

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

Name: _____

DOB: ___/___/___ IFSP: ___/___/___

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)

- | | | |
|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Gross Motor | <input type="checkbox"/> Receptive Language | <input type="checkbox"/> Adaptive |
| <input type="checkbox"/> Fine Motor | <input type="checkbox"/> Expressive Language | |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> 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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