**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 [ ]  NoConsent for use [ ]  Yes [ ]  No Consent for use [ ]  Yes [ ]  NoMedicaid 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: |
|       |
| **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) 1.
2.
3.
4.

How does the team plan on measuring progress? [ ]  Provider Progress Notes [ ]  Parent Report [ ]  Service Coordinator contact with FamilyWhen 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 eligibilitySummary 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) 1.
2.
3.
4.

How does the team plan on measuring progress? [ ]  Provider Progress Notes [ ]  Parent Report [ ]  Service Coordinator contact with FamilyWhen 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 eligibilitySummary 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 [ ]  GroupFrequency       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 [ ]  GroupFrequency       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 [ ]  GroupFrequency       Session       Units/Miles     Financial Responsibility [ ] Medicaid [ ] Part C [ ] Private Insurance [ ] School District [ ]  Other       (List other)**Section 4b****Obligate Data**Provider       Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       **Section 4c**Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       Service Type       Method [ ]  Individual [ ]  GroupStart Date       End Date       Frequency       Session       Units/Miles     Comments:      Provider       Service Type       Method [ ]  Individual [ ]  GroupStart 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**