

Babies Can't Wait Program

August 2010

AB-0810-003

ACTION BULLETIN

BCW referrals from Children 1st System Point of Entry and Beginning Date of 45-day Federal Timeline for Initial IFSP Completion

Background: In September 2008, the US Department of Education, Office of Special Education Programs (OSEP), conducted an onsite verification monitoring visit of the Babies Can't Wait (BCW) program. On February 23, 2009, the Georgia Department of Human Resources, Division of Public Health received a verification visit letter with several required actions. One of the required actions related to the federal requirement to ensure that all eligible children have an initial IFSP meeting within 45 calendar days from referral. OSEP required that BCW develop and disseminate revised procedures for referrals to BCW. Children 1st is the designated agency for BCW referrals. The 45 day timeline begins when Children 1st receives a BCW referral. The purpose of this Action Bulletin is to provide written clarification on BCW referrals.

BCW Referrals

Automatic BCW Referral Based on a Suspected Developmental Delay: In the following instances, Day 1 of the 45 day time period begins **on the day** the Children 1st System Point of Entry office receives the call or fax indicating a referral for BCW. Examples include:

- A physician initiates the referral due to a suspected developmental delay or Category One diagnosis;
- A CAPTA referral is made by a Division of Family and Children Services (DFCS) caseworker for a child (birth to three) with substantiated abuse or neglect;
- A referral is received with documentation of Category One eligibility for BCW; or
- A referral is received from a parent, family member, child care provider or anyone who is concerned about a child's development. The referral source may or may not mention BCW.

Children 1st Birth to Five Staffing Results in BCW Referral: In the following instances, a referral to BCW must be made within two working days of the receipt of the child specific information by Children 1st that indicates a suspected developmental delay or Category One diagnosis:

Electronic Birth Certificates (EBCs)

- EBCs are received by Children 1st for every birth in Georgia. Within 2 working days of receipt of EBCs, a decision is made through the Children 1st Staffing process that a BCW referral is appropriate based on a suspected developmental delay or Category One diagnosis. Day 1 of the 45 day time period is the day the child is identified through the Children 1st Staffing process as having a suspected developmental delay or Category One diagnosis.

Referrals Made Through Maternal Child Health Assessment

- When Children 1st receives information from county health department staff, including WIC, who have identified a child with suspected developmental delays through a Maternal Child Health Assessment and/or developmental screening, a decision is made via the Children 1st Staffing process that a BCW referral is appropriate. Children 1st Staff have 2 working days from receipt of this information to make a BCW referral. Since these referrals consist of children with suspected developmental delays, day 1 of the 45 day time period begins on the day Children 1st receives the information from the referral source.

Developmental Screening: A developmental screening for referrals that do not have a BCW Category 1 condition should be completed prior to the BCW eligibility determination process. Developmental screenings completed by sources outside of BCW are acceptable including a physician, DFCS or its contractors, qualified public health staff, childcare staff or another source deemed to be qualified by the local lead agency. The developmental screening must occur within the BCW 45 day timeline allowing sufficient time for the BCW eligibility determination process and IFSP to be completed within the same 45 day period if the child is determined eligible for BCW.

Children 1st Birth to Five System Point of Entry: Children 1st provides identification, screening, assessment, referral/linkage, and monitoring for all children birth to five in Georgia that are at-risk for poor health and/or development. The Children 1st system is designed to help families of at-risk children get needed assistance and extra support in meeting the challenges of parenthood as well as to ensure linkage to a primary care physician. Many referrals to Children 1st are not referrals to BCW. Children 1st has an established set of risk criteria to determine program eligibility that are not the same as BCW eligibility criteria for significant developmental delay. The Children 1st Screening and Referral Form contains the Level 1 and Level 2 risk criteria used in determining the appropriate linkages to all public health programs for children identified to be at-risk. The Children 1st Screening and Referral form is attached for your information. Some examples of risk factors that would make a child eligible for Children 1st but would not require a referral for BCW include children who have:

- A mother less than 20 years of age;
- A mother whose education is less than 12 years;
- A history of family violence;
- A family with difficulty in parenting due to lack of family/social support;
- Inadequate material resources affecting care of the child; or
- A parent incarcerated



DIRECTIONS: Please complete form on every child, birth to age 5, having any of the conditions listed on 1st or 2nd page. Circle or fill in as much information as possible. Send form to local *Children 1st* Coordinator.

Screening and Referral Form

SECTION A CHILD AND FAMILY INFORMATION

Child: Last Name First MI	Mother: Last Name First MI Maiden	Father: Last Name First MI
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<p>CHILD'S INFORMATION</p> <p>Child's Address _____ Street/Route Apt Complex # / Mobile Hm Park # City County Zip</p> <p>Phone # _____ Emergency Contact # _____</p> <p>Directions to Home _____</p> <p>Latino/Hispanic: Y/N/UNK</p> <p>Select one race: (1) White (2) Black or African American (3) American Indian or Alaska Native (4) Asian (5) Hawaiian or Other Pacific Islander (6) Multiracial (7) Unknown</p> <p>Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Date of Birth _____ Birth weight _____ Gestational Age _____</p> <p>Hospital _____ Discharge Date _____ Transfer Hospital _____ Discharge Date _____</p> <p>Type of Insurance: Private <input type="checkbox"/> Tri-Care <input type="checkbox"/> PeachCare <input type="checkbox"/> Medicaid <input type="checkbox"/> None/Unknown <input type="checkbox"/> Medicaid # (if known) _____</p>	<p>MOTHER'S INFORMATION</p> <p>Age _____ Date of Birth _____</p> <p>Education (last grade completed) _____</p> <p>Marital Status (<i>circle only 1</i>): M NM SEP D W Live in Partner: Y/N</p> <p>Parity G: _____ P: _____ Pre-Term: _____ AB: Elective/Spontaneous _____ / _____</p> <p>Prenatal Care 1st 2nd 3rd None</p> <p>Medicaid # _____</p> <p align="center">GUARDIAN/FOSTER PARENT (If different from above)</p> <p>_____</p> <p align="center">Last Name First MI</p> <p align="center">CHILD'S PRIMARY MEDICAL/HEALTH CARE PROVIDER</p> <p>_____</p> <p>Name _____</p> <p>Street or Route _____</p> <p>City State Zip</p> <p>Phone _____ Fax _____</p>
LANGUAGE NEEDS	
Primary Language: _____ Translator/Interpreter Needed: Y/N	

SECTION B HOSPITAL INFORMATION

<p>Newborn Hearing Screening: Not screened Family Refused Screening</p> <p>Inpatient: Date: ___/___/___ L: Passed/Referred R: Passed/Referred Equipment: AOAE AABR Other</p> <p>Outpatient: Date: ___/___/___ L: Passed/Referred R: Passed/Referred Equipment: AOAE AABR Other</p>	<p>Vaccines Given During Hospital Stay:</p> <p>Hepatitis B Vaccine (date) _____</p> <p>HBIG (date) _____</p>
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SECTION C LEVEL 1 RISK CONDITIONS (Families Offered In-Home Assessment)

<p align="center">Conditions Identified at Birth</p> <p>XXX.11 <input type="checkbox"/> Negative Family Index (includes XXX.12, V62.3 & V62.9) XXX.12 <input type="checkbox"/> Maternal Age <20 years V62.3 <input type="checkbox"/> Maternal Education <12 Years V62.9 <input type="checkbox"/> No Father's Name on Birth Certificate</p> <p>XXX.13 <input type="checkbox"/> Negative Healthy Start Index (765, V23.7, & XXX.17) 765 <input type="checkbox"/> Birth weight <2500 Grams (5 lbs. 8 oz.) V23.7 <input type="checkbox"/> No 1st Trimester Prenatal Care XXX.17 <input type="checkbox"/> Mother Smoked and/or Drank (> 7 drinks/week) during Pregnancy</p> <p>XXX.14 <input type="checkbox"/> 2 or More of the 6 Risk Conditions Listed Above</p> <p align="center">Medical/Biological Conditions Present in the Child (Any 1)</p> <ul style="list-style-type: none"> ● XXX.15 <input type="checkbox"/> Special Care Nursery >48 hours (specify medical conditions on back) ● 764.9 <input type="checkbox"/> Small for Gestational Age (birth weight ≤ 10% for gestational age) ● 795.8 <input type="checkbox"/> HIV+ by EI, WB or PCR ● 779.5 <input type="checkbox"/> Drug Withdrawal Syndrome in Newborn 	<p align="center">Socio-Environmental Conditions Present in the Family (Any 1)</p> <p>V19.2 <input type="checkbox"/> Family History of Hearing Impairment V61.5 <input type="checkbox"/> Multiparty in Mother <20 Years (more than 3 pregnancies) V61.21 <input type="checkbox"/> Previous or Current Child Protective Services/Foster Care V61.8 <input type="checkbox"/> History of Family Violence V62.89 <input type="checkbox"/> Difficulty Parenting Due to Lack of Family/Social Support V61.20 <input type="checkbox"/> Questionable Mother/Child Attachment V61.7 <input type="checkbox"/> Abortion Sought or Attempted this Pregnancy V61.4 <input type="checkbox"/> Maternal Substance Abuse (alcohol, street, prescription or OTC drugs as documented by self-report, drug screen or court record)</p> <p>V60.0 <input type="checkbox"/> Homelessness V17.0 <input type="checkbox"/> Maternal Mental Illness, Especially Depression V18.4 <input type="checkbox"/> Maternal Mental Retardation V16-V19 <input type="checkbox"/> Maternal Physical Illness or Disability Affecting Care of Child V60.2 <input type="checkbox"/> Inadequate Material Resources Affecting Care of Child V62.5 <input type="checkbox"/> Parental Incarceration XXX.16 <input type="checkbox"/> Three or More Injuries in 1 Year Requiring Medical Attention XXX.06 <input type="checkbox"/> Other Maternal Conditions Significantly Affecting Care of Child Specify _____</p>
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SECTION D SIGNATURES

Name of Person Completing Form	Agency	Phone	Date
Parent Signature (encouraged but not required for referral)		Parent Informed of Referral? Yes/No	

Child's Name: _____	Mother's Name: _____
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SECTION E LEVEL 2 RISK CONDITIONS
(Circle all that apply) (Medical/Biological Conditions Present in Child Indicating Referral to Public or Private Sector Care)

Conditions Identified in Newborn Period

- ☞ 765.0 Birth weight ≤1000gms (2lbs. 3oz.)
- ☞ 765.14-765.15 Birth weight ≤ 1500 Grams (3lbs.5oz.) and >1000gms
- 770.9 Significant Respiratory Distress (vent. > 48hrs)
- ☞ 768.5 Apgar ≤ 3 at 5 Minutes (asphyxia)
- ☐ 772.1 Intraventricular Hemorrhage (IVH) Grade III or IV
- ☐ 434.9 Periventricular Leukomalacia (PVL)
- ☞ 774.6 Hyperbilirubinemia Requiring Exchange Transfusion
- 777.5 Necrotizing Enterocolitis Requiring Surgery
- ❖ 770.7 Bronchopulmonary Dysplasia
- 779.0 Seizures in Newborn
- 770.8 Apnea
- 362.21 Retinopathy of Prematurity
- 767 Injury During Perinatal Period

Serious Problems or Abnormalities of Body Systems

- ❖ ☐ ☞ 749 Cleft Palate/Lip
- ❖ 750-751 Digestive System
- ❖ 752-753 Genito-Urinary System
- ❖ 745-747 Heart/Circulatory System
- ☞ 744 Head, Ear and Neck
- ❖ 756 Musculoskeletal System
- ❖ 748 Respiratory System
- ❖ 493 Asthma
- ❖ 759 Other Congenital Abnormalities

Specify Conditions for All Above

Congenital Infections (Documented)

- ☐ ☞ 771.1 Cytomegalovirus
- 774.4 Hepatitis B (Infant)
- V02.6 Hepatitis B (Mother)
- ☐ ☞ 771.2 Herpes
- ☐ ☞ 771.0 Rubella
- ☐ ☞ 090 Syphilis
- ☐ ☞ 771.2X Toxoplasmosis

Other Significant Conditions

- ☐ 760.71 Fetal Alcohol Syndrome
- 783.4 Failure to Thrive/Growth Deficiency(Growth below 5th %)
- ☐ ☞ 389.9 Hearing Impairment ☐☐☐☐☐☐
- ❖ ☐ ☞ 389.9X Suspected Hearing Impairment
- ❖ ☐ 369.9 Visual Impairment
- ❖ 369.9X Suspected Visual Impairment
- ☐ 299.0 Autism
- ❖ ☐ 358-359 Neuromuscular Disorder
- 779.3 Significant Feeding Problems/
 Reflux/Feeding Tubes
- ☐ 315.9 Developmental Delay
- ☐ 315.9X Suspected Developmental Delay
- ☐ 315.3 Speech/Language Delay
- ♥ ❖ 984 Lead Level ≥ 20ug/dl (Venous)
Specify _____
- ♥ 984.X Lead Level ≥ 10 <20 ug/dl (Venous)
Specify _____
- ☞ 960.6 –960.8 Ototoxic medications
- ☞ 854.00 Head Trauma
- ☞ 382.9 Recurrent or persistent otitis media
- ☞ 237.72 Neurofibromatosis Type II and
neurodegeneration disorders
- ❖ XXX.03 Other Medical Condition(s) Affecting Child
Specify _____

Acquired Infections (Documented)

- ☞ 323.9 Encephalitis
- ☐ ☞ 320 Meningitis, Bacterial
- ☞ 321 Meningitis, All Other

Clinical Evidence of CNS Abnormality/Disorder

- 779.9 Abnormal Reflexes/Motor Functioning
- ❖ ☐ 343 Cerebral Palsy
- ☐ 740 Anencephalus
- ❖ ☐ 742.3 Hydrocephalus
- ❖ ☐ 742.1 Microcephalus
- ❖ ☐ 741 Spina Bifida/Myelomeningocele
- ☐ 348.3 Encephalopathy
- ❖ ☐ 345 Seizure Disorder/Epilepsy

Genetic Conditions

- ❖ ☐ ❖ 758.0 Down Syndrome
- ❖ ☐ 758 Major Chromosomal Abnormal Specify _____
- ❖ ☐ ❖ XXX.07 Metabolic Disease Specify _____
- ❖ ❖ 282 Hemoglobinopathy Specify _____

SECTION F REFERRAL CRITERIA LEGEND

Symbols indicate conditions addressed by the programs below. The *Children 1st* Coordinator/appropriate staff should make referrals.

- High Risk Infant Follow-Up if <1 year ❖ Genetics
- ❖ Children's Medical Services ♥ Lead Program
- ☐ Babies Can't Wait if <3 years ☞ Track/Monitor for Hearing Loss

SECTION G COMMENTS

Comments:

SECTION H FOR HEALTH DEPARTMENT USE ONLY

Date Form Received _____

Source of Referral (circle only 1):

Birth Certificate	Head Start	School
Hospital	Pre-K	Daycare Center
Physician	Parent	Public Health
DFCS	UNHS	Other _____
SSI (Supplemental Security Income)		

Date Assessment Completed: _____

Referrals Resulting from Assessment

Yes	No
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Date of Referral Directly to PH Programs
(Level 2 only): _____

Reason for Discharge (circle only 1):

Cannot Locate	Unresponsive
Pending in _____	Moved out of State
Active in _____	Moved out of Care
Inappropriate Referral	
Consent Withdrawn/Refused Date: _____	
Out of Service Age Group	