

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)*:

