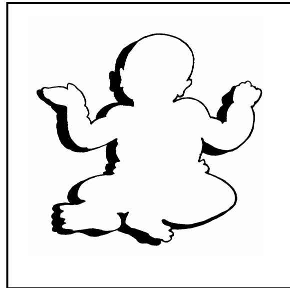
Idaho Infant Toddler Program
Individualized Family Service Plan (IFSP)

Created on ______________________________
(Today's Date)

For the family of ______________________________
(Child's Name)

Who was born on ______________________________
(Date of Birth)



Health History 2

Description of Child 3

Family Priorities 4

Plan: Things to be done 5

Service Coordination Plan 6

Transition Plan 7

Summary of Early Intervention Services 8

Team Members 9

Additional Plan Pages

____________________ ____

____________________ ____

____________________ ____

____________________ ____

____________________ ____

Dear Family,

The development of an Individualized Family Service Plan (IFSP) is a process in which family members and service providers work together as partners. Together we will create a plan of action to support your family in meeting your child's developmental needs.

You know your child better than any professional. You are an essential member of the team. Please speak freely to help us understand what will be useful to you and your child. It will be helpful to learn about the daily routines of your family in order to find the best learning opportunities for your child. Service providers will give you information about available services. You can then decide what services will best address your concerns. We are committed to making this planning process comfortable and valuable to you, your child, and other team members. This plan will be reviewed every six months, or more frequently upon request, to respond to your child's and family's changing needs. We look forward to developing a meaningful relationship with you and hope you will share your ideas and suggestions on how this process can be improved.

This page summarizes your child's health and medical background. This information helps determine which services will be most beneficial to your child.

Please describe your child in the following areas. You may also attach a summary of current health information and or evaluations that address these areas.

- φ **Birth history**
- φ **Current overall health**
- φ **Nutrition**
- φ **Growth**
- φ **Vision**
  Do you have any concern about your child's vision? Has your child had a vision screening or evaluation?
- φ **Hearing**
  Do you have any concern about your child's hearing? Has your child had a hearing screening or evaluation?
- φ **Medical conditions or diagnosis**
- φ **Immunizations**
- φ **Other information**
  Medications, therapies, previous evaluations, assistive devices used, etc..

________________________'s Health History

(Child's Name)

In describing your child's overall health, please list any medical conditions or hospitalizations, significant injuries, illnesses, etc. Please include information about your child's birth history, immunization record, nutrition, growth, vision, and hearing.
Birth History:
Health:
Nutrition:
Growth:
Vision:
Hearing:
Medical Conditions:
Immunizations:
Other Information:

This page summarizes information about your child's current development. Think about the following for your child:

- φ How does your child learn/use knowledge and skills?
- φ Does your child take actions to meet his/her needs?
- φ Does your child have positive social relationships?

Please describe what your child is doing and what you would like to see him or her doing in each of the following areas. The professionals who have evaluated your child will also note their observation and evaluation findings.

φ **Thinking and learning** (e.g., look for dropped toy, pull toy on a string, do a simple puzzle).

φ **Understanding and communication** (e.g., startle at loud noises, point to desired objects, use two or more word sentences).

φ **Doing things for himself or herself** (e.g., help hold a bottle, reach for a toy, help dress himself or herself).

φ **Movement and coordination** (e.g., reach for and play with toes; sit, roll, and crawl; throw a small ball; thread cord through large beads)

φ **Getting along with others** (e.g., smile and coo, pull on your hand or clothes to gain attention, share a toy, take turns with others).

A Description of ______________________

(Child's Name)

What are your child's strength? (Things your child can do.)	
Parent/Caregiver Input	**Other Data Sources** (Observation, Evaluation. Results, Child Information Sheet, Medical records, etc.).

Within this next year, what do you hope to see your child do, or do better? (Parent/Caregiver Input)

Priorities for ___________________’s Family

(Child’s Name)

Children learn best in familiar places where they are comfortable and routinely spend time. The Infant Toddler Program provides services in these places, which are called the child’s natural learning environments.

To help determine your child’s natural learning environments, please consider your family’s typical activities and routines. Think about where your child spends time. Are there places you would like your child to spend more time? Are some of these places possible sites for early intervention activities?

Your child’s learning can hinge upon your family’s strengths, needs and resources. To best serve your child, it is helpful to know about issues or concerns that are important to your family.

You may share as much or as little family information as you choose. This will be used to connect you with information and resources as needed. The following categories may guide your thinking as you respond to the questions:

- φ **Physical** (food, shelter, transportation, assistive technology, etc.).
- φ **Financial** (income, bills, etc.).
- φ **Health** (medical, safety, immunizations, etc.).
- φ **Guidance** (discipline, parenting, etc.).
- φ **Emotional** (nurturing, love, companionship, etc.).
- φ **Recreation** (free time, activities, sports, etc.).

What are your child’s daily routines and activities? Where do they take place? Who usually spends time with him or her? (Natural Learning Environments)
What people, places and things are (or could be) supportive and helpful to your family and child? (Resources/Supports)
Within this next year, what things are most important or of most concern to you and your family?

______________________________’s Plan: Things to be done

(Child’s Name)

This page will define what you and your family can expect from early intervention. Based upon your input and information on the preceding pages, this plan will outline what we want to accomplish, and the specific steps required. Please identify and share your top priority goal(s) for your child and/or family (Outcomes). Each outcome will be written on a separate page. Activities such as talking, singing, and reading to your child help build the foundational skills needed for later school success. The objectives listed below will include activities to build language and pre-literacy and skills and should be age-appropriate for your child.

What do we want to accomplish? (Outcome) Key Word and/or Number:___________________________________

Who will be involved?	* Review Codes 1 = We did it! 2 = Still working on it 3 = Objective changed 4 = Postponed 5 = Parent declined service 6 = Objective not addressed a. Waiting for placement b. No funding source c. Other

What steps need to be taken? (List measurable behavioral objectives.**)**	**How will we know when the objective is achieved?** (Measurable evaluation criteria.)	**Strategies and Activities**	**Where will this happen?** (Provide justification if not a natural learning environment.)	**Objective Reviewed?** (*Code/Date/Initials.)

______________________________’s Service Coordination Plan

(Child’s Name)

Service Coordination is provided to all families enrolled in the Idaho Infant Toddler Program. A Service Coordinator will help your child and family access the following: a multidisciplinary evaluation, IFSP development, procedural safeguards and parental rights, and the services outlined in this plan. Your Service Coordinator can work across agency lines and will be your primary point of contact in solving problems and making changes in the service you receive. Based upon your input and requests, this page will outline steps and activities to assist you and your child as you move through the early intervention system.

What do we want to accomplish? (Service Coordination Outcome) Key Word and/or Number:______________________________			
Who will be involved?		* Review Codes 1 = We did it! 2 = Still working on it 3 = Objective changed 4 = Postponed 5 = Parent declined service 6 = Objective not addressed a. Waiting for placement b. No funding source c. Other	
What steps need to be taken? (List measurable service coordination objectives.**)**	**How will we know when the objective is achieved?** (Measurable evaluation criteria.)	**Strategies and Activities**	**Objective Reviewed?** (*Code/Date/Initials.)

______________________________'s Transition Plan

(Child's Name)

This page describes transition activities that you and your family can expect when participating in the Idaho Infant Toddler Program. Transitions are big changes that occur in your early intervention services or family's life. Transitions include things like: bringing your child from the hospital to home, changing a child care provider, going to preschool, etc. Based upon your input, the Transition Plan will outline steps and activities to support your child and family through these changes. This plan can help you explore future placement options, changes in service delivery, or identify new skills your child may need to be most successful in a new setting.

<table>
<tr><td colspan="2">What do we want to accomplish? (Transition Outcome)</td><td colspan="2">Key Word and/or Number:____________________________</td></tr>
<tr><td colspan="2">Who will be involved?</td><td colspan="2"><u>* Review Codes</u>
1 = We did it!
2 = Still working on it
3 = Objective changed
4 = Postponed
5 = Parent declined service
6 = Objective not addressed
a. Waiting for placement
b. No funding source
c. Other</td></tr>
<tr><td>What steps need to be taken?
(List measurable transition objectives.)</td><td>How will we know when the objective is achieved? (Measurable evaluation criteria.)</td><td>Strategies and Activities</td><td>Objective Reviewed?
(*Code/Date/Initials.)</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>

Summary of Early Intervention Services

Child's Name ______________________ Birth Date ______________ SS# ________________ Date of IFSP ________________

Parent's Name(s) _________________________________ Phone_____________________ Review Due ________________
(6 month / Annual / Other)

Address _______________________________________ City_______________________ Date Review Completed___________

Insurance Co. ___________________________________ Policy # ____________________ Eligibility/Diagnosis Code(s) ________

Dr.'s Name___________________ Medicaid # ________________ Healthy Connections? Y N _________________________

Service Coordinator _________________________ Agency _________________ Service Coordinator Phone ____________________

Early Intervention Services	**Outcome** (Key Word or Number)	**Method** (Group/Individual), **Intensity of Service** (Total Minutes/Month), and **Frequency** (How Often)	**Duration** (Start/End Date)	* Payment Source	Person(s) / Agency(ies) Responsible

Parental Consent for Services

I (We) understand and have participated in the development of this plan. I (We) give consent to implement the services outlined above.

_______________________________________ ______________
(Signature) and relationship to the child (Date)

_______________________________________ ______________
(Signature) and relationship to the child (Date)

When the parent is in attendance and has received a copy of Parent's Rights, this plan serves as prior written notice for evaluation, placement, and/or the provision of listed services.

Physician Signature

I have reviewed the above health-related services and certify that they are medically necessary.

_______________________________________ ______________
Physician Signature (* Required for Medicaid reimbursement) (Date)

*Financial Authorization

I have reviewed and authorize payment for the above listed early intervention services as defined in the *Individuals with Disabilities Education Act* (IDEA) *Reauthorization*, Public Law 108-446, Part C.

_______________________________________ ______________

Lead Agency Authorizing Signature (Date)

Team Members

________________________ 's plan was developed by the following people:
(Child's Name)

Name/Signature	Role	Address	Phone
	Parent		
	Service Coordinator		

Others who may be helpful to the IFSP team: (If primary health care provider is not listed above, please include below)

Name	Role	Address	Phone