

DATE: _____

IFSP TYPE: (CHECK) Interim

Initial

Annual

Review Date: _____

ENROLLMENT INFORMATION

Date Referral Received:

Child's Name: _____

Resident School: _____

Gender: Male Female Date of Birth: _____

Birth to 3 Area: _____

Social Security Number (optional) _____

Medicaid Number: (if applicable) _____

			Comments
Medicaid Eligible	Yes	No	
Previously Eligible	Yes	No	
Consent for use	Yes	No	Parent initial: _____
Private Insurance	Yes	No	Parent initial: _____
Consent for use	Yes	No	Parent initial: _____

Race/Ethnicity: American Indian/Alaska Native
 Asian
 Black or African American
 Hispanic/Latino
 Native Hawaiian/Pacific Islander
 White
 Other: _____
(may choose 2 or more)

Source of Referral: _____

Name of Child's Primary Care Physician: _____

Telephone Number: () _____

PARENTS/SURROGATE PARENTS INFORMATION: (Please indicate specific relationship to child)

Name: _____

Name: _____

Relationship to Child: _____

Relationship to Child: _____

Telephone Number: Day: () _____

Telephone Number: Day: () _____

Night: () _____

Night: () _____

Best time to call: _____

Best time to call: _____

Mailing address: _____

Mailing address: _____

Town/City: _____

Town/City: _____

State: _____ Zip Code: _____ County: _____

State: _____ Zip Code: _____ County: _____

Primary Language/Mode of Communication: _____

Primary Language/Mode of Communication: _____

Directions to child's home: _____

SERVICE COORDINATION INFORMATION

Name: _____

Telephone: () _____

Agency: _____

Address: _____

Town/City/State/Zip _____

CHILD'S NAME:

DATE:

FAMILY CONSIDERATIONS FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

NOTE: THIS SECTION IS OPTIONAL UPON INFORMED, FAMILY CONSENT.

Family declines

Parent's Initials _____

1. PLEASE DESCRIBE WHAT YOU BELIEVE THE STRENGTHS OF YOUR FAMILY ARE IN MEETING YOUR CHILD'S NEEDS.

2. WHAT TYPE OF HELP WOULD YOU WANT FOR YOUR CHILD AND FAMILY IN THE MONTHS OR YEAR AHEAD?

3. BIRTH TO THREE CONNECTIONS MAY BE ABLE TO HELP YOU TO IDENTIFY AND LOCATE A VARIETY OF RESOURCES/INFORMATION TO ADDRESS SOME CONCERNS THAT YOU OR OTHER FAMILY MEMBERS HAVE. PLEASE CHECK (✓) BELOW ANY AREAS YOU WOULD LIKE TO LEARN MORE ABOUT.

FOR YOUR CHILD:

FOR YOUR FAMILY:

- ___ getting around
- ___ communicating
- ___ learning
- ___ feeding, nutrition
- ___ having fun with other children
- ___ challenging behaviors or emotions
- ___ equipment or supplies
- ___ health or dental care
- ___ pain or discomfort
- ___ vision or hearing
- ___ Other:

- ___ meeting other families whose child has similar needs/support group
- ___ finding or working with doctors or other specialists
- ___ coordinating your child's medical care
- ___ finding out more about how different services work or how they could work better for you
- ___ planning or expectations for the future
- ___ information about other available resources
- ___ transportation
- ___ legal/advocacy advice
- ___ remodeling/making adaptations to your home
- ___ parenting skills training

- ___ child care
- ___ finding or working with people who can help you in the home/care for your child so that you can have a break
- ___ housing, clothing, jobs, food, telephone services
- ___ family training
- ___ information/group activities for brothers, sisters, friends relatives, others
- ___ information about the disability or diagnosis
- ___ help to cover the extra costs of child's special needs
- ___ help with insurance/SSI/Medicaid
- ___ recreation
- ___ Other:

4. WHAT ELSE DO YOU THINK WOULD BE HELPFUL FOR OTHERS TO KNOW ABOUT YOUR CHILD AND FAMILY?

5. ARE THERE OTHER CONCERNS YOU WOULD LIKE TO DISCUSS?

CHILD'S NAME:

DATE:

HOW IS MY CHILD DOING? Summary of Child's Present Levels of Performance

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.

Include a statement about: What the child knows and understands, and the process of learning (Cognition): how the child gives and receives messages (gestures, facial expression, talking) (Communication Skills); social and emotional skills; and physical development, including large and small motor development, vision and hearing; and self help skills.

Abilities, Interests, Motivations, New Skills:

Concerns, Worries, Frustrations, Things to Work On:

Domain	Tester/Discipline	Date of Test	Test Used	Test Scores	Test Scores
KNOWLEDGE/SKILLS					BDI-2
Cognitive					
Communication	Receptive				
	Expressive				
APPROPRIATE BEHAVIORS TO MEET NEEDS					
Physical Development	Gross				
	Fine				
Adaptive Development					
SOCIAL SKILLS					
Social/Emotional					
Vision					
Hearing					

ELIGIBILITY: NO YES: Informed Clinical Opinion Medical Diagnosis 28 Weeks or Less Gestation 1.5 Standard Deviation

PROLONGED ASSISTANCE: YES NO

CHILD'S NAME:

DATE:

FAMILY'S DESIRED MEASURABLE RESULTS OR OUTCOMES

CHECK THE AREA BEING ADDRESSED IN THIS OUTCOME: Knowledge/Skills Appropriate Behaviors to Meet Needs Social Skills
(Cognitive / Rec Comm & Exp Comm) (Gross Motor & Fine Motor / Adaptive) (Social/Emotional)

WHAT'S HAPPENING NOW? (CURRENT STATUS)

WHAT DO YOU WANT TO WORK TOWARD? (RESULTS OR OUTCOME STATEMENT/ANNUAL GOAL)

Things we'll do to achieve this result or outcome (Activities/Strategies/Short term objectives)	SERVICES to CONSIDER	RESOURCES/PEOPLE who will teach/learn/do	WHERE? Location/Daily Routine

NOTES, COMMENTS/REVIEW INFORMATION:

DEGREE OF PROGRESS:

Date Reviewed: _____

Team's Assessment:

- 1. Situation Changed; no longer needed
- 2. Implementation begun, outcome partially attained or accomplished
- 3. Outcome completed, accomplished or attained to the family's satisfaction
- 4. Re-evaluate for Part C eligibility
- 5. Re-evaluate for prolonged assistance
- 6. Re-evaluate for graduation from Birth to 3 Connections

Continue Activity #s: _____

Modify Activity #s: _____

Discontinue Activity #s: _____

CHILD'S NAME:

DATE:

EARLY INTERVENTION SERVICES

SERVICE	FREQUENCY / INTENSITY-LENGTH	METHOD	LOCATION CODE	RESPONSIBLE AGENCY/PROVIDER	INITIATION Mo/Day/Yr	DURATION Mo/Day/Yr	FINANCIAL RESPONSIBILITY
SERVICE COORDINATION							

Physician approval for Medicaid or private insurance billable services: YES NO PENDING Explanation:

EARLY INTERVENTION SERVICE OPTIONS INCLUDE:

***Transportation and related costs include the cost of travel, including mileage or travel by taxi, common carrier, or other means and the related tolls and parking expenses that are necessary to enable a child eligible under this article and the child's family to receive early intervention services.** _____ Needed by the family _____ Not Needed by the family

- A = Assistive Technology
- B = Audiological Services
- C = Family Training, Counseling, Home Visits
- D = Health Services
- E = Medical Diagnostic Services
- F = Nursing Services
- G = Nutrition Services
- H = Occupational Therapy
- I = Physical Therapy
- J = Psychological Services
- L = Social Work Services
- M = Special Instruction
- N = Speech/Language Therapy including Sign & Cued Language
- O = Transportation
- P = Vision Services

CO-THERAPY: Identify both services that will be provided, i.e. H/N

FREQUENCY: Indicate whether WEEKLY or MONTHLY.

INTENSITY-LENGTH: Time in minutes or hours of one session.

METHOD OF SERVICE DELIVERY: I = Individual, G = Group.

LOCATION CODES:

- 200 = Home
- 210 = Program designed for typically developing children
- 230 = Service Provider Location
- 240 = Program designed for children with developmental delays or disabilities
- 250 = Hospital (Inpatient)

- 260 = Residential Facility
- 270 = Other setting / please describe:

Natural Environments

Description of natural environments, that are settings that are natural or normal for the child's age peers who have no disability, in which early intervention will be provided. Include justification of the extent, if any, to which the services will not be provided in a natural environment.

Street/city address if services are provided in daycare or setting other than home:

CHILD'S NAME:

DATE:

OTHER SERVICES

No other services identified at this time

SERVICE	STEPS TO BE TAKEN	FUNDING SOURCE	WHO'S RESPONSIBLE/HELPER?

PARENT/GUARDIAN CONSENT

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.

Parent/Surrogate signature

Date

Parent/Surrogate signature

Date

Date IFSP Copy Delivered to Parent/Surrogate(s): _____

Signature of Service Coordinator: _____

CHILD'S NAME:

DATE:

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:		

Transition Planning Comments:

CHILD'S NAME: _____

DATE: _____

IFSP MODIFICATION/REVISION CHECKLIST

DATE OF CURRENT IFSP: _____

DATE OF THIS REVIEW: _____

6 Month Review

Parent Request

Other: _____

TARGET DATE FOR NEXT REVIEW: _____

ITEM/PAGE #	MODIFICATIONS/REVISIONS:	SUMMARY COMMENTS:

COMPLETE AND ATTACH TO THE REVISED IFSP PAGES. MARK ON EXISTING PAGES (DO NOT REMOVE)

CHILD'S NAME:

DATE:

IFSP MODIFICATION/REVISION

Meeting Participants: The following individuals attended the IFSP review meeting and participated in the development of these revisions.

NAME	TITLE	AGENCY/ADDRESS	TELEPHONE
	/PARENT		
	/PARENT		
	/SERVICE COORDINATOR		
	/		
	/		
	/		
	/		
	/		

IFSP Input: In addition to IFSP Team Meeting participants, this plan was developed with information provided by the following person(s)

PARENTAL CONSENT FOR PROVISION OF EARLY INTERVENTION SERVICES

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Parent/Surrogate signature

Date

Parent/Surrogate signature

Date

Date IFSP Copy Delivered to Parent/Surrogate(s): _____

Signature of Service Coordinator: _____

CHILD'S NAME: _____

DATE: _____

OPTIONAL PAGE

To the extent appropriate, early intervention services must be provided in the types of settings in which all infants and toddlers and their families participate. Section III is designed to help families and early intervention providers successfully integrate services into the child's and family's life. The IFSP team explores all settings and services developed to meet the family's lifestyle and culture and the child's developmental needs.

"ALL ABOUT MY CHILD"

Who Provided Information? _____

Child's Nickname: _____

Things my child likes to do: Put a "+" in front of them.
Things I'd like my child to do: Put an "0" in front of them.
Use this space for additional activities that are not on the list below.

People my child is with: (names, nicknames, ages, amount of time)

in my home...

at day care...

who are friends...

who are neighbors, relatives...

- _____ hold/play with toys
- _____ take a bath/play with water
- _____ watch/listen to TV
- _____ play outside
- _____ visit relatives/friends
- _____ eat
- _____ get and give hugs
- _____ play with Dad
- _____ play with Mom
- _____ listen to music
- _____ go to church/religious activities

- _____ play with sister(s)
- _____ play with brother(s)
- _____ enjoy other children
- _____ eat out
- _____ go to a playground
- _____ take a walk
- _____ "rough house"
- _____ ride in the car
- _____ go grocery shopping
- _____ take naps
- _____ go to community center

The following sections should be utilized during the IFSP meeting to identify potential locations for each individual service as identified in the IFSP to meet the Outcomes. IFSP Team members should use the information provided above in selecting the natural setting for each individual service in this IFSP. It is possible that specific services could be delivered in different settings/locations.

Possible locations/programs your child is presently involved in and that should be considered for possible sites for early intervention services:

- _____ Child's Home
- _____ Other Family Location
- _____ Family Day Care
- _____ Community-Based program
- _____ Child Care Program
- _____ Early Head Start
- _____ Infant/Toddler Play Group
- _____ Early Intervention Classroom/Center
- _____ Hospital
- _____ Clinic/Provider's Office
- _____ Other: _____
- _____ Other: _____

What needs to be done to provide services in the setting(s) chosen by the IFSP Team?

CONFIDENTIAL DOCUMENT

INDIVIDUALIZED FAMILY SERVICE PLAN

CONFIDENTIAL DOCUMENT

CHILD'S NAME:

DATE:

ADDENDUM TO PAGE _____