

Name: _____

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

Services

Service Category / Provider	Frequency / Length	Duration	Intensity / Location	Transportation	Start / End
Add Date: ___/___/___					
Service Category*	Frequency* ___ X ___		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> N/A <input type="checkbox"/> Declined	Start ___/___/___
Service Provider*	Length* ___ mins	Duration* ___ mo.	Location*	<input type="checkbox"/> Accepted miles	End ___/___/___
Add Date: ___/___/___					
Service Category*	Frequency* ___ X ___		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> N/A <input type="checkbox"/> Declined	Start ___/___/___
Service Provider*	Length* ___ mins	Duration* ___ mo.	Location*	<input type="checkbox"/> Accepted miles	End ___/___/___
Add Date: ___/___/___					
Service Category*	Frequency* ___ X ___		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> N/A <input type="checkbox"/> Declined	Start ___/___/___
Service Provider*	Length* ___ mins	Duration* ___ mo.	Location*	<input type="checkbox"/> Accepted miles	End ___/___/___
Add Date: ___/___/___					
Service Category*	Frequency* ___ X ___		<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> N/A <input type="checkbox"/> Declined	Start ___/___/___
Service Provider*	Length* ___ mins	Duration* ___ mo.	Location*	<input type="checkbox"/> Accepted miles	End ___/___/___

Name: _____

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

Justification Statements

Location Justification Statement

Service & Setting Requiring Justification: _____

Explain why the outcome cannot be met if the service is provided in the natural environment. *

Explain how services provided outside the natural environment will be generalized within activity settings and routines of the family. *

Describe a plan with time lines and supports necessary to allow the outcome to be satisfactorily achieved in a natural environment. *

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DOB: ____/____/____ IFSP: ____/____/____

Non-EI Services

(any services the child and family needs or is receiving through other sources, but that are neither required nor funded under Part C):

Non-EI Service Provider* _____

Note

Non-EI Service Provider* _____

Note

Service Categories

- | | | |
|-----------------------|------------------------|---------------------------------|
| • Special Instruction | • Family Training | • Nutrition |
| • OT | • Assistive Technology | • Psychological |
| • COTA | • Audiology | • Respite Care |
| • PT | • Health Services | • Service Coordination |
| • PTA | • Medical | • Social Work |
| • SLP | • Nursing | • Sign Language and Cued Speech |

USDB Service Categories

- | | | |
|-------------------------|-------------------------------------|---------------------------------|
| • PIP BVI | • PIP DHH Deaf Toddler Group | • USDB Deaf Mentor |
| • PIP BVI Toddler Group | • PIP Sign Language and Cued Speech | • USDB Intervener |
| • PIP DHH | • USDB Deaf-Blind | • USDB Orientation and Mobility |