**Infant & Toddler Connection of Virginia – Individual Child Data Form**

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| **Child’s Full Name: First, M I, Last Name****Street Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City, State Zip**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone:** (\_\_\_ \_\_\_ \_\_\_) \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_**City/County of Residence:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Race Code:** \_\_\_\_\_ **Gender:** [ ]  Male [ ]  Female**Service Coordinator:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Referral Source Code:** \_\_\_\_ Other *(specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)***Date of Referral:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_**Intake Date:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | ITOTS Id: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Local Case Number: *\_\_\_\_\_\_\_\_\_\_\_\_* |
| *(Mark the check box to the right of the parent’s name below if their address is different from the child’s address. Use the space below to record that parent’s address.)=***Parent Name:** **First, M I, Last Name** [ ] **Parent Name:** **First, M I, Last Name** [ ] **Street Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City, State Zip**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone:** (\_\_\_ \_\_\_ \_\_\_) \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Was Eligibility Determined?[ ]  Yes [ ]  No **Date Eligibility Determined:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_***Result:***[ ]  Ineligible [ ]  Unable to Contact[ ]  Eligible/Declined Services [ ]  Deceased[ ]  Eligible/Will Receive Services [ ]  Declined Eligibility Determination[ ]  Eligible/Chose Other Services [ ]  Family Moved Before Eligibility[ ]  Eligible/Unable to Contact[ ]  Eligible/Decline assessment for service planning[ ]  Eligible/Ineligible at assessment for service planning**Exit Date:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_ |
| **IFSP Date:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_Mitigating circumstances related to exceeding 45-day timeline[ ]  Child ill [ ]  Provider unavailability[ ]  Family ill [ ]  Temporarily lost contact[ ]  Family scheduling preference [ ] Foster/Surrogate Parent [ ] Disaster/Severe Weather related issues |
| **Race Codes:** A = AsianB = Black/African American H = Hispanic/LatinoP = Pacific Islander or Hawaiian Native  | N = American Indian/Alaskan NativeW = White/CaucasianT = Two or more races U = Unknown | **Referral Source Codes:** 1. CSB2. Local School 3. Health Department 4. DSS (Non-CAPTA)5. Private, Non-profit Org | 6. Hospital7. Pediatrician/Family Physician Group/ Practice 8. Private Therapy9.Friend/Neighbor/Relative | 10. Parent/Guardian 11. DSS CAPTA12. VISITS 13. Another System 14. Other |
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| **Primary Service Setting**  *(check only one)*[ ]  1. Program Designed for Children with Developmental Delays or Disabilities [ ]  2. Community-based setting for Typically Developing Children *(i.e. center or home-based childcare, preschool, library, park, grocery stores, etc.)*[ ]  3. Home [ ]  4. Hospital (inpatient) [ ]  6. Service Provider Location *(center/clinic/hospital)*[ ]  5. Residential Facility [ ]  7. Other *(specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* | **Medically Fragile** (Does this child meet the definition of medically fragile as defined in the instructions?)[ ]  Yes [ ]  No |

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| **Developmental Delay** *(check all that apply)*[ ]  Cognitive[ ]  Physical: including fine & gross motor[ ]  Communication[ ]  Social or emotional[ ]  Adaptive | **Atypical Development** *(check all that apply)*[ ]  Atypical or questionable sensory-motor responses[ ]  Atypical or questionable behaviors that interfere with acquisition of developmental skills [ ]  Atypical or questionable social-emotional development[ ]  Impairment in social interaction and communication skills along with restricted and repetitive behaviors |
| **Diagnosed Disabling Condition** *(check all that apply)* |
| [ ]  Autism Spectrum Disorder [ ]  Brain or spinal cord trauma, with abnormal neurologic exam at discharge[ ]  Cleft Lip and/or Palate [ ]  Congenital or acquired hearing loss[ ]  Chromosomal abnormalities[ ]  Effects of toxic exposure including fetal alcohol syndrome, drug withdrawal, exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants[ ]  Endocrine Disorders [ ]  Failure to thrive [ ]  Gestational Age Less Than or Equal to 28 Weeks[ ]  Hemoglobinopathies (Sickle Cell) | [ ]  Inborn errors of metabolism[ ]  Meningomyelocele (spina bifida)[ ]  Microcephaly [ ]  NICU Stay of ≥28 Days[ ]  Periventricular Leukomalacia [ ]  Seizures with significant encephalopathy [ ]  Severe attachment disorder[ ]  Severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage[ ]  Significant central nervous system anomaly *(e.g. cerebral palsy)*[ ]  Symptomatic congenital infection[ ]  Visual disabilities [ ]  Other (*please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* |
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Family Survey Language:

[ ]  Arabic

[ ]  Mandarin

[ ]  English

[ ]  Farsi

[ ]  Korean

[ ]  Spanish

[ ]  Urdu

[ ]  Vietnamese

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 **Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Risk factors** *(check all that apply)*[ ]  Apgar Score of 0-3 at 5 minutes[ ]  Birth Weight - Low (1500 g to <2500 g or 3.25lbs to 5.5 lbs) [ ]  Birth Weight - Very Low (<1500 grams or <3.25 lbs.)[ ]  Brain or spinal cord trauma[ ]  Diagnosed genetic disorders[ ]  Documented systemic infection, congenital or acquired Environmental – social risk factor:[ ]  Domestic violence [ ]  Lack of adequate shelter [ ]  Lack of familial support[ ]  Family history of childhood Blindness[ ]  Family history of childhood Deafness[ ]  Founded child abuse/neglect[ ]  Hyperbilirubinemia requiring exchange transfusion[ ]  Lack of well-child care [ ]  Lead poisoning[ ]  Major congenital anomalies (see instructions) | [ ]  Maternal age 15 or less[ ]  Maternal conditions during pregnancy such as accidents, phenylketonuria (PKU), maternal diabetes or sickle cell[ ]  Meningitis[ ]  Mother HIV Positive[ ]  Neonatal Seizures[ ]  Oxygen Therapy Greater than 28 days[ ]  Persistent pulmonary hypertension [ ]  Preemie – Gestational Age: 28-31 weeks[ ]  Preemie – Gestational Age: 32-37 weeks[ ]  Seizure disorder--excluding recurrent febrile seizures[ ]  Severe chronic illness Severe parenting risk factor[ ]  Mental illness[ ]  Intellectual disability[ ]  Physical disability[ ]  Substance Abuse[ ]  Small for gestational age (10th percentile or less) |
| **Entitled Part C Service** | **Frequency** | **Intensity** | **Setting** | *(Please also note “Other” service setting here)* |
| # of Times | Every/ only | Times During | Day/Week/Month/Year | Minutes (5-360) | **Provider** | Local Provider |
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| **Entitled Part C Services** | **Service Settings**1. Program Designed for Children with Developmental Delays or Disabilities
2. Community-based setting for Typically Developing Children *(i.e. center or home-based childcare, preschool, library, park, grocery store, etc.)*
3. Home
4. Hospital (inpatient)
5. Residential Facility
6. Service Provider Location *(center/clinic/hospital)*
7. Other *(Specify other service setting in row above)*
 |
| * Assistive Technology Services/ Devices
* Audiology
* Counseling Services
* Developmental Services
* Health Services
* Medical Services (diag/eval)
* Nursing Services
* Nutrition Services
* Occupational Therapy
* Physical Therapy
 | * Psychological Services
* Respite Care
* Service Coordination
* Sign/Cued Language
* Social Work Services
* Speech/Lang. Pathology
* Transportation
* Vision Services
* Other Entitled Part C Services
* *(Specify Other Entitled Part C Services Above)*
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| **Service Provider Codes:**1. Community Services Board2. Local Education Agency3. Department of Health4. Department of Social Services5. Department for the Blind and Visually Impaired |  6. Department for the Deaf and Hard of Hearing7. Extension Agency8. Va. School for the Deaf and Blind9. Private, Non-profit Organization | 10. Hospital 11. Child Care Center and Organization12. Pediatrician/Family Physician13. Private Therapy Group/Practice 14. Other Service Provider *(Specify)* |
| **Date Of Closure:** \_\_\_ \_\_\_/ \_\_\_ \_\_\_/ \_\_\_ \_\_\_ \_\_\_ \_\_\_**Transition Destination:** *(select one only)*[ ]  Another Part C System in Virginia *(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* | **Third Party Health Coverage** *(Check all that apply)*[ ]  Family Fees [ ]  Medicaid/FAMIS ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  None [ ]  Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Policy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  TRICARE ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Deceased[ ]  Exit At Age 3 – No referrals[ ]  Exit with Referrals \_\_\_ Preschool/Day Care \_\_\_ Headstart \_\_\_ Private Therapy[ ]  IFSP Complete *(Child < 3)* | [ ]  Left Virginia [ ]  Lost Contact With Family[ ]  Other *(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*[ ]  Parent Withdrew[ ]  Public School/Part B Eligible[ ]  Part B Referral, Eligibility Not Yet Determined |
| **Indicator Assessment** | **Entry** | **Interim 1** | **Interim 2** | **Exit** | **Missing Exit Data Justification** |
| Assessment Date |  |  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Positive Social Relationship |  |  |  |  |  |  |  |  |  |  |  |
| Using Knowledge & Skills |  |  |  |  |  |  |  |  |  |  |
| Takes Action to Meet Needs |  |  |  |  |  |  |  |  |  |  |
| **Missing Exit Data Justification:** 1. Exited without sufficient notice // 2. Unable to Schedule – child ill // 3. Unable to Schedule – family scheduling // 4. Unable to Schedule – provider unavailability // 5. Other (*Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* |