

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)*:

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

Summary of Information Collected From Family

Date*: ____/____/____

Family-directed assessment tool*:
(check only one)

- A Routines-based Assessment
- Program CPR Checklist
- Assessment Declined by Family

Family Notes (family comments may be added if assessment declined)

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Family Concerns, Priorities, and Resources

Family Concerns*

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Family Priorities*

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Family Resources*

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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				

Services

Service Category / Provider	Frequency / Length	Duration	Intensity / Location	Transportation	Start / End
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Add Date: ____/____/____

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

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: _____

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

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

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

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 | • Audiology |
| • OT | • Health Services |
| • PT | • Medical |
| • SLP | • Nursing |
| • Family Training | • Nutrition |
| • Assistive Technology | • Psychological |
| | • Respite Care |
| | • Service Coordination |
| | • Social Work |
| | • 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 |