agency.

Solely Low Incidence Intake: Infants whose only presenting concern is hearing loss and who qualify for the ES program will be accepted by the designated SD as ‘solely low incidence’, regardless of whether the SD ES program has openings or is full. In SLI status, the SD Early Childhood Special Educator is the family’s Service Coordinator, and SD/SELPA will be responsible for all Early Start educational services. Additional ES agencies may participate, such as CCS.

Note: Infants with hearing impairment sometimes appear to have multiple concerns (delays in communication, social, or other skills). If developmental delays are a direct result of the hearing impairment, infants should be considered for 'solely low incidence' status. If the delays are the result of a concomitant condition (prematurity, syndrome, illness), the infant should be considered for 'dual' status.

6. All children referred for hearing loss, regardless of whether or not it is unilateral or bilateral, will have consultation by a Deaf/Hard of Hearing (DHH) credentialed teacher. The DHH teacher will review the medical records/audiogram, interview parents if indicated, and conduct or review the assessment, following these steps:

   i. Schedule joint intake with DHH teacher (“DHH”) and ECSE.
   ii. DHH and ECSE collaborate on the assessment. Either jointly assesses or DHH reviews the ECSE’s assessment. DHH reviews Audiological report. DHH always signs the Assessment report.
   iii. DHH may attend the IFSP (but not required)
   iv. If Early Start eligible, DHH recommends the level of service to go on the IFSP- may be direct services, or consultative. Level of service must be indicated on the IFSP, and consultation will be specified as direct or indirect, and will specifically note which professionals will be present, and whether or not the child and family will be present.
   v. Minimum level of consultation by DHH will be every 6 months, at time of annual reviews, between professionals.

7. The Early Start Service Coordinator will forward to VCOE Hearing Conservation copies of all audiological reports.
8. All children with unilateral hearing loss will be taken in as eligible under CCR 3031 (c), be monitored and assessed (including DHH Specialist) for three, six month intervals, or until 24 months of age, whichever comes first. At that time, if child no longer meets eligibility criteria below, they will be exited. If at any time the hearing assessment results indicate that the child’s hearing is within normal limits, the child will be exited.

9. Legal reference for eligibility:
   - CCR Title 5, Section 3031 (c) “The child has a disabling medical condition or congenital syndrome which the IEP team (sic) determines has a high predictability of requiring intensive special education and services.”

Appendix I. The following Regional Center offices are considered the ‘single point of entry’ for all initial infant referrals, including Deaf/Hard of Hearing infants, who reside in these areas:

North Los Angeles County Regional Center: Las Virgenes USD, (resident of LA County)

Tri-Counties Regional Center East Office: Conejo Valley USD, Moorpark USD, Oak Park USD, Simi Valley USD, Pleasant Valley SD, Somis Union SD, Las Virgenes USD (resident of Ventura County)

Tri-Counties Regional Center West Office: Briggs ESD, Fillmore USD, Hueneme ESD, Mesa Union SD, Mupu ESD, Ocean View SD, Ojai USD, Oxnard ESD, Rio SD, Santa Clara ESD, Santa Paula USD, Ventura USD

Appendix II. Regional Center will use the following list of school district Early Start Programs for all initial infant referrals, including Deaf/Hard of Hearing infants, who reside in these areas:

Conejo Valley USD Early Start Program: Conejo Valley USD, Las Virgenes USD, Oak Park USD. Contacts: Julie Raplere, ECSE, (805) 492-4051 x220

Simi Valley USD Early Start Program: Moorpark USD, Pleasant Valley SD, Simi Valley USD, Somis Union SD. Contacts: Keisha Carroll, ECSE. (805) 520-6619 x3123.
   Rama Dasu, ECSE, (805) 520-6619 x3123.

Oxnard Elementary SD Early Start Program: Hueneme ESD, Ocean View SD, Oxnard ESD. Contacts: Sofia Ramirez, ECSE, (805) 385-1518
   Natalie Gonzalez, ECSD, (805) 385-1518

Ventura USD Early Start Program: Briggs ESD, Fillmore USD, Mesa Union SD, Mupu ESD, Ojai USD, Rio SD, Santa Clara ESD, Santa Paula ESD, Ventura USD. Contacts: Karly Stern, ECSE, (805) 672-2705 x2219
Appendix III. School districts will refer Deaf infants to the following school district Deaf/Hard of Hearing Early Start Programs
(Hard of Hearing infants will be served by their home school district Early Start Program, with consultation provided by the following D/HH ES Programs):

Simi Valley USD Early Start D/HH services:
All districts within the Conejo Valley USD Early Start Program and the Simi Valley USD ES Program.
Contact person: Erin MacIntyre, Simi Valley USD, (805) 520-6619

Ventura USD Early Start D/HH services:
All districts within Ventura USD ES Program.
Contact person: Karly Stern, VUSD ECSE, (805) 672-2705 x2219

Oxnard Elementary School District Early Start D/HH services:
All districts within the Oxnard Elementary School District ES Program.
Contact person: Sofia Ramirez, OSD ECSE, (805) 385-1518