

Name: _____

DOB: ____/____/____

SC: _____

Individualized Family Service Plan (IFSP)

Annual IFSP Start Date*: ____/____/____ Initial Interim Periodic Six-month Annual

Prior Notice Date °: ____/____/____ Consent for Services Date °: ____/____/____

Proposed Six-month Review*: ____/____/____ Primary Language*: _____

Secondary Language: _____

Primary Family Contacts (family where child resides)

| | |
|---|---|
| Parent/Guardian*: _____ | Parent/Guardian: _____ |
| Relationship*: _____ | Relationship: _____ |
| Email: _____ | Email: _____ |
| Mobile Phone: _____ | Mobile Phone: _____ |
| Work Phone: _____ <input type="checkbox"/> Do Not Release | Work Phone: _____ <input type="checkbox"/> Do Not Release |

| | |
|--------------------------|--|
| Address*: _____ | Primary Phone*: _____ |
| City*: _____ Zip*: _____ | <input type="checkbox"/> Do Not Release Address or Phone |

Alternate Family Contacts

| | |
|---|---|
| Parent/Guardian*: _____ | Parent/Guardian: _____ |
| Relationship*: _____ | Relationship: _____ |
| Email: _____ | Email: _____ |
| Mobile Phone: _____ | Mobile Phone: _____ |
| Work Phone: _____ <input type="checkbox"/> Do Not Release | Work Phone: _____ <input type="checkbox"/> Do Not Release |

| | |
|------------------------|--|
| Address: _____ | Primary Phone: _____ |
| City: _____ Zip: _____ | <input type="checkbox"/> Do Not Release Address or Phone |

Alternate Family Contacts

| | |
|---|---|
| Parent/Guardian*: _____ | Parent/Guardian: _____ |
| Relationship*: _____ | Relationship: _____ |
| Email: _____ | Email: _____ |
| Mobile Phone: _____ | Mobile Phone: _____ |
| Work Phone: _____ <input type="checkbox"/> Do Not Release | Work Phone: _____ <input type="checkbox"/> Do Not Release |

| | |
|------------------------|--|
| Address: _____ | Primary Phone: _____ |
| City: _____ Zip: _____ | <input type="checkbox"/> Do Not Release Address or Phone |

Child Care Provider (if applicable)

Name/Organization*: _____

Phone*: _____

Fax: _____

Street Address*: _____

Mailing Address: _____

City*: _____ Zip*: _____

City: _____ Zip: _____

Current Child Eligibility*

Current Eligibility Date*: ___/___/___

Standard Score (check qualifying domains)

Gross Motor

Receptive Language

Adaptive

Fine Motor

Expressive Language

Cognitive

Social/Emotional

Medical Diagnosis

Baby Watch Approved Qualified Diagnosis: _____

Medical Record Reviewed: ___/___/___

Informed Clinical Opinion

EI II Member: _____

Other Staff: _____

Our concern(s) about what the child is or is not doing is (are)*:

In our clinical opinion, the specific reason(s) that the child is eligible for early intervention is (are)*:

