

Interagency Collaboration Guidebook:  
A Strategic Planning Tool for Child Welfare & Part C Agencies

*developed by the*

**JFK Partners  
Early Identification Project**

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# Interagency Collaboration Guidebook: A Strategic Planning Tool for Child Welfare & Part C Agencies

## TABLE OF CONTENTS

<b>Introduction.....</b>	<b>1</b>
<ul style="list-style-type: none"> <li>▪ What is the Early Identification Project?</li> <li>▪ Why use a community collaborative approach?</li> <li>▪ Who are the key players in collaboration for this community?</li> </ul>	
<b>Guide 1. Defining the Problem.....</b>	<b>3</b>
<ul style="list-style-type: none"> <li>▪ How can more children receiving child welfare services be screened for Part C eligibility?</li> <li>▪ Supporting Evidence: What does national research indicate about this population of children?</li> <li>▪ Statewide &amp; Local Data: What is the status of these children in Colorado &amp; in this community?</li> </ul>	
<b>Guide 2. Understanding Part C &amp; Child Welfare Services.....</b>	<b>5</b>
<ul style="list-style-type: none"> <li>▪ Defining Part C: Federal, State, &amp; Local Roles &amp; Responsibilities How are Part C services provided in this county?</li> <li>▪ Defining Child Welfare: Federal, State, &amp; Local Roles &amp; Responsibilities How are child welfare services provided in this county?</li> </ul>	
<b>Guide 3. Understanding Parents’ Rights &amp; Responsibilities.....</b>	<b>14</b>
<ul style="list-style-type: none"> <li>▪ What is the role of the caseworker in the Part C consent process?</li> <li>▪ What are the rights and responsibilities of parents and foster parents?</li> <li>▪ What is a surrogate parent for Part C and how do you become one?</li> </ul>	
<b>Guide 4. Identifying Existing Resources.....</b>	<b>19</b>
<ul style="list-style-type: none"> <li>▪ Financial: What is the Part C Funding Hierarchy?</li> <li>▪ Medical: How can Public Health and EPSDT be utilized for Part C services?</li> <li>▪ Legal: What can be the role of the Courts and CASAs in securing Part C services?</li> </ul>	
<b>Guide 5. Strengthening Interagency Collaboration.....</b>	<b>29</b>
<ul style="list-style-type: none"> <li>▪ Which local agencies are currently involved in serving children 0-3?</li> <li>▪ What formal/informal arrangements are in place between/among agencies?</li> <li>▪ What is a suggested framework for child welfare and Part C services collaboration?</li> </ul>	
<b>Guide 6. Designing the Community Collaborative Plan.....</b>	<b>35</b>
<ul style="list-style-type: none"> <li>▪ Which individuals/agencies will provide leadership in developing collaboration?</li> <li>▪ What “next steps” has the community identified toward collaboration?</li> <li>▪ What is the timetable for local collaboration efforts?</li> </ul>	
<b>References.....</b>	<b>37</b>
<b>Appendices:</b>	
<b>A. Resource Materials for Community Meetings .....</b>	<b>38</b>
<b>B. MOU – CDE &amp; DHS.....</b>	<b>44</b>
<b>C. FSP &amp; IFSP Forms.....</b>	<b>45</b>
<b>D. CDE Policy – Part C Surrogate Parent.....</b>	<b>46</b>
<b>E. Part C Funding Hierarchy.....</b>	<b>47</b>

## INTRODUCTION

### **What is the Early Identification Project?**

The purpose of the Early Identification Project is to enhance the identification and referral of infants and toddlers involved with county child welfare agencies to local Part C early intervention services. The Early Identification Project is funded by a four-year federal grant from the Office of Special Education and Rehabilitative Services (OSERS) awarded to JFK Partners in September 1999.

### ***The statewide goals for the Early Identification Project are:***

- Increased collaboration between Child Welfare, Part C, the Parent Training Initiative (PEAK Parent Center) and other agencies at state and local levels
- Increased referrals of eligible children from Child Welfare to Part C
- Increased enrollment into Part C of eligible children under one year of age

The need for the Early Identification Project was identified based on an analysis of statewide data showing a significant number of children receiving social services who were potentially eligible for Part C services, yet had not been referred.

A pilot study for the Early Identification Project (EIP) began in Arapahoe County in December 1999. Health and developmental screenings were provided to a 60 children ages birth to three who were “open” cases with the Department of Human Services. Based on the clinical opinions of a developmental pediatrician and a certified nurse practitioner, 63% of the children were determined eligible for Part C early intervention services.

The results of the Arapahoe County pilot indicate that local collaboration between child welfare and Part C agencies is necessary to ensure appropriate identification and referral of children within child welfare who are eligible for Part C. The Early Identification Project plans to work with local communities to help them develop interagency linkages to increase the number of children identified and referred for Part C early intervention services.

### **What are the objectives of this guidebook?**

This guidebook will provide communities with a format for learning about Part C early intervention services, child welfare services, and how the two systems, along with other community partners can collaborate to improve the identification of Part C eligible children within the child welfare system.

After completing this guide, participants will be able to:

- 1) Describe Part C services
- 2) Describe Child Welfare Services
- 3) Describe the rationale for early developmental screening of children in child welfare
- 4) Identify community strategies for identifying Part C eligible children in the child welfare system
- 5) Develop a community plan for improving the identification of Part C eligible children within the child welfare system

### **Why use an interagency collaboration approach?**

We believe interagency collaboration at the local level will be vital to achieve the goals of the Early Identification Project. We have identified a potential gap in services that Colorado provides to young children. We believe that the solution to assure that young children receive all the services they need will come from the agencies that serve young children at the local level.

### **Who are the key players in successful collaboration?**

The involvement of many agencies will be essential for the project's success. Any agency invested in serving young children and families are potential partners in this project. Potential stakeholders include:

- Parents and Family Advocacy Groups
- Local Early Childhood Connections
- Child Find Agencies
- Primary Health Care Providers
- Mental Health Centers
- Early Head Start
- County Department of Social Services
- Department of Health/Public Health Nursing
- Court Appointed Special Advocates (CASA)

### **Discussion:**

- **In what ways do these agencies work together in your community?**
- **How is working together helpful for children and families? What are the challenges?**

## **GUIDE 1: DEFINING THE FOCUS**

### **What issue does the Early Identification Project seek to address?**

The Early Identification Project is working to increase identification of Part C eligible children within the child welfare system. The children in the child welfare system who may be at risk for needing early intervention services through Part C include children in foster care, children relinquished for adoption and children in families receiving family preservation services.

### **What is known about the developmental status of children receiving child welfare services?**

#### ***National Research***

National research shows that children in foster care have a high risk of having developmental delays: (See “Fast Facts” Sheet in Appendix A for details and sources)

- 50-60% of children in foster care exhibit developmental problems
- Children with four risk factors by age two develop learning disabilities, behavioral problems, and mental illness; children in foster care have 14+ risk factors
- 80% of foster children have at least one chronic medical condition; 25% have 3 or more
- Prematurity and disability are risk factors for abuse; children with disabilities are maltreated at a rate 1.7x higher than children without disabilities

Early childhood specialists also raise concerns about the health and development of children in child welfare. In *From Neurons to Neighborhoods*, a book summarizing the science of early childhood development, the authors recommend that “all children who are referred to a protective service agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of the Individuals with Disabilities Act.” (Shonkoff and Phillips, 2000, p. 402)

#### ***Arapahoe County Pilot Project***

In Arapahoe County, we provided developmental evaluations to 60 children ages 0-3 with open child welfare cases. The children were randomly selected from all open cases. The evaluation consisted of a family history questionnaire, the Ages and Stages Questionnaire completed by the family or foster family, the Bayley Scales of Infant Development, and a physical and developmental examination by a developmental pediatrician.

Of the 60 children who received developmental evaluations, 63% were determined eligible for Part C based on clinical opinion. Fifty-two percent scored below the cutoff in at least one area on the Ages and Stages Questionnaire. Thirty-five percent scored 1.5 standard deviations below average on either the mental or motor scale of the Bayley. (See Slides in Appendix A for additional data)

As part of the pilot project, we talked to caseworkers in Arapahoe County who had clients who had received a developmental screening. Few of the caseworkers indicated that they knew about Part C before the study, and none had heard of Arapahoe Early Childhood Connections. The caseworkers indicated that their training regarding child development and developmental screening is limited. The caseworkers said they were open to the idea of universally screening children in the child welfare system, but had concerns about the capacity of the early intervention system.

### **What does Colorado data indicate?**

In Colorado, few children in child welfare are also enrolled in Part C. This information is based on data from CWEST (the Department of Human Services data system) and the Part C data count for 2000.

#### **2000 Data**

Number of children (0-3) in Child Welfare	Number of children in Part C	Number of children in both systems
7,133	3,789	313 (4.4%)

### **What does local data indicate?**

\_\_\_\_\_ County

Number of children (0-3) in Child Welfare	Number of children in Part C	Number of children in both systems

### **What happens next?**

The Arapahoe County Pilot Study indicates that many children in child welfare may be eligible for Part C services. The Colorado data shows that the overlap between children receiving services from both child welfare and Part C is low. The Early Identification Project is prepared to meet with individual communities in an effort to stimulate community examination of their system of services to young children. Early Identification Project team members will facilitate collaboration and assist with identification of resources within the community to ensure that infants and toddlers in the child welfare system are identified and referred to early intervention services as needed.

## GUIDE 2: OVERVIEW OF CHILD WELFARE AND PART C SERVICES

In this section, we will provide information about child welfare and Part C services from a federal and state level. Local child welfare and Part C service providers have been invited to describe how these services are implemented in your community. Questions about services provided to children and families by these two systems are welcomed to further the understanding of possible opportunities for collaboration.

### Overview of Child Welfare

- Federal – The most recent legislation affecting child welfare at the national level is the Adoption & Safe Families Act (ASFA) of 1997 (PL 105-89). AFSA set three main priorities in the delivery of child welfare services: 1) safety, 2) permanency, and 3) well-being. While the safety and protection of children is of paramount importance to child welfare, AFSA’s emphasis on permanency has had perhaps the greatest impact on how child welfare responds to cases involving neglect or abuse. AFSA guidelines require that plans for the permanent placement of children under the age of six be implemented within certain time frames to facilitate their ability to form attachments and minimize further emotional harm. As a result of this policy, many young children are placed in foster/adoption homes and are subsequently adopted by the family. Many other children are being cared for by relatives who in many cases assume permanent custody of the child.
- State – In Colorado, the Department of Human Services (DHS) has administrative responsibility for ensuring the mandates of federal legislation are implemented within the state. Federal guidelines were adopted at the state level and are reflected in Colorado state statutes commonly known as the Colorado Children’s Code (Title 19-1-101 et seq). In conjunction with the state legislature, DHS establishes state policy consistent with federal law and works with county administrations that must develop local policies and procedures for implementing child welfare services.
- Local – Counties administer child welfare services in the state of Colorado. Local offices for child welfare vary greatly in the size and scope of services available. County offices may be referred to as “Social Services”, “Human Services”, “Children’s Protective Services” (CPS), or other similar names. The county agency designated to provide child welfare services, however, is required to do so in a manner consistent with established standards in order to receive both federal and state funding. As an example, AFSA legislation requires that each case opened for

child welfare services has a Family Service Plan developed which outlines the needs of the child and family, and the ways in which those needs will be addressed. Services for certain identified needs may be paid for through social service funding for Core Services. A list of qualifying services has been established by the state, with additional services covered if so determined by the particular county.

### **CWLA Standards: Health Care Services for Children in Out of Home Care (1988)**

Written in conjunction with the American Academy of Pediatrics, the Child Welfare League of America has issued practice standards regarding health care services for children in out of home placement. The following excerpts from the standards are most relevant to the population of young children having special needs:

*Children in out of home placement are assumed to have the right to access medical services, including access to any specialized health services, and that such medical needs should be routinely incorporated into an individualized health plan.*

According to the established CWLA standards, infants and young children should 1) receive routine pediatric care through age 24 months, then 2) have at least annual follow-up that should include assessment of their physical, developmental, behavioral, and mental health status.

3.9 Health & Mental Health Services for chronically ill children and children with special needs – Recognizes high rates of health problems for children in out of home care. Child welfare agencies should assure appropriate services are provided including but not limited to speech therapy, physical therapy, occupational therapy, environmental modifications, caretaker support, counseling.

3.10 Access to Services should be provided by child welfare agencies - Recommendations include 1) resource list of local resources and service providers, 2) current information regarding appropriate and available services, and 3) recruitment of service providers and development of community resources.

4.22 Training Curriculum for caretakers and caseworkers – Should include information regarding child development and behavior.

4.26 Caretakers – Should be provided with information regarding special health needs of children.

4.34 Agency – Policy and procedures should reflect health care of children as a high priority.

## Colorado Child Welfare Practice Handbook

### ***Ch.5 Comprehensive Family Assessment***

#### 5:5 Children with Special Needs

Special needs considered as any “serious” medical, physical, and/or developmental disability. Eligibility for services based on family economic and categorical status, NOT on presence of condition. Caseworker’s role should include facilitation of family’s defining their needs and desired services.

### ***Ch. 6 Planning & Delivery of Services***

#### 6:12 The Family Services Plan

Federal law (PL 96-272) and Colorado state statute (CRS 19-1-104) requires the development and written documentation of a Family Service Plan (FSP) for every child receiving services through child welfare. The FSP must be completed within 30-60 days of case opening, depending on whether the child remains in their own home or an out of home placement is made. The FSP should 1) prioritize the child/family problems and needs, 2) define the goals and objectives in addressing those problems and needs, and 3) identify available resources that will aid in resolving the problems and meeting the needs.

#### 6:15 Core Services Program

Certain designated services are mandated to be provided throughout the state once need and eligibility for the service has been determined. The two primary purposes of “core services” are to prevent out of home placements, and to facilitate family reunification and/or permanency for children in out of home placement. Identified core services include: home-base intervention, intensive family therapy, sexual abuse therapy, day treatment, life skills, special economic assistance, mental health services, substance abuse treatment services, and after-care service. In addition, counties may determine if other services meet the purpose of the core services program and can designate funding for such services as deemed appropriate.

### ***Ch.7 Achieving Permanency***

#### 7:12 Special Needs Adoption Subsidies

Eligibility for adoption subsidy based on 1) physical disability, 2) mental retardation, 3) emotional disturbance, 4) hereditary factors, 5) high-risk infants, or 6) other conditions deemed as barriers to adoption.

***Funding for adoption subsidies are available from two sources:***

- Federal IV-E monies when Medicaid eligibility is met
- State/County monies for Family Maintenance payments when ineligible for Medicaid

## **Ch. 8 Placement**

### 8:42 Common Issues Requiring Teamwork Between Providers & Caseworkers

Collaboration regard children with special needs is NOT mentioned, but should be considered in at least two placement situations:

- Fost-adopt placements – Prospective adoptive parents should be given information regarding a foster child’s developmental status and any future considerations.
- Reunification with birth parents – Transitioning of the IFSP and continuity of early intervention services should be including in reunification planning.

### **Appendix I: Stages of Child Development**

#### 19:28 Children with Developmental Disabilities

Addresses parental response to birth of child with handicapping condition. Notes that the additional demands of the daily care could contribute to increased risk of abuse or neglect.

#### 19:29 Effects of Maltreatment on Development

Maltreatment contributes to higher risk for developmental delays, both cognitive and motor. Notes the special vulnerability during the prenatal and infancy experience. Possible sociobehavioral effects of maltreatment include learning problems, irritability, impulsivity and poor social skills. Effects can be diminished or exacerbated by quality of caretaking and other environmental factors.

***“At all ages of childhood...maltreatment can interfere with... developmental tasks.”***

### **Appendix E: Developmental Disabilities**

This appendix provides a reprint of the “Start Here! Guide to Resources and Services for Families of Children with Disabilities.”

#### 15:3 List of Advocacy agencies & support groups

#### 15:13 List of County Part C Coordinators with contact information

#### 15:15 Family-Based Intervention in Working with Children with Developmental Delays

Prepared by Dr. Virginia Cruz, this section identifies specific impairments to adaptive functioning and areas of development to be routinely evaluated. Degrees of mental retardation as defined by DSM-IV criteria is outlined, and considerations in assessing abuse or neglect with children with developmental disabilities are discussed.

#### 15:23-15:60 Definitions & general information on 12 disabling conditions



## Overview of Part C

### What is “Part C”?

Part C is a component of the federal law (PL 105-17) known as the Individuals with Disabilities Education Act (IDEA) passed in 1997. The Part C component of the law provides financial assistance to States to maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities or developmental delays and their families. The law specifically states that another purpose of the financial assistance is to enhance the capacity of state and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations. (34 C.F.R.§303.1)

### History of Education Legislation for Children with Disabilities

1975	P.L. 94-142, Education for All Handicapped Children Act	◆ Landmark legislation establishing free, appropriate public education for children with disabilities ◆ Did not address infants and toddlers
1986	P.L. 99-457, Education of the Handicapped Amendments of 1986	◆ Established early intervention programs for children and toddlers with disabilities
1990	P.L. 101-476, Individuals with Disabilities Education Act (IDEA)	◆ Changed the name of the law ◆ No major changes for infants and toddlers
1997	P.L. 105-17, Individuals with Disabilities Education Act Amendments of 1997 (IDEA '97)	◆ Part H of the P.L. 99-457 became Part C of P.L. 105-17

**NOTE:** The federal legislation describes who is eligible for Part C. Each state is responsible for defining the scope of eligibility and the services that are provided to families.

### **Who qualifies for Part C services?**

Part C services are available to infants and toddlers (age birth through two years) who:

- Are experiencing significant delays in cognitive, physical, communication, social, emotional, or adaptive development, or
- Have a physical or mental condition with a high probability of resulting in developmental delay.

### **How is eligibility for Part C determined?**

Part C requires the lead agency to implement a comprehensive child find system to identify, locate, and evaluate children needing early intervention services. Children with certain conditions or risk factors are automatically eligible for Part C services. These conditions include:

- ❑ Chromosomal syndromes, including but not limited to Down Syndrome, Turner's Syndrome, and Fragile X
- ❑ Congenital Syndromes or Conditions, including but not limited to Apert's, Fetal Alcohol, hydrocephaly and meningocele
- ❑ Sensory Impairments
  - Hearing impairment or deafness
  - Vision impairment or blindness
- ❑ Metabolic disorders, including but not limited to galactosemia and osteogenesis imperfecta
- ❑ Pre- and Peri-natal conditions resulting in significant medical problems such as
  - TORCH infections (congenital infections including syphilis and cytomegalovirus)
  - Severe intraventricular hemorrhage (Grade 3 or 4) , periventricular leukomalacia
  - Exposure to teratogens including drugs or alcohol
  - Cerebral palsy
  - HIV Positive
  - Meningitis
  - Very low birth weight (1200 grams or less)

***When a child is identified as being potentially eligible for Part C, the law requires a formal referral to be made to Part C within two working days of identification. Part C requires timely comprehensive, multidisciplinary evaluations to determine initial and continuing eligibility. All children who are referred to Part C are required to have an evaluation completed and (for those determined eligible) an Individual Family Service Plan developed within 45 days of referral.***

**What services does Part C provide?**

- ❑ Part C early intervention services are designed to meet the developmental needs of the eligible child and the needs of the family to enhance the child's development.
- ❑ Every family with an eligible child receives a service coordinator who helps the family navigate the system of early intervention services, secure funding for services, and provides support for the family.
- ❑ The early intervention services provided to the family are based on an Individual Family Service Plan (IFSP). Part C services are family-centered, and the family is important to the development of the IFSP. The IFSP includes information about the child and family, specific early intervention services needed, and expected outcomes. The service coordinator is responsible for the implementation of the IFSP, in coordination with other agencies and people as needed.

**How is Part C Implemented in Colorado?*****State Level Implementation***

- ❑ The Colorado Department of Education (CDE) is the lead agency for implementing Part C.
- ❑ The Colorado Interagency Coordinating Council (CICC) is an interagency advisory group that sets policy direction for Part C and advises CDE in Part C implementation. The Department of Human Services is represented on the CICC, along with the Department of Public Health and Environment (HCP Program) and Health Care Policy and Financing, as well as other programs and agencies.
- ❑ The state is responsible for assuring that the required components of Part C are in place across the state.

***County Level Implementation***

- ❑ Early Childhood Connection agencies (ECC's) are responsible for the local implementation of Part C. ECC agencies are county or sometimes multi-county programs.
- ❑ Child Find agencies (usually through the school districts) identify and evaluate children who are potentially eligible for Part C. By state education rules, school districts are responsible for maintaining year round child find services to screen, evaluate, and provide multidisciplinary assessment for all Part C eligible infants and toddlers.
- ❑ Service coordinators (provided through ECC or partner agencies) are responsible for assuring that individual children and families receive their entitlements.

**Who can refer a child to Part C?**

Any concerned person who has knowledge of the child can refer a child to ECC for an assessment. This can include the birth parent, foster parent, caregiver, social worker, medical workers, grandparents, or extended family members.

**How can a child be referred?**

*Persons interested in referring a child can call toll-free 1-888-777-4041. This number will automatically connect you with the local ECC agency.*

**Will all referred children be assessed?**

All children who are referred should be screened and if concerns are confirmed a full evaluation will be completed within forty-five calendar days.

**Who pays for the Child Find assessment?**

The assessment is a free service through ECC. The family is not required to pay.

**Who will help the family decide which services would be most helpful?**

A service coordinator can assist the family in making decisions about services being suggested for their child. Service coordination is a free service to the family under Part C.

**What kind of questions can the family ask the service coordinator?**

Any kind of question that concerns the family can be asked to the service coordinator. The service coordinator will help the family find resources to answer their questions. It can be questions about car repair, buying clothes, finding childcare, locating a food bank, etc. The questions can be about, but not limited to, medical needs of the child.

**DISCUSSION QUESTIONS:**

- **How is Part C implemented in this community?**
- **Where is the local ECC office?**
- **Who is the lead contact person for the local ECC?**
- **How many children are served through the local ECC?**
- **How many service coordinators are available?**
- **What is the best way to make referrals for Part C evaluation?**

### **GUIDE 3. UNDERSTANDING PARENTS' RIGHTS AND RESPONSIBILITIES**

#### **What is the process for obtaining consent to evaluate or provide services for a child that may be eligible for Part C of IDEA?**

Written parental consent must be obtained before conducting the initial evaluation and assessment of a child and before initiating the provision of early intervention services. If consent is not given, the public agency shall make reasonable efforts to ensure that the parent is fully aware of the nature of the evaluation and assessment or the services that would be available; and understands that the child will not be able to receive the evaluation and assessment or services unless consent is given.

#### **How is parental consent defined?**

Prior to giving consent, the parent must be fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication. Consent is obtained when the parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

#### **Can a state agency challenge the decision of a parent who refuses to consent?**

A public agency may initiate procedures to challenge a parent's refusal to consent to the initial evaluation of the parent's child, and, if successful, obtain the evaluation. In challenging a parent's decision to refuse consent, the decision would go to a due process hearing and be decided by a due process hearing officer. Parents have the right to appeal the decision of a due process hearing officer. This provision applies only to parental consent for evaluation, and not to delivery of early intervention services. Part C law gives the parents the right to accept or decline early intervention services and does not provide for state agencies to challenge parents' decisions.

#### **How is a parent defined under Part C?**

*Part C regulations define "parent" to mean--*

- (1) A natural or adoptive parent of a child;
- (2) A guardian;
- (3) A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare); or
- (4) A surrogate parent who has been assigned in accordance with Sec. 303.406.

**Who has parental rights for a child living out of the home of the natural parent?**

If parental rights have not been terminated, then the natural parents are considered responsible for providing parental consent, unless a court has appointed a guardian with educational decision-making authority for a child or the parent has given the responsibilities of parenting to another person (e.g. a grandparent). If the parent maintains parental rights but cannot be located, and educational decision-making has not been granted to another person either through the courts or by the parents, then a surrogate parent should be assigned.

**What are the rights of parents who are incarcerated?**

Parents who are incarcerated still have the same parental rights as any parent. Incarceration alone is not reason enough to terminate parental rights. Efforts should be made by the caseworker to notify a parent who is incarcerated of any assessment and/or services the child may need and consent should be requested.

**What is a surrogate parent under Part C law?**

A surrogate parent acts on behalf of the child when 1) No parent has been identified for the child 2) After reasonable efforts, the parents cannot be located, and 3) The child is a ward of the state. The surrogate parent may represent the child in all matters related to the evaluation and assessment of the child, the development and implementation of the child's IFSPs, and the ongoing provision of early intervention services to the child.

**Who may serve as a surrogate parent?**

Any individual who is a Colorado resident, over 18 years old, and does not have an interest that conflicts with the interest of the child may serve as a surrogate parent. Additionally, individuals must complete the Colorado Department of Education's Training for Part C surrogate parents. Guardian ad litem can be appointed as surrogate parents, but they must attend Part C surrogate parent training, unless a court appoints them and specifically gives them authority to make educational decisions.

**What is the role of foster parents in obtaining Part C services for foster children?**

A foster parent may act as a parent under Part C of the Act if 1) the natural parents' authority to make the decisions required of parents under the Act has been extinguished under State law; and 2) the foster parent has an ongoing, long-term parental relationship with the child, is willing to make the decisions required of parents under the Act, and has no interest that would conflict with the interests of the child. If either criterion for foster parents is not met, and the natural parents cannot be located, then a surrogate parent should be assigned.

**What is the role of caseworkers in obtaining Part C services for a child?**

The county department caseworker is an integral and valued part of the student's educational planning and decision-making team. Participation is essential and appreciated due to the caseworker's knowledge of and the professional relationship with the child/youth. Under IDEA rules, caseworkers are not authorized to give permission for assessment or placement in a special education program due to the possibility of a conflict of interest. Due to this potential conflict of interest, caseworkers are unable to act as an educational or Part C surrogate parents for children on their caseload or with other children in the county department who require an educational or Part C surrogate parent. However, caseworkers may request surrogate parent training to increase their knowledge of the IFSP or IEP process, educational services, children's rights, and due process.

**How else is the caseworker involved with the parent in the Part C process?**

For any child receiving child welfare services and determined eligible for Part C services, the caseworker should be considered as part of the planning team involved with the child and family. Caseworkers often will play a key role in initiating a referral for a developmental assessment and informing the parent about the child's developmental needs. The caseworker should participate in the development of the Individualized Family Service Plan and incorporate the plan for meeting the child's special needs within the Family Service Plan (FSP).

- *In cases where a child is returned to the custody of the parent, the caseworker should incorporate the continuation of the child's services as part of the FSP.*
- *In cases where the parent's rights are terminated and the child is adopted, the caseworker should provide information to the adoptive parents about the nature of the child's special needs and help include the adoptive parents in assuring that services for the child continue without interruption.*

## **RESOURCES FOR PARENTS & FAMILIES OF CHILDREN WITH SPECIAL NEEDS**

### **What services does PEAK Parent Center offer?**

- Up-to-date disability information
- Information about special education process
- SPEAK OUT newsletter
- Calendar of Parent Support Activities in conjunction with the Colorado Department of Education. Available in print or at [www.peakparent.org](http://www.peakparent.org)
- Inclusion resources that show how students can be successfully included in general education classrooms
- Referral to medical, educational, child care or human services
- Training in Basic IEP, IDEA '97, Continuity, Accommodations & Modifications, Advocacy, Tolerance, and Friendship
- The annual conference on Inclusive Education in Colorado
- Resource library by appointment
- Website with current information [www.peakparent.org](http://www.peakparent.org)
- Parent Advisors answer questions and give information on resources, parent rights, and referral to parent support groups

### **Is there a cost for Peak Parent Center's services?**

These PEAK services are provided at no cost. PEAK also provides consultation, customized in-service trainings, and project evaluation services to school districts on a fee-for-service basis.

### **How can I get in touch with Peak Parent Center?**

- Call us at 719-531-9400 or 800-284-0251
- Send us a fax at 719-531-9452
- Email us at [info@peakparent.org](mailto:info@peakparent.org)
- Visit our website at [www.peakparent.org](http://www.peakparent.org)
- Write to us at 611 N. Weber St. Suite 200, Colorado Springs Co. 80903
- 1177 Grant St. suite 104, Denver CO 80203

### **Who should call Peak Parent Center?**

Parents of children with disabilities, family members, friends, individuals with disabilities, and professionals in education, medical and human services should feel free to call Peak Parent Center anytime.

**What agencies serve people with disabilities in the local community?**

- Family Voices is a national grassroots network of families and friends speaking on behalf of children with special health care needs. The state coordinator is Christy Blakely 303-973-5780 or email at [www.Christy957@aol.com](mailto:www.Christy957@aol.com). The website for the national organization is <http://www.familyvoices.org>.
- The local Early Childhood Connections has the mandate for birth through two years old. The number to reach the local ECC is 1-888-7774041 or visit the web page at [www.cde.stste.co.us](http://www.cde.stste.co.us).
- The Community Centered Board (CCB) is the agency that helps individuals with developmental disabilities and their families who live in the area served by the Board. It serves people from birth-to-death. For a local contact call the Colorado State Councils on Developmental Disabilities at 720-941-0176 or visit their web page at [www.cddpc@state.co.us](http://www.cddpc@state.co.us).
- Child Find is a program within the public school system designed to identify children birth to twenty-one years that might need special education supports. For more information on a local contact call the Colorado Department of Education at 303-866-6943 or visit their web page at <www.cde.state.co.us>.
- Public Health Department and nursing services offer a program for children who are financially eligible and have special health care needs. Every state has a Title V program which is funded, in part, through the Federal Title V Block Grant that provides health-related services to children with special health care needs. In Colorado it is the Health Care Program for Children with Special Needs (HCP). The number is 800-688-7777
- Department of Human Services serve disadvantaged families and persons with disabilities. Their toll free number is 800-536-5298 or visit the state web page at [www.state.co.us](http://www.state.co.us).
- Social Ministries such as Catholic Charities, Lutheran Family Services, Ecumenical Social Ministries all provide services to families. These are listed in the phone book under “Charities”. In addition, the local Chamber of Commerce and the local library keep listings of other philanthropic organizations, such as local Masons, and Elk Club, and Junior League chapters. To find a local contact, visit the state web page and click on community. [www.state.co.us/business-dir/chambers.html](http://www.state.co.us/business-dir/chambers.html).

## **GUIDE 4. IDENTIFYING EXISTING RESOURCES**

Strategies to improve identification of children eligible for Part C who are receiving child welfare services will involve collaboration between many programs and agencies. This section suggests resources that may be valuable to your community's strategic plan including potential funding streams, use of the court system, and programs and initiatives to engage public programs and primary care providers in the process of developmental screenings. This is by no means an exhaustive list of resources, programs, or strategies that may be valuable in your community.

### **Funding Hierarchy for Special Health Care Needs**

The primary program component funded for Part C is service coordination for children and their families to facilitate 1) the identification of developmental concerns, and 2) access to early intervention. Part C is NOT funded to pay directly for needed intervention and/or treatment services. It is important, therefore, that both Part C and child welfare personnel understand the principles regarding the financing of special health care needs for young children, and the hierarchy of funding sources to be utilized.

*Two of the guiding principles in funding special health care needs are:*

1. Access to evaluation and treatment should not be denied due to inability to pay
2. Private financing, including private health insurance, should be accessed before other public sources of funding

**Based on these principles the following funding hierarchy should be considered:**

- ❑ **Private financing** – Direct payment for services
- ❑ **Private Health Insurance**
  - Coverage dependent on individual policy benefits
  - SB 1088 – 20 visit treatment mandate may apply
- ❑ **Public Health Insurance**
  - Medicaid – EPSDT
  - CHP+ (No EPSDT)
  - HCP Title V – Developmental Evaluation Clinics
- ❑ **Public Mental Health**
  - MHASA Carve out exclusions may apply
- ❑ **Social Service Funds**
  - Title IV/TANF – Transitional support
  - Title XX/SSBG – Family Preservation  
Out of Home Placement
  - CCBG – Child care funding
- ❑ **Community Center Boards**
  - Early Intervention Resources
  - Family Support Services Program

## **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program**

### **What is EPSDT?**

EPSDT is a voluntary health care program within Medicaid for children from birth to 21 years.

EPSDT is designed to detect and treat health problems early through:

- regular medical, dental, vision, and developmental screening;
- diagnosis of problems; and
- treatment of dental, eye, hearing, and other medical problems

### **What does an EPSDT health check up include?**

- A complete health, nutritional, and developmental history
- A “head-to-toe” unclothed physical exam
- Health education
- Growth and developmental checks
- Urine and blood tests if needed
- Baby immunizations, if needed
- Additional tests or exams, as needed

The child’s age determines which parts of the check up the child receives. For children under one year, 6-8 check ups per year are recommended. For children age one to two years 2-3 check ups per year are recommended.

### **Who is eligible?**

Any child age birth to 21 with a current Medicaid card is eligible for EPSDT services.

### **How is EPSDT implemented?**

EPSDT has two components: Direct Services and Outreach. The direct service component includes the services the child receives from the Primary Care Physician when the family requests and EPSDT Health Check. The outreach component includes a county-based EPSDT outreach worker. The EPSDT outreach worker is available to assist families with enrolling in Medicaid, making appointments and accessing other health-related resources in the area.

*To find out more about EPSDT or to locate the EPSDT outreach worker in your county, contact your county health department or nursing service, or call*

**303-692-2229 (Denver Metro)**

**1-800-688-7777 (Statewide)**

## **Medical Home**

### **What is a medical home?**

A medical home is an approach to providing health care that involves partnership between the child's family, the primary care provider, and community resources. The Maternal and Child Health Bureau defines the medical home as a source of ongoing routine health care in the community where providers and families work as partners to meet the needs of children and families. The American Academy of Pediatrics endorses the medical home concept and expects care delivered in a medical home to be accessible, continuous, comprehensive, family centered, coordinated and compassionate.

One of the key components of a medical home is the delivery of preventive care that includes developmental assessments and appropriate screenings. The delivery of health care within a medical home increases early detection of health and developmental problems. Because care delivered in a medical home involves partnership with community resources, it also increases referral to early intervention services.

### **Colorado's Medical Home Initiative**

The Health Care Program for Children with Special Needs (HCP) within the Colorado Department of Public Health and Environment is coordinating a medical home initiative in Colorado that includes the Colorado Chapter of the American Academy of Pediatrics, JFK Partners, Family Voices, and various private providers and other community partners. The goal of the initiative is to assure that all children with special health care needs receive primary care within a medical home. The Medical Home Initiative will include training for primary care providers and families across Colorado about the concept of the medical home and how to implement medical homes in various primary care settings.

*For more information about Colorado's Medical Home Initiative, contact Kathy Watters, Director of HCP at 303-692-2417*

## **Public Health: Health Care Program for Children with Special Needs and Developmental Evaluation Clinics**

### **What is the Health Care Program for Children with Special Needs?**

The Health Care Program for Children with Special Needs (HCP) assists families in identifying, accessing and paying for needed health care and support services for their children with special health care needs. The program works with other programs, agencies and organizations to develop coordinated, community based systems of care to meet the needs of families. Through contracts with local public health agencies, the program assists families in understanding and coordinating available resources including:

- Medicaid
- Social Security Income (SSI)
- Child Health Plan Plus (CHP+)
- Special education and developmental disabilities services

HCP also funds medical specialty services for low-income children with eligible diagnoses who are not eligible for Medicaid or CHP+.

*HCP is organized regionally. To find out who to contact in your regional office, you may call the State HCP office at the Colorado Department of Public Health and Environment at 303-692-2370.*

### **What are Developmental Evaluation Clinics?**

Developmental Evaluation Clinics (D&E clinics) provide comprehensive developmental evaluations for children who have developmental delays. The clinics always include a developmental pediatrician or pediatric rehabilitation physician. They also include consultation by one or more related disciplines, including physical, occupational, or speech therapy. Developmental evaluation clinics are a joint effort between the Colorado Department of Public Health and Environment, the Colorado Department of Education, and Health Care Policy and Financing. Communities that have D&E Clinics also have a D&E Clinic Coordinator. Contacts are listed in the table below:

## Established Developmental Evaluation Clinics in Colorado

Location	Contact Information
Denver	Wendy Knoble 1360 Vine Street Denver, CO 80206
Sterling (Logan County)	Sherri Yahn 700 Columbine St. Sterling, CO 80524
Moffat County	Judy Shelton 970-878-3196
Pueblo	Pam Olson 719-583-4559
Alamosa County	Mark Cisneros 719-589-4313
Fremont County	Bobbie Dawes 719-275-1626
Colorado Springs (El Paso County)	Patricia Vincent CDC PO Box 25184 3090 N. Academy Colorado Springs, CO 80917
Rocky Ford (Otero County)	Lorene Nelson 719-254-5300
Durango (La Plata County)	Kelly Conlan San Juan Basin Health Dept. Box 140 Durango, CO 81302
Tri-County Health Department (Adams, Arapahoe, Douglas)	Diane Goldberg 303-368-1065
Greely (Weld County)	Jean Miles
Grand Junction (Mesa County)	John Drogos 970-243-5236

## **Mental Health**

### **Who does Colorado's State Mental Health System serve?**

Mental Health Services provides statewide services for persons with serious mental illness of all ages, including children and adolescents with serious emotional disturbances or mental illness.

### **What are the major components of Colorado's State Mental Health System?**

- 1) ***Mental Health Services (MHS)*** - is one of four units that comprise the Office of Health and Rehabilitation Services (OHRS), a major subdivision of the Colorado Department of Human Services (CDHS). MHS is responsible for providing policy oversight for the state's entire public mental health system, as well as administrative and programmatic oversight for the community mental health systems.
- 2) ***Community Mental Health Centers (CMHCs) and Clinics*** - Community mental health services are delivered through contracts with six specialty clinics and 17 not for profit community mental health centers. The state is divided into geographic service areas, and each CMHC is responsible for providing a comprehensive array of services for the residents of its assigned area.
- 3) ***Mental Health Assessment and Service Agencies***- Mental Health Assessment and Service Agencies (MHASAs) are the newest component of Colorado's public mental health service system. At present, there are nine MHASAs responsible for implementing Medicaid mental health capitation and case management programs through contracts with MHS. The MHASAs currently operate managed care programs serving all of Colorado's 63 counties. Each MHASA is responsible for managing the delivery of mental health services to Medicaid-eligible individuals in its assigned geographic service area.

*For more details, visit <http://www.cdhs.state.co.us/ohr/mhs/index.html>*

### **What's going in the area of infant mental health in Colorado?**

In Colorado, a group called the Mental Health Harambe gathers regularly to consult about early childhood mental health. The Harambe includes representatives from families, child care providers, early childhood mental health programs, governmental agencies, researchers, child care resource & referral and other stakeholders. The goal of the Mental Health Harambe is to build a statewide system (collaborative network) of providers & families who promote the social/emotional development of young children through prevention and early intervention. Find more information on the web at <http://www.corra.org/CORRAPrograms/Harambe.asp>

## **Using the Court System to Assure Developmental Screening of Young Children in Child Welfare**

Most children receiving child welfare services have some contact with the court system through child protective hearings. The role of the court in child protective proceeding was established by Congress in 1980 in the Adoption Assistance and Child Welfare Act (PL-272) and reinforced by the Adoption and Safe Families Act of 1997 (ASFA). PL 96-272 defined the court as the central decision-maker and monitor of out-of-home placements. The law required the courts to assure that “reasonable efforts” be made to prevent out-of-home placements and reunify families. While ASFA signaled a departure for an emphasis on family preservation and towards permanency and adoption, it strengthened the court’s role as the ultimate decision-maker in child welfare proceedings. Additionally, ASFA emphasized the importance of the child’s health and safety in making placement decisions and gave the courts broad authority to address the child’s health needs.

### **The Court Process**

*The attached diagram displays the role of the courts in child protection proceedings from the child’s removal from the home to placement in foster care, to substantiating the charges of abuse and neglect, to making decisions about the placement of the child.*

An emergency court order, in most cases, is required to remove a child from home. A court order is required for a child to be placed in foster care. As a part of this order, the court can order evaluations of the child and/or the family. The court order to place a child in foster care presents an opportunity for the child’s representatives to request a developmental evaluation of the child. Information gathered during this phase can be considered evidence during the adjunct hearing, when the merits of the child abuse and neglect charges are evaluated. If substantiated, the next court proceeding is the disposition hearing where the case service plan is reviewed and services are ordered. The disposition hearing is another opportunity to bring the need for developmental screening of the child to the attention of the court. While the child is in an out-of-home placement, the court reviews the case periodically until a permanent placement (either reunification or termination of parental rights and adoption) is obtained. Each review by the court represents an opportunity for the court to receive ongoing information about the child’s health and development and to order services as needed.

### **Recommendations to the Courts**

The Permanent Judicial Commission on Justice for Children is a multidisciplinary commission focused on the needs of young children whose lives are affected by the court system. The Commission has developed a checklist of ten questions to help courts identify the health needs of young children involved in child welfare proceedings. One of the items recommended by the Commission is for courts to determine whether the child has received a developmental screening by a provider with experience in child development. If the answer is no, the court has the opportunity to order a developmental screening for the child. The recommendations of the Commission underscore the vital role courts play in assuring that children receive developmental screening, and the important role of professionals who interact with the court system to utilize the influence of the courts to ensure the healthy development of young children receiving child welfare services.

### **DISCUSSION QUESTIONS:**

**Where is the appropriate court located in this community?**

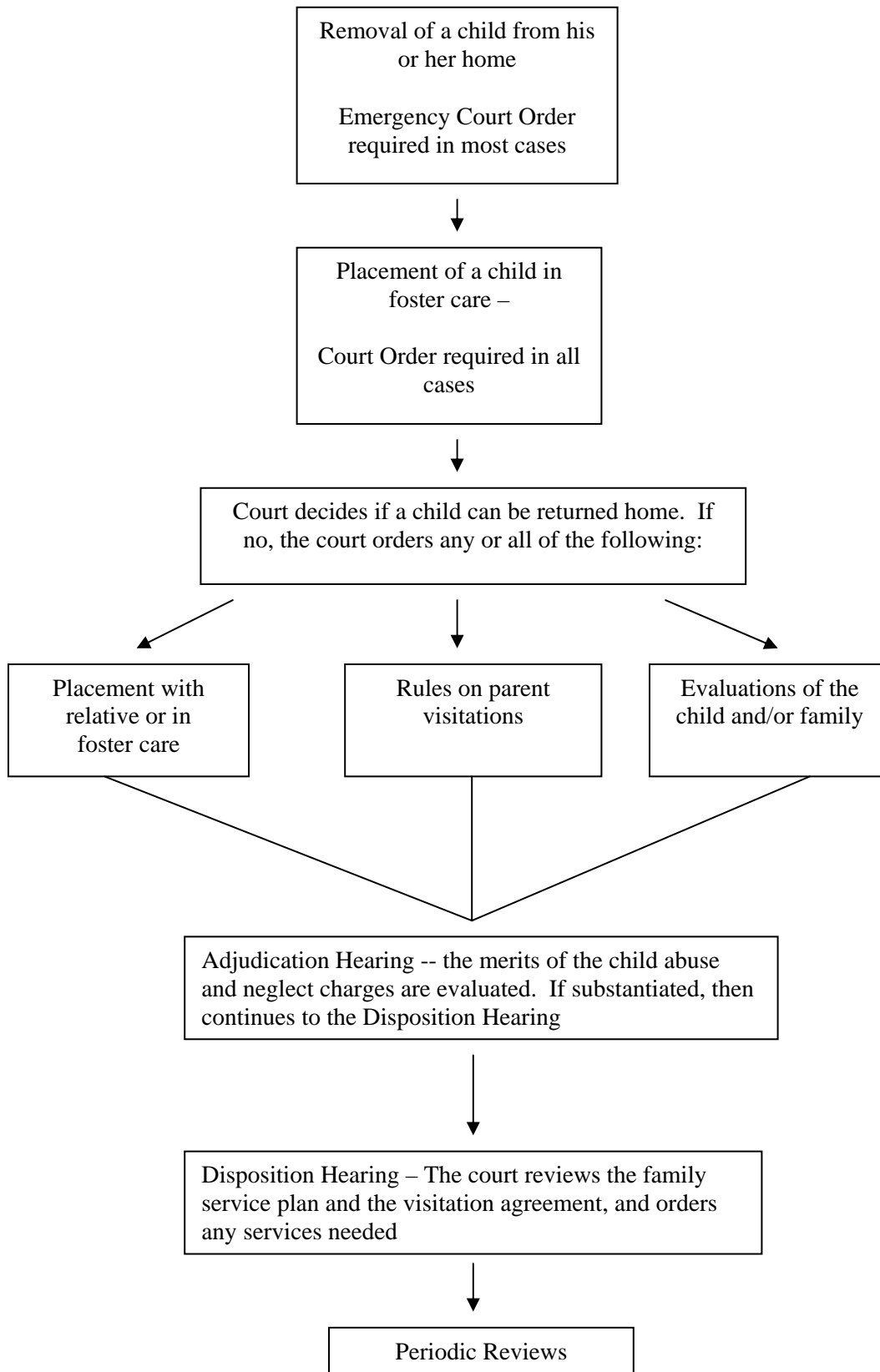
**Who are the judges and/or magistrates most concerned with this population of children?**

**How accurately does the following chart reflect judicial procedures in this community?**

**Are there legal procedures related to this population that are unique to this community?**

**What are the current arrangements with the court regarding orders for special needs services?**

### Diagram of the Court Process for Out-of-Home Placement for Children



## **CASA: Court Appointed Special Advocate**

### **What is a CASA?**

A CASA is a trained volunteer appointed by the Court to advocate for the best interests of children who have been victims of abuse or neglect, or who are involved in conflictive custody cases.

### **What exactly does a CASA volunteer do?**

CASA volunteers are assigned to an abuse or neglect case by a judge. They conduct thorough research on the background of the case, reviewing documents, interviewing everyone involved including the child. They make reports to the court, recommending what they believe is best for the child, providing the judge with information that will help her make an informed decision. CASA volunteers can be instrumental in assuring that a child or family receives services which the court has ordered. These could include such things as substance abuse counseling or special education testing.

### **What training does a CASA volunteer receive?**

CASA's undergo a full training course to learn about courtroom procedures, effective advocacy techniques, and receive information that help them serve children, including information about sexual abuse, early childhood development, and adolescent behavior.

### **How can the CASA worker benefit young children (0-3) with developmental disabilities?**

The CASA worker can assist in the process of identifying children who are eligible for Part C within child welfare services and serve as a linkage between the caseworker and Part C service coordination.

### **What counties have CASA organizations?**

#### **Adams:**

CASA of Adams County  
303-654-3378

#### **Denver:**

Denver CASA  
303-832-4592

#### **Larimer:**

CASA of Larimer County  
970-498-7904

#### **Arapahoe, Douglas, Elbert and Lincoln**

Advocates for Children  
303-695-1882

#### **Eagle, Lake, and Summit:**

CASA of the Continental  
Divide  
970-748-8090

#### **Mesa:**

CASA of Mesa County  
970-242-4191

#### **Boulder:**

Voices for Children  
303-440-7059

#### **El Paso and Teller:**

CASA of Colorado Springs  
719-329-7000

#### **Pueblo:**

CASA of Pueblo  
729-583-4902

#### **Delta and Montrose**

CASA of 7<sup>th</sup> Judicial District  
970-874-7699

#### **Jefferson and Gilpin:**

CASA of Jefferson and  
Gilpin Counties  
303-279-2742

#### **Weld:**

CASA of Weld County  
970 353-5970

## GUIDE 5: STRENGTHENING INTERAGENCY COLLABORATION

In this section, we will review the components of the IDEA '97 Part C federal law pertaining to interagency collaboration. We will examine components of successful collaboration, including some of the common barriers to collaboration. Specifically, we will look at the steps needed to increase the identification of Part C eligible children within the child welfare system, and identify opportunities for interagency collaboration within each of the steps. We will learn how your community agencies currently work together, and identify new ways that they collaborate to reach the goal of increasing identification of Part C eligible children in the child welfare system.

### **Collaboration and IDEA '97 – The State Interagency Coordinating Council**

States are required to establish an Interagency Coordinating Council (ICC) whose members are appointed by the governor (34 CFR §303.600). The functions of the State ICC are to advise and assist the lead agency in the development and implementation of the policies for the statewide early intervention system for children birth to five, including achieving the full participation, coordination, and cooperation of all appropriate public agencies in the State. To assist in establishing a coordinated statewide system, the ICC may seek information from service providers, service coordinators, parents, and others about any Federal, State, or local policies that impede timely service delivery; and may take steps to ensure that identified system problems are resolved. *In establishing a statewide early intervention system, the ICC may advise appropriate agencies in the State with respect to the integration of services for at-risk infants and toddlers and their families, regardless of whether at-risk infants and toddlers are eligible for early intervention services in the State.* The ICC may also assist the lead agency in the resolution of disputes (34 C.F.R. 303.650).

The Colorado Interagency Coordinating Council (CICC) has a Memorandum of Understanding (MOU) Subcommittee. *Members of this subcommittee include representatives from the Colorado Department of Education, the Colorado Department of Human Services* (including representatives from Developmental Disabilities Services and Mental Health Services), Colorado Department of Public Health and Environment, Health Care Policy and Finance (Medicaid), and JFK Partners, Colorado's University Center of Excellence. The MOU subcommittee, along with the entire ICC advises the Colorado Department of Education regarding the development and implementation of a comprehensive, coordinated early intervention system in Colorado.

## Essential Elements of Successful Collaboration

- Recognition and Definition: There must be a shared recognition of the need for collaboration and a shared definition of the meaning of the partnership.
- Clear, Concrete Goals: Clear concrete goals form the basis of a successful collaboration.
- Effective Informal Relationships: Though formal structures are needed to stabilize collaborations, informal relationships between the collaborating partners are equally important. These include clarifying roles, developing trust, sharing anxieties, conflict resolution, and identifying resources and needs.
- Policies and Procedures: Once guiding principles are established, staff must know what is expected of them by their own agency and what they can expect of other agencies.
- Training: Multi-agency training is often a powerful catalyst for collaboration.
- Collaboration must be perceived as mutually beneficial: To ensure successful collaboration, the reasons must be clear and the stated benefits must outweigh the perceived costs.
- Shared Responsibility: All participating organizations share equal responsibility to ensure that one organization does not dominate the partnership.
- Coordination: Establishing a mechanism for coordinating the responsibilities of the partnership ensures that skills and resources will be utilized appropriately.

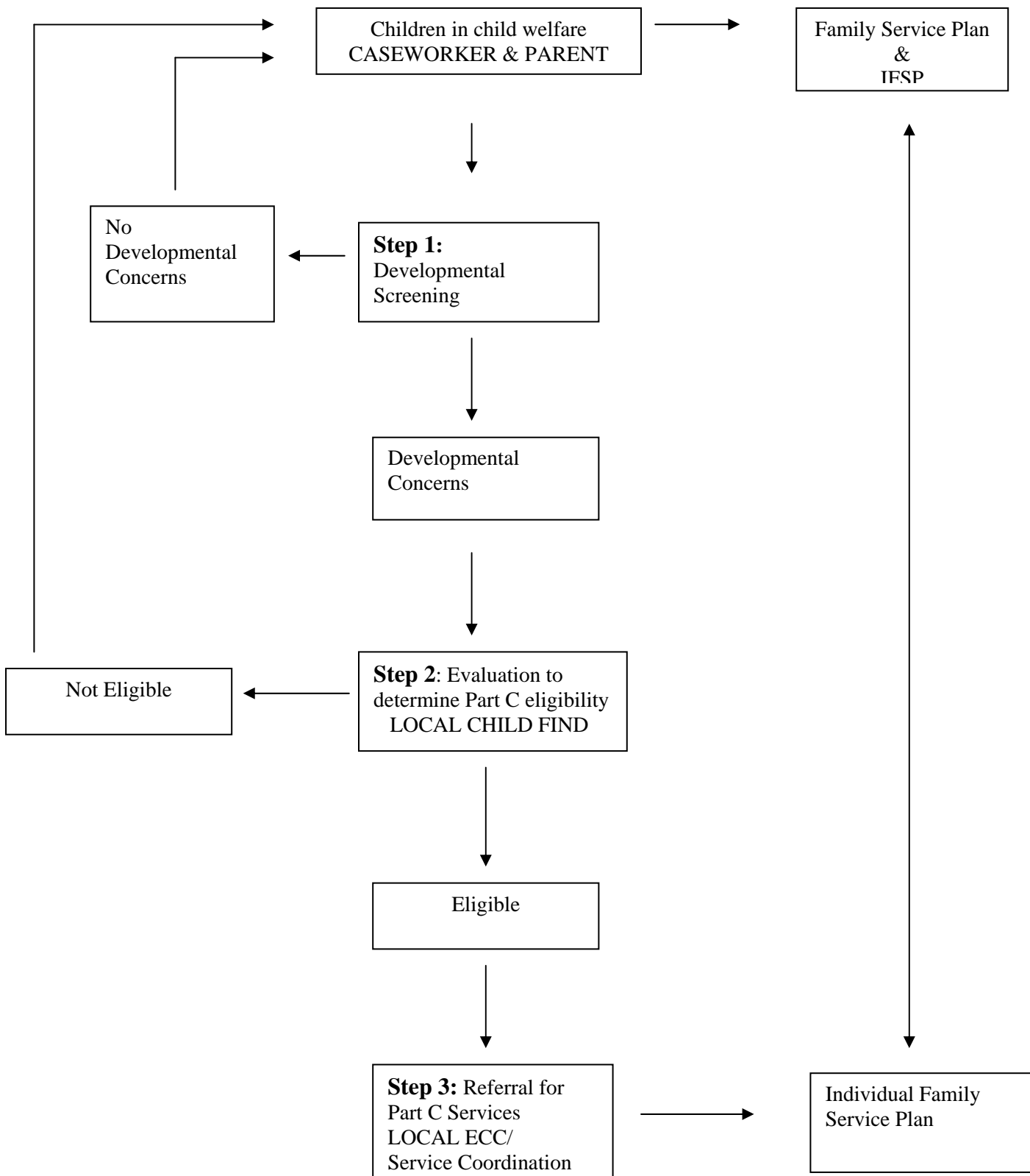
*“ Partnership or collaboration  
is about sharing information,  
accountability and communication ”.*  
(Morrison, 1993)

## Potential Obstacles to Interagency Collaboration

- Unique Agency Structures and Systems: All agencies have unique histories, cultures, and priorities. Expectations about accountability, supervision and responsibility are vastly different. These factors all make successful collaboration particularly challenging.
- Selective Communication: Information is power and sharing it symbolizes some relinquishment of authority. The sharing of information can be very threatening to one or all groups involved in the collaborative process.
- Perceived Differences in Status and Power: Differences in types of employment, professional training, occupational status, and gender, race, class, language, and public image all contribute to the sense of real and perceived power. Failure to acknowledge these issues threatens the success of collaboration.
- Conflicting Professional and Organizational Priorities: Conflicting commitments, diverse professional perspectives and different past professional experiences all make identifying collaborative priorities difficult.



### Steps to Increasing Identification of Part C Eligible Children within Child Welfare







[SAMPLE]

## **Interagency Collaboration Plan** Date of Agreement

**County Department of Human Services**  
and  
**Local Part C Organization(s)**  
*Early Childhood Connections*  
*et al*

In a collaborative effort to improve services and supports to families with young children who have special developmental needs, the above-named agencies propose the following activities:

- The Social Services administrator has been invited and has agreed to serve on the local interagency advisory council for the local ECC.
- Representatives from the local ECC and other Part C organizations have been invited and have agreed to attend monthly meetings with the Expedited Permanency Planning (EPP) group for consultation and coordination purposes.
- The local ECC will also be available as a training resource for 1) new worker and 2) foster parent orientation groups.
- To reduce duplication of services, consideration will be given for Parent Education referrals of young children ages birth to 3 to be made to a Part C organization when appropriate.
- The local ECC can be available to provide training for workers who have cases with children in Part C on their role in the development and utilization of the Individualized Family Service Plan (IFSP). [Note: DHS workers will serve as members of the IFSP team but are not responsible for completion of the IFSP paperwork.]
- Further discussion will focus on the needs of specific populations being served through DHS who have young children with special developmental needs, including teen and adoptive parents.

Proposal respectfully recorded & submitted by:

M. Kay Teel, Early Identification Project Coordinator  
kay.teel@uchsc.edu/303.355.8322

## References

### Guide 1: National research on children in foster care

See Sources on “Fast Facts on the Developmental Health of Foster Children”

National Research Council and Institute of Medicine (2000) *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Shonkoff, JP and Phillips, DA, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

### Guide 2: Part C

Early Intervention Program for Infants and Toddlers with Disabilities 34 CFR Part 303; Final Regulations (1999).

Federal Register, 34 CFR Part 303 Early Intervention Program for Infants and Toddlers with Disabilities; Proposed Rule (September 5, 2000).

National Information Center for Children and Youth with Disabilities (1998). The IDEA Amendments of 1997. NICHCY News Digest, Volume 26, Revised Edition.

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Yell, M.L. (1998). The History of the Law and Children with Disabilities. In The Law and Special Education (pp. 62-66). Upper Saddle River, NJ: Prentice-Hall.

Colorado Service Coordination Core Training Notebook, (2000). Colorado Department of Education, Early Childhood Connections for Infants, Toddlers, and Families

### Guide 4: Collaboration

Morrison, T. (1996) Partnership and Collaboration: Rhetoric and Reality. *Child Abuse and Neglect*, 20,127-140.

Hoel, JL (1998). *Cross-System Collaboration: Tools That Work*. Washington, D.C: CWLA Press.

Early Intervention Program for Infants and Toddlers with Disabilities 34 CFR Part 303; Final Regulations (1999).

### Guide 5: Resources

Dicker, S and Gordon, E. (2000) Harnessing the hidden Influence of the Courts to Enhance the Healthy Development of Foster Children. *Protecting Children*, 16:1, 36-45

Ensuring the Healthy Development of Foster Children, A Guide for Judges, Advocates, and Child Welfare Professionals. New York State Permanent Judicial Commission on Justice for Children.

## **APPENDIX A**

### **Resource Materials Used at the Community Meetings**

- 1. Child Welfare League of America – State Profile – Colorado 2002. <http://www.cwla.org/> This website may be accessed for a state specific profile.**
- 2. PowerPoint slides overview of project and summary of Arapahoe County Pilot Project**

## Child Welfare League of America

<http://www.cwla.org/>

### COLORADO'S CHILDREN 2002

State Population (2000) <sup>1</sup>	4,323,410
State Population for Children Under 18 (2000) <sup>2</sup>	1,100,795
State Poverty Rate (2000) <sup>3</sup>	7.9%
State Poverty Rate for Children Under 18 (2000) <sup>4</sup>	11%
State Poverty Rate for Children Ages 5-17 (2000) <sup>5</sup>	10%

#### CHILD ABUSE AND NEGLECT

- In 1999, 28,774 children were reported as abused or neglected and referred for investigation in Colorado, a rate of 27 per 1,000 children, representing a 53% decrease from 1998.<sup>6</sup>
- In 1999, 6,989 children were substantiated or indicated as abused or neglected in Colorado, a rate of 6.6 per 1,000 children, representing a .3% decrease from 1998. Of every 1,000 children, 4.6 were neglected, 1.8 were physically abused, and 1.0 were sexually abused.<sup>7</sup>
- In 1999, 32 children died as a result of abuse or neglect.<sup>8</sup>
- On September 30, 1999, 7,639 children in Colorado lived apart from their families in out-of-home care, compared with 7,859 children on September 30, 1998. In 1999, 22.8% of the children living apart from their families were age 5 or younger, and 20.3% were 16 or older.<sup>9</sup>

#### CHILD POVERTY AND INCOME SUPPORT

- The total number of TANF individual recipients in Colorado decreased from 95,788 in August 1996 to 27,137 in June 2001, a decrease of 72%. The number of families receiving TANF in 2001 was 10,653, also a 70% decrease from 1996.<sup>10</sup>
- In 2000, a family of three receiving only TANF and food stamp benefits in Colorado was 43% below the federal poverty guideline of \$14,630.<sup>11</sup>
- In 2000, Colorado spent \$204,624,192 in TANF funds, including 23.4% on cash assistance, 1.66% on transportation and support activities, and 0% on child care.<sup>12</sup>
- In 2000, 53% of child support cases in Colorado actually received some financial support, a 6% decrease from 1999.<sup>13</sup>
- In 2001, the fair market rent for a two-bedroom apartment in Colorado was \$792 per month, or 96% of the average monthly income for a worker earning the federal minimum wage, and 113% of the maximum monthly TANF cash assistance grant plus food stamps for a family of three.<sup>14</sup>

#### CHILD CARE, HEALTH, AND FAMILY SUPPORT

- In 1999, a monthly average of 23,790 Colorado children were in subsidized child care.<sup>15</sup>
- In 2000, 9,333 Colorado children were served by Head Start, a 2% increase from 1999.<sup>16</sup>
- In 1999, 89.7% of high school seniors graduated in Colorado, whereas 89.6% graduated in 1998.<sup>17</sup>
- An estimated 153,858 children in Colorado are uninsured. Of these, 54% are potentially eligible for Medicaid, SCHIP, and other state-sponsored programs, but they are not enrolled.<sup>18</sup>
- In 2000, the rate of births to teen mothers was 39 for every 1,000 girls ages 15-19.<sup>19</sup>
- As of December 2000, 8,143 adults and adolescents, as well as 19 children under age 13, were living with HIV/AIDS in Colorado, compared with 8,133 adults and adolescents and 34 children under age 13 in June 2000.<sup>20</sup>
- An estimated 67,213 Colorado residents need alcohol or substance abuse treatment.<sup>21</sup>

#### PERMANENT FAMILIES FOR CHILDREN

- In 2000, 24,565 Colorado grandparents were caring for their grandchildren.<sup>22</sup>
- Of the 5,675 children exiting out-of-home care in 1999, 71.5% were reunified with their birthfamilies.<sup>23</sup>
- In 2000, 711 children were legally adopted through the public child welfare agency in Colorado, a 2% decrease from 1999.<sup>24</sup>

#### JUVENILE VIOLENCE AND DETENTION

- In 1999, 40 young people from birth to age 19 were killed in firearms homicides in Colorado. Another 25 were determined to have committed suicide using a firearm, a 1% decrease from 1998.<sup>25</sup>
- In 2000, 48,636 children were arrested in Colorado, a 14% increase from 1999. Of the year 2000 arrests, 891 were for a violent crime, and 705 were for possession of a weapon.<sup>26</sup>
- A 1999 census of juvenile offenders showed 1,979 children and youth in juvenile correctional facilities in Colorado.<sup>27</sup>

For additional child welfare statistics, references, and pertinent notes, please visit CWLA's National Data Analysis System at <http://ndas.cwla.org>.

## REFERENCES

1. U.S. Bureau of the Census (2001). United States Census 2000. (Published June 13, 2001-August 22, 2001). Washington, DC: Government Printing Office.
2. U.S. Bureau of the Census. (2001). Current population survey, March 2001. Available online at [www.census.gov/population/www/index.html](http://www.census.gov/population/www/index.html). Washington, DC: Author.
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## Early Identification Project

- Federal Grant
- Office of Special Education Programs
- Interagency Collaboration for Colorado Part C Child Find
- Four year funding: September, 1999- August 2003

## Early Identification Project Goals

- **Goal 1.** Increase collaboration between Child Welfare, Part C, and Parent to Parent at state and local levels
- **Goal 2.** Increase referrals of eligible children from Child Welfare to Part C
- **Goal 3.** Increase enrollment into Part C of eligible children under one year of age

## Objectives

Participants will be able to:

- Describe Part C services
- Describe Child Welfare services
- Describe the rationale for early developmental screening of children in child welfare
- Identify community strategies for identifying Part C eligible children in the child welfare system
- Begin the development of a community plan for improving identification of Part C eligible children in the child welfare system

## Interagency Collaboration

- Identified the issue through interagency collaboration at the state level
- Local interagency collaboration will be critical to developing solutions to assure that young children receive all the services they need

## Guide 1: Defining the Focus

What is known about the developmental status of children receiving child welfare services?

## National Research Findings

- 50-60% of children in foster care exhibit developmental problems
- Children with four risk factors by age two develop learning disabilities, behavioral problems, and mental illness; children in foster care have 14+ risk factors
- 80% of foster children have at least one chronic medical condition; 25% have 3 or more
- Prematurity and disability are risk factors for abuse; children with disabilities are maltreated at a rate 1.7x higher than children without disabilities

## National recommendations

- *From Neurons to Neighborhoods*, Shonkoff and Phillips
  - Recommend that “all children who are referred to a protective service agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of IDEA.”

## Comparison of Child Welfare and Part C Databases-2000

	Number in Part C	Number in CW (age 0-3)	Number in both systems
Statewide	3,789	5,360	313 (4.4%)
Arapahoe	426	748	31 (4.1%)

## Rationale

- National studies show that 50-60% of children in foster care exhibit developmental problems
- In Colorado, few children in child welfare receive Part C early intervention services

## Arapahoe County Pilot Study

- Why Arapahoe County?
  - Size
  - Diversity
  - Location
- Sungate
  - March - November, 2000

## Research Design and Methods

- Random sample of open cases 0-3 years old
- Medical and Developmental Screening
  - Family History Questionnaire
  - Ages and Stages Questionnaire (ASQ)
  - Bayley Scale of Infant Development
  - Physical Examination
- Summary Report & Recommendations
  - Sent to caseworker, parent, or legal guardian
- Focus Groups
  - Foster Parent Association
  - Child Welfare Administration & Staff

## Residence Information

- Place of residence
  - 19% with birth parents
  - 38% in foster care
  - 17% in kinship care (with a relative)
  - 14% in foster/adopt situations
  - 12% adopted
- Time in current placement
  - Ranged from less than 1 month to 32 months
  - Average time was 10 months

## Developmental Concern Indicators

- Ages and Stages Questionnaire
  - 51.9% had scores below the cutoff in at least one area
- Bayley Scale of Infant Development
  - 35% had scores below 1.5 standard deviation on either the PDI or the MDI, or both
- Informed Clinical Opinion
  - 63% were determined eligible for Part C based on clinical assessment

## What caseworkers said...

- Few knew about Part C before the study
- Formal training regarding child development and developmental screening is limited
- They were open to the idea of systematic screening, but have concerns about the capacity of the early intervention system

## Areas of developmental delay

- Areas of delay for the 38 children determined eligible for Part C:
  - Cognitive- 18 children (47%)
  - Communication - 22 children (58%)
  - Physical - 29 children (76%)
  - Social - 6 children (16%)
  - Adaptive - 10 children (26%)
- Note: Children may experience a delay in more than one area

## Summary of Findings

- A high proportion of children in child welfare appear eligible for Part C
- Overlap between children enrolled in Child Welfare and children enrolled in Part C is low
- Systematic screening of children in child welfare would improve identification
  - Interagency plan to assure systematic screening will be best developed at the local level

## Next Steps

- Work with local communities to facilitate the development of interagency strategies to assure
  - Children in child welfare receive systematic developmental assessments
  - Children with developmental concerns are referred to Part C as appropriate

## Anticipated Project Outcomes

- Enhanced local interagency collaboration between Child Welfare, Part C and other relevant agencies
- Development and implementation of interagency strategies to increase the number of children within child welfare identified and referred to Part C
- Increase the number of children involved with child welfare who are also enrolled in Part C

## **APPENDIX B**

### **MOU – CDE & DHS**

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**Memorandum**

**Of**

**Understanding**

**2002**

**found at**

**[www.cde.state.co.us/earlychildhoodconnections/pdf/MOU.pdf](http://www.cde.state.co.us/earlychildhoodconnections/pdf/MOU.pdf)**

## **APPENDIX C**

### **FSP**

**The Family Service Plan used by Colorado Department  
of Human Services – each state should contact their State  
for comparable forms**

### **IFSP Forms**

**Most current form can be found at**

**[http://www.cde.state.co.us/earlychildhoodconnections/service\\_co.htm#IFSP%20forms](http://www.cde.state.co.us/earlychildhoodconnections/service_co.htm#IFSP%20forms)**

## **APPENDIX D**

**CDE Policy – Part C Surrogate Parent  
Can be found at**

**<http://www.cde.state.co.us/earlychildhoodconnections/pdf/surrogate.pdf>**

## **APPENDIX E**

### **Part C Funding Hierarchy**

The Funding Hierarchy as recommended in federal Part C guidance was used to lead the community discussion regarding resources for financing supports and services.



## Funding Hierarchy for Children Birth to Three Eligible for Part C

Family Cost Participation: Co-Payments, Deductibles
Private Insurance Plans Public Insurance Plans CHP+ CUHIP
Colorado Health Care Policy and Finance (Medicaid) HMO's Primary Care Physician Program Home and Community Based Waivers
Health Care Program for Children With Special Needs (Title V)
Department of Social Services Title IV – TANF (AFDC) CCCDBG Title XX/SSBG
Developmental Disabilities Service/Community Centered Boards Early Intervention Resources Case Management Resources Family Support Resources
Colorado Early Childhood Connections (Federal Part C)



## Funding Hierarchy

Public Funds	Funding			Basis of Eligibility		AGES			
	F	S	L	I	C	0-3	3-18	18-21	Over 21
Medicaid	X	X	X	X		X	X	X	X
Waivers	X	X			X	X	X	X	X
EPSDT Mandate	X	X		X		X	X	X	
HCP	X	X		X	X	X	X	X	
Social Service									
TANF	X	X	X	X		X	X	X	X
SSBG	X	X	X	X		X	X	X	X
CCBG	X	X		X		X	X		
CCB's	X	X	X		X	X	X	X	X
MHASA	X	X	X		X	X	X	X	X
Voc Rehab	X	X			X	X	X	X	X
IDEA	X	X	X		X	X	X	X	

F=Federal S=State L=Local I=Income C=Categorical



## Funding Sources

<b>Selected Services</b>	<b>Insurance</b>	<b>Medicaid</b>	<b>Title V</b>	<b>Social Services</b>	<b>CCB'S</b>	<b>Education</b>
Counseling/Behavioral Support	PD	X		X	X	X
Physical Therapy	PD	X	X	X	X	X
Occupational Therapy	PD	X	X	X	X	X
Speech/Language Therapy	PD	X	X	X	X	X
Medications	PD	X	X	X	X	X
Communication Technology	PD	X	X		X	X
Mobility Technology	PD	X	X		X	X
Vision/Hearing Devices	PD	X	X	X	X	X
Physical Assistance with ADL's	PD	X		X	X	X
Special Diet	PD	X	X	X	X	X
Respite Care for Families	PD	X		X	X	

PD – Plan Dependent