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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00989F (02/2017) | | | | | | | **STATE OF WISCONSIN** | | |
| **EARLY INTERVENTION TEAM REPORT /**  **WISCONSIN EARLY INTERVENTION ELIGIBILITY DETERMINATION** | | | | | | | | | |
| Child’s Name | | | | | | | | Date of Report | |
| Enter date | | | | | | | | Click here to enter a date. | |
| **WPN:** The following decision has been made regarding your child’s eligibility determination: | | | | | | | | | |
|  | This child meets the eligibility criteria for early intervention (Birth to 3 Program). | | | | | | | | |
|  | This child does not meet eligibility criteria for early intervention (Birth to 3 Program) based upon (list parental/caregiver input, names of standardized tests, observations, review of records, etc.) and reasons (list what the information states): | | | | | | | | |
|  | Click here to enter text. | | | | | | | | |
| Other Decisions Considered | | | | | | | | | |
|  | Not applicable; other decisions not discussed. | | | | | | | | |
|  | This child meets the eligibility criteria for early intervention (Birth to 3 Program). | | | | | | | | |
|  | This child does not meet the eligibility criteria for early intervention (Birth to 3 Program). | | | | | | | | |
| This eligibility determination is being made based upon the following information (list parental/caregiver input, names of standardized tests, observations, review of records, etc.) and reasons (list what the information states): | | | | | | | | | |
|  | | 1. A developmental delay of 25 percent or greater or -1.3 standard deviation in the following area(s) and based upon: | | | | | | | |
|  | | | Click here to enter text. | | | | | | |
|  | | | | | | | | | |
|  | | 1. A diagnosed physical or mental condition exists that has a high probability of resulting in a developmental delay. | | | | | | | |
| Diagnosis: | | | | Click here to enter text. | | | | | |
| Related Conditions: | | | | | Click here to enter text. | | | | |
| The Early Intervention team reviewed the following documents identifying the diagnosis: | | | | | | | | | |
|  | | | Click here to enter text. | | | | | | |
|  | | | | | | | | | |
|  | | 1. Atypical development based on: | | | | | | | |
|  | | | Click here to enter text. | | | | | | |
|  | | | | | | | | | |
| You have the right to agree with or refuse the eligibility determination. Accompanying this early intervention team report is a copy of the parent and child rights. This is a brief review of the rights. If you would like a complete copy of the parent and child rights, please contact the Service Coordinator. | | | | | | | | | |
|  | | | | | | | | | |
| If this child has met the eligibility criteria for early intervention, the next step is to develop an Individualized Family Service Plan (IFSP). | | | | | | | | | |
|  | This child meets the eligibility criteria for early intervention services, and the family has agreed to participate in the Birth to 3 Program. | | | | | | | | |
|  | This child meets the eligibility criteria for early intervention services; however, the family declines participation in the Birth to 3 Program at this time. | | | | | | | | |
|  | | | | | | | | | |
| If this child did not meet the eligibility criteria for early intervention, the following is being offered to the family. | | | | | | | | | |
|  | Rescreen the child within six months. Notes: | | | | | | | | |
| Click here to enter text. | | | | | | | | | |
|  | The following community resources might benefit the family: | | | | | | | | |
| Click here to enter text. | | | | | | | | | |
|  | The following information was given to the family: | | | | | | | | |
| Click here to enter text. | | | | | | | | | |
| **PARTICIPANTS IN EARLY INTERVENTION TEAM MEETING**  **Date of Meeting:** Enter date | | | | | | | | | |
| By signing below, I acknowledge that the Birth to 3 Program requested information from me to include in this early intervention (EI) report, and I provided the most up-to-date information about my child and participated in the discussions that resulted in this EI report. I further understand and acknowledge that I had the opportunity to review and request changes to the information in this EI report and that I have the right to dispute the decisions regarding my child’s eligibility for the Birth to 3 Program. I was also informed that disclosure of this report will not occur unless otherwise permitted by law. | | | | | | | | | |
| **SIGNATURE** – Parent / Guardian | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – Parent / Guardian | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – County Coordinator | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – Service Coordinator | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – Other | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – Other | | | | | | Date Signed | | | Print Name / Title  Enter date |
| **SIGNATURE** – Other | | | | | | Date Signed | | | Print Name / Title  Enter date |
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