	Prompt Question	1/9 Stakeholder Webinar (consensus recommendations)	Survey (individual recommendations)	Discussion Board (individual recommendations)
Child Find: Slides 7-8	**Slide 7** **How should the early intervention system ensure resources through other programs serving young children with disabilities and their families do not contain duplications?**	Is there a duplication, do these programs provide what we do. These are programs we must coordinate with for Childfind and for referrals. I don't think we have ever gotten referrals from them. That we establish a committee with representation from each of these organizations so that we are communicating and have an understanding of each other.	• A state system should be implemented that whenever a child is provided with early intervention, be it through BabyNet, DDSN, private contractors, Head Start, the information is logged into the system. The information would include any testing performed and the results. If all shareholders have access to the system (e.g. special education director in school system, case managers of DDSN,hospitals providing outpatient pediatric therapies) then duplication would be cut down. • Health Departments and doctor offices should be part of this process but there must be a central office to coordinate names received. • They should send trainers out to do inservices in daycare centers. Many of the daycare providers have no clue about typical development, and they don't know they can refer children to BabyNet. • Make sure that there is no duplication on IFSPs. Referrals should start with hospital and pediatrician referrals.	Perhaps a heirarchy list could be given to a possible referral agencies. There could be a flow chart which started with developmental concerns which funneled to appropriate agencies. ex. motor concern - BabyNet, Private agencies (NextStep), private PT providers from our BN provider list ex. cognitive- BabyNet, County FS Parents As Teachers or HC Parent home program
	How should we ensure that other program resources are used to identify and refer all young children who may be eligible for early intervention services?	Goes back to committee and having communication of what we are doing.		
	What activities do you recommend that could help these agencies coordinate identifying children and referring them to the lead agency?	Educate the providers of the law and the process. Electronic referral forms Easy ways to make referrals, providers are busy		
	Who should be involved in any of these activities?	All of the agencies		
	What should each agency's role be to help with identification and referral?	Collaborate with each other. We used to do that when we had BNCT meetings in person. Recommendation for face to face meetings in each region.		

	<u>Slide 8</u> **How should we let referral sources know about this requirement?** **.**	Have a note on the referral form, phone message and inform the team of the new requirement. Mass communication to agency partners. The communication should come from Babynet and add the information into Child Find materials	• It should ALWAYS be up to family WHO they get their services from. EI is defined as occurring in the "most natural environment (home or school)" BUT those service providers ARE NOT usually THE BEST provider. Parents should have more of a say about who they want working with their child. Multiple families come to my facility and turn down Baby Net because they want to continue with the therapists in our office. • Pediatricians/GP offices should have posters and handouts, health departments should have information, hospitals that deliver babies should give parent(s) handout on BabyNet when leaving the hospital even with a "normal" newborn. • When first referred, families should receive a packet of books and healthy snacks. Referring agencies should receive points toward grants for their programs to provide outreach for the concerned communities. Referral sources need a state memo from governor's office. Testing needs to be more immediate.	
	What activities should be used to encourage immediate referral of families when their child is identified by referral sources as potentially having a developmental delay?	Distribute more pulications and materials to make families, doctors etc aware of referring children to Babynet. Make sure referral sources have access to the correct phone number etc to make referrals. More community awareness.		
	Who should be involved in these activities?	Family Connections, Babynet System personnel, providers, Babynet Leadership Team, ICC, collaborating agencies, front line staff, other service providers to children birth to 3 such as Head Start, DSS, First Steps, and child care centers.		
	How should we help facilitate the process for referral sources?	Convening a committee to help facilitate the referral process and continuing with public awareness. Distributing information (from Babynet) to physcians (medical professionals) and all referral sources via e-mail or letters.		
	How should this process be made easier for families?	Familes can count on the agency making the referral and following up to ensure the families are contacted in a timely manner (based on staffing considerations, caseloads etc). Confirmaton of referral to the referral source.		

	How should we ensure that referrals come from all areas of the state and represent state characteristics such as ethnicity/race categories, so that all children potentially in need are referred?	Convening a committee with statewide representation from the native Am. population, homeless, Latin American, domestic violence (shelters) etc. Continue to follow-up on contact with other birthing hospitals to increase referrals. Equal representation from all families in the state. Make sure we are making the same effort in rural as well as urban counties.		
Screening: Slides 9-11	**<u>Slide 9</u>** **Should screening procedures be a part of the first 45 day timeline?**	Yes, screening should be a part of the first 45 day timeline. It should be by phone, initially.	• Yes. ICO is not sufficient. Parent should sign a permission to screen form. The person should tell the parent that screening determines if there may be a delayed in an area, not that there is a problem. Screening drives the next step, which is evaluation. • Early screening procedures should be provided by early childhood educators or trained personnel. Parents should know that the screening provides info to help enrich the child's mental/educational potentials. • You should contract out screenings for speech-language and let the private contractors go into daycare centers and screen children. • Conduct screening process similar to what DSN does for services. There are service/eligibility specific questions that are asked to the caller to determine if further steps are needed. Intake coordinators can save lots of time if this is done first! • yes-but by a qualified service provided. For example, if speech or OT is in question, then SLP or OT should be the screener and not an Early Interventionist who is not	I feel screening should happen by the referral source when possible prior to intake. Due to SPOE staffing shortages, having the child come in for screening with the possibility of no intake, takes a lot of time and energy for the parent and BNIC.
	Who should conduct it?	The screening should be conducted by the referral source such as DSS or the physcian to conduct the ASQ.		
	What methods should be used to conduct the screening?	ASQ and Bartelle screening		

	When should it be conducted (timeline)?	Screening should be conducted upon the initial contact or shortly after.	qualified or trained to make judgments.	
	What should the person conducting the screening say to parents about the screening intent?	Tell the families the screening is a general overview of the child's level of functional to determine if further assessments are needed.		
	<u>Slide 10</u> How should notice of screening results be provided?	Notice of screening results should be provided sending the family a copy of ASQ by mail and t	• There should be a brief screening report that can be checked off as normal/possible delay in all areas screened that is given to the parent(s) and put in the child's chart. • Trained educators should meet individually with parents to explain the results of the screenings. • Something can be sent to parent in writing informing them of screening results • Notice should be conducted by meeting. Within a week of screening with the examiner and parents. See guidelines being used at the SC DOE	
	When should it be provided? by whom?	Provide the family the results after the screening is completed.		
	What should the person sharing this information with families say to families about the results?	Ask the family if they want additional assessment.		
	How should BabyNet schedule the evaluation activities as the next step?	Work with the family to schedule the eval. at the time that is convenient to the family. See question in the chat room regarding whether a screening		

		and assessment can be conducted during the same visit.	to address how screening procedures are followed thru with school age children.	
	Slide 11 **How should notice of screening results be provided?**	If the child shows a delay., inform the family at the time of screening and follow-up in writing. Notify the referral source of the screening and/or assessment results.	• same answer as above • Trained educators should meet individually with parents to explain the results of the screenings.	
	When should it be provided? by whom?	Immediately by the person conducted the screening or the SPOE personnel		
	What should the person sharing this information with families say to families about the results?	Discuss whether the child shows delays or not and ask if the family wants further assessments.		
Evaluation and Assessment Slides: 13-18	**Slide 13** **How should we ensure that medical records are considered as part of the evaluation for eligibility, which must always be conducted using formal and informal evaluation activities?**	-meet with the family to get permission to gather records and then use those to make determination. This record request may take a long time and can come at a cost.	• case manager should obtain medical records with referral. Any diagnosis that goes with developmental delay, such as Downs or cerebral palsy, should automatically qualify the child for services. Medical records should be on the list of required documentation to place a child into BabyNet services. • The involved health depts and doc • medical records are hard to get let alone one is expected to pay for the cost. Use an RX from MD with documentation of diagnosis. Use prior therapy records for eligiblity purposes. • Medical records via checklist. Diagnosis from a professional or team should be accepted i.e. report from Duke or from a neurologist or developmental pediatrician. Team should review information and either accept or reject.	
	-What type of information from medical records should be acceptable in lieu of an evaluation for eligibility determination?	Clarify regulation requirements and we should continue using medical records for children with diagnoses but only consider for children with DD.		
	Where should the medical information come from?			
	Who should review the medical information for use in eligibility determination?			
	Slide 14 **How should we assure that evaluations and assessments**	Intake coordinators need language to document other informal assessments used. Therapists may include informal	• Have all evaluation done by one or two offices per city/country... or 10	Informal measures should include observation of the child at play as well as observation of the child interacting with caregivers. Research shows that

	are conducted using both formal and informal measures?	info w/in evaluations that can be used.	mile radius. The information would be much more uniform and have better reliability/validity. • Should be a standardized report that includes the formal and informal assessments that are acceptable for use in determining eligibility. Informal assessments should include informal conversational/play assessments, parent interview, direct observation of child in home or daycare setting during regular activities, and informal probes of skills, such as stacking blocks or pointing to the picture named in a field of three. The case manager or lead professional, such as psychologist, should be responsible. • Early childhood people are trained to do this. Informal measures include notes on interactions with people and materials. • The best way to evaluate a child's speech and language is to collect a natural language sample. I have the parent take a 24 hour language sample and then see what a child says at home. Usually it has 5-10 word or fewer! That's an authentic assessment to use along with the standardized tools. • Informals measures include criterion reference testing, probes, checklists, data logs, language samples by qualified professionals.	parents of children with limited verbal communication unknowingly change their interactive style with their child and these changes are less facilitative of increasing effective verbal communication. Additionally, informed clinical opinion based on research evidence should be given serious consideration in determining eligibility beyond a formal test score. In the field of speech-language pathology there is research to support the use of several diagnostic indicators that will differentiate children who will not outgrow their language problem from those who may (disorder versus delay). An expressive language disorder (receptive-expressive language gap) should be added to the current established risk factors and the diagnosis of expressive language disorder added to the list of approved diagnosis for eligibility.
	What informal measures should be used along with formal tests for both assessment and evaluation?	parent report, observations, any anecdotal information obtained about the child.		
	Who should ensure that these measures are used to determine eligibility and develop the IFSP	? Intake coordinator and the IFSP team. There need to be more guidelines for using informal assessments to assist in making determinations under ICO.		
	<u>Slide 15</u> How should we ensure timelines are met for evaluation and assessment activities?	Additional intake staff. Explore the possibility of folks being called upon to complete roles in the intake process. Are there other entities that use the BDI-II that we can use their info to make children eligible?	• The Intake Coordinator should be the first to handle the initial referral, complete a screening (at home) and request records from the family (if they have any) and/or consent for requesting records that could help in eligibility determination. Then the	
	How should assessment for IFSP development be	Parent to parent support might make the IFSP process move along more		

	scheduled to happen next (or along with evaluation for eligibility)?	quickly. Have the same person complete the evaluation for eligibility and then move right in to assessment if the child is eligible.	parent should be given a choice of a provider to conduct the assessment in the family's home. The provider would be a current special instruction provider who is trained in the BDI and has an agreement with BabyNet to conduct initial assessments. The SI provider can be any current provider with or without an agency. That person goes to the home, completes the BDI and, following scoring, discusses the families priorities and concerns for their child and his/her development. In the event that there is a major concern such as speech, motor, etc., the SI/Assessment provider contacts the intake provider to share scores and request a therapy eval based on that need. The intake coord. then schedules a therapy eval, and a team meeting when all information is received. Eligibility is then determined based on all gathered info - the BDI, the therapy eval, the medical and other reports and anecdotal information. The team agrees to the end result, the parent is informed and the IFSP is then scheduled and completed. The process would be timely because the parent is offered a choice of providers at the first visit, not waiting for a phone call, and is informed that the choice is for determining eligibility and that if their choice ever is to change, the parent can change at any time. Team members are selected based on those willing to do initial assessments. If a SI provider is unavailable at the time, the parent is offered another choice (or goes to the matrix). The issue of ongoing providers doing assessments would	
	How will we ensure assessment for children with DD? **How should team members be selected to conduct the evaluation and the assessment?**	You should start with the disciplines that reflect the parent's primary concern. Have a conversation with family and then the intake worker takes the discipline specific person with them to the hv.		
	Who should the team members be?	It is dependent upon the greatest needs of the child and family but staffing issues are present. It would still be best to take the staff from the specific discipline.		

			not be a conflict because the parent chooses AHEAD of time to have a provider evaluate their child. And they can choose another provider at anytime (after assessment if desired) and they have a neutral party to call (Intake Coordinator). This can be in the 45 days because a lot of the delay is waiting for parents to call back. • Hold on to good EIs. Better pay? There is too much turnover with EIs that coordinate the child's care. • quarterly reports that require documentation of whether the timeline was met for the children evaluated during that period. If child failed screening, evaluation should be scheduled within the next three weeks to determine eligiblity. Possiblydo screening/evaluation clinics at the local health department monthly or every Friday (depending on need). A team should have a case manager that does the paperwork and developmental history with parent, a speech language pathologist, a physical therapist, an occupational therapist, a nurse/LPN to do vision, height/weight, and a psychologist. • Expectations for completion of processes can be set and conducted by early childhood educators and those trained in these activities. • Parents should have choice on qualified assessors	
	<u>Slide 16</u> **What should be the process for determining disciplines to be represented in an evaluation, assessment, and IFSP team?**		• Therapeutically speaking, if a non-home based facility offers two or more disciplines it is a MUCH better choice than having multiple, disconnected independent providers come in to the home. Services in	
	What is the parent's major			

	concern or the referral sources major concern?		preschools and daycare facilities are least favorable. The parent SHOULD BE PRESENT AT ALL TIMES!	
	How should the disciplines work together to conduct a timely, comprehensive, multidisciplinary evaluation and assessment?		• There should be an evaluation team that agrees to meet at a certain time each week/month and backup personnel if someone is unable to attend. The evaluation should take place where the child can go from one to the other so that one discipline can observe the other discipline's evaluation or ask if the child demonstrated a skill so the child isn't asked to identify body parts for five people. The disciplines should do a complete evaluation that either rules out the need for services or determines the need for services and the appropriate goals to be worked on. If evaluations are morning and placements are afternoon, then all could be done in one day. The report could be computerized and laptops provided so all disciplines could document the results and write the IFSP goals after finishing the evlauation. • Disciplines should represent the total child: health, education, mental health. • It should based on child needs. If a child has physical and speech involvement a PT, OT and SLP should be on the team with an assigned EI.	
	Are there other professions out there that can conduct some of these evaluations or assessments?			
	What should these disciplines do in an initial evaluation and assessment?	the BDI-II, gather records and any other information that is out there about the child		
	Who should make this decision?	the team.		
	How should these team members be contacted?	social media should be considered		
	What process should take place if the desired discipline is not available?	move to the discipline that is the next closest in alignment.		
	<u>Slide 17</u> In determining the native language, who should be involved in making this decision?	The parents	• The parent should be asked native language for child and that's what should be honored. • Bilingualism is a plus in today's society. • Ask the parent, obviously if they can't speak English then an interpreter needs to be used.	
	What procedures should be considered?	A discussion with the parent about what is most comfortable for them		

	What types of formal or informal measures should be used?	conversations with families-informal measures.	• An interpreter should be made available to parents at all phases. Measures to be used include tests which have normative data for ESL	
	Slide 18 **How should BabyNet ensure that these requirements are implemented?**	you get with the discipline that is next most closely aligned with the parent's area of concern.	• Case manager for the child is responsible for team, should be a BabyNet manager for a counth that would oversee the individual case managers and then at state level should be regional coordinators. A program is only as good as the administrators. Training and ensuring time lines are met are imperative at each level. • Ethical and experienced supervisors. • Top-down and bottom up implementation. Team members should include EI, SLP, OT, PT and could include medical personnel, interpreter, psychologist.	
	Who should be responsible at the team level	? the intake coordinator		
	At the supervisory level?	SPOE supervisor		
	At the system level?	First Steps monitoring at the local level		
IFSP: Slides 20-24	**Slide 20** **Which disciplines should be involved in the initial IFSP?**	-the disciplines should be related to the area/s of concern that prompted the referral and/or the area/s that made the child eligible	• Speech pathology should also take part when available. Speech and Occupational Therapy ALWAYS. Again, having evaluations done in a multidiscipline facility would be the best place to start. • Psychologist, speech language therapist, occupational therapist, RN, and physical therapist should be involved. Could do phone conferences if professional couldn't attend in person. There should be a way for the professional to document his/her results and recommendations and not attend a meeting. If those disciplines aren't involved with a child, for example, a hearing impaired child only that has no physical delays, so only psychologist and speech language pathologist would be needed to evaluate, then that would be the only ones needed at the IFSP.	
	Should there be different methods for participation or involvement?			
	What process should take place if the desired discipline is not available or there are no other disciplines involved with the family?	-perhaps use of therapy "consultants" who could serve in this capacity with the initial IFSP team -hired and regionalized so you know they are always there -this could also address the primary service provider model, as well as the E&A Team model		

			• Using therapists is time consuming and will cost the state more money rather than save money. Use the intake coordinator and the SC as long as they have 2 different degrees (Social worker and education). These are 2 different disciplines, are they not???? • Ditto from question 11 except that only the discipline services which the child receive should be involved in the IFSP.	
	<u>Slide 21</u> **How should BabyNet ensure that the NE requirements noted here are implemented?**	-additional clarification is needed for this requirement -does this mean the goals change, or the services to consider, or the justification itself -is the justification considered part of the goal, or separate.	• case manager at team level, county coordinator at supervisory level, and regional manager at state level. Appropriate services should be provided in the county the child resides in. Setting up a therapy section in the health department where parents could bring the child to receive the services may help. Parents should be given written information with names and phone numbers of who to contact with questions at each level. • EI should be responsible for education component as part of transition services.	
	Who should be responsible at the team level?	-BNSC		
	At the supervisory level?	-BNSC Supervisor		
	At the system level?	-BNSO via contractual wording		
	What activities should be conducted by each level?			
	How should this requirement be explained to parents?			
	How should teams ensure that "an education component" is included in IFSPs– who is responsible at the team, supervisory, system level?			
	<u>Slide 22</u> **How should we assure that medical and other services funded through other sources**	-wouldn't we just keep doing it the way we are, and assist family in finding the sources -sources of this information: family	• The case manager should coordinator all referrals for the child. All recommendations should be given	

	are identified for the family and child?	assessment, IFSP team input and discussion, IFSP format currently prompts the BNSC and IFSP team to discuss this -assurance via file monitoring of IFSP, relationship between IFPS and service notes, complaints, etc.	verbally and in writing to the parent(s). The IFSP Team should make the recommendations for referral to additional services/medical experts. • EI should coordinate services and help with the identification of services and to steps to assist child/family to secure services.	
	Who should coordinate this?	-BNSC		
	Who should contribute to the identification of services and to the steps to assist the child and family in securing these services?	IFSP Team		
	<u>Slide 24</u> **What are some suggestions to improve current communication on the local level between BabyNet and Part B related to transition?**	*encourage to have school personnel attend monthly BN calls *increase our attempts to contact LEA personnel prior to transition conference* encourage SC to lead scheduling for transition conference.	• BabyNet should be required to document when information is sent along with making a phone call/email contact with the party that the infomration is being sent to. The transition inforamtion should be sent out quarterly so that any child turning 3 in March would be transitioned during the July, August, September quarterly meeting. • Redo transition referral form, allow for documention of what services child rcvs through BN and any medical/developmental concerns noted by team. BN conduct training with all LEA's to let me know the transition process, timelines, etc... • no suggestions	
: Slides	**<u>Slide 25 and 31</u>** **What could be some barriers to conducting transition conferences?**	*dates that LEA's have for their scheduling.* staffing for summer conferences *LEA's combining meeting with screening, conference,etc. * family transportation *family unable to attend/participate in conference * as Lead Agency we have to keep reminding SC's to have confeneces within proper timelines (training issues	• BabyNet sends information to wrong school district; sends it two days before the child turns 3; sends it without any documentation of services so don't know what type of evaluation the child will need until comes into the school for the evaluation, sends without diagnosis	

		with staff) * reminding that LEA cannot make conference late.	(e.g. Down Syndrome child came for an evaluation and no BabyNet paperwork had that the child had Downs. Should be a computerized system that alerts the case manager/EI when a child needs to be transitioned and continues to alert them until it is documented the meeting has been held. Parents may not understand about the transition conference. • children turning age 3 in the summer when schools are out of session.	
	What could be solutions/strategies to improve the transition conference data to the required 100%?	* new BT data system to notify about upcoming dates. * GS to assure that conferences are occurring as they are reported. *same should be sure for planning and conference *provide training about the timelines of when planning and conference are due and not allow LEA to dictate time or date.		
	<u>Slide 26</u> What components should be included in the transition agreement with SDE/LEAs?	*adding language policy so that all districts will be required to receive same information based on what is written Law (basic requirements) *LEA will participate with BN SC in planning conference date and time. * Transition Agreement will delineate the responsibility for what each agency is to do.		
	Should any components be streamlined/merged within the Notification and Referral process?	*SC's should be handling the referrals by completing the forms in addition to the notifications that state office is sending * assuring that the appropriate LEA staff are recieving the notifications and referrals.		
	Could there be barriers to transition conference? *			
	How should barriers be eliminated?			
	<u>Slide 27</u> Should there be general supervision components/process to ensure that transition planning is occurring	? *yes* 2 fold- immediate supervisors are to ensure that staff are following through with planning, State office is to follow up to make sure that it actually occured. * possible add to exit survey for families to offer feedback. * state staff with condcut random file QA's to	• The EI's are doing a great job with this, and I don't feel as if they need any MORE regulations!!!!!!!! Less is better. • LEA should be responsible for general supervisions of the process.	

		assure dates in files match what is reported on BT		
	What could ensure that these components are effective	? *QA and Family feedback		
	Should there be processes in place to ensure the timeframes are followed (9mos-90days)?	*More general supervision to include ongoing monitoring of activity through data.*training on how to access and use date from BT.		
	What resources should be provided to families with children who are not found eligible for part B services?	*offer families Central Directory information in the form of handout or flyer with number and wed address. *(DDSN) Community Resource Guide.		
	<u>Slide 28</u> **What could be possible barriers to providing services and supports for families during transition planning?**	*transportation, availablity of part B staff.	• School districts not wanting to provide immediate services for children who turn 3 in the summer. They tend to wait until August.	
	What could be some strategies to engage families in transition planning ?	*family self-assessments *referrals to other agencies- Pro-Parents		
	How could community and state programs be better identified to assist families with their transition needs	? * Central Directory information		
	<u>Slide 30</u> **How could the transition notification process be more efficient process for families and providers?.**	*training staff on timelines and roles and responsibilities.* review LEA contacts are going to appropritate personnel and are being referred to correct district	• Provide documentation of services being provided, diagnosis, reports from any outside agency or physician that has evaluated the child. For example, a child was seen for a transition evaluation with no reference to hearing problems. The parents stated the child had had a hearing evaluation two months ago and was waiting to receive	
	How should the process be documented for tracking?	*general supervision *QA file review to assure paperwork is in file as reported on BT *staff training		
	How should consent be	*consent to be given for info to be sent		

	received for additional family information?	to LEA at the IFSP closest to transition. * at transition mtg, LEA using exit COSF info for their entry COSF info instead of conducting other evals.	hearing aids. The evaluation was stopped as it was invalid to test knowing the child couldn't hear and didn't have aids on. If BabyNet had informed the LEA that the child had a hearing loss, the psychologist would have known to ask about hearing aids and waited to schedule the evaluation after the child had them. • It's not broken. Don't fix something that isn't broken. It's working fine. Jan 9, 2012 7:14 PM • COSF can be used for tracking in the schools---using something similar for birth to age 3.	

Additional Changes: Slides 35-40	**Slides 35-37** **1. How should the BNSC explain this to families?** **2. How should the BNSC document this?** **3. How should monitoring processes at local, participating agency, and lead agency verify this?**	Slide 35: language added to release form, verification that family knows this by provision of their signature. Inclusion in the BN Notice of Child and Family Rights. Kinds of TA/Trng supports: Video regarding procedural safeguards for families and and BN System Personnel. Revision of consent on IFSP section 14. Operational definition of 3rd party; inclusive or exclusive of IFSP team members Slide 36: change in Notice of Child and Family Rights; document in IFSP and/or service notes when provided to family. PSA p/p would also need to be reviewed and changed. Does the family's request need to be in writing? Verification of both request and compliance with request within specified timeliness would be expedited if in writing, or notify LA Procedural Safeguards Officer that a family has made this request. Second bullet: revise IFSP to capture documentation of when each IFSP is mailed to family. Is the BNSC responsible for provision of evals to family, or the provider; if the provider, how does the BNSC meet their obligations to assure this has occurred? Slide 37: add into PO manual and notice of child and family rights.		

	<u>Slides 38-40</u> **1. How should the BNSC explain this to families?** **2. How should the BNSC document this?** **3. How should monitoring processes at local, participating agency, and lead agency verify this?**	if parents can deny Part C access to use of public/private insurance or benefits, how do we afford this, esp. if benefits include CRS and service is e.g., an AT request. Current service delivery model is also a variable in the system of payments. CURRENT version of insurance and resources form begins to address this, but will need to be reviewed. Families are currently encouraged/not required, but also informed that if there is a lapse in private/public benefits, BN coverage is available. Notification requirement may already be addressed in insurance/resources consent form. The specific conditions under which consent is needed, and the specific policies of each insurance carrier need to be made VERY clear for BNSC, Supervisors, families, as well as when changes in insurance policies occur. To what extent can families be supported in assisting the service coordination in making sure this information is up to date. Primary BNSC responsibility change is with the initial and EACH increase service; this means a new consent with each increase in service or addition of a new service. Practically speaking this is probably how this will be done; but the technically this would only be needed with the conditions for consent would so indicated.		