	INTRODUCTION TO 1304.20 Waldo Community Action Partners Head Start Program's commitment to wellness embraces a comprehensive vision of health for children, families, and staff. The object of 45 CFR 1304.20 is to ensure that, through collaboration among families, staff, and health professionals, all child health and developmental concerns are identified, and children and families are linked to an ongoing source of continuous, accessible care to meet their basic health needs. The standards in this section address the initial determination of a child's health status and developmental needs, and discuss ongoing services provided in collaboration with parents and professional service providers.
Performance Standard - 1304.20	**Strategies:**
Child Health and Developmental Services **(a) Determining Child Health Status** **(b) Screening for Developmental, Sensory, and Behavioral Concerns** **(c) Extended follow up and Treatment** **(d) Ongoing Care** **(e) Involving Parents** **(f) Individualization of the program**	
1304.20 (a) (1) (i) **(a) Determining child health status**	
(1) In collaboration with parents and as quickly as possible, but no later than 90 calendar days (with the exception noted in paragraph (a) (2) of this section) from the childs entry into the program (for the purposes of 45CFR 1304.20 (a) (1), 45 CFR 1304.20(a) (2), and CFR 1304.20 (b) (1), "entry" means the first day that Early Head Start or Head Start services are provided to the child), grantee and delegate agencies must:	
(i) Make a determination as to whether or not each child has an ongoing source of continous, accessible health care. If a child does not have a source of ongoing health care, grantee and delegate agencies must assist theparents in accessing a	• Information on a child's medical and dental provider is obtained at the time of application. • If an enrolled family has no medical or dental home Family Advocates, Home Visitors or the Early Head Start Nurse assist families in finding one within 90 days of enrollment. • Family Advocates and Home Visitors also assist families who need help finding transportation, bearing in mind that a goal of parental

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source of care;	involvement and social service activities is to encourage independence and developing skills in meeting time lines when seeking services for children. • Family Advocates and Home Visitors assist eligible families in applying for Maine Care during the application process, on home visits and throughout the program year as the need arise. • Waldo Community Action Partners Head Start Program has funding available to pay for services for children in the absence of insurance or other available funding. Waldo Community Action Partners Head Start Program is considered "The payer of last resort". • Finding a medical and dental home as well as obtaining a copy of the child's up to date physical and dental exam will be made a goal for the family in the FPA. This will be monitored by the Family Advocate or Home Visitor.
1304.20 (a) (1) (ii)(ii) obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental and mental health. Such a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening Diagnosis, and Treatment (EPSDT) program of the medicaid agency of the state in which they operate, and the latest immunization recommendations isued by the Centers for Disease Control and Prevention, as well as any additional recommendations from the local Health Advisory Committee that are based on prevalant community health problems:	• During the initial application process the Family Advocates or Home Visitors inform families that within 30 days of enrollment a copy of the most recent physical and dental examinations must be provided. • Parents sign a consent form at the time of application so that this information can be shared. • Forms are provided by Head Start or the doctor may submit the Maine Care (EPSDT), or electronic medical record form. • Within 30 days of enrollment every child must have documentation of up to date immunizations. • If there is a medical reason or philosophical reason the child is not current with their immunizations a waiver must be signed. The Head Start Health Coordinator, in conjunction with the Early Head Start Nurse, affiliated School Nurses, the Health Advisory Committee and Center for Disease Control, will inform families if an outbreak of the specific disease occurs which the child is not protected from, the child will be excluded until such time that it is deemed safe for them to return. The Health Advisory Committee meets 4 times throughout the program year to assist the Health Coordinator and program to make decisions regarding any community health related concerns.
1304.20 (a) (1) (ii) (A)	
(A) For children who are not up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must assist parents in making the necessary arrangements to bring the child up-to- date;	• The Health Coordinator or the Early Head Start Nurse receives and enters into PROMIS all health information for each child. A determination is made at that time as to whether or not the child is up to date on an age appropriate schedule of well child care. • If the child is not up to date with an age appropriate schedule it will be noted on the form and sent back to the Family Advocate or Home Visitor. A missing information letter will be sent to the family stating what is required to bring the child up to date.
(B) For children who are up-to-date on an age-appropriate schedule of well child care, grantee and delegate	• The Health Coordinator runs a Health Summary Report from the PROMIS database that is reviewed weekly regarding physical and dental information on all children in the 3-5 year-old Head Start

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agencies must ensure that they continue to follow the recommended schedule of well child care; and	Program. The Early Head Start Nurse runs the report for children in the 0-3 year-old Early Head Start program. After the first 30 days of the program year the Health Coordinator or the EHS Nurse will send out letters to parents indicating which health items are not up to date and a time frame of two weeks from the time of receipt in which they must provide the health information. • The Health Coordinator communicates with Family Advocates on a weekly basis regarding children who are not up to date and may need assistance. The EHS Nurse communicates this information to the Home Visitors or Family Advocate. • Family Advocates and Home Visitors assist families in finding transportation and/or the scheduling of appointments throughout the program year as needed. • Information is given to parents regarding the importance of well child care through weekly family packs, at monthly Parent group meetings and during EHS Home Visits. • An ongoing health record is part of each child's file. The health record contains information on each child's health with physical, dental, immunization, lead, hemoglobin and nutrition status. • The Health Coordinator, Family Advocates and the EHS Nurse enter all health information into PROMIS throughout the program year.
(C) Grantee and delegate agencies must establish procedures to track the provision of health care services.	• Children with identified health needs are tracked by the Health Coordinator and the EHS Nurse using the PROMIS data base, and Individual Health Plans (IHP). The Health Coordinator and the EHS Nurse review the data throughout the program year and work with the family, Teachers and Home Visitors to develop a comprehensive Individual Health Plan (IHP) for any child diagnosed with a specific health need. All plans are approved by the child's PCP.
1304.20 (a) (1) (iii) & (iv)	
(iii) Obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified professional for each child with an observable, known or suspected health or developmental problem; and	• Any child that requires follow up will have that care as a goal documented on the FPA. The Family Advocate will report goal progress to the Health Coordinator. Home Visitors report to the EHS Nurse. • If a health or developmental concern is suspected or identified by classroom Teachers, Home Visitors and/or parents the Health Coordinator, the EHS Nurse, and the Education & Disabilities Coordinators will work with Head Start consultants, service professionals and the family to ensure that referrals for further evaluations are signed by parents, screenings/evaluations are completed and a meeting is scheduled with the parents, staff and health related providers to discuss evaluation results and develop a written plan. • If a parent or classroom Teacher identifies areas of behavioral or mental health concerns the Education & Disabilities Coordinator receives a referral specifically noting the child's strengths and areas of concern. Following the receipt of the referral, which may be instituted by either the parent, the classroom Teacher or Home

	Visitor but with full consent of the parent, a meeting is scheduled with the parent, Teacher, Home Visitor and Education & Disabilities Coordinator and/or consultant to more clearly understand the issues facing the child in the home and in the classroom. If necessary, a full clinical evaluation is conducted with parental permission in order to support the child or to make referrals to outside sources.
(iv) Develop and implement a follow-up plan for any condition identified in 45 CFR 1304.20(a) (1) (ii) and (iii) so that any needed treatment has begun.	• For health concerns an Individual Health Plan (IHP) will be developed collaboratively with the child's physician, the Health Coordinator, EHS Nurse, teaching staff or Home Visitors and the family. The plan will include documented staff training on emergency contact information, allergy information, diagnosis, and health care plan checklist. • For developmental concerns parental permission is obtained by the classroom teacher or Home Visitor for a referral to Child Development Services (CDS) for further evaluation. Once evaluations are complete CDS will hold a meeting with the family, program staff, service professionals, and CDS staff to discuss evaluation results and develop an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Goals and objectives will be generated from the ECT team members to develop a plan for the child focused on current strengths, interests, and abilities. Head Start staff will use the IEP/IFSP goals and objectives to embed activities in the child's daily routine to enhance current skill levels. All efforts will be made to adjust the classroom environment and/or individualized teaching practices to more fully meet the needs of the child when possible and applicable. This process will be observed and monitored carefully and ongoing in order to determine effectiveness and to identify any possible next steps which could support identified IEP/ IFSP goals and objectives. Case conferences will be conducted as needed to offer additional support.
(2) Grantee and delegate agencies operating programs of shorter durations (90 days or less) must complete the above processes and those in 45 CFR 1304.20(b)(1) within 30 calendar days from the child's entry into the program.	• Not applicable to Waldo Community Action Partners Head Start Program.
1304.20 (b) (1)	
(b) Screening for developmental, sensory, and behavioral concerns. (1) In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate screening procedures	• Newly enrolled children who have not been previously screened are screened within 45 calendar days of enrollment by the appropriate staff or consulting agency. The Health Coordinator or EHS Nurse collaborates with the local WIC office so hemoglobin/hematocrits are completed as well. • Children enrolled in the EHS center-based option will be screened within 45 days of enrollment by the Education & Disabilities Coordinator or classroom Teacher. The Early Head Start Nurse, in

to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b) (3) for additional information). To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background.	conjunction with the Health Coordinator, the Nutrition Consultant, WIC and pediatricians, ensures that vision and hearing screenings are completed. She also ensures the completion of hemoglobin/hematocrits as appropriate. • Children enrolled in the Early Head Start home-based option are screened by the Home Visitor within 45 days. The Early Head Start Nurse, in conjunction with the Health Coordinator, the Nutrition Consultant, WIC and pediatricians, ensures that all screenings are completed. She also ensures the completion of hemoglobin/hematocrits as appropriate. • Children screened by Child Development Services prior to entry into the program are monitored by Child Development Services (CDS). Upon entry into the Head Start program CDS releases screening results to the program once parental permission has been received. The Education & Disabilities Coordinator is responsible for reviewing the screening results and forwarding information to classroom Teachers or Home Visitors for planning purposes.
1304.20 (b) (2)	
(2) Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs.	• The Education & Disabilities Coordinator monitors the developmental portions of each screening, collaborating with CDS, Head Start Health Coordinator, Education Manager, the Mental Health Consultant, EHS Nurse, Teachers and Home Visitors to ensure that appropriate follow-up occurs.
1304.20 (b) (3)	
(3) Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior.	Teachers, Family Advocates, Home Visitors and content area Coordinators keep records on each child utilizing multiple sources of information including documented observations, results of health, developmental and behavioral screenings and assessments and ongoing input from families. Such input includes information gathered at initial home visits, during parent-teacher conferences, during regular home visits and at any other time a family member communicates with staff regarding their child.
Performance Standard **1304.20(c) (1) & (2) (c) Extended Follow up and treatment.**	
(1) Grantee and delegate agencies must establish a system of ongoing communication with the parents of children with identified health needs to facilitate the implementation of the follow-up plan.	• The Head Start Health Coordinator and Early Head Start Nurse work closely with teaching staff, Home Visitors, parents and other Head Start staff to develop and implement any plans related to identify health needs. Teachers communicate with the families at the Open House scheduled prior to the child's first day of attendance, at home visits that occur twice a year at a minimum, during Parent-Staff conferences held in and the fall and spring of each program year and during daily drop off/pick up times. • Teachers, Family Advocates and Home Visitors communicate weekly with families of children who have health needs and

	document communication with the family in the contact notes in the child's file. Documentation is shared with the Head Start Health Coordinator and the EHS Nurse on a regular basis. • Families with children enrolled in the Early Head Start center-based option receive daily written reports from the teaching staff. In addition to these opportunities to communicate with families regarding plans related to health concerns parents may call to speak to the Health Coordinator, the EHS Nurse or may request a meeting at any time. • Documentation of follow up visits for care and treatment is forwarded from the primary physician/parent to the Head Start Health Coordinator or EHS Nurse to ensure that the IHP is up to date and the child is being properly cared for throughout the program year. This is to ensure all direct service staff members are well informed and or trained with regard to their responsibilities regarding any child health concerns. • For any child requiring follow up care, either medical or dental the Family Advocate or Home Visitor will make that follow up care a goal for the family and the child on the FPA. Goal progress will be monitored by the Family Advocate or Home Visitor with assistance from the Health Coordinator or EHS Nurse as necessary. For children enrolled in the Early Head Start center-based option, FPAs will be developed and monitored by the EHS Family Advocate with assistance from the EHS Nurse.
(2) Grantee and delegate agencies must provide assistance to the parents, as needed, to enable them to learn how to obtain any prescribed medications, aids or equipment for medical and dental conditions.	• The Health Coordinator, EHS Nurse and Nurse Consultant provide assistance as needed for families in obtaining medication, aid, and equipment once the needs are assessed by the Health Coordinator or EHS Nurse. The Family Advocates and Home Visitors are also able to provide assistance in filling out necessary paperwork and making transportation arrangements. In cases where a child is diagnosed with a specific health concern an Individual Health Plan (IHP) is developed with the parents and teaching staff. The Health Coordinator and or EHS Nurse monitor this plan. When follow-up is noted the EHS Nurse and Health Coordinator work with the parents and teaching staff to support the child.
1304.20 (c) (3) (i) & (ii) (3) Dental follow-up and treatment must include:	
(i) Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and **(ii) Other necessary preventive measures and further dental treatment as recommended by the dental professional.**	• Dental follow up is provided by the child's dental provider. Fluoride is provided by the dentist and documented on the dental form or by the child's physician and noted on the physical form. • All recommended dental treatment and follow up is noted on the dental form by the child's primary doctor or dentist. The Health Coordinator or EHS Nurse reviews each dental form and tracks data in PROMIS. The Family Advocates and Home Visitors assist families in making referrals and appointments when the need arises. • Head Start children brush their teeth daily with fluoride toothpaste. Good oral hygiene is consistently modeled by all staff. Home Visitors support parents enrolled in the Early Head Start home-based option to learn and practice good oral hygiene for infants and

	toddlers.
1304.20 (c) (4)	
(4) Grantee and delegate agencies must assist with the provision of related services addressing health concerns in accordance with the Individualized Education Program (IEP) and the Individualized Family Service Plan (IFSP).	• The Health Coordinator and EHS Nurse will work with the Education & Disabilities Coordinators, if appropriate, to develop a plan to address health-related concerns of any child diagnosed with a disability. Within the first 45 days upon enrollment the Health Coordinator, EHS Nurse and Education & Disabilities Coordinator review all health and developmental records. The Education Manager may also be consulted. If it is determined that an Individual Health Plan (IHP) is warranted a meeting is scheduled with the family to develop the plan.
(5) Early Head Start and Head Start funds may be used for professional medical and dental services when no other source of funding is available. When Early Head Start or Head Start funds are used for such services, grantee and delegate agencies must have written documentation of their efforts to access other available sources of funding.	• When it becomes apparent that the WCAPHSP is being requested to pay for necessary medical or dental services for an enrolled child the Health Coordinator or EHS Nurse, along with the Family Advocate or Home Visitor who is assigned to the family, will determine that no other source of funding is available. The Family Advocate or Home Visitor documents all attempts to access alternative funding sources. The Health Coordinator or EHS Nurse is given all pertinent documentation and signs off on this. All options must be exhausted. • If it is determined by the Director and Management Staff that Head Start funding will be used the Health Coordinator or EHS Nurse will write out a purchase order as the payer of last resort. The documenting label will be completed and attached to the yellow copy of the purchase order.
1304.20 (d)	
(d) Ongoing care. In addition to assuring children's participation in a schedule of well child care, as described in Sec. 1304.20(a) of this part, grantee and delegate agencies must implement ongoing procedures by which Early Head Start and Head Start staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns. In addition, these procedures must include observations from parents and staff.	• Teachers document observations of children on a daily basis. Teachers in the Early Head Start center-based option send home daily records documenting behavior, feeding, sleeping and voiding patterns of infants and toddlers. • Input is received from parents at home visits, conferences, during daily pick-up or drop-off, or at any time via a phone call or request for a meeting. • Home Visitors record weekly documentation of home visits and related observations, including input from parents. • Regularly scheduled health, developmental and behavioral assessments are documented and shared with parents. • If concerns are noted by either parents or staff, the Health Coordinator, EHS Nurse and/or Education & Disabilities Coordinators are contacted. Parents are notified within 24 hours of observation of an injury, illness, developmental or behavioral concern. • If necessary, a referral is made to the appropriate service provider and assistance is provided to the family as needed. • All information is documented in the contact notes in the child's file.

1304.20 (e) (1) (2) (3) (4) (5) (e) Involving parents.	
In conducting the process, as described in Sec. Sec. 1304.20 (a), (b), and (c), and in making all possible efforts to ensure that each child is enrolled in and receiving appropriate health care services, grantee and delegate agencies must:	
(1) Consult with parents immediately when child health or developmental problems are suspected or identified;	• When a health or developmental concern is suspected or identified, • parents will be notified within 24 hours by any one or combination of the following staff members: The teaching staff, Home Visitors, Education & Disabilities Coordinator, Education Manager, EHS Nurse or the Health Coordinator.
(2) Familiarize parents with the use of and rationale for all health and developmental procedures administered through the program or by contract or agreement, and obtain advance parent or guardian authorization for such procedures. Grantee and delegate agencies also must ensure that the results of diagnostic and treatment procedures and ongoing care are shared with and understood by the parents; **(3) Talk with parents about how to familiarize their children in a developmentally appropriate way and in advance about all of the procedures they will receive while enrolled in the program;**	• Parents are assisted with all necessary follow up. • Parents are asked to sign consent forms for all health and developmental procedures that are done by Waldo Community Action Partners Head Start Program at the time of application. • Results of screenings are shared with the family at the time of the screening, at parent - staff conferences, or at home visits. • Care is given to ensure that the families understand the results of the screenings and any necessary follow up. • Information is distributed in weekly family packs, monthly Combo Option home visits, and during weekly EHS home visits. • At monthly Parent Group meetings, through information sent home in Family Packs and in other ways, education is provided on child development and developmentally appropriate ways to help children understand and be prepared to participate in screenings and assessments that take place in the program. • Parents enrolled in the Early Head Start home-based option meet weekly with a Home Visitor to learn about child development and develop their skills at communicating with their child in appropriate ways.
(4) Assist parents in accordance with 45 CFR 1304.40(f)(2) (i) and (ii) to enroll and participate in a system of ongoing family health care and encourage parents to be active partners in their children's health care process; and	• Parents are encouraged to enroll and participate in a system of ongoing family health care and to be active partners in their children's health care process. This is accomplished thru the goals in the Family Partnership Agreement, and thru information in family packs and trainings at parent group meetings throughout the program year and during weekly home visits for families enrolled in the EHS home-based option. • Family Advocates and Home Visitors also assist with finding health care providers, medical and dental homes, making appointments and finding transportation if needed. Family Advocates and Home Visitors also assist families in filling out paperwork to enroll in Maine Care.

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(5) If a parent or other legally responsible adult refuses to give authorization for health services, grantee and delegate agencies must maintain written documentation of the refusal.	• Parent consent is obtained for all health services provided or arranged. If, after all attempts at counseling (by the Health Coordinator, EHS Nurse, Family Advocate or Home Visitor), a family still refuses health services a waiver is signed by the family and placed in the health section of the child's file. All attempts at educating the parents on the importance of ensuring that their children receive appropriate health services are documented in the contact notes in each child's file.
1304.20 (f) (1) (f) Individualization of the program. (1) Grantee and delegate agencies must use the information from the screening for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs.	• Results from all health, developmental and behavioral screenings and assessments as well as observations from staff and parents are reviewed by the appropriate Head Start staff and shared with the family. If warranted, an Individual Health Plan (IHP), Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) is developed and implemented. Teaching staff and Home Visitors develop weekly curriculum plans that reflect the needs and interests of individual children. Teaching styles and methods utilized are adapted as necessary to respond to each child's individual characteristics, strengths and needs. Weekly plans and documentation in each child's file reflects the steps taken to ensure individualization, including individualized goals. These individualized goals are part of ongoing assessment. • Home visits and parent staff conferences provide opportunities for families to share information on child's interests and strengths, needs, and temperament.
1304.20 (f) (2) (i)	
(2) To support individualization for children with disabilities in their programs, grantee and delegate agencies must assure that: **(i) Services for infants and toddlers with disabilities and their families support the attainment of the expected outcomes contained in the Individualized Family Service Plan (IFSP) for children identified under the infants and toddlers with disabilities program (Part H) of the Individuals with Disabilities Education Act, as implemented by their State or Tribal government;**	• Services for infants and toddlers are provided through a home-visiting option and a center-based option. Goals for children with an IFSP are monitored either by a Home Visitor or a credentialed infant-toddler Teacher. Implementation of all IFSP goals for children in either option is also monitored by the Education & Disabilities Coordinator and a case manager from Child Development Services (CDS). •
1304.20 (f) (2) (ii)	
(ii) Enrolled families with infants and toddlers suspected of having a disability are promptly referred to the local early intervention agency designated by the State Part H plan to coordinate any needed evaluations,	• All infants and toddlers are screened using the Denver II within 45 calendar days of enrollment in the Early Head Start program. Results of the screening are shared with family. If the screening indicates a need for further evaluation, a referral is made to Child Development Services (CDS). CDS schedules an evaluation and is then responsible for coordinating the development of an IFSP if

determine eligibility for Part H services, and coordinate the development of an IFSP for children determined to be eligible under the guidelines of that State's program. Grantee and delegate agencies must support parent participation in the evaluation and IFSP development process for infants and toddlers enrolled in their program;	warranted. Parents and Early Head Start staff, including Teachers or Home Visitors, the Education & Disabilities Coordinator and the EHS Nurse, if appropriate, are involved in the development of the IFSP.
1304.20 (f) (2) (iii)	
(iii) They participate in and support efforts for a smooth and effective transition for children who, at age three, will need to be considered for services for preschool age children with disabilities; and	• Transition planning for all children in any Early Head Start program option begins at age 28 months or six months prior to the transition to the Head Start program. Parents are involved in developing the transition plan. The plan includes coordinating with CDS for appropriate evaluations, scheduling a meeting with both sending and receiving Head Start staff, development of an IEP, transfer of records, determination of appropriate placement and securing appropriate services. • In addition, the plan includes appropriate ways to prepare and familiarize the child with the transition to a new setting. This may include utilizing the services of the Start Mental Health Consultant to provide support directly to the family and the child and to provide the staff with information and techniques to support the child.
1304.20 (f) (2) (iv)	
(iv) They participate in the development and implementation of the Individualized Education Program (IEP) for preschool age children with disabilities, consistent with the requirements of 45 CFR 1308.19.	• See above.

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