Exhibit K

Florida HEALTH early steps

Consultation Documentation

(To be completed by those participating in consultation session)

Parent was notified and invited to participate on __________________ by (method)___________________________

If the consultation meeting will potentially result in change of outcomes or services, the Primary Service Provider will contact Service Coordinator prior to meeting. Service Coordinator contacted on __________________ by (method) ___________________________

Child's Name: _______________________________ DOB: ____

Service Coordinator: ____________________________ Date of Consultation: _______________________________

Start Time: ____________ End Time: ____________ Location: ____

- **Successes to implementing strategies and achieving goals for Outcome # _____**

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- **Challenges to implementing strategies and achieving goals for Outcome # _____**

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The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

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IFSP Team meeting is needed to discuss recommended changes in services, frequency, and/or duration of services:

☐ **YES** ☐ **NO**

Participating Team Members/Signatures: (PSP indicated with *)

Parent/ Guardian: ____________________________________ ITDS ____
Face-to-Face Phone Face-to-Face Phone

OT ____ PT ____
Face-to-Face Phone Face-to-Face Phone

SLP ____ EI ____
Face-to-Face Phone Face-to-Face Phone

Service Coordinator:__________________________________ Other ____
Face-to-Face Phone Face-to-Face Phone

Copy to: Family/ Guardian
Early Steps Service Coordinator within 5 business days
Team Providers (whether present or not)

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Consultation Documentation, Continued

Child's Name: ______________________________ DOB: ____

Service Coordinator: ___________________________ Date of Consultation: ______________________________

- **Successes to implementing strategies and achieving goals for Outcome # _____**

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- **Challenges to implementing strategies and achieving goals for Outcome # _____**

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The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

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- **Successes to implementing strategies and achieving goals for Outcome # _____**

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- **Challenges to implementing strategies and achieving goals for Outcome # _____**

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The **team** (*family, caregivers, primary service provider and supporting providers*) **will continue or modify the following strategies to achieve goals for Outcome # _____**

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CONSULTATION DOCUMENTATION FORM INSTRUCTIONS

The purpose of this form is to serve as uniform documentation of consultation services. Each team member who is billing must have a form completed for each Consultation in which they participate. During consultation sessions, the members participating should appoint a recorder to LEGIBLY complete the form from *Child's Name* to *IFSP Team Meeting Yes No.* Copies should then be made for each participant and the family. The original goes to the Service Coordinator to place in the child's file. Each enrolled Early Steps provider can bill for Consultation using the form as invoice documentation. Although they may participate in the consultation, professionals and providers who are not enrolled would not be able to bill. If any team provider did not participate in the Consultation session, a copy should be provided to them so they can be informed.

Instructions:

Child's Name: *Full name of child* **DOB**: *Date of birth of child*

Service Coordinator: *Name* **Date of Consultation:** *MM/DD/YYYY*

Start Time: *Beginning time of consultation session* **End Time:** *End time of consultation session*

Location: *This is the location where the meeting occurred. If face-to-face, enter the location as i.e. Home, Local Early Steps, Playpen Therapy; if occurred by phone, enter the location as Phone.*

Successes and-Challenges to implementing strategies and achieving goals: *Narrative of the discussion, by individual outcome.*

The team (*family, caregivers, primary service provider and supporting providers*) will continue or modify the following strategies to achieve goals: *Narrative of the recommendation(s) resulting from the consultation, by individual outcome.*

PSP: *Name and credentials of the current Primary Service Provider*

Consulting Team Members: *List all members participating in the consultation and check Face-to-Face or Phone and obtain signatures of those present.*

Family Participation: *The name(s) of the family member(s) and check Phone, Face-to-Face or Declined Invitation*

ALL THE ABOVE FIELDS SHOULD BE IDENTICAL FOR ALL PARTICIPANTS' FORMS

When each provider receives their copy of the completed form, they will complete the remaining fields before billing.

Provider/Participant Name (Print): *LEGIBLE name of provider/participant* **Signature**: *Provider/Participant signature*

Each participant should find their designation and sign, if face-to-face. Provider signature lines should include the code signifying if participation was Face-to-Face or Phone

Consultation time must be authorized on the Individualized Family Support Plan (IFSP).Billing is based on the location of the Consultation session.

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