

Name: _____

DOB: ____/____/____

SC: _____

Individualized Family Service Plan (IFSP)

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

Review Date*: ____/____/____ Prior Notice: ____/____/____

Consent for Services Date °: ____/____/____

Proposed Annual 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: _____ Do Not Release

Work Phone: _____ Do Not Release

Address*: _____

Primary Phone*: _____

City*: _____ Zip*: _____

Do Not Release Address or Phone

Alternate Family Contacts

Parent/Guardian*: _____

Parent/Guardian: _____

Relationship*: _____

Relationship: _____

Email: _____

Email: _____

Mobile Phone: _____

Mobile Phone: _____

Work Phone: _____ Do Not Release

Work Phone: _____ Do Not Release

Address: _____

Primary Phone: _____

City: _____ Zip: _____

Do Not Release Address or Phone

Alternate Family Contacts

Parent/Guardian*: _____

Parent/Guardian: _____

Relationship*: _____

Relationship: _____

Email: _____

Email: _____

Mobile Phone: _____

Mobile Phone: _____

Work Phone: _____ Do Not Release

Work Phone: _____ Do Not Release

Address: _____

Primary Phone: _____

City: _____ Zip: _____

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)*:

.....

.....

.....

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

.....

.....

.....

Name: _____

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

Present Levels of Development

Health

Vision

Hearing

Gross Motor (strengths and needs related to body movement)

Name: _____

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

Fine Motor (strengths and needs related to using hands and fingers)

Name: _____

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

Present Levels of Development (cont...)

Cognitive (strengths and needs related to thinking and learning)

Receptive Communication (strengths and needs related to understanding words, gestures, and signs)

Expressive Communication (strengths and needs related to using words, gestures, and signs)

Social or Emotional (strengths and needs related to expressing and responding to feelings and interacting with others)

Adaptive (strengths and needs related to dressing, feeding, grooming, toileting, household responsibility)

Other Narrative



Name: _____

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



Name: _____

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

EI Outcomes

Num*	Date*	Outcome: What I want for my child and family*	Activities / Strategies (including who will be involved)	Review (most recent)
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
				Date: Rater: Rating: M PM NM D Comments:
Review Rating Key: M = Met goal PM = Partially Met NM = Not Met D = Discontinued				

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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. *

Location Justification Statement

Service & Setting Requiring Justification: _____

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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

Name: _____

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

Signatures

I (parent or guardian) have participated in the development of this Individualized Family Service Plan and understand that I can accept or refuse any or all of the services identified in it. I understand that my consent for services may be withdrawn at any time.

I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed; (b) I have received the "Baby Watch Parents' Rights in Early Intervention" booklet and understand my parents rights in early intervention; and (c) I give consent to carry out our Individualized Family Service Plan as written.

Signature of Parent or Guardian*

Date* (mm/dd/yyyy)

Signature of Parent or Guardian*

Date* (mm/dd/yyyy)

Service Coordinator*

Date* (mm/dd/yyyy)

Other Participant

Date (mm/dd/yyyy)

Other Participant

Date (mm/dd/yyyy)

TRANSITION INFORMATION

The EI Provider provides services to eligible children from birth to age three. When your child is 27 months old, your early intervention program will talk with you about options that may be available depending on your child's abilities. Your three-year-old child may be eligible for special education preschool or you may consider other community preschool settings. If your child is not eligible for special education preschool, your service coordinator or service providers will help you identify community preschool setting options. A Transition Plan will be developed to help your family move from early intervention services to other services where appropriate.

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