

Procedure for BWEIP Eligibility Form

Eligibility: Determined by at least two professionals representing different disciplines who have knowledge and expertise in the area of concern. At least one must hold an Early Intervention Specialist II credential. Parents should be actively involved in the evaluation and eligibility process.

How To Use This Form:

Customize the form to meet your program's process by:

- a.) Inserting your program name at the top of the page, and
- b.) Inserting any evaluation and assessment names used that do not appear on this form.
- c.) No other changes are allowed

1. Enter Child's Name:

2. Enter Qualifying Diagnosis: (from BWEIP diagnosis list *or* a diagnosis *with* documentation that has a high probability of resulting in developmental delay.)

Enter Date documented: (date your program receives documentation verifying diagnosis.)

3. Pertinent records: The E.I. nurse must determine whether the child has any significant health/medical history that requires a review of records. The nurse should consider whether the child's past or current health status has any implications for early intervention eligibility.

Enter Date Records reviewed: If health/medical information is required for eligibility, specify date the pertinent records are reviewed.

Mark checklist of concerns: These identify health/medical considerations used in determining whether to request records, as well as health information that may need to be considered during eligibility determination. (The nurse may find that the concerns listed are not factors contributing to the child's developmental delay, do not have any implications for intervention, and do not warrant the gathering of medical/health records.)

Your Program's Name											
1. Child's Name: _____		2. Qualifying Diagnosis: _____				Date documented: _____		Date records reviewed: _____			
3. Pertinent records: <input type="checkbox"/> No pertinent medical/health history requiring a review: <input type="checkbox"/> Pertinent medical/health history requiring a review:											
<input type="checkbox"/> Premature gestation: _____		<input type="checkbox"/> Heart condition		<input type="checkbox"/> Ear infections		<input type="checkbox"/> PE tubes		<input type="checkbox"/> Respiratory		<input type="checkbox"/> Sleep	
<input type="checkbox"/> ROP		<input type="checkbox"/> On medications		<input type="checkbox"/> Drug/alcohol exposed		<input type="checkbox"/> Allergies		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Nuerological		<input type="checkbox"/> Poor weight gain									
4. Evaluation results: <i>Identify all tests used & date administered, provide clinical opinion & observation details in # 5 & # 6</i> DOB: _____ CA: _____ Adj. Age: _____											
Vision		<input type="checkbox"/> Vision Screen R-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> L-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> Date: _____		<input type="checkbox"/> Ophthalmology Report Date: _____		Results/Date: _____		<input type="checkbox"/> VDS <input type="checkbox"/> Functional <input type="checkbox"/> (XXXXXX)		Date: _____ Date: _____ Date: _____	
Hearing		<input type="checkbox"/> Newborn Screen date: _____ <input type="checkbox"/> BWEIP Screen date: _____ <input type="checkbox"/> EI OAE/booth date: _____ <input type="checkbox"/> R-ear <input type="checkbox"/> pass <input type="checkbox"/> referral <input type="checkbox"/> L-ear <input type="checkbox"/> pass <input type="checkbox"/> referral		<input type="checkbox"/> Audiology Report Date: _____ <input type="checkbox"/> USDB clinical opinion		Results/Date: _____		<input type="checkbox"/> LDS <input type="checkbox"/> Functional <input type="checkbox"/>		Date: _____ Date: _____ Date: _____	
Parent Concerns		<input type="checkbox"/> Interview <input type="checkbox"/> ASQ <input type="checkbox"/> TABS		<input type="checkbox"/> CSBS <input type="checkbox"/>		Concerns to be addressed in evaluation & assessment:					
Domain	Norm-reference Instruments				Standard Score	Assessments used to support clinical opinion <i>(when possible, used Conversion Chart)</i>				Age Equivalent	Significance of Delay mild -1.0, 16 th moderate -1.5, 7 th severe -2.0, 2 nd
Gross Motor	<input type="checkbox"/> Mullen Date: _____	<input type="checkbox"/> BDI Date: _____	<input type="checkbox"/> Bayley Date: _____	<input type="checkbox"/> Peabody Date: _____	<input type="checkbox"/> Infanib Date: _____ <input type="checkbox"/> AIM Date: _____	<input type="checkbox"/> HELP Date: _____ <input type="checkbox"/> Brigance Date: _____ <input type="checkbox"/> IDA Date: _____ <input type="checkbox"/> ELAP Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Fine/Visual Motor	<input type="checkbox"/> Mullen Date: _____	<input type="checkbox"/> BDI Date: _____	<input type="checkbox"/> Bayley Date: _____	<input type="checkbox"/> Peabody Date: _____	<input type="checkbox"/>	<input type="checkbox"/> HELP Date: _____ <input type="checkbox"/> Brigance Date: _____ <input type="checkbox"/> IDA Date: _____ <input type="checkbox"/> ELAP Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Cognitive	<input type="checkbox"/> Mullen Date: _____	<input type="checkbox"/> BDI Date: _____	<input type="checkbox"/> Bayley Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HELP Date: _____ <input type="checkbox"/> Brigance Date: _____ <input type="checkbox"/> IDA Date: _____ <input type="checkbox"/> ELAP Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Receptive Language	<input type="checkbox"/> Mullen Date: _____	<input type="checkbox"/> BDI Date: _____	<input type="checkbox"/> PLS-3 Date: _____	<input type="checkbox"/> CSBS Date: _____	<input type="checkbox"/>	<input type="checkbox"/> HELP Date: _____ <input type="checkbox"/> Brigance Date: _____ <input type="checkbox"/> IDA Date: _____ <input type="checkbox"/> ELAP Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Expressive Language	<input type="checkbox"/> Mullen Date: _____	<input type="checkbox"/> BDI Date: _____	<input type="checkbox"/> PLS Date: _____	<input type="checkbox"/> CSBS Date: _____	<input type="checkbox"/> G-FTA Date: _____ <input type="checkbox"/> Arizona Date: _____	<input type="checkbox"/> HELP Date: _____ <input type="checkbox"/> Brigance Date: _____ <input type="checkbox"/> IDA Date: _____ <input type="checkbox"/> ELAP Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

4. Enter Evaluation results after completing evaluation table, including date of birth, chronological age, and adjusted age.

Vision Evaluation results:

- a.) Indicate results of the vision screen performed by the E.I. by checking pass or fail and writing the date.
- b.) If there is an Ophthalmology Report indicate the date.
- c.) In the results Box put the date you review the report and briefly indicate the results. i.e., "Congenital Cataracts." If there is no report, write a clinical opinion, briefly write the results, and indicate the date completed.
- d.) In the Assessment box, check the box, write the name of the assessment(s) used, and indicate the date completed. If a functional assessment is used, write the results based on observation and parent report, and indicate date written.
- e.) Indicate if the child is USDB eligible, or not eligible.

Your Program's Name						
1. Child's Name: _____		2. Qualifying Diagnosis: _____		Date documented: _____		
3. Pertinent records: <input type="checkbox"/> No pertinent medical/health history requiring a review: <input type="checkbox"/> Pertinent medical/health history requiring a review: <input type="checkbox"/> Date reviewed for eligibility: _____						
<input type="checkbox"/> Premature gestation: _____ <input type="checkbox"/> Heart condition <input type="checkbox"/> Ear infections <input type="checkbox"/> PE tubes <input type="checkbox"/> Respiratory <input type="checkbox"/> Sleep <input type="checkbox"/> Seizures <input type="checkbox"/> Nuerological <input type="checkbox"/> Poor weight gain <input type="checkbox"/> ROP <input type="checkbox"/> On medications <input type="checkbox"/> Drug/alcohol exposed <input type="checkbox"/> Allergies <input type="checkbox"/> Other: _____						
4. Evaluation results: <i>Identify all tests used & date administered, provide clinical opinion & observation details in # 5 & # 6</i> DOB: _____ CA: _____ Adj. Age: _____						
Vision	<input type="checkbox"/> Vision Screen R-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> L-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> Date: _____	<input type="checkbox"/> Ophthalmology Report Date: _____ <input type="checkbox"/> USDB clinical opinion	Results/Date: _____	<input type="checkbox"/> VDS <input type="checkbox"/> Functional <input type="checkbox"/> _____ <input type="checkbox"/> _____	Date: _____ Date: _____ Date: _____	<input type="checkbox"/> USDB eligible <input type="checkbox"/> Not eligible <input type="checkbox"/> Not determined
Hearing	<input type="checkbox"/> Newborn Screen date: _____ <input type="checkbox"/> BWEIP Screen date: _____ <input type="checkbox"/> EI OAE/booth date: _____ <input type="checkbox"/> R-ear <input type="checkbox"/> pass <input type="checkbox"/> referral <input type="checkbox"/> L-ear <input type="checkbox"/> pass <input type="checkbox"/> referral	<input type="checkbox"/> Audiology Report Date: _____ <input type="checkbox"/> USDB clinical opinion	Results/Date: _____	<input type="checkbox"/> LDS <input type="checkbox"/> Functional <input type="checkbox"/> _____	Date: _____ Date: _____ Date: _____	<input type="checkbox"/> USDB eligible <input type="checkbox"/> Not eligible <input type="checkbox"/> Not determined
Parent Concerns	<input type="checkbox"/> Interview <input type="checkbox"/> ASQ <input type="checkbox"/> TABS	<input type="checkbox"/> CSBS <input type="checkbox"/> _____ <input type="checkbox"/> _____	Concerns to be addressed in evaluation & assessment:			

Hearing Evaluation results:

- a.) Indicate results of hearing screening performed by the E.I. by checking pass or fail and writing the date.
- b.) If there is an Audiology Report, indicate the date.
- c.) In the results Box put the date you review the report and briefly indicate the results. If there is no report, write a clinical opinion, indicate the date completed and briefly write the results.
- d.) In the Assessment box, check the box, write the name of the assessment(s) used, and indicate the date completed. If a functional assessment is used, write the results based on observation and parent report, and indicate date written.
- e.) Indicate if the child is USDB eligible, or not eligible.

Your Program's Name						
1. Child's Name: _____		2. Qualifying Diagnosis: _____		Date documented: _____		
3. Pertinent records: <input type="checkbox"/> No pertinent medical/health history requiring a review: <input type="checkbox"/> Pertinent medical/health history requiring a review: <input type="checkbox"/> Date reviewed for eligibility: _____						
<input type="checkbox"/> Premature gestation: _____ <input type="checkbox"/> Heart condition <input type="checkbox"/> Ear infections <input type="checkbox"/> PE tubes <input type="checkbox"/> Respiratory <input type="checkbox"/> Sleep <input type="checkbox"/> Seizures <input type="checkbox"/> Nuerological <input type="checkbox"/> Poor weight gain <input type="checkbox"/> ROP <input type="checkbox"/> On medications <input type="checkbox"/> Drug/alcohol exposed <input type="checkbox"/> Allergies <input type="checkbox"/> Other: _____						
4. Evaluation results: <i>Identify all tests used & date administered, provide clinical opinion & observation details in # 5 & # 6</i> DOB: _____ CA: _____ Adj. Age: _____						
Vision	<input type="checkbox"/> Vision Screen R-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> L-eye <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> Date: _____	<input type="checkbox"/> Ophthalmology Report Date: _____ <input type="checkbox"/> USDB clinical opinion	Results/Date: _____	<input type="checkbox"/> VDS <input type="checkbox"/> Functional <input type="checkbox"/> _____ <input type="checkbox"/> _____	Date: _____ Date: _____ Date: _____	<input type="checkbox"/> USDB eligible <input type="checkbox"/> Not eligible <input type="checkbox"/> Not determined
Hearing	<input type="checkbox"/> Newborn Screen date: _____ <input type="checkbox"/> BWEIP Screen date: _____ <input type="checkbox"/> EI OAE/booth date: _____ <input type="checkbox"/> R-ear <input type="checkbox"/> pass <input type="checkbox"/> referral <input type="checkbox"/> L-ear <input type="checkbox"/> pass <input type="checkbox"/> referral	<input type="checkbox"/> Audiology Report Date: _____ <input type="checkbox"/> USDB clinical opinion	Results/Date: _____	<input type="checkbox"/> LDS <input type="checkbox"/> Functional <input type="checkbox"/> _____	Date: _____ Date: _____ Date: _____	<input type="checkbox"/> USDB eligible <input type="checkbox"/> Not eligible <input type="checkbox"/> Not determined
Parent Concerns	<input type="checkbox"/> Interview <input type="checkbox"/> ASQ <input type="checkbox"/> TABS	<input type="checkbox"/> CSBS <input type="checkbox"/> _____ <input type="checkbox"/> _____	Concerns to be addressed in evaluation & assessment:			

Parent Concerns: Enter information and/or scores gathered through an intake interview or parent questionnaire related to the concerns the parent has about his/her child's development. This information should be used to determine the types of evaluations/assessments used for eligibility determination.

Domains: E. I. programs are encouraged to use standardized norm-reference tools whenever possible.

- 1.) Identify the test used by checking the box or writing in the name of the evaluation/ assessment.
- 2.) Specify the date administered (month & year.)
- 3.) Report the resulting scores.

Norm-reference instrument scores: These are best reported as percentiles or standard deviations.

Assessments used to support clinical opinion scores should be reported as 1.) age equivalents, 2.) age approximations, or 3.) age ranges, when appropriate. The examiner should use the BWEIP conversion chart to convert these age scores into significance of delay. (See attachment A.)

Your Program's Name										
Domain	Norm-reference Instruments				Standard Score	Assessments used to support clinical opinion <i>(when possible, used Conversion Chart)</i>			Age Equivalent	Significance of Delay mild –1.0, 16 th moderate –1.5, 7 th severe –2.0, 2 nd
Gross Motor	<input type="checkbox"/> Mullen	Date:	<input type="checkbox"/> Infanib	Date:		<input type="checkbox"/> HELP	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Not significant
	<input type="checkbox"/> BDI	Date:	<input type="checkbox"/> AIM	Date:		<input type="checkbox"/> Brigance	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Mild
	<input type="checkbox"/> Bayley	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> IDA	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Peabody	Date:				<input type="checkbox"/> ELAP	Date:	<input type="checkbox"/>		<input type="checkbox"/> Severe
Fine/Visual Motor	<input type="checkbox"/> Mullen	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> HELP	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Not significant
	<input type="checkbox"/> BDI	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> Brigance	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Mild
	<input type="checkbox"/> Bayley	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> IDA	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Peabody	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> ELAP	Date:	<input type="checkbox"/>		<input type="checkbox"/> Severe
Cognitive	<input type="checkbox"/> Mullen	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> HELP	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Not significant
	<input type="checkbox"/> BDI	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> Brigance	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Mild
	<input type="checkbox"/> Bayley	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> IDA	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Moderate
			<input type="checkbox"/>	Date:		<input type="checkbox"/> ELAP	Date:	<input type="checkbox"/>		<input type="checkbox"/> Severe
Receptive Language	<input type="checkbox"/> Mullen	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> HELP	Date:	<input type="checkbox"/> Rosetti	Date:	<input type="checkbox"/> Not significant
	<input type="checkbox"/> BDI	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> Brigance	Date:	<input type="checkbox"/> REEL	Date:	<input type="checkbox"/> Mild
	<input type="checkbox"/> PLS-3	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> IDA	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Peabody	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> ELAP	Date:	<input type="checkbox"/>		<input type="checkbox"/> Severe
Expressive Language	<input type="checkbox"/> Mullen	Date:	<input type="checkbox"/> G-FTA	Date:		<input type="checkbox"/> HELP	Date:	<input type="checkbox"/> Rosetti	Date:	<input type="checkbox"/> Not significant
	<input type="checkbox"/> BDI	Date:	<input type="checkbox"/> Arizona	Date:		<input type="checkbox"/> Brigance	Date:	<input type="checkbox"/> REEL	Date:	<input type="checkbox"/> Mild
	<input type="checkbox"/> PLS	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> IDA	Date:	<input type="checkbox"/>	Date:	<input type="checkbox"/> Moderate
	<input type="checkbox"/> CSBS	Date:	<input type="checkbox"/>	Date:		<input type="checkbox"/> ELAP	Date:	<input type="checkbox"/>		<input type="checkbox"/> Severe

About Supporting Evaluation Tools:

Conversion chart This is used with assessment instruments that provide age equivalent scores, age approximation scores or age ranges. The chart lets the examiner approximate the significance of a child's developmental delay to compare with the BWEIP definition for eligibility. To use the chart the examiner must determine the number of months of delay, or the difference between the child's chronological age and the child's tested developmental age or age range. (See attachment A.)

Test administration manual The examiner must use the instructions provided in the manual accompanying the test instrument selected by the agency to measure development. Interpretation of criterion and curriculum reference assessments often requires clinical judgment and item analysis when determining approximate developmental levels. There are no exact rules or formulas that will apply for every child or every assessment to ascertain developmental levels.

Examples Following are *sample* assessment tables similar to those found in some test administration manuals. These should not be generalized to any particular assessment. Examiners must adhere to each test's own administration guidelines.

Assessment tools that provide age levels The examiner identifies the highest developmental age level at which the child displays mastery (receives credit for a predominant number of items tested at an age level) and subtracts the developmental age from the child's chronological age.

Example: Child's chronological age: 20 Months
 developmental age (mastery level): -16 Months
 which equals a 4 month delay = 4 Month delay (-4)

Gross Motor Domain

16 months	Stands on one foot....	+
	Walks up stairs with help...	+
18 months	Climbs into adult chair...	+
	Seats self in small chair...	+
	Runs...	-
	Pushes & pulls large objects	-
	Throws ball....	-

Mastery level

This child would have an age approximation of 16 months

Next the examiner finds the 20 month column on the conversion chart and locates the -4 months of delay.

Chronological Age	19m	20m	21m
Mild	-3	-3	-3
Moderate	-4	-4	-4
Severe	-5	-5	-5

In the example, the 20-month-old child with a -4 month delay would have a moderate significance of delay in the gross motor domain, based on this assessment.

Assessments with developmental strands: Where there is not a significant age level difference between strands within a domain, a service provider, using clinical opinion, can report one approximate age level for the entire domain.

Example: Child's chronological age: 8 months
 developmental age approximation: -3-5 months (in the gross motor domain)
 which equals a -3 to -5 month delay. = 3-5 month delay

HELP- Gross Motor Profile

3-1	Prone	3-5 months
3-2	Supine	4-5 months
3-3	Sitting	4-5 months
3-4	weight bearing and standing	3-5 months

This child would have an age range approximation of 3-5 months

Next the examiner finds the 8 month column on the conversion chart and locates the -3 to -5 months of delay.

8m	9m	10m	Chronological Age
-2	-2	-2	Mild
-3	-3	-3	Moderate
-4	-4	-4	Severe

In the example, the 8-month-old child with a -3 to -5 month delay would have a severe significance of delay in the gross motor domain, based on this assessment.

In cases where there is a significant difference between strands within a domain, a single age range for a domain cannot be determined. (As shown below.)

HELP- Gross Motor Profile

3-1	Prone	0-2 months
3-2	Supine	0-2 months
3-3	Sitting	5-6 months
3-4	weight bearing and standing	5-6 months

Use of two or more sources of information: When more than one evaluation or assessment instrument is used to assess a domain, the more precise test scores should be used to determine significance of delay. For example the Peabody Gross Motor evaluation is more accurate than an ELAP criterion test when assessing gross motor skill development.

Domain	Norm-reference Instruments				Standard Score	Assessments used to support clinical opinion <i>(when possible, used Conversion Chart)</i>				Age Equivalent	Significance of Delay mild -1.0, 16 th moderate -1.5, 7 th severe -2.0, 2 nd
Gross Motor	<input type="checkbox"/> Mullen <input type="checkbox"/> BDI <input type="checkbox"/> Bayley <input type="checkbox"/> Peabody	Date: Date: Date: Date:	<input type="checkbox"/> Infanib <input type="checkbox"/> AIM	Date: Date: Date:		<input type="checkbox"/> HELP <input type="checkbox"/> Brigance <input type="checkbox"/> IDA <input type="checkbox"/> ELAP	Date: Date: Date: Date:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date: Date: Date:		<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Fine/Visual Motor	<input type="checkbox"/> Mullen <input type="checkbox"/> BDI <input type="checkbox"/> Bayley <input type="checkbox"/> Peabod	Date: Date: Date: Date:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date: Date: Date:		<input type="checkbox"/> HELP <input type="checkbox"/> Brigance <input type="checkbox"/> IDA <input type="checkbox"/> ELAP	Date: Date: Date: Date:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date: Date: Date:		<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Feeding, regulation/sleep and sensory function: Development in the areas of feeding, regulation/sleep, and sensory function are not considered separate domains. Delays or dysfunction in these areas may impact, to a differing degree, one or all domains. Assessment information from these areas should be considered and incorporated when determining the “significance of delay” reflected in the adaptive and/or the social emotional domains, or other affected domains. The sensory information is very useful for determining intervention methodologies.

Your Program's Name																																																	
<i>Provide details below # 5 & 6</i>	Feeding (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date: <input type="checkbox"/> date: <input type="checkbox"/> date:	Regulation/sleep (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date: <input type="checkbox"/> date: <input type="checkbox"/> date:	Sensory function (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> Sensory Profile date: <input type="checkbox"/> ITSC date: <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date:	Assistive technology & augmentative needs requiring assessment <input type="checkbox"/> Sensory Profile <input type="checkbox"/> environmental <input type="checkbox"/> ITSC <input type="checkbox"/> controls <input type="checkbox"/> checklist <input type="checkbox"/> vision <input type="checkbox"/> observation <input type="checkbox"/> hearing																																													
<p>5. Clinical observations and parent report of atypical characteristics and excessive behaviors:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> None Observed</td> <td><input type="checkbox"/> dislikes stomach position</td> <td><input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair</td> <td><input type="checkbox"/> Seeks excessive sensory input</td> <td><input type="checkbox"/> Lines up objects</td> </tr> <tr> <td><input type="checkbox"/> Poor motor planning</td> <td><input type="checkbox"/> Tube feeding</td> <td><input type="checkbox"/> Articulation not typical for age</td> <td><input type="checkbox"/> Upset by changes in routine</td> <td><input type="checkbox"/> Short attention span</td> </tr> <tr> <td><input type="checkbox"/> High tone</td> <td><input type="checkbox"/> Weak/disorganized suck</td> <td><input type="checkbox"/> Disorganized connected speech</td> <td><input type="checkbox"/> Dislikes tactile input</td> <td><input type="checkbox"/> Aggressive</td> </tr> <tr> <td><input type="checkbox"/> Low tone</td> <td><input type="checkbox"/> Poor suck/swallow/breath</td> <td><input type="checkbox"/> Stutter</td> <td><input type="checkbox"/> Easily distracted</td> <td><input type="checkbox"/> Overly active</td> </tr> <tr> <td><input type="checkbox"/> Poor balance</td> <td><input type="checkbox"/> Dislikes food textures</td> <td><input type="checkbox"/> Poor functional language</td> <td><input type="checkbox"/> Poor social play</td> <td><input type="checkbox"/> Overly irritable</td> </tr> <tr> <td><input type="checkbox"/> Walks on toes</td> <td><input type="checkbox"/> Mouth breathing</td> <td><input type="checkbox"/> Echolalia</td> <td><input type="checkbox"/> Self-stim behavior</td> <td><input type="checkbox"/> Inactive</td> </tr> <tr> <td><input type="checkbox"/> Hemiparesis</td> <td><input type="checkbox"/> Drooling</td> <td><input type="checkbox"/> MLU (from lang. sample) _____</td> <td><input type="checkbox"/> Poor eye contact</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Indwelling thumbs</td> <td><input type="checkbox"/> Choking/gagging</td> <td><input type="checkbox"/> Withdrawn/non-engaging</td> <td><input type="checkbox"/> Biting, hitting</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Fisted hands</td> <td><input type="checkbox"/> Vomits following eating</td> <td><input type="checkbox"/> Agitated, sleeps poorly</td> <td><input type="checkbox"/> Dislikes loud noises</td> <td>_____</td> </tr> </table>					<input type="checkbox"/> None Observed	<input type="checkbox"/> dislikes stomach position	<input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair	<input type="checkbox"/> Seeks excessive sensory input	<input type="checkbox"/> Lines up objects	<input type="checkbox"/> Poor motor planning	<input type="checkbox"/> Tube feeding	<input type="checkbox"/> Articulation not typical for age	<input type="checkbox"/> Upset by changes in routine	<input type="checkbox"/> Short attention span	<input type="checkbox"/> High tone	<input type="checkbox"/> Weak/disorganized suck	<input type="checkbox"/> Disorganized connected speech	<input type="checkbox"/> Dislikes tactile input	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Low tone	<input type="checkbox"/> Poor suck/swallow/breath	<input type="checkbox"/> Stutter	<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Overly active	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Dislikes food textures	<input type="checkbox"/> Poor functional language	<input type="checkbox"/> Poor social play	<input type="checkbox"/> Overly irritable	<input type="checkbox"/> Walks on toes	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Echolalia	<input type="checkbox"/> Self-stim behavior	<input type="checkbox"/> Inactive	<input type="checkbox"/> Hemiparesis	<input type="checkbox"/> Drooling	<input type="checkbox"/> MLU (from lang. sample) _____	<input type="checkbox"/> Poor eye contact	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Indwelling thumbs	<input type="checkbox"/> Choking/gagging	<input type="checkbox"/> Withdrawn/non-engaging	<input type="checkbox"/> Biting, hitting	_____	<input type="checkbox"/> Fisted hands	<input type="checkbox"/> Vomits following eating	<input type="checkbox"/> Agitated, sleeps poorly	<input type="checkbox"/> Dislikes loud noises	_____
<input type="checkbox"/> None Observed	<input type="checkbox"/> dislikes stomach position	<input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair	<input type="checkbox"/> Seeks excessive sensory input	<input type="checkbox"/> Lines up objects																																													
<input type="checkbox"/> Poor motor planning	<input type="checkbox"/> Tube feeding	<input type="checkbox"/> Articulation not typical for age	<input type="checkbox"/> Upset by changes in routine	<input type="checkbox"/> Short attention span																																													
<input type="checkbox"/> High tone	<input type="checkbox"/> Weak/disorganized suck	<input type="checkbox"/> Disorganized connected speech	<input type="checkbox"/> Dislikes tactile input	<input type="checkbox"/> Aggressive																																													
<input type="checkbox"/> Low tone	<input type="checkbox"/> Poor suck/swallow/breath	<input type="checkbox"/> Stutter	<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Overly active																																													
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<p>6. Evaluation Summary: _____</p> <p>_____</p> <p>_____</p>																																																	
<p>Prior Notice for Determination of Eligibility date of meeting to review eligibility: _____</p> <p>The multidisciplinary team has reviewed the evaluation results and proposes the following:</p> <p><input type="checkbox"/> Your child has been identified as possessing a developmental delay consistent with Utah’s Baby Watch definition or has a diagnosed condition that has a high probability of resulting in developmental delays.</p> <p><input type="checkbox"/> Your child does not have a developmental delay as defined by Utah’s Baby Watch definition or a diagnosed condition that has a high probability of resulting in developmental delays.</p> <p>Name, title: _____</p> <p>Name, title: _____</p>																																																	

Scenario A:

A child with identified sensory concerns also has significant feeding delays specifically in the areas of chewing, food texture, and hand washing. This child’s adaptive domain is being effected by his sensory concerns. Therefore, the developmental assessment used to assess his adaptive skills scored the child with a developmental delay.

The team must consider how the sensory issues are impacting development and which developmental domains are being impacted.

Scenario B:

Another child has identified sensory and regulatory concerns but demonstrates age appropriate skills in all domains. Two things should be considered related to eligibility. One, the child’s sensory and regulatory concerns are not influencing development and, “at this time” she is not eligible. Second, the assessment used to test the social/emotional and adaptive domain was not sensitive enough to document a developmental delay. This is frequently found to be the case with children who have behavior problems.

The team must determine if additional information, testing, observation is needed because of conflicting test scores and/or insufficient testing and information.

Your Program’s Name																
Social/ Emotional	<input type="checkbox"/> BDI <input type="checkbox"/> Bayley <input type="checkbox"/> ITSC <input type="checkbox"/> SIB-R	Date: Date: Date: Date:	<input type="checkbox"/> Vineland	Date: Date: Date: Date:		<input type="checkbox"/> HELP <input type="checkbox"/> Brigance <input type="checkbox"/> IDA <input type="checkbox"/> ELAP	Date: Date: Date: Date:	<input type="checkbox"/>	Date: Date: Date: Date:	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe						
Adaptive	<input type="checkbox"/> BDI <input type="checkbox"/> PEDI <input type="checkbox"/> SIB-R	Date: Date: Date: Date:	<input type="checkbox"/>	Date: Date: Date: Date:		<input type="checkbox"/> HELP <input type="checkbox"/> Brigance <input type="checkbox"/> IDA <input type="checkbox"/> ELAP	Date: Date: Date: Date:	<input type="checkbox"/>	Date: Date: Date: Date:	<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe						
Provide details below # 5 & 6	Feeding (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date: <input type="checkbox"/> date: <input type="checkbox"/> date:		Regulation/sleep (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date: <input type="checkbox"/> date: <input type="checkbox"/> date:		Sensory function (significance of delay reflected in adaptive/social emotional domains) <input type="checkbox"/> Sensory Profile date: <input type="checkbox"/> ITSC date: <input type="checkbox"/> checklist date: <input type="checkbox"/> observation date:			Assistive technology & augmentative needs requiring assessment <input type="checkbox"/> Sensory Profile <input type="checkbox"/> environmental <input type="checkbox"/> ITSC <input type="checkbox"/> controls <input type="checkbox"/> checklist <input type="checkbox"/> vision <input type="checkbox"/> observation <input type="checkbox"/> hearing								
<p>5. Clinical observations and parent report of atypical characteristics and excessive behaviors:</p> <p><input type="checkbox"/> None Observed</p> <table style="width:100%;"> <tr> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Poor motor planning <input type="checkbox"/> High tone <input type="checkbox"/> Low tone <input type="checkbox"/> Poor balance <input type="checkbox"/> Walks on toes <input type="checkbox"/> Hemiparesis <input type="checkbox"/> Indwelling thumbs <input type="checkbox"/> Fisted hands <input type="checkbox"/> Poor hand-eye coordination </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> dislikes stomach position <input type="checkbox"/> Tube feeding <input type="checkbox"/> Weak/disorganized suck <input type="checkbox"/> Poor suck/swallow/breath <input type="checkbox"/> Dislikes food textures <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Drooling <input type="checkbox"/> Choking/gagging <input type="checkbox"/> Vomits following eating </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> Articulation not typical for age <input type="checkbox"/> Disorganized connected speech <input type="checkbox"/> Stutter <input type="checkbox"/> Poor functional language <input type="checkbox"/> Echolalia <input type="checkbox"/> MLU (from lang. sample) _____ <input type="checkbox"/> Withdrawn/non-engaging <input type="checkbox"/> Agitated, sleeps poorly </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Seeks excessive sensory input <input type="checkbox"/> Upset by changes in routine <input type="checkbox"/> Dislikes tactile input <input type="checkbox"/> Easily distracted <input type="checkbox"/> Poor social play <input type="checkbox"/> Self-stim behavior <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Biting, hitting <input type="checkbox"/> Dislikes loud noises </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Lines up objects <input type="checkbox"/> Short attention span <input type="checkbox"/> Aggressive <input type="checkbox"/> Overly active <input type="checkbox"/> Overly irritable <input type="checkbox"/> Inactive <input type="checkbox"/> Other: _____ _____ _____ </td> </tr> </table>												<input type="checkbox"/> Poor motor planning <input type="checkbox"/> High tone <input type="checkbox"/> Low tone <input type="checkbox"/> Poor balance <input type="checkbox"/> Walks on toes <input type="checkbox"/> Hemiparesis <input type="checkbox"/> Indwelling thumbs <input type="checkbox"/> Fisted hands <input type="checkbox"/> Poor hand-eye coordination	<input type="checkbox"/> dislikes stomach position <input type="checkbox"/> Tube feeding <input type="checkbox"/> Weak/disorganized suck <input type="checkbox"/> Poor suck/swallow/breath <input type="checkbox"/> Dislikes food textures <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Drooling <input type="checkbox"/> Choking/gagging <input type="checkbox"/> Vomits following eating	<input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> Articulation not typical for age <input type="checkbox"/> Disorganized connected speech <input type="checkbox"/> Stutter <input type="checkbox"/> Poor functional language <input type="checkbox"/> Echolalia <input type="checkbox"/> MLU (from lang. sample) _____ <input type="checkbox"/> Withdrawn/non-engaging <input type="checkbox"/> Agitated, sleeps poorly	<input type="checkbox"/> Seeks excessive sensory input <input type="checkbox"/> Upset by changes in routine <input type="checkbox"/> Dislikes tactile input <input type="checkbox"/> Easily distracted <input type="checkbox"/> Poor social play <input type="checkbox"/> Self-stim behavior <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Biting, hitting <input type="checkbox"/> Dislikes loud noises	<input type="checkbox"/> Lines up objects <input type="checkbox"/> Short attention span <input type="checkbox"/> Aggressive <input type="checkbox"/> Overly active <input type="checkbox"/> Overly irritable <input type="checkbox"/> Inactive <input type="checkbox"/> Other: _____ _____ _____
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Assistive technology & augmentative needs: This area is *not* required in determining eligibility, but is a useful reminder for the team for further assessment in both this area and IFSP development.

5. Clinical Observations and parent report of atypical characteristics and excessive behaviors: These behaviors and characteristics have been identified as concerns that are not usually evaluated or identified by typical testing methods or reflected in the evaluation scores. They are behaviors and characteristics that require the use of clinical opinion to determine the importance and impact of the behavior/characteristic on the child’s development. Record any clinical observation and parent report of atypical characteristics and excessive behaviors in section 5.

None observed: Check this box if there were no atypical characteristics and excessive behaviors observed or reported by the parent.

Significance of Delay: The team, determines the significance of delay for each domain. This decision must consider all information available related to the each domain.

- **not significant:** Test results indicate age appropriate development or a delay less than -1 standard deviation, 16th percentile, or the equivalent on the conversion chart for the child's age.
- **Mild:** Test results indicate a developmental delay of at least -1 standard deviations below the mean, or at or below the 16th percentile.
- **Moderate:** Test results indicate a developmental delay of at least -1.5 standard deviations below the mean, or at or below the 7th percentile
- **Severe:** Test results indicate a developmental delay of at least -2 standard deviations below the mean, or at or below the 2nd percentile.

Moderate: Test results indicate a developmental delay of at least -1.5 standard deviations below the mean, or at or below the 7th percentile. (ADDED JANUARY 2007)

Your Program's Name											
Social/Emotional	<input type="checkbox"/> BDI <input type="checkbox"/> Bayley <input type="checkbox"/> ITSC <input type="checkbox"/> SIB-R	Date: Date: Date: Date:	<input type="checkbox"/> Vineland	Date: Date: Date:		<input type="checkbox"/> HELP <input type="checkbox"/> Brigance <input type="checkbox"/> IDA <input type="checkbox"/> ELAP	Date: Date: Date: Date:	<input type="checkbox"/>	Date: Date: Date:		<input type="checkbox"/> Not significant <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
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5. Clinical observations and parent report of atypical characteristics and excessive behaviors:

- None Observed**
- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Poor motor planning | <input type="checkbox"/> dislikes stomach position | <input type="checkbox"/> Speech intelligibility <input type="checkbox"/> poor <input type="checkbox"/> fair | <input type="checkbox"/> Seeks excessive sensory input | <input type="checkbox"/> Lines up objects |
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| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Echolalia | <input type="checkbox"/> Self-stim behavior | <input type="checkbox"/> Inactive |
| <input type="checkbox"/> Indwelling thumbs | <input type="checkbox"/> Drooling | <input type="checkbox"/> MLU (from lang. sample) _____ | <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fisted hands | <input type="checkbox"/> Choking/gagging | <input type="checkbox"/> Withdrawn/non-engaging | <input type="checkbox"/> Biting, hitting | _____ |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> Vomits following eating | <input type="checkbox"/> Agitated, sleeps poorly | <input type="checkbox"/> Dislikes loud noises | _____ |

6. Evaluation Summary:

Prior Notice for Determination of Eligibility date of meeting to review eligibility: _____

The multidisciplinary team has reviewed the evaluation results and proposes the following:

- Your child has been identified as possessing a developmental delay consistent with Utah's Baby Watch definition or has a diagnosed condition that has a high probability of resulting in developmental delays. Qualifying diagnosis Standard Scores Clinical Opinion
- Your child does not have a developmental delay as defined by Utah's Baby Watch definition or a diagnosed condition that has a high probability of resulting in developmental delays.

Name, title: _____

Name, title: _____

6. Evaluation Summary: This should be an integrated summary of the evaluation information, not a series of statements written by each team member as a summary of the individual test results. This conclusive statement provides parents with a complete explanation of their child's current developmental status.

Eligibility Determination Meeting:

1. Enter the date of the meeting when eligibility was discussed with the parents.
2. The team, including parents, should review the evaluation results and other pertinent information and determine whether the child is a child with a developmental delay consistent with the BWEIP definition or is a child with a diagnosed condition that has a high probability of resulting in a developmental delay.
3. Check the appropriate box(es) indicating the teams decision and the process used for determining eligibility (diagnosis, standard scores, clinical opinion).

Names & Titles: The evaluation team signs or may be listed. Parent signature is optional.

Conversion Chart

The conversion chart is used with an assessment instrument that provides an age equivalent score/age approximation. The chart allows the examiner to approximate the severity of a child's developmental delay. To use the chart the examiner must determine the number of months of delay; which is the difference between the child's chronological age and the child's tested developmental age. This is done by identifying the highest developmental age level at which the child displays mastery (receives credit for a predominant number of items tested at an age level) and subtracting this developmental age from the child's chronological age. Example: chronological age 20 months, developmental age (mastery level) is 16 months in the gross motor domain which equals a 4-month delay (-4). Next the examiner would find the 20-month column. In the example the 20-month-old child with a -4 month delay would have a moderate delay in the area of gross motor.

Baby Watch Definition of Developmental Delay:

*1.5 standard deviations at or below the mean, or at or below the 7th percentile in one or more areas of development

Chronological Age	3m	4m	5m	6m	7m	8m	9m	10m	Chronological Age
Mild	-1	-1	-1	-1	-1	-2	-2	-2	Mild
Moderate	-1.5	-1.5	-1.5	-2	-2	-3	-3	-3	Moderate
Severe	-2	-2	-2	-3	-3	-3	-4	-4	Severe

Chronological Age	11m	12m	13m	14m	15m	16m	17m	18m	Chronological Age
Mild	-2	-2	-2	-2	-2	-2	-2	-2	Mild
Moderate	-3	-3	-3	-3	-3	-3	-3	-3	Moderate
Severe	-4	-4	-4	-4	-4	-4	-4	-4	Severe

Chronological Age	19m	20m	21m	22m	23m	24m	25m	26m	Chronological Age
Mild	-3	-3	-3	-3	-3	-3	-3	-3	Mild
Moderate	-4	-4	-4	-4	-4	-4	-4	-4	Moderate
Severe	-5	-5	-5	-5	-5	-5	-5	-5	Severe

Chronological Age	27m	28m	29m	30m	31m	32m	33m	34m	35m	Chronological Age
Mild	-3	-4	-4	-4	-5	-5	-5	-6	-7	Mild
Moderate	-4	-5	-5	-5	-6	-6	-6	-7	-8	Moderate
Severe	-5	-6	-6	-6	-7	-7	-7	-8	-9	Severe