Name: _____

DOB: ___/___/_____

SC: _____

Individualized Family Service Plan (IFSP)

Annual IFSP Start Date*: ___/___/_____ ☐ Initial ☐ Interim ☐ Periodic ☐ Annual

Prior Notice Date °: ___/___/_____ Consent for Services Date °: ___/___/_____

Proposed Periodic Review*: ___/___/_____ Primary Language*: _____

Secondary Language: _____

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
- ☐ Fine Motor
- ☐ Cognitive
- ☐ Receptive Language
- ☐ Expressive Language
- ☐ Social/Emotional
- ☐ Adaptive

☐ 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)*:

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

Present Levels of Development

Health

Hearing

Vision

Gross Motor (strengths and needs related to body movement)

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Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

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

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Family Health

Name: _____

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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

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

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)

Family Concerns, Priorities, and Resources

Family Concerns*

Family Priorities*

Family Resources*

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

EI Outcomes

Num*	Date*	Outcome: What I want for my child and family*	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

Name: ______________________________

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

Services

Service Category / Provider	Frequency / Length	Duration	Intensity / Location	Transportation	Start / End
Add Date: ___/___/______					
Service Category* ______________________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined ☐ Accepted	Start ___/___/_____
Service Provider* ______________________	Length* ___ mins	Duration* ___ mo.	Location* __________	___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ______________________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined ☐ Accepted	Start ___/___/_____
Service Provider* ______________________	Length* ___ mins	Duration* ___ mo.	Location* __________	___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ______________________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined ☐ Accepted	Start ___/___/_____
Service Provider* ______________________	Length* ___ mins	Duration* ___ mo.	Location* __________	___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ______________________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined ☐ Accepted	Start ___/___/_____
Service Provider* ______________________	Length* ___ mins	Duration* ___ mo.	Location* __________	___ miles	End ___/___/_____
Add Date: ___/___/______					
Service Category* ______________________	Frequency* ___ X ___		☐ Individual ☐ Group	☐ N/A ☐ Declined ☐ Accepted	Start ___/___/_____
Service Provider* ______________________	Length* ___ mins	Duration* ___ mo.	Location* __________	___ miles	End ___/___/_____

Utah Department of Health & Human Services
Family Health

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: _____

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.*

Name: _____

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

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

TRANSITION INFORMATION

The EI Provider provides services to eligible children from birth to age three. Prior to turning three your early intervention program will talk with you about the service options available in your community. Your three-year-old child may be eligible for special education preschool services or you may consider other community-based services. A Transition Plan will be developed to help your family move from early intervention services to other services where appropriate. Discussions regarding transitioning out of early intervention and the development of a Transition Plan include multiple steps. These steps are completed at various points in time throughout your child's enrollment in early intervention. The Transition Plan will be completed in its entirety prior to your child's third birthday.

Transition to Special Education Preschool or Community

Transition Referral Notification	**Discussion**
1. Describe available service options for child at age three.	Discussion Date* ____/____/_____
2. Describe special education preschool eligibility criteria.	Discussion Date* ____/____/_____
3. Discuss referral process to special education preschool.	Discussion Date* ____/____/_____
4. Discuss automatic referral notification to special education preschool. If the parent has declined automatic referral notification, skip steps "5. Transition Plan for Special Education Preschool" and "6. Transition Conference," and fill out step "5. Transition to Community Program."	Discussion Date* ____/____/_____ ☐ No, I do not want my child's and family's information sent to the Utah State Board of Education and local school district special education preschool program. I am declining the referral notification. Date Declined ____/____/_____

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

5. Develop transition plan for transitioning to Special Education Preschool.

Transition Planning (Steps and Services)	**Discussion**
a. Provide information about local special education preschool services, placement options, and the Individualized Education Program(IEP).	Discussion Date* ____/____/_____
b. Identify required skills.	Discussion Date* ____/____/_____
c. Develop IFSP outcomes, and any services or activities needed to prepare the child and family for a preschool environment.	Discussion Date* ____/____/_____
d. Discuss the release and exchange of information in the child's early intervention record to local school district.	Discussion Date* ____/____/_____ ☐ Release and Exchange Information in the Early Intervention Record to local School District _____ (Name of School District)* _____ (Address) Date Authorized ____/____/_____

e. Discuss and arrange a transition conference.	Discussion Date* ____/____/_____
f. Discuss other services that may be available in the community in addition to special education preschool.	Discussion Date* ____/____/_____

Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

6. Transition Conference

Transition Conference Date (Date the Transition Conference Occurred) Conference Deadline ____/____/_____ (Deadline is 90 days before the child turns 3 years old.) Prior Notice Sent* ____/____/_____ Transition Conference Note	Prior Notice Sent* ____/____/_____ Conference Status* ○ Completed ○ Declined **Transition Conference Completed** ☐ I met today to discuss transition options, including special education preschool, for my child who is currently receiving early intervention services. **Transition Conference Declined** ☐ I have been given the opportunity to meet with my child's special education preschool representative to discuss transition options but wish to decline at this time. ☐ I understand that once my child turns three, I can call the school district any time to refer my child to be evaluated for eligibility for special education services. ☐ I understand that I may reverse my decision to decline this transition conference in writing at any time.

Attendees	**Signature**
Parent/Guardian*	_____
Parent/Guardian	_____
EI Service Provider*	_____
EI Service Provider	_____
EI Service Provider	_____
School District* LEA Representative*	_____ _____ ☐ LEA Representative not in attendance*
USDB*	_____ ☐ USDB Representative not in attendance*
Other	_____

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

5. Develop a transition plan for transitioning to a community program.

Community Transition Planning (Steps and Services)	Discussion
a. Discuss information about community options.	Discussion Date* ____/____/_____
b. Identify required skills.	Discussion Date* ____/____/_____
c. Develop IFSP outcomes, and any services or activities needed to prepare the child and family for a community setting.	Discussion Date* ____/____/_____
d. Discuss releasing records to community programs.	Discussion Date* ____/____/_____
e. Other community planning.	Discussion Date* ____/____/_____

Utah Department of Health & Human Services
Family Health

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" brochure 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)

Service Categories

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

USDB Service Categories

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