

Handout III: Sample Individualized Family Service Plan

<http://www.birthe23.org/Publications/CurrentProcedures/Forms/Form%203-1-IFSP.doc>

INDIVIDUALIZED FAMILY SERVICE PLAN

*Date: _____

*Type of meeting: ☐ Interim IFSP ☐ Initial IFSP ☐ Annual ☐ Review

***Child's Name:** _____

***Date of Birth:** _____

☐ *Male

☐ *Female

Parent/Foster Parent/Guardian/Family Member (circle one)	Parent/Guardian/Family Member (circle one)
*Name	*Name
*Address	*Address
*City *State *Zip	*City *State *Zip
*Phone (day) (evening)	*Phone (day) (evening)
*Primary Language	*Primary Language

*Surrogate Parent: _____ *Phone: _____

*Address: _____

*Service Coordinator/Program: _____ *Phone: _____

*Address: _____

*Physician/Health Care Provider: _____ *Phone: _____

*Address: _____

*School District: _____ Contact Person/Phone: _____

*Recommended school district referral date, no later than: _____
(Refer the child any time after the 2nd birthday. The decision to refer must be made no later than age 21/2)

☐ *Check if release to LEA (form 3-3) is on file

☐ *Check if referral to LEA (form 3-8) is on file

*Denotes part of the electronic record

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION I. SUMMARY OF CHILD'S PRESENT ABILITIES, STRENGTHS, AND NEEDS

1. Indicate the dates and types of evaluation or assessment report, which were used to develop this plan:

2. Summarize below additional observations by family and other team members of the child's abilities, strengths, and needs in daily routines. Areas to include:

- What are your child's likes and dislikes?
 - What are your child's frustrations?
 - How does your child spend his/her day?
- Bathing, feeding, dressing, toileting – Adaptive/Self help skills
 - Thinking, reasoning and learning – Cognitive skills
 - Moving, hearing, vision, health – Physical development
 - Feelings, coping, getting along with others – Social/Emotional development
 - Understanding, communicating with others and expressing self with others – Communication skills

[illegible]

(Attach additional pages as needed)

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION II. SUMMARY OF FAMILY'S CONCERNS, PRIORITIES, AND RESOURCES AS THEY RELATE TO ENHANCING THEIR CHILD'S DEVELOPMENT - Family Outcome

1. Information about our family for the IFSP: (Suggestions)	<ul style="list-style-type: none">● Things we like to do as a family● Who is part of our family?● Important events that have occurred	<ul style="list-style-type: none">● People and agencies we find helpful.● Our family's strengths in meeting our child's needs.● How our child's special needs affect our family
2. What would be helpful for our family in the months and year ahead? (Family Outcome)		
3. What assistance or information will we need to achieve this outcome? (Strategies)		

SECTION III. OTHER SERVICES THAT ARE IN PLACE OR ARE NEEDED

Services such as medical, recreational, religious, social and other child related services, not covered by the CT Birth to Three System, that contribute to this plan.

Resource/Program/Support Service	✓ If Needed	Payment Source

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION IV. PLAN FOR TRANSITION FROM THE BIRTH TO THREE SYSTEM TO PRESCHOOL SPECIAL EDUCATION OR OTHER APPROPRIATE SERVICES

1. Information that would be helpful for our child and family to plan for the future. •Community program options •LEA information •Referral process •Rights and responsibilities •Parent training •Visiting community programs •Adaptive equipment •Transportation •Time with other children •Information sharing.	
2. What are the next steps? Date to be completed:	Who will be involved:

After the initial IFSP meeting, this plan may only be modified at an IFSP periodic review meeting or annual IFSP meeting.

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION V. OUTCOME # _____

What we want is: _____

What is happening now: _____

What are the next steps (objectives) to reach this outcome?	Expected timeframe for reaching objective

Strategies: methods for working on this outcome during your child and family's daily activities and routines

People who will be involved

--	--

(Attach additional pages as needed)

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION VI. EARLY INTERVENTION SERVICES AND SUPPORTS

*What is going to happen (including assistive technology)	*Delivered by: (Discipline responsible)	*Location Code	*How Often	*How Long	*Start Date	*End Date
		<input type="checkbox"/>				

☐ Check here if additional pages are attached to list or clarify the services being provided or the schedule of services.

Primary service location codes: 1=home 2=setting designed for typical children 3=hospital (inpatient) 4=residential facility 5=service provider office 6=setting designed for children with delays 7=other

☐ *Check if any early intervention service cannot be achieved satisfactorily in a natural environment and attach a justification for each service.

Informed Consent by Parents. Check and sign below:

1. _____ I understand my rights under this program and received a written copy of *Parent Rights Under IDEA Part C* and

2a. _____ I give permission to carry out this Individualized Family Service Plan as written. or

2b. _____ I do not accept this Individualized Family Service Plan as written, however I do give permission for the following services to begin:

Parent Signature _____ Date _____ Parent Signature _____ Date _____

I have reviewed this Individualized Family Service Plan, which is based in part on an evaluation in all areas of development. I confirm the appropriateness of the diagnosis(es) as stated by the diagnostic (ICD-9) code and the recommendations for the treatment services as they are written.

Physician Signature: _____ LIC#: _____ *Date: _____

*Print Name: _____ *ICD-9 Code(s) _____, _____, _____, _____

*Denotes part of the electronic record

Services are paid for by the Birth to Three System unless otherwise indicated:

Service Coordinator/ Discipline/ Program Name/phone #:

Service Coordination is provided to all families at least monthly and is most often part of the early intervention visit

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

SECTION VII. IFSP TEAM MEMBERS

The following individuals have participated in the development of the IFSP and/or will assist in its implementation. There will be ongoing verbal communication between the IFSP team members listed below to assist in the implementation of the IFSP.

Name	Relationship	Phone	Method of participation

Meeting Notes: (discussion, specific scheduling issues, and any other issues)

Early Intervention and Education

Section R-1: Individualized Family Service Plan (IFSP) Review: Outcomes



Child's Name: _____ DOB: _____ Review Date: _____

☐ Periodic review

Date of IFSP being reviewed: _____ Reason for review: _____

☐ Annual review

Outcome #	Outcome(s)	Progress towards reaching <i>family</i> outcomes	Status

Outcome #	Outcome(s)	Progress towards reaching <i>child</i> outcomes	Status
Progress on Transition Plan			

Attach additional pages as needed and additional outcomes if developed.

Early Intervention and Education

Section R-2 Individualized Family Service Plan (IFSP) Review: Services and Supports

Child's Name: _____ DOB: _____ Date of IFSP being reviewed: _____ Review Date: _____

Result of Review: _____

SUMMARY OF REVISED EARLY INTERVENTION SERVICES AND SUPPORTS

(To be completed after review of outcomes)

*What is going to happen (including assistive technology)	*Delivered by: (Discipline responsible)	*Location	*How Often	*How Long	*Start Date	*End Date
		code				

☐ Check here if additional pages are attached to list or clarify the services being provided or the schedule of services.

Primary service location codes: 1=home 2=setting designed for typical children 3=hospital (inpatient) 4=residential facility 5=service provider office 6=setting designed for children with delays 7=other

☐ *Check if any early intervention service cannot be achieved satisfactorily in a natural environment and attach a justification for each service.

Informed Consent by Parents. Check and sign below:

1. _____ I understand my rights under this program and received a written copy of *Parent Rights Under IDEA Part C* **and**

2a. _____ I give permission to carry out this Individualized Family Service Plan as written. **or**

2b. _____ I do not accept this Individualized Family Service Plan as written, however I do give

Services are paid for by the Birth to Three System unless otherwise indicated:

Service Coordinator/Program/Discipline/phone#:

Service Coordination is provided to all families at least monthly and is most often part of the early intervention visit

Parent Signature _____ Date _____ Parent Signature _____ Date _____

I have reviewed the revisions made to this Individualized Family Service Plan. I confirm the appropriateness of the diagnosis(es) as stated by the diagnostic (ICD-9) code and the recommendations for the treatment services as they are written.

Physician Signature: _____ LIC#: _____ *Date: _____

*Print Name: _____ *ICD-9 Code(s) _____, _____, _____, _____

*Denotes part of the electronic record

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

JUSTIFICATION FOR EARLY INTERVENTION SERVICES THAT CANNOT BE ACHIEVED SATISFACTORILY IN A NATURAL ENVIRONMENT

LOCATION OF SERVICE: _____ **SERVICE:** _____

1. *Explain how and why the child's outcome(s) could not be met if the service were provided in the child's natural environment with supplementary supports. If the child has not made satisfactory progress towards an outcome in a natural environment, include a description of why alternative natural environments have not been selected or outcome not modified.*

2. *Explain how services provided in this location will be generalized to support the child's ability to function in his or her natural environment.*

3. *Describe a plan with timelines and supports necessary to allow the child's outcome(s) to be satisfactorily achieved in his or her natural environment.*

Early Intervention and Education

Child's Name: _____ DOB: _____ Date: _____

ADDITIONAL PAGE
INDIVIDUALIZED FAMILY SERVICE PLAN

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.