



# Eligibility Determination Form

**Child's Name:** \_\_\_\_\_

**Date of Eligibility Determination:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Adjusted Age:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_

**Service Coordinator's Name** \_\_\_\_\_

**Eligibility determination type** (check one):  Initial  Annual  Interim

**Eligibility Established by Records** (When this box is checked only the statement of eligibility and a signature must be completed)  
Records used: \_\_\_\_\_

**Statement of Eligibility:**

- Child is determined NOT eligible for the Infant & Toddler Connection of Virginia
  - Referral(s) were made to: \_\_\_\_\_
- Child is determined eligible for the Infant & Toddler Connection of Virginia based on the following criteria (check all that apply):
  - Developmental Delay** – Children who are functioning at least 25% below their chronological or adjusted age in at least one area of development.
  - Atypical development**
  - A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.**

Check (✓) the diagnosed physical or mental condition for which there is documentation.

- These conditions include, but are not limited to the following:
- |  |  |
|--|--|
| <input type="checkbox"/> seizures with significant encephalopathy;   | <input type="checkbox"/> inborn errors of metabolism;  |
| <input type="checkbox"/> significant central nervous system anomaly;   | <input type="checkbox"/> microcephaly;   |
| <input type="checkbox"/> severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage;   | <input type="checkbox"/> severe attachment disorders;  |
| <input type="checkbox"/> symptomatic congenital infection;   | <input type="checkbox"/> failure to thrive;  |
| <input type="checkbox"/> effects of toxic exposure including fetal alcohol syndrome, drug withdrawal and exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants; | <input type="checkbox"/> autism spectrum disorder;   |
| <input type="checkbox"/> meningomyelocele;   | <input type="checkbox"/> endocrine disorders with a high probability of resulting in developmental delay;      |
| <input type="checkbox"/> congenital or acquired hearing loss;  | <input type="checkbox"/> hemoglobinopathies with a high probability of resulting in developmental delay;       |
| <input type="checkbox"/> visual disabilities;  | <input type="checkbox"/> cleft lip or palate;  |
| <input type="checkbox"/> chromosomal abnormalities, including Down syndrome;   | <input type="checkbox"/> periventricular leukomalacia;   |
| <input type="checkbox"/> brain or spinal cord trauma, with abnormal neurologic exam at discharge;  | <input type="checkbox"/> gestational age less than or equal to 28 weeks;                                       |
|  | <input type="checkbox"/> NICU stay of greater than or equal to 28 days;  |
|  | <input type="checkbox"/> other physical or mental conditions at the multidisciplinary team members' discretion |
- Specify other: \_\_\_\_\_

**Methods and documents used to determine eligibility** (If "Eligibility Established by Records" is not checked above).

Check (✓) if used in eligibility determination

- Review of pertinent medical records less than six (6) months old from the primary care physician and other sources related to the child's current health status, physical development (including vision and hearing), and medical history. Records Reviewed: \_\_\_\_\_
- Review of other records, such as birth records, newborn screening results and early medical history, with parent consent, even if those records are more than six (6) months old.
- Ongoing Assessment (only for interim or annual determination)
- Parent Report
- Formal/informal observation
- Informed clinical opinion
- Part C Vision Screening
- Part C Hearing Screening
- Comprehensive developmental screening
  - o Person Completing Developmental Screening: \_\_\_\_\_
  - o Developmental Screening Tool Used: \_\_\_\_\_
- Other
  - o Specify other: \_\_\_\_\_



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**Child's Name:**

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**Date of Birth:**

**Age:**

**Adjusted Age:**

**Eligibility Narrative**

(Highlights of the information and how it was used to determine eligibility.)

**Eligibility Team**

The following individuals participated in the eligibility determination process:

<p><i>Service Coordinator (signature):</i></p>	<input type="checkbox"/> Attended Meeting <input type="checkbox"/> Submitted Written Report <input type="checkbox"/> Reviewed Written Report from Outside Source <input type="checkbox"/> Participated by Phone, Email, etc.
<p><i>Provider (signature and credentials):</i></p> <p><i>Discipline:</i>  <input type="checkbox"/> Educator/Special Educator             <input type="checkbox"/> Occupational Therapist             <input type="checkbox"/> Physical Therapist             <input type="checkbox"/> Speech-Language Pathologist  <input type="checkbox"/> Nurse             <input type="checkbox"/> Other</p>	<input type="checkbox"/> Attended Meeting <input type="checkbox"/> Submitted Written Report <input type="checkbox"/> Reviewed Written Report from Outside Source <input type="checkbox"/> Participated by Phone, Email, etc.
<p><i>Provider (signature and credentials):</i></p> <p><i>Discipline:</i>  <input type="checkbox"/> Educator/Special Educator             <input type="checkbox"/> Occupational Therapist             <input type="checkbox"/> Physical Therapist             <input type="checkbox"/> Speech-Language Pathologist  <input type="checkbox"/> Nurse             <input type="checkbox"/> Other</p>	<input type="checkbox"/> Attended Meeting <input type="checkbox"/> Submitted Written Report <input type="checkbox"/> Reviewed Written Report from Outside Source <input type="checkbox"/> Participated by Phone, Email, etc.
<p><i>Provider (signature and credentials):</i></p> <p><i>Discipline:</i>  <input type="checkbox"/> Educator/Special Educator             <input type="checkbox"/> Occupational Therapist             <input type="checkbox"/> Physical Therapist             <input type="checkbox"/> Speech-Language Pathologist  <input type="checkbox"/> Nurse             <input type="checkbox"/> Other</p>	<input type="checkbox"/> Attended Meeting <input type="checkbox"/> Submitted Written Report <input type="checkbox"/> Reviewed Written Report from Outside Source <input type="checkbox"/> Participated by Phone, Email, etc.

Two different disciplines must be represented on this form unless eligibility is established by records, in which case only one signature is needed.

Typed names or electronic signatures are acceptable.