Reset Form

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
PILOT FORM/DRAFT

First Steps

IFSP		
Initial date (*month, day, year*)	Annual effective date (*month, day, year*)	County

SECTION 1: IDENTIFYING INFORMATION

Name of child (*last, first, middle initial*) *		A.K.A. name	
Social Security number **	Date of birth (*month, day, year*) *	Chronological / adjusted age *	Gender *
First Steps identification number *			
Family's primary language / mode of communication			
Child's primary language / mode of communication *			
Type of representative (*check one*): * ☐ Parent ☐ Guardian ☐ Foster parent ☐ Surrogate parent			
Name of representative(s) *			
Address (*number and street*) *			
City * , IN	ZIP code *	County *	
Work telephone number *		Home telephone number *	
Cellular telephone number *		E-mail address	

OTHER CONTACT INFORMATION

Name(s) of other contacts		
Address (*number and street*)		
City , IN	ZIP code	County
Work telephone number *		Home telephone number *
Cellular telephone number *		E-mail address

SECTION 2: SERVICE COORDINATION INFORMATION

Name of service coordinator *		Name of agency *
Telephone number(s) *		Fax number *
Address (*number and street*) *		E-mail address
City * , IN		ZIP code *
Name of intake coordinator		Telephone number
Fax number		E-mail address
Address (*number and street*)		
City * , IN		ZIP code *

* Denotes part of the electronic record.

** Your child's Social Security number is requested in order to expedite processing this IFSP. Disclosure is voluntary and you will not be penalized for refusal per I.C. 4-1-8-1.

Name of child	FSID	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 3: SUMMARY OF CHILD'S PRESENT LEVEL OF PERFORMANCE & EVALUATION INFORMATION

Please document the requested information below. All information should relate to the developmental needs of the child and family and should be gathered from discussion with the family.

List child / family strengths:

Concerns / needs related to the child's development:	Medical diagnosis / health status:

Screening results: **Vision:** ☐ Passed ☐ Concerns Comments:	Screening results: **Hearing:** ☐ Passed ☐ Concerns Comments:

Please document information relating to the child's development. Information may be gleaned from assessments, structured observation or other methods. **Parent report must be utilized.** The statement about the child's present level of performance must be based on professionally acceptable objective criteria. This information is then to be utilized in the determination of eligibility.

DOMAIN (*Person / Date*)	**ASSESSMENT PROCEDURES** *Please check all procedures used.*	**STATEMENT OF CHILD'S CURRENT LEVEL OF PERFORMANCE** ☐ Child in NICU *Describe the child's current level of performance. In addition, provide Raw score and Standard Deviation. Check if services are recommended.*	
Physical ** Development Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Fine Motor: Raw Score _____ Deviation _____ Services recommended: ☐ Yes ☐ No	Gross Motor: Raw Score _____ Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Adaptive Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Cognitive Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Communication Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No
Social Date (*mo., day., yr.*)	☐ Structured observation ☐ State approved assess.* ☐ Other assessment ☐ Parent report (*required*)	Raw Score _____ Services recommended: ☐ Yes ☐ No	Deviation _____ Evaluation recommended: ☐ Yes ☐ No

* State approved assessment: Assessment, Evaluation, and Programming System for Infants and Children (AEPS) Second Edition.
** Physical Development is defined as motor skills, vision and hearing.

Name of child	FSID	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 4: OUTCOMES

This page should be duplicated as needed for additional outcomes

Child outcome #:

What does the family want the child to do? (Functional)
Why is this outcome important to the family? (Real life)
What will change (routine) with the child's new skill?

(child's name) will *(positive verb)**

in order to *(specific action(s) and behavior(s) related to the routine)**

We will know we are making progress when…

**The verb should be positive and not what the child cannot do. Be specific and avoid words like more, less, increase, decrease, greater, etc.*

What are the **natural environments** for this child and family?

Strategies and Activities *(include activity settings, people, and everyday routines of the child and family)*

How does the team plan on measuring progress?	When does the team plan on measuring progress?
☐ Provider notes ☐ Parent report ☐ Service Coord. contact w/family	☐ Weekly ☐ Monthly ☐ Quarterly ☐ 6-mo. review

IF REVIEWED Review date:		
	Modification to outcome?	☐ Yes ☐ No
	Outcome status	☐ Continue as written ☐ Continue with changes ☐ Discontinue
	Summary of progress	

Family outcome #:

Family Outcome Statement and Criteria:

Strategies and Activities *(What strategies will we work on together toward this outcome?)*

How does the team plan on measuring progress?	When does the team plan on measuring progress?
☐ Provider notes ☐ Parent report ☐ Service Coord. contact w/family	☐ Weekly ☐ Monthly ☐ Quarterly ☐ 6-mo. review

IF REVIEWED Review date:		
	Modification to outcome?	☐ Yes ☐ No
	Outcome status	☐ Continue as written ☐ Continue with changes ☐ Discontinue
	Summary of progress	

Name of child	FSID	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 5: TEAM COMMUNICATION PLAN

The Service Coordinator will contact the family/provider regarding progress toward outcomes as written in the IFSP as follows:

Family's preferred method of contact: *(e.g. face-to-face, email, text, phone, etc.)*	
Family's preferred frequency of contact:	
Provider's preferred method/frequency:	

Therapist(s) will disseminate progress reports to the family and Service Coordinator by the following dates. (The Service Coordinator will disseminate to the physician.)

3 month report:	
6 month report:	
9 month report:	
Annual report:	

Other Notes *(as needed)*

SECTION 6: TRANSITION

Anticipated date for transition from the First Steps program:

Transition Topic	Transition Activities	Date	Person Responsible
1. Discuss with parents what "transition" from early intervention means.			
2. Inform school district of child's potential eligibility and provide directory information at 30 months of age.			
3. Discuss preschool special education as well as other community program options for the child.			
4. With parental consent, send specified information to school district and/ or community programs by 30 months of age.			
5. With parental consent and prior notice, hold a transition meeting with all required persons to develop a transition plan.			
6. Discuss activities/ supports to help the child and family prepare for the new setting.			
7. Identify other changes in the family's life *(as applicable)*			

☐ Check if transition was completed during previous IFSP. Date of transition meeting:_____

SECTION 7: NATURAL ENVIRONMENT

Outcome #	Service	Discuss why service cannot be provided in natural environment	Describe how the intervention will be generalized into the child and family's daily activities	Identify steps for a plan to move intervention into a natural environment

Name of child	FSID	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 8: EARLY INTERVENTION SERVICES

This page is part of the electronic record. Early intervention services (**EI services**) must meet the developmental needs of the child and family and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided under public supervision by qualified personnel in conformity with the IFSP. Unless otherwise indicated, the EI services listed below are processed through the Central Reimbursement Office. Any service that is to be provided in a setting other than the natural environment of the child must be documented in Section 7 of the IFSP.

EI SERVICES (auth required)		OTHER SERVICES			LOCATION
Assistive technology	Occupational therapy	CDHHE Deaf Mentor	Hoosier Healthwise/CHIP	TANF	1. Program designed for children with delays or disabilities
Audiological services	Psychological services	Child care/CCDF	Mental health	VIPS	2. Program designed for typically developing children
Developmental therapy	Social work services	CSHCS	Nurse Family Partnership	Waiver	3. Home
Health services	Speech therapy	Deaf-Blind Services (ISU)	Parents as Teachers	WIC	4. Hospital (inpatient)
Medical diagnostic srvcs.	Transportation	Family preservation	Preschool	Other	5. Residential facility
Nursing services	Vision services	Head Start/Early Head Start	Respite		6. Service provider location
Nutrition services		Healthy Families	SNAP		7. Other setting

SERVICES	OUTCOME #	SERVICE FREQUENCY & INTENSITY	START DATE	END DATE	LOCATION CODE	IF ON-SITE	AUTH Y/N	PROVIDER'S INFO NAME AND AGENCY
Service Coordination	ALL	Ongoing						

The contents of this completed IFSP have been fully explained to me. I give informed, written consent to implement the services described in this section of the IFSP confirmed by my signature on this form. I also acknowledge the following:

I understand that this form serves as my ten (10) day written notice of the actions being proposed / refused and have been given an explanation of why the action is being proposed / refused. I have received a copy of parent's rights and complaint procedures (under section 470 IAC 3.1-14-1) for the First Steps Early Intervention System and had these rights explained verbally by my Service Coordinator. The notice was written in language understandable to me and in my native language, or translated orally or by other means to my native language or other mode of communication. I understand that I may refuse any proposed service(s) / action(s) and my Service Coordinator will document my refusal.

I am responsible to meet all First Steps financial obligations and I am aware that if payments are sixty (60) days or greater past due, copay eligible services will be suspended until payment is received to bring my First Steps account current. If I would like further consideration of my payment obligation, I may provide documentation of income or family medical expenditures to my Service Coordinator, who will review the income and deductions within thirty (30) days of my request. If income verification is not provided, I will be billed the maximum allowable monthly co-payment fee.

☐ I consent to First Steps accessing my insurance.

☐ I am NOT providing consent to access my insurance. I understand that First Steps will not retroactively bill my insurance at a later date.

☐ Not applicable due to lack of insurance.

Signature of parent / guardian / surrogate parent	Date (*month, day, year*)	Signature of parent / guardian / surrogate parent	Date (*month, day, year*)

BASED ON THE ATTACHED SUMMARY OF THE CHILD'S PRESENT LEVEL OF PERFORMANCE AND EVALUATION INFORMATION, I AGREE THAT THE RECOMMENDED THERAPIES ARE NECESSARY AND APPROPRIATE AND MAY BE PROVIDED AS LISTED FOR UP TO ONE YEAR FROM THIS DATE.

Printed name of physician *(signature applies to authorized services only)*	Telephone number	Fax number

Signature of physician *(signature applies to authorized services only)*	Date (*month, day, year*)

Please return the signed copy of this page to the child's Intake / Service Coordinator, _____ / _____.

Telephone number	Fax number

If you have additional questions relating to the evaluation information for this child, you may contact the Assessment Team (AT):

Name of contact	Telephone number	Fax number

Name of child	FSID	Date of birth (*month, day, year*)	IFSP date (*month, day, year*)

SECTION 10: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

IFSP meetings **must include** the parent(s), other family members as requested by the parent, an advocate or person outside the family as requested by the parent, the Service Coordinator, person(s) directly involved in conducting the evaluations and assessments, and as appropriate, persons who will be providing services to the child or family.

PRINTED NAME	ROLE	TELEPHONE	SIGNATURE	TIME IN	TIME OUT	AUTH. TIME
	Parent *					
	Parent *					
	Intake Coord.					
	Service Coord.					
	AT Team member					
	AT Team member					

A copy of this IFSP will be sent to the individuals listed above, the providers listed in section 8, as well as those persons indicated below.

Name of person	Name of person

IFSP MEETING MINUTES

Written documentation of the IFSP meeting must be recorded. Notes should document general discussion, any unresolved issues, and follow-up activities. (*Attach additional pages as needed*)

Signature of note taker	Location of meeting	Today's date (*month, day, year*)

NOTES: