**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 = Asian  B = Black/African American  H = Hispanic/Latino  P = Pacific Islander or Hawaiian Native | N = American Indian/Alaskan Native  W = White/Caucasian  T = Two or more races  U = Unknown | | **Referral Source Codes:**  1. CSB  2. Local School  3. Health Department  4. DSS (Non-CAPTA)  5. Private, Non-profit Org | | 6. Hospital  7. Pediatrician/Family Physician Group/ Practice 8. Private Therapy  9.Friend/Neighbor/Relative | 10. Parent/Guardian  11. DSS CAPTA  12. VISITS  13. Another System  14. Other |
| |  |  | | --- | --- | | **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 | | | | | | | |
| **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

**Infant & Toddler Connection of Virginia – Individual Child Data Form** Page 2

**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)* | | | | | | | | | | |
| **Service Provider Codes:**  1. Community Services Board  2. Local Education Agency  3. Department of Health  4. Department of Social Services  5. Department for the Blind and Visually Impaired | | | | | | | | | 6. Department for the Deaf and Hard of Hearing  7. Extension Agency  8. Va. School for the Deaf and Blind  9. Private, Non-profit Organization | | | | | | | | | 10. Hospital  11. Child Care Center and Organization  12. Pediatrician/Family Physician  13. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)* | | | | | | | | | | | | | | | | | | | | | |