**Section 1**

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| **CONFIDENTIAL DOCUMENT** | | | | | | | | | | | | | | **INDIVIDUALIZED FAMILY SERVICE PLAN** | | | | | | | | | | | | **CONFIDENTIAL DOCUMENT**  **REVISION 10/16** | | | |
|  | | IFSP TYPE: (CHECK) | | | | | | | | Interim | | | Initial | | | Annual | | | Review | | | | | | Meeting Date: | | | | |
| **ENROLLMENT INFORMATION** | | | | | | | | | | | | | **Date Referral Received:** | | | | | | | | | | | | Routines Based Interview (RBI) Date: | | | | |
| Child’s Name: | | |  | | | | | | | | | | Gender: Male  Female | | | | | Date of Birth: | | | | | | | Resident School: | | | |  |
| Source of Referral: | | | | | | | | | Name of Child’s Primary Care Physician: | | | | | | | | | Telephone Number: | | | | | | | Birth to 3 Area: | | | |  |
| **Medicaid Eligible**  Yes  No **Private Insurance**   Yes  No  Consent for use  Yes  No Consent for use  Yes  No  Medicaid Number | | | | | | | | | | | | | | | **Ethnicity:** (Choose only one)  Is this student Hispanic/Latino?  No, not Hispanic/Latino  Yes, Hispanic/Latino | | | | | | | | | | **Race:** (may choose 1 or more)  American Indian/Alaska Native  Asian  Black or African American  Native Hawaiian/Pacific Islander  White | | | | |
| **PARENTS/SURROGATE PARENTS INFORMATION: (Please indicate specific relationship to child)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | Name: | | |  | | | | | | | | | |
| Relationship to Child: | | | | |  | | | | | | | | | | | | Relationship to Child: | | | | | | | | | |  | | |
| Telephone Number: | | | | | | | Day: | | | | Night: | | | | | | Telephone Number: | | | | | | | Day: | | | Night: | | |
| Best time to call: | | | | | |  | | | | | | | | | | | Best time to call: | | | | | |  | | | | | | |
| Mailing address: | | | | | |  | | | | | | | | | | | Mailing address: | | | | | |  | | | | | | |
| City: | | | | | | | | State       Zip      County | | | | | | | | | City: | | | | | | | | | | State       Zip      County | | |
| Primary Language/Mode of Communication: | | | | | | | | | | | |  | | | | | Primary Language/Mode of Communication: | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Directions to child’s home: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SERVICE COORDINATION INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | | | Agency | | | | Telephone | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | City/State/Zip | | | | | , | | | | | | | |
| **Section 2** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *To be completed by the IFSP Team, drawing from description of the child, assessments, evaluations and/or observations, for each category.*  Statement of child's current health status, including vision, hearing and physical development. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Testing (2 Tests are Required)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BDI-II Evaluator Name:       Discipline: ECSE/SI  PT  SLP  OT  Other (Please type in Discipline)  Name of Test       Evaluator Name:       Discipline: ECSE/SI  PT  SLP  OT  Other (Please type in Discipline)  Name of Test       Evaluator Name:       Discipline: ECSE/SI  PT  SLP  OT  Other (Please type in Discipline)  Name of Test       Evaluator Name:       Discipline: ECSE/SI  PT  SLP  OT  Other (Please type in Discipline) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ELIGIBILITY:  NO  YES:  Informed Clinical Opinion  Medical Diagnosis  28 Weeks or Less Gestation  1.5 Standard Deviation  PROLONGED ASSISTANCE:  YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Section 3a**

*"Before we get into the day, can you please tell me what your main concerns for your child and family are?"*

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| Main concerns: |

*"I will ask you more about these things as we go through the day."*

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| **Present Levels of Development in Daily Routines and Activities** |

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| **Routine** | **Task Difficulty** | **Activity** |
| Wake Up | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Dressing/Toileting | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Mealtime | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Outings | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |

**Section 3b**

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| Play | Easy  Some Concerns  Difficult | What’s working well:    Areas to work on: |
| Bathtime | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Bedtime/Naps | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Other Routine 1: | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Other Routine 2: | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |
| Other Routine 3: | Easy  Some Concerns  Difficult | What’s working well:  Areas to work on: |

**Section 3c**

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| *“Now let me ask you a couple of general questions. When you lie awake at night, what do you worry about?”*  *“If there’s anything you’d like to change about your life, what would it be?* | |
| **Family Assessment** | |
| *"What would the family like to focus on (priorities)?" (please have family rank in order)*  Ranking Priority Item                          *"What resources does the family use or need?”* | |

**Section 3d**

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| **Child Outcome** | |
| Outcome #        (name) will participate in       (routine) by       (action). We will know       (name) can do this when       (measurement).  Strategies and Activities: (Include activities, settings, people and every day routines of the child and family)         How does the team plan on measuring progress?  Provider Progress Notes  Parent Report  Service Coordinator contact with Family  When will progress toward the outcome be measured?  Each week  Monthly  6 month review  Every other month  Quarterly  **Review**  Review Date:  Outcome Status:  Continue as written  Discontinue, explanation in comments below  Outcome met  All outcomes met, early graduation  Reevaluate for prolonged assistance  Reevaluate for Part C eligibility  Summary of Progress Comments: |

**Section 3e**

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| **Family Outcome** | |
| Outcome:  Strategies and Activities: (Include activities, settings, people and every day routines of the child and family)         How does the team plan on measuring progress?  Provider Progress Notes  Parent Report  Service Coordinator contact with Family  When will progress toward the outcome be measured?  Each week  Monthly  6 month review  Every other month  Quarterly  **Review**  Review Date:  Outcome Status:  Continue as written  Discontinue, explanation in comments below  Outcome met  All outcomes met, early graduation  Reevaluate for prolonged assistance  Reevaluate for Part C eligibility  Summary of Progress Comments: |

**Section 4a**

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| **Early Intervention Services** | |
| Start Date       End Date      Service Type  Primary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Secondary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Responsible Agency/Provide       Method  Individual  Group  Frequency       Session       Units/Miles  Financial Responsibility Medicaid Part C Private Insurance School District  Other       (List other)  Start Date       End Date      Service Type  Primary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Secondary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Responsible Agency/Provide       Method  Individual  Group  Frequency       Session       Units/Miles  Financial Responsibility Medicaid Part C Private Insurance School District  Other       (List other)  Start Date       End Date      Service Type  Primary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Secondary Location  200 Home  210 Program Designed for Typically Developing Children  270 Other Setting  Responsible Agency/Provide       Method  Individual  Group  Frequency       Session       Units/Miles  Financial Responsibility Medicaid Part C Private Insurance School District  Other       (List other)  **Section 4b**  **Obligate Data**  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider       **Section 4c**  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  Provider  Service Type       Method  Individual  Group  Start Date       End Date       Frequency       Session       Units/Miles  Comments:  **Physician Approval**  Physician approval for Medicaid or private insurance billable services  Yes  No  N/A  Explanation |
| **Natural Environment**  Address  City/State/Zip      , | |

**Section 5**

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| **TRANSITION PLANNING CHECKLIST** | **The IFSP must include steps to ensure a smooth transition for the child and family.** | |
| Transition Plan Provisions | Describe Activities | Responsible Person(s) |
| Notify the local school district in written form that the child will shortly reach the age of eligibility for preschool services under part B. | Planned Date of Notification: |  |
| With the approval of the parent(s) of the child, convene a conference among the parent(s), local education agency, and appropriate representatives of the local network at least 90 days (and at the discretion of all such parties, not more than 9 months ) before the child is eligible for preschool services, to discuss any such services that the child may receive. | Planned Date of Transition Meeting: |  |
| With the approval of the parent(s) of the child, make reasonable efforts to convene a conference among the parent(s), appropriate representatives of the local network, and providers of other appropriate services for children who are not eligible for preschool services under part B, to discuss appropriate services that the child may receive. |  |  |
| Help the parent(s) to identify, evaluate, and apply for community programs and services that meet their interests and needs. |  |  |
| Identify and implement steps to help the child and parent(s) adjust to new settings and environments. |  |  |
| Other: |  |  |
| Other: |  |  |

**Section 6a**

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| **IFSP Meeting** |
| Meeting Date:       Meeting conducted in language other than native language (explanation) |
| **IFSP Meeting Attendees**  Parent (s)  Telephone       Email  Address       City/State/Zip      ,  Service Coordinator  Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  **IFSP Meeting Attendees (continued) Section 6b**  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  **IFSP Input:** In addition to IFSP Team participants, this plan was developed with information provided by the following person(s)  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      ,  Provider  Sub Provider/Non-Provider Guest  Title/Agency       Telephone       Email  Address       City/State/Zip      , |

**Consent & Signature**

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| **Parental Consent for Provision of Early Intervention Services** |

I HAVE HAD MY PARENTAL RIGHTS THOROUGHLY REVIEWED WITH ME, BOTH VERBALLY AND IN WRITING. I GIVE CONSENT FOR MY CHILD/FAMILY TO RECEIVE THE SERVICE(S) LISTED IN THIS IFSP.

"Consent" means that the parents have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parents understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parents is voluntary and may be revoked in writing at any time.

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**