

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)\*:

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

\_\_\_\_\_  
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