Appendix E

Individualized Family Service Plan

Type of IFSP and Date

o Interim___/___/___ o Initial___/___/_____
o Periodic Review___/___/___ o Annual___/___/_____

Child's Name **(include middle initial)** _____
Gender o Boy o Girl
Date of birth_____/_____/_____
Child's county of residence _____

Initial Referral Date____/_____/_____
Made by_____
Made to _____

Parents/Legal Guardians
Name_____
Address_____
_____
Home phone _____
Work phone_____
Email _____
Message phone: _____

Name_____
Address_____
_____
Home phone _____
Work phone_____
Email _____
Message Phone: _____

The Child Lives With

Name	Relationship	Age

Other Family Members and Friends
_____
_____
_____
_____

Child's Ethnicity_____
Primary language spoken at home_____
Is an interpreter needed? o Yes o No

P rofessiona Is/Prog rams Currently Involved With the Family
Name_____Ph_____
Name_____Ph_____
Name_____Ph_____
Name_____Ph_____
Name_____Ph_____
Name_____Ph_____

School District Where the Child Lives _____
Child Find contact _____
Phone_____

Family's Private Insurance
Name of insured_____
Insurance carrier_____
Group #_____Policy #_____

Public Insurance
o Medicaid o CHP+
Medicaid or CHP+ #_____

No Private or Public Insurance o

Service Coordinator _____
Service Coordinator's agency_____
Phone_____

Information About Our Family

How I describe my child: _____

_____

_____

Things my child does well: _____

_____

_____

The people, places, activities my child enjoys: _____

_____

_____

The people, places, activities our family enjoys: _____

_____

_____

Our family's strengths: _____

_____

_____

Our family's informal resources (people, activities, programs, and/or organizations, other than health and early intervention related services, that are sources of support, e.g. moms & tots group, faith communities, recreation programs): _____

_____

_____

Desired future for my child: _____

_____

_____

My concerns for my child/family: _____

_____

Additional information I would like the other IFSP team members to know about my child and family: _____

_____

_____

For purposes of IFSP development, (check one) The family agrees to share this information The family declines sharing this information.

Child's Name: _____ Date: _____

Appendix E

Health Information

Child's Medical Home Is there a particular doctor's office, health center, or other place you regularly take your child for check-ups, shots, or illness? o Yes o No If so, list the name, mailing address, and phone number of this health provider or center below.

Name _____ Phone ( ) _____

Mailing Address _____

Child's General Health (physical, emotional, behavioral)

Was your child born prematurely? o Yes o No If so, how many weeks early? _____

When was the last time your child had a well-child (general) check up? Date: ___/___/___

Does your child have a medical diagnosis? o Yes o No If so, what is it?

Does your child see any medical specialists? o Yes o No If so, please list them.

What medication is your child taking and why?

Vision Has your child's vision been tested? o Yes o No If yes, when: ___/___/___ by: _____

Results: Pass Rescreen Referral made to: _____

Hearing Has your child's hearing been tested? o Yes o No If yes, when: ____/____/____ by: _____

Results: ___ Pass Rescreen Referral made to: _____

Dental Has your child seen a dentist? o Yes o No

Are there any concerns about your child's dental health? o Yes o No If so, please specify.

Eating and Nutrition

Are there any concerns about your child's eating, nutrition, or growth? o Yes o No If so, please specify.

Sleep

Are there any concerns about your child's sleep patterns? o Yes o No If so, please specify.

Additional 1 nformation/h !story related to physical or social emotional health that should be considered during IFSP planning

Appendix E

Present Levels of Development

Using My Hands and Moving My Body (Motor Development)	
Things I do well	Things I find difficult or need help with

Understanding and Using Gestures, Speech and Language (Communication Development)	
Things I do well	Things I find difficult or need help with

Child's Name: _____ Date: _____

Appendix E

Present Levels of Development

Playing, Thinking, and Exploring (Cognitive Development)	
Things I do well	Things I find difficult or need help with
Relating to Others (Social/Emotional Development)	
Things I do well	Things I find difficult or need help with

Child's Name: _____ Date: _____

 (Revised 12/07)

Present Levels of Development

Eating, Dressing, Toileting (Adaptive Development)	
Things I do well	Things I find difficult or need help with

Other Information Provided from Outside Sources About Present Levels of Development

Child's Name: _____ Date: _____

Appendix E

Multidisciplinary Evaluation/Assessment (used for itia evaluation/assessment only)

Signatures of Multidisciplinary Evaluation/Assessment Team Members	Discipline & Agency or Family Role/Date
Names of Others Who Provided Information About the Child's Development	**Discipline or Role/Date**

Methods and Procedures Used

- ☐ Review of records
- ☐ Developmental history
- ☐ Family report
- ☐ Routines-Based Interview
- ☐ Observation of child
- ☐ Language sample
- ☐ Play-based evaluations
- ☐ Criterion-referenced instrument (specify): _____
- ☐ Norm-referenced instrument (specify): _____
- ☐ Developmental checklist (specify): _____
- ☐ Other: _____

For children who are Not Eligible

The results of the evaluation were explained to me and I understand my child is not eligible for early intervention services.

Date of determination of ineligibility: ___/___/_____

Parent signature _____

CCB Representative _____

For children who are *Eligible* **(check one only)**

☐ *Eligible based on a* ***diagnosed condition(s)*** *associated with significant developmental delays.* **Specify name of condition:** _____

Qualified health professional **Medical facility/agency** _____

Name & credential _____

CCB representative _____ **Date of determination of eligibility** ___/___/___

☐ *Eligible based on a* ***significant delay in development*** **Area(s) of delay:** _____

_____

CCB representative _____ **Date of determination of eligibility** ___/___/___

The results of the evaluation were explained to me and I understand my child is eligible for early intervention services.

Parent signature _____ **date** ___/___/___

Concerns and Priorities

List the Family's Concerns and Identify Immediate Priorities

Child's Name: _____ Date: _____

Appendix E

Plan of Action

What is the priority this outcome will address:

1 What we see now	2 Outcome Statement: what we would like to see happen for our child/family

3 Strategies selected to address this outcome within the child/family's everyday routines, activities, and places

Child's Name: _____ Date: _____

Appendix E

Plan of Action

What is the priority this outcome will address:	
1 What we see now	2 Outcome Statement: what we would like to see happen for our child/family
3 Strategies selected to address this outcome within the child/family's everyday routines, activities, and places	

Child's Name: _____ Date: _____

(Revised 12/07)

Appendix E

Plan of Action

What is the priority this outcome will address:	
1 What we see now	2 Outcome Statement: what we would like to see happen for our child/family
3 Strategies selected to address this outcome within the child/family's everyday routines, activities, and places	

Child's Name: _____ Date: _____

(Revised 12/07)

Supports and Services

Informal Supports to Meet the Outcomes

Early Intervention Services

Early Intervention Service & Name of Provider	Activity/ Location	Method	Frequency & Intensity	Projected Start Date (mm/dd/yy)	Projected End Date	Funding Source

If the projected funding source listed above is not available, the funding hierarchy will be followed retroactively to the service initiation date.

Other Services Necessary to Meet the Outcomes

Other Service	Time Frame	Funding Source	Steps Taken to Secure Service (when applicable)

Appendix E

Rishts, Procedural Safesuards, and Sionatures

Parent's or legal guardian's initials:

_____The following rights and procedural safeguards were explained to me and I received a written description of each

• Informed Consent	• Information in Native Language	• Access to Records
• Multidisciplinary Evaluation/Assessment	• Individualized Family Service Plan	• Dispute Resolution
• Service Coordination	• Services Provided in Natural Environments	• Right to Decline Services
• Prior Written Notice	• Confidentiality	• Transition Plan

_____I participated fully in the development of this plan.

_____I give my consent to begin supports/services on this plan.

_____I understand I can ask to reconvene the team at any time to modify or make changes to this plan.

Parent/ Legal Guardian Signature_____Date___/___/_____

Parent/ Legal Guardian Signature_____Date___/___/_____

Other IFSP Team Members' Signatures	Date	Role	Need Copy?

Other Copies

In addition to the IFSP team members, I give my consent for copies of this IFSP to be mailed to the individuals listed below for the purpose of coordination of services.

Parent/ Legal Guardian Signature_____Date_____

- ▫ Primary Health Provider_____Address_____
- ▫ Other _____Address_____
- ▫ Other _____Address_____

Periodic Review

Note: The IFSP **MUST** be reviewed and revised at least every 6 months. Document progress in achieving outcomes based on current assessment information. Participants in the review must sign the Periodic Review page. The Supports & Services page must be updated and attached at each review. If more than 3 outcomes are being reviewed attach another Periodic review page. Attach a new Plan of Action page if: 1) an outcome is being modified; or 2) a new outcome is being added. If a new service is added during a Periodic Review, the family and other participants must sign the Rights, Procedural Safeguards, and Signatures page.

Describe Child's Progress Toward Achieving Each Outcome (include any changes in health status)
Outcome: Progress:
Outcome: Progress:
Outcome: Progress:
Outcome: Progress:

IFSP Team Members' Signatures	Date	Role

_____My rights and procedural safeguards were explained to me and I received a written description of each.

Parent/ Legal Guardian Signature _____Date____/____/_____

Child's Name_____ Date_____

Appendix E

Child and Famil Transition Plan

Child's Name_____DOB _____/ /_____Date plan was started _____/ /_____

Steps to be taken to support the child and family's transition	Persons who need to be involved	Date to be completed by

List below those who participated in the Transition Conference Date transition conference was held _____/ /_____

Team Member's Signatures	Phone	Role	Need a Copy?
		Parent/legal guardian (required)	
		Parent/legal guardian (optional)	
		Additional family member (optional)	
		Service coordinator (required)	
		Representative from present service (required)	
		Representative from future service (required)	
		Medical personnel (when appropriate):	
		Other (optional):	
		Other (optional):	

Additional Activities

List the additional activities that the family has identified as important to their child and family. This page is optional and the activities documented here are not considered necessary by the IFSP team to meet the outcomes of this plan.

Justification for Services in Settings Other than the Natural Environment

Part C of IDEA, 20 U.S.C. 1436(d)(5); 34 CFR §303.344(d)(ii): "the provision of early intervention services for any infant or toddler with a disability occurs in a setting other than a natural environment that is most appropriate, as determined by the parent and the individualized family service plan team, only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment."

Justification as to why a natural environment cannot be used to meet outcome number (s) ____

Document why proposed setting was chosen:

Document strategies to move toward providing the service(s) in everyday routines, activities, and places: