

## Early Intervention Program Self-Assessment

Certified providers must complete a Program Self- Assessment and submit to DHS. The Self-Assessment is intended to serve as both an internal quality assurance tool and to report on adherence to performance standards as set forth in the RI Certification Standards and the RI State Performance Plan. Each program seeking recertification must complete a record review for a sample of ten (10) percent of children enrolled during the review period (July 1-June 30) prior to the date of the recertification process. Please see attached for record review sample. A random sample of these review forms will be verified during on-site focused monitoring visits to assure reliability and validity.

### Self- Assessment Summary

| Area | Total # of applicable records | # Compliant | % Compliant (# Compliant/Total) | Explain reasons for non-compliance (use separate page if needed) | Plan for correction (use separate page if needed) |
|------|-------------------------------|-------------|---------------------------------|--|---|
| A1   |                               |             |                                 |  |   |
| A2   |                               |             |                                 |  |   |
| A3   |                               |             |                                 |  |   |
| B1   |                               |             |                                 |  |   |
| B2   |                               |             |                                 |  |   |
| B3   |                               |             |                                 |  |   |
| B4   |                               |             |                                 |  |   |
| B5   |                               |             |                                 |  |   |
| B6   |                               |             |                                 |  |   |
| B7   |                               |             |                                 |  |   |
| C1   |                               |             |                                 |  |   |
| C2   |                               |             |                                 |  |   |
| C3   |                               |             |                                 |  |   |
| C4   |                               |             |                                 |  |   |
| C5   |                               |             |                                 |  |   |
| C6   |                               |             |                                 |  |   |
| C7   |                               |             |                                 |  |   |

|           |  |  |  |  |  |
|-----------|--|--|--|--|--|
| <b>C8</b> |  |  |  |  |  |
| <b>C9</b> |  |  |  |  |  |
| <b>D1</b> |  |  |  |  |  |
| <b>D2</b> |  |  |  |  |  |
| <b>D3</b> |  |  |  |  |  |
| <b>D4</b> |  |  |  |  |  |
| <b>D5</b> |  |  |  |  |  |
| <b>D6</b> |  |  |  |  |  |
| <b>E1</b> |  |  |  |  |  |
| <b>E2</b> |  |  |  |  |  |
| <b>E3</b> |  |  |  |  |  |
| <b>E4</b> |  |  |  |  |  |

# Self-Assessment Record Review Form

Child ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Referral Date: \_\_\_\_\_

## Comprehensive Child Find

| #  | Requirement  | Date | Compliant |
|----|--|------|-----------|
| A1 | Service coordinator is appointed as soon as possible upon receipt of referral  |      |           |
| A2 | Written feedback to primary referral source provided within 45 days from date of referral (mark N/A if parent self-referred) |      |           |
| A3 | Physician authorization form signed  |      |           |

## Evaluation/Assessment

| #  | Requirement  | Date | Compliant |
|----|--|------|-----------|
| B1 | Parent consent was obtained  |      |           |
| B2 | Prior written notice was provided  |      |           |
| B3 | Conducted by two qualified members of multidisciplinary team   |      |           |
| B4 | Information is obtained about the child's level of functioning in each of the following areas: (1) cognition (2) physical development, including vision and hearing (3) communication (4) social and emotional development (5) adaptive skills |      |           |
| B5 | Eligibility determination/category consistent with documentation   |      |           |
| B6 | Eligibility determination made within 45 days from date of referral by primary referral source   |      |           |
| B7 | Evaluation/Assessment conducted annually (mark N/A is child not in program for at least one year)  |      |           |

## Individual Family Service Plans

| #  | Requirement  | Date | Compliant |
|----|--|------|-----------|
| C1 | Initial IFSP meeting conducted within 45 days from date of referral by primary referral or appropriate justification was documented (not including provider reason)  |      |           |
| C2 | Prior written notice was provided  |      |           |
| C3 | Participants in the IFSP meeting included at least (1) parent (2) service coordinator (3) at least one professional that participated in the evaluation/assessment (4) any other person as requested by parent |      |           |
| C4 | Periodic review occurred at least every 6 months   |      |           |
| C5 | Periodic review included a review of all outcomes  |      |           |
| C6 | Prior written notice was provided for periodic review  |      |           |
| C7 | IFSP was completed annually  |      |           |

|    |  |  |  |
|----|--|--|--|
| C8 | Initial services began within 30 days from consent (parent signature) or appropriate justification was documented (not including provider reason)                        |  |  |
| C9 | Services must be provided in the natural environment or an acceptable justification that answers each of the three questions on the plan are documented for each outcome |  |  |

**Transition**

| #  | Requirement  | Date | Compliant |
|----|--|------|-----------|
| D1 | Child has a completed individualized transition plan that includes specific steps, person responsible, and date to be completed, to the extent appropriate |      |           |
| D2 | If child is 24 months or older, family received a copy of "Transition from Early Intervention: A Family Guide"   |      |           |
| D3 | Child was referred to the LEA and appropriate community services if parental consent given for children 28 months and older                                |      |           |
| D4 | Transition conference held at least 90 days prior to the child's third birthday, if appropriate  |      |           |
| D5 | Prior written notice was provided for transition conference, if scheduled  |      |           |
| D6 | Child's eligibility for special education was determined and document in the record, if child discharged   |      |           |

**Procedural Safeguards and Other Related Requirements**

| #  | Requirement   | Date | Compliant |
|----|---|------|-----------|
| E1 | Procedural safeguards were explained to family and family received a copy of the "Family Rights and Responsibilities" booklet |      |           |
| E2 | Family received a copy of the "Central Directory"   |      |           |
| E3 | Child Outcomes Summary Form completed for entry   |      |           |
| E4 | Child Outcomes Summary Form completed for exit, if child discharged   |      |           |