Exhibit D

Consultation Documentation

(To be completed by those participating in consultation session)

Parent was notified and invited to participate on _____ by (method)_____

If the consultation meeting will potentially result in change of outcomes or services, the Primary Service Provider will contact Service Coordinator prior to meeting. Service Coordinator contacted on _____ by (method) _____

Child's Name: _____ DOB: _____

Service Coordinator: _____ Date of Consultation: _____

Start Time: _____ End Time: _____ Location: _____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

_____

IFSP Team meeting is needed to discuss recommended changes in services, frequency, and/or duration of services:

☐ **YES** ☐ **NO**

Participating Team Members/Signatures: (PSP indicated with *)

Parent/ Guardian: _____	Face-to-Face	Phone	ITDS _____	Face-to-Face	Phone
OT _____	Face-to-Face	Phone	PT _____	Face-to-Face	Phone
SLP _____	Face-to-Face	Phone	EI _____	Face-to-Face	Phone
Service Coordinator:_____	Face-to-Face	Phone	Other _____	Face-to-Face	Phone

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)

Revised Jan 2015

Exhibit D

Consultation Documentation, Continued

Child's Name: _____ DOB: _____

Service Coordinator: _____ Date of Consultation: _____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

_____

_____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

_____

- **Challenges to implementing strategies and achieving goals for Outcome # _____**

_____

_____

_____

The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

_____

_____

_____

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)

Revised Jan 2015

Exhibit D

CONSULTATION DOCUMENTATION FORM INSTRUCTIONS

This form serves two primary purposes:

- Statewide uniform documentation of Consultation services paid for by contract funds
- Statewide uniform billing documentation for providers participating in Consultation

Each team member must have a form completed for each Consultation in which they participate. During consultation sessions, the members participating should appoint a recorder to LEGIBLY complete the form from *Child's Name* to *IFSP Team Meeting Yes No*. Copies should then be made for each participant and the family. The original goes to the Service Coordinator to place in the child's file. Consultation is between direct service providers on the child's IFSP team. Each enrolled Early Steps provider can bill for Consultation using the form as invoice documentation. Although they may participate in the consultation, professionals and providers who are not enrolled would not be able to bill. If any team provider did not participate in the Consultation session, a copy should be provided to them so they can be informed.

Field Entry Guidance:

Child's Name: *Full name of child* **DOB**: *Date of birth of child*

Service Coordinator: *Name* **Date of Consultation:** *MM/DD/YYYY*

Start Time: *Beginning time of consultation session* **End Time:** *End time of consultation session*

Location: *This is the location where the meeting was scheduled to be. If face-to-face, enter the location as i.e. Home, Local Early Steps, Playpen Therapy; if scheduled to be by phone, enter the location as Phone.*

Successes and Challenges to implementing strategies and achieving goals: *Narrative of the discussion, by individual outcome.*

The team (*family, caregivers, primary service provider and supporting providers*) will continue or modify the following strategies to achieve goals: *Narrative of the recommendation(s) resulting from the consultation, by individual outcome.*

PSP: *Name and credentials of the current Primary Service Provider*

Consulting Team Members: *List all members participating in the consultation and check Face-to-Face or Phone and obtain signatures of those present.*

Family Participation: *The name(s) of the family member(s) and check Phone, Face-to-Face or Declined Invitation*

ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS' FORMS

When each provider receives their copy of the completed form, they will complete the remaining fields before billing.

Provider/Participant Name (Print): *LEGIBLE name of provider/participant* **Signature**: *Provider/Participant signature*

(*Each participant should find their designation and sign, if face-to-face. Provider signature lines should include the code signifying if participation was Face-to-Face or Phone*

Consultation time must be authorized on the Individualized Family Support Plan (IFSP).Billing is based on the location of the Consultation session.

Revised-Jan 2015